

23 April 2019

Professor Bruce Robinson
Chair, MBS Review Taskforce

E: MBSReviews@health.gov.au

Dear Professor Robinson,

Re: Medicare Benefits Schedule (MBS) Review - Pain Management Clinical Committee Report

The Royal Australian College of General Practitioners (RACGP) thanks the Pain Management Clinical Committee for the opportunity to provide feedback on its draft report.

The RACGP's response covers the following:

1. The integral role of general practitioners and primary care
2. Patients with multimorbidity
3. Prescribing
4. Mental health care plans
5. New Medicare Benefit Schedule items
6. Improved access to multidisciplinary teams

1. The integral role of general practitioners and primary care

Australians access general practice more than any other area of the health system, with 87.8% of the population visiting their general practitioner (GP) at least once each year¹. The basis for effective chronic pain management is a strong, continuous therapeutic doctor-patient relationship² and integrated multidisciplinary care.

GPs are best placed to manage and review these complex patients, given the GP's regular contact with the patient, accessibility, and knowledge of the patient's medical history. The essential role of GPs in this process cannot be overlooked. GPs ensure that patients are triaged appropriately, acting as an important steward to ensure that limited healthcare resources are allocated wisely.

Recommendation 27 – Access to appropriately trained allied health services (p 71)

It is crucial that GPs are included and directly involved in a patient's chronic pain management in order to find appropriate solutions that are achievable, fully implemented and integrated throughout the whole health system. Bypassing GPs would not solve the problem of fragmentation of care. In fact, fragmentation would be further exacerbated, particularly in the case of patients with chronic pain, which is not an isolated condition. A whole patient approach is important in patients who have multiple chronic conditions, who require complex coordination and management.

Access to specialised pain units can be extremely restricted. The GP is often the only medical practitioner that a patient with chronic pain has timely access to. Any changes to the MBS items should acknowledge that patient access to pain management is not always straight-forward.

Deskilling and distancing GPs from the care of these vulnerable patients would also have a negative effect, particularly when they return to the GP after the specialist care is no longer warranted.

The RACGP does not support recommendations that other specialists refer patients directly to allied health professionals, without consultation with the patient's GP. This will distance GPs from the management of this serious medical, social and economic problem.

2. Patients with multimorbidity

The majority of the draft report focuses on pain as a single condition. Most chronic pain patients have complex needs and require treatment for other conditions alongside their chronic pain. Patients with multiple health concerns are best managed by a generalist physician who has excellent knowledge of the patient's biopsychosocial condition and can provide accessible, longitudinal care. In Australia, this is the role of the GP.

3. Prescribing

The draft report does not comment on prescribing responsibilities. The report also references a 'chronic pain specialist' but it is unclear who this is. The patient's GP would be most appropriate to manage and review the patient's prescriptions.

4. Mental health care plans should be developed according to the needs of individual patients

The RACGP recognises that mental health problems are often a consequence of chronic pain. Rebate systems for chronic pain should acknowledge that some patients will need access to complex multidisciplinary care without a GP Mental Health Treatment Plan.

The RACGP recommends in the guideline *Prescribing drugs of dependence, Part C2: The role of opioids in pain management* that:

Psychological approaches aim to increase self-management, behavioural change, and cognitive change rather than directly eliminate the locus of pain. Psychologist intervention is advocated for assessment and management of selected presentations².

It is also unclear how a Multidisciplinary Pain Management Plan founded on a mental health care plan provides better access to physiotherapy and occupational therapy services. This requires further clarification from the Committee.

5. Recommendations for new Medicare Benefit Schedule items

Recommendation 26 – Access to multidisciplinary pain management planning (p 66)

The RACGP does not agree on the introduction of a multidisciplinary chronic pain management plan item number or the construction of single-condition item numbers. Existing chronic disease management item numbers, and mental health care item numbers (separately, and together) can be used for chronic pain.

Patients often present with multiple, not single conditions. Existing GP Management Plan (GPMP) and GP Mental Health Treatment Plan items should be optimised to allow team-based and proactive management, with the value of care coordination recognised. Case conferencing, as recommended by the Allied Health Reference Group and the General Practice and Primary Care Clinical Committee Committees would help in this regard, i.e. asynchronous and with rebates for all key attendees to reduce patient out of pocket expenses.

The RACGP rejects the recommendations that require GPs to undertake additional training in order to use any new items. GPs understand the biopsychosocial aspects of chronic pain and the need for multidisciplinary input. These are facilitated by item numbers for accessing private psychology and allied health. The recommendations by the MBS Allied Health Reference Group and the General Practice and Primary Care Clinical Committee to improve case conferencing access and uptake will support patients with chronic pain.

Similarly, these two MBS committees supported stepped care. In stepped care, a GP reassesses patient progress against goals and can request access to further allied health involvement, moving away from a one-size-fits-all approach. GP review is a vital step in this process to ensure patient interests are kept central to focus care on those who most need it.

The RACGP recommends that pain management specialists undertake a significant placement in general practice in order to learn the skills of longitudinal care across the ages, with attention to multimorbidity and use of available community resources.

Fee for service for high need patients

High need patients will benefit from state provided multidisciplinary intensive treatments – for example, those requiring surgical implants and the services of specialised teams. The RACGP recommends there should not be an attempt to use fee-for-service for this narrowly defined group.

6. Improve access to multidisciplinary teams

The RACGP agrees with the proposal to improve access to multidisciplinary teams to address chronic pain, following further review by their GP (for the reasons previously stated in this response). In particular, increasing the number of visits of allied health practitioners from 5 to 10 (as per current Mental health care plans).

The RACGP thanks the MBS Review Taskforce for the opportunity to comment. If you have any further queries please contact Mr Stephan Groombridge, Manager, eHealth and Quality Care on (03) 8669-0544 or at stephan.groombridge@racgp.org.au



Royal Australian College of General Practitioners

Healthy Profession.
Healthy Australia.

Yours sincerely

Dr Harry Nespolon
President

1. The Royal Australian College of General Practitioners. General Practice: Health of the Nation 2018. East Melbourne, Vic: RACGP, 2018.
2. The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management. East Melbourne, Vic: RACGP, 2017.