



Australian Government

Medical Services Advisory Committee

Public Summary Document

Applications 1167 and 1171 – Addiction Medicine Items and Sexual Health Medicine items

Sponsor/Applicant/s: The Australasian Chapter of Addiction Medicine (AChAM) and The Australasian Chapter of Sexual Health Medicine (AChSHM)

Date of MSAC consideration: 1 August 2013

1. Purpose of applications

In October 2010, applications were received from the Australasian Chapter of Addiction Medicine (AChAM) and Australasian Chapter of Sexual Health Medicine (AChSHM), requesting two new (separate) structures of Medicare Benefits Schedule (MBS) items for professional attendances provided by addiction medicine (AM) and sexual health medicine (SHM) specialists.

This followed recognition of AM and SHM as specialties by the Australian Medical Council (AMC) and Australian Government in 2009, with subsequent access to MBS Group A3 specialist professional attendance items approved by the Australian Government from 1 November 2010.

AM and SHM specialists claimed that the MBS Group A3 fee structure did not reflect their contemporary modes of clinical practice.

MBS Group A3 items tend to suit procedural specialties, not discussion-based specialties.

2. Background

At its meeting of April 2012, the Protocol Advisory Sub-Committee (PASC) of MSAC recommended that two independent assessment reports be prepared for MSAC to assess the overall body of evidence for the comparative safety, clinical effectiveness and cost-effectiveness of models of care involving AM and SHM specialists, compared with alternative models of care.

3. Proposal for public funding

Two options were presented for revised MBS funding for each specialty. Both options align with AChAM's and AChSHM's requests, being the introduction of new MBS professional attendance (i.e. consultation) items that allow:

- in the case of AM, delivery of contemporary (evidence-based) interventions for people who have (or are at risk of developing) substance-use disorders or other forms of addiction; and
- in the case of SHM, delivery of contemporary (evidence-based) interventions for

people who have (or are at risk of developing) sexually transmissible infections and/or sexual function disorders.

Both options are very similar within each specialty, with the main difference being configuration of initial and subsequent consultations. Option 1 (for both AM and SHM) used so-called ‘physician-equivalent’ items (detailed assessment/assessment or review items), while Option 2 was based on these consultation items being ‘time-tiered’. The proposed item structures would sit within new MBS Groups (i.e. MBS Group 31 for AM, and MBS Group 32 for SHM) within Category 1 of the MBS.

	<u>Addiction Medicine</u>	<u>Sexual Health Medicine</u>
Option 1	Two (2) consultation items for patient assessment and review (comparable to initial and subsequent consultation items 110 and 116)	Two (2) consultation items for patient assessment and review (comparable to initial and subsequent consultation items 110 and 116)
	Two (2) consultation items for complex patient treatment and management planning (comparable to items 132 and 133)	Two (2) consultation items for complex patient treatment and management planning (comparable to items 132 and 133)
	Two (2) items for telehealth (one short and one long consult, comparable to items 112 and 114)	Two (2) items for telehealth (one short and one long consult, comparable to items 112 and 114)
	One (1) group therapy item (comparable to item 342)	Two (2) consultation items for home visits (comparable to items 122 and 128)
	Eight (8) case conferencing items (comparable to consultant physician case conferencing items 820 to 828)	Eight (8) case conferencing items (comparable to consultant physician case conferencing items 820 to 828)
Option 2	Four (4) time-tiered consultation items for patient assessment and review (with the longest consult having an MBS fee comparable to item 110)	Four (4) time-tiered consultation items for patient assessment and review (with the longest consult having an MBS fee comparable to item 110)
	Two (2) consultation items for complex patient treatment and management planning (comparable to items 132 and 133)	Two (2) consultation items for complex patient treatment and management planning (comparable to items 132 and 133)
	One (1) consultation item for telehealth (comparable to psychiatry MBS telehealth item 288)	One (1) consultation item for telehealth (comparable to psychiatry MBS telehealth item 288)
	One (1) group therapy item (comparable to item 342)	Two (2) consultation items for home visits (comparable to items 122 and 128)
	Eight (8) case conferencing items (comparable to consultant physician case conferencing items 820 to 828)	Eight (8) case conferencing items (comparable to consultant physician case conferencing items 820 to 828)

Currently, there are no specific MBS professional attendance (or case conferencing) items for AM and SHM specialists. AM and SHM specialists currently access MBS Group A3 specialist items 104 and 105 (generally available for procedural specialists), as well as general practitioner (GP) items (if qualified) and consultant physician or psychiatrist items (if qualified). Historically, the needs of patients with substance-use disorders and sexual health issues have been addressed by GPs, in consultation with a range of medical specialists (including psychiatrists and infectious disease physicians).

GPs will continue to provide the majority of patient interventions, with more complex cases being referred to AM and SHM specialists. Specialists in other areas will continue to be required for patients with highly complex or specific needs.

4. Proposed intervention's place in clinical management

Medical conditions addressed by the new AM specialty include (but are not necessarily limited to) patients with substance-use disorders arising from legally or illegally obtained alcohol, opioids, cannabis, stimulants, hallucinogens and benzodiazepines. AM specialists have the capacity to address the comprehensive bio-psycho-social needs of patients with substance use-disorders across the continuum of care. AM specialists are available to offer advice and support, specialist patient consultations, intensive treatment for acute conditions, and ongoing management of complex and 'challenging' patients with substance-use disorders.

The primary contribution of SHM specialists is their capacity to identify the complex range of needs for people experiencing sexual-health-related problems, and implement or otherwise coordinate an appropriate combination of evidence-based interventions to successfully manage these problems (e.g. sexually transmissible infections (STIs), blood borne viruses or sexual dysfunction), and minimise their impact on affected individuals.

5. Evidence to support increased MBS funding for ADDICTION MEDICINE consultations

There is no specific evidence that proves a particular structure of consultation items (as recommended in Option 1 or 2) will have a direct impact on health outcomes. However, the literature demonstrated the effectiveness of a range of pharmacological and psychosocial interventions for addiction-related conditions.

A total of 89 studies of the highest levels of National Health and Medical Research Council (NHMRC)-rated evidence (Levels I and II) were reviewed to evaluate the clinical effectiveness of interventions provided for substance abuse (and selected other addiction-related) disorders.

Evidence also indicated that an appropriate mix of interventions is required in order to maximise the likelihood of success for patients with addiction-related conditions. A number of therapeutic combinations have been demonstrated to result in more successful treatment outcomes, for example:

- pharmacotherapy for methadone maintenance with psychological counselling;
- pharmacotherapy for smoking cessation with behavioural intervention; and
- combination psychological therapies (counselling and coping skills training) for cannabis dependence.

Outcomes of other interventions have been identified to be more successful when delivered in specialist (rather than primary care) settings, such as:

- substance detoxification;
- cognitive behavioural therapy;
- contingency management interventions;
- community reinforcement approaches; and
- motivational enhancement therapy.

The contracted assessment report concluded that qualitative reports demonstrate that patients will benefit from new addiction medicine MBS items because:

- the items will allow delivery of the same standard of care available in the public sector;
- the items will meet needs of patients who are unwilling to attend public clinics;
- the items will promote workforce development and increase access to services for patients;
- the items will support the capacity of GPs to deliver effective care; and
- patient out-of-pocket costs will be less, with overall costs compared with other specialists treating substance-use disorders in the private sector.

6. Evidence to support increased MBS funding for SEXUAL HEALTH MEDICINE consultations

There is no specific evidence that proves a particular structure of consultation items (as recommended in Option 1 or 2) will have a direct impact on clinical and public health outcomes.

However, the literature demonstrated clear evidence for the effectiveness of a range of interventions for sexual health conditions. There is strong (Levels I and II) National Health and Medical Research (NHMRC)-rated evidence in the scientific literature for the effectiveness of pharmacotherapy and other interventions for sexual health conditions.

Evidence indicated that an appropriate mix of interventions is required in order to maximise the likelihood of success for patients with sexual health problems. A number of therapeutic combinations have been demonstrated to result in more successful treatment outcomes, for example:

- pharmacotherapy for erectile dysfunction, with psychological counselling; and
- pharmacotherapy for genital or pelvic pain, with behavioural intervention.

Outcomes of other interventions have been identified to be more successful when delivered in specialist (rather than primary care) settings, such as:

- management of more complex drug regimens, such as those required for HIV/AIDS or viral hepatitis;
- cognitive behavioural therapy when combined with other therapies;
- when more comprehensive laboratory investigations and other evaluations are required;
- when there are other factors complicating the presentation of the patient's problem; e.g. erectile dysfunction in young patients with a history of pelvic or perineal trauma or congenital penile deformity; and
- when there is a request from the patient or a medico-legal requirement for further evaluation (Review – no NHMRC level of evidence, Wagner et al 2002).

There is a more limited body of evidence examining the safety of clinical interventions provided by different medical specialists. Qualitative reports from specialists, and descriptive reports in the peer-reviewed literature, consistently emphasise that the relative safety of interventions provided to patients with sexual health problems requires:

- knowledge of the wide range of issues associated with sexual diseases, prescription medications and sexuality; in addition to
- the capacity to intervene in a manner that reduces the likelihood of identifiable risks developing or impacting on patients and others in the community (e.g. through transmission of infectious diseases).

Therefore, from the available evidence, services provided by SHM specialists are possibly safer and more effective than the same services provided across a range of different specialties.

7. Key Issues for MSAC from ESC

Workforce issues

ESC expressed concern about viability of these new specialties, which are in their infancy. In Australia in 2013, around 142 of a total of 174 working AM specialists, and 113 of a total of 132 working SHM specialists, are below retirement age. The average age of an AM specialist is 58 years, while the average age of an SHM specialist is 56 years. When combined with only 2 to 3 new trainees entering these specialties per annum, the future workforce may not be able to meet the expected increase in patient demand, or the needs of GPs (and other practitioners) for expert AM and SHM advice. Improved MBS rebates may provide an incentive for trainees to enter (and remain in) the AM and SHM specialties, rather than electing to work in specialties in which they believe their expertise is more appropriately remunerated. ESC discussed whether there was a reasonable price for a specialist's services, especially where the specialist relies on patient discussions/education (rather than 'fee-for-service' surgical interventions) to achieve improved clinical and public health outcomes.

Public/private shift

Most AM and SHM services (70%) are currently provided through public clinics. If these new private services are funded through the MBS, there may be an economic incentive for some service provision to be shifted to the private sector, but ESC did not expect this shift would be large if public sector clinics remain in operation. However, ESC expressed some concern that an increased percentage of services provided in public clinics may be billed to these new MBS services. Agreement was reached that this is a broader cost-shifting issue.

Risk of GP-to-specialist item creep by AM and SHM specialists

ESC discussed the risk of current AM and SHM specialists (who are treating patients suffering from addiction and sexual health issues in their capacities as GPs) moving all of their treatment to these new specialist items (i.e. a GP who is also an AM or SHM specialist sees their patient for a regular GP issue, but bills the new AM or SHM specialist items because the patient also happens to be their AM or SHM patient).

ESC agreed this would be a risk with all dual qualification practitioners, but noted that these new services are referred services, so should relate to particular episodes of AM and SHM care, with clinical case notes reflecting this. ESC also agreed that, given these patients are likely to have complex needs, what might normally be considered a routine visit to a GP may be compounded by the variety of medications these patients are taking.

Time-tiered versus modified physician-equivalent item structure

ESC did not express a strong view about its preference for Option 1 (involving modified physician-equivalent consultation items) or Option 2 (involving time-tiered consultation items). Discussion included:

- The proposed 'modified' physician-equivalent structure for AM and SHM would allow a higher rebated item (i.e. Group A4 consultant physician 'initial' item 110) to be billed once, but at any time during an episode of care (unlike other 'consulting' practitioners who must bill their item 110-equivalent for the 'initial' consultation). This billing flexibility would fit patients' needs within these particular specialties (given pharmacotherapy is often the starting point, and (more time-consuming) psychotherapy is needed later in an episode of care).
- AM specialist clinical practice is similar to psychiatrists, so time-tiered may be more

appropriate. However, the AM assessment report indicated a preference for the traditional structure for AM specialists. ESC agreed that, if AM specialists were to have a different structure from SHM specialists, the issue may need further exploration.

- ESC saw some merit in creating new structures for each of these new specialties (as opposed to locating the new items in a generic structure). Separate MBS groups for these specialties would provide clear data on consultation activity within AM and SHM. However, ESC also discussed the current number and complexity of MBS item groupings, allocated by practitioner type within Category 1 of the MBS.

Outcomes for patients

ESC discussed whether individual patient and broader public health outcomes would be improved if a patient only needed to consult one expert specialist (in this case, AM or SHM), as opposed to a range of other doctors (given evidence showed, in the absence of AM and SHM specialists, patients need to consult at least two specialists). The assessment reports presented evidence that, in the absence of an AM or SHM specialist in a patient's clinical journey, unnecessary GP consultations and incorrect pharmacotherapies could disrupt a patient's path to health.

ESC commented that the assessment reports could have provided more financial evaluation of potential reductions (or increases) in flow-on costs associated with AM and SHM specialists. For example, if improved MBS funding results in (gradual) increases in the numbers of AM and SHM specialists, would an episode of care involve additional MBS GP costs (for referrals), additional MBS psychiatrist and/or psychologist costs (for psychotherapy), and PBS costs (for pharmacotherapy). Or alternatively, would an increase in availability of AM and SHM specialists result in more targeted, streamlined care, with fewer GP (and other specialist) visits and fewer negative outcomes from adverse pharmacotherapy interactions.

The assessment reports demonstrated that the quality of inputs (and outputs) is improved when AM and SHM services are provided by AM and SHM specialists. The assessment reports reviewed high level (Levels I and II NHMRC-rated) evidence that demonstrated contemporary (evidence-based) AM and SHM treatments produce quality outcomes. Lower level evidence (survey results), both published and unpublished, demonstrated that GPs are reluctant (i.e. feel uncomfortable or unskilled) when dealing with more complex AM and SHM issues (for example, complex psychosocial issues in AM, and in SHM, an ageing cohort of patients with HIV/AIDS, suffering from multiple morbidities).

The reports compared the most similar specialists (psychiatrists for AM, and infectious disease physicians for SHM) to demonstrate slightly reduced MBS costs (and patient out-of-pocket costs) when AM and SHM specialists treat AM and SHM issues.

Has a case been demonstrated to justify increased MBS funding

ESC agreed that AMC had already demonstrated that AM and SHM specialists provide valuable expert inputs to improve clinical outcomes for patients. ESC agreed that these patient populations are often disenfranchised due to the complexity (and social effects) of their conditions.

ESC agreed that AM and SHM specialists provide GPs with alternative (and appropriate) pathways for patients (similar to pain and palliative medicine specialists, who have had access to their own group of consultant-physician equivalent MBS items since 2006). AM and SHM specialists also provide GPs with a source of specialist expert advice about contemporary medications and treatments.

ESC was aware that (if these services were approved by Government) it would take time for workforce numbers to increase, meaning it is unlikely that AM and SHM services (and associated MBS expenditure) would increase in an unsustainable manner in the short to medium term.

ESC also noted that it would be useful if future assessment reports dealing with consultation items include additional background and/or history on ‘related’ adjacent items on the MBS. This would facilitate consideration of the context in which proposals for new MBS items are being considered, rather than viewing them as stand-alone items.

8. Financial/budgetary impacts

Estimated MBS expenditure

	TOTAL MBS \$ over four years <i>OPTION 1</i> <i>(Modified traditional consultant physician structure)</i>	TOTAL MBS \$ over four years <i>OPTION 2</i> <i>(Time-tiered structure)</i>
Addiction Medicine	\$10.4 million	\$10.2 million
Sexual Health Medicine	\$10.1 million	\$11.8 million

9. Summary of consideration and rationale for MSAC’s advice

MSAC noted that applications were received from the Australasian Chapter of Addiction Medicine (AChAM) and Australasian Chapter of Sexual Health Medicine (AChSHM) in 2010, both requesting increased fees via a new structure of Medicare Benefits Schedule (MBS) items for professional attendances provided by addiction medicine (AM) and sexual health medicine (SHM) specialists. Due to similarities between the applications, MSAC agreed to consider the applications together.

Prior to creation of both these specialty groups, MSAC noted that patients with substance-use disorders and sexual health issues would have been attended to by GPs, in consultation with a range of other medical specialists (including psychiatrists and infectious disease physicians). With contemporary practice, MSAC agreed that GPs would continue to be involved with primary care of the patient, however more complex cases would likely be referred to AM and SHM specialists. MSAC acknowledged that these new specialties were recognised and accepted by the Australian Medical Council in 2009, and the Australian Government in 2010, and that both are currently able to access MBS Group A3 specialist professional attendance items. However, both specialties claim that this fee structure does not reflect their current clinical practice, as MBS Group A3 items suit procedural specialties, not discussion-based specialties.

Two options for a new MBS structure were proposed for each specialty (AM and SHM). Option one proposed ‘modified traditional structure, physician-equivalent’ items (detailed assessment item, plus assessment/review item), while Option two is based on the consultation items being ‘time-tiered’, but still at ‘physician-equivalent’ rebate rates. MSAC acknowledged that there is no traditional evidence base to evaluate whether a particular structure of consultation items will have a direct impact on clinical and health outcomes.

For AM, 89 studies were reviewed to evaluate the clinical effectiveness of interventions provided for substance abuse (and selected other addiction-related) disorders. Based on this

evidence, MSAC noted that a mix of interventions, such as pharmacotherapy for methadone maintenance with psychological counselling, is likely to be required for more successful treatment outcomes for patients with addiction-related conditions. Outcomes of interventions, such as substance detoxification, may potentially be more successful when delivered in specialist (rather than primary care) settings.

For SHM, studies were evaluated for the effectiveness of pharmacotherapy and other interventions for sexual health conditions. Based on this evidence, MSAC noted that a mix of interventions, such as pharmacotherapy for erectile dysfunction with psychological counselling, is likely to be required for more successful treatment outcomes for patients with sexual health-related conditions. Outcomes of interventions, such as cognitive behavioural therapy when combined with other therapies, may potentially be more successful when delivered in specialist (rather than primary care) settings.

For SHM specialists, the available evidence suggests that services are possibly safer and more effective than the same services provided across a range of different specialties. However, MSAC noted there is limited evidence examining the safety of clinical interventions provided by different medical specialist services.

Overall, MSAC considered that services provided by AM and SHM specialists would likely provide better outcomes for management of complex patients.

MSAC noted that there appears to be a substantial demand for AM and SHM services, particularly in rural and remote areas where there is limited access to these specialists, with trends showing increasing patient demand across all substance-use disorders and reportable sexually transmitted infections. MSAC agreed this could impact on the future workforce of both AM and SHM specialists being able to meet the expected increase in patient demand, especially if (as the submissions claim) new trainees are difficult to attract to a discussion-based (non-procedural) specialty, with patient rebates lower than GP rebates. However, MSAC noted that there is no evidence that adding the requested MBS items would improve this situation.

MSAC considered that sufficient evidence was presented to support increased public funding for AM and SHM professional attendance items. Taking into account the psychiatric component of AM services, MSAC considered that a new structure of 16 time-tiered MBS items was appropriate for AM services, with rebates aligned with consultant-physician rates. For SHM specialists, MSAC considered that a new structure of 16 modified traditional structure 'consultant physician-equivalent' MBS items was appropriate, based on similarity with the services provided by infectious disease physicians.

MSAC noted that the estimated total cost of the proposed new structures to the MBS over 4 years was \$10.2 million for AM specialists and \$10.1 million for SHM specialists.

MSAC's advice to the Minister

After considering the strength of the available evidence in relation to the safety, clinical effectiveness and cost-effectiveness of Addiction Medicine and Sexual Health Medicine consultation items, MSAC supports public funding of 16 new time-tiered MBS items for AM services and 16 new modified traditional structure 'consultant physician-equivalent' MBS items for SHM services.

10. Applicant's comments on MSAC's Public Summary Document

No comment.

11. Context for decision

This advice was made under the MSAC Terms of Reference.

MSAC is to:

Advise the Minister for Health and Ageing on medical services that involve new or emerging technologies and procedures and, where relevant, amendment to existing MBS items, in relation to:

- the strength of evidence in relation to the comparative safety, effectiveness, cost-effectiveness and total cost of the medical service;
- whether public funding should be supported for the medical service and, if so, the circumstances under which public funding should be supported;
- the proposed Medicare Benefits Schedule (MBS) item descriptor and fee for the service where funding through the MBS is supported;
- the circumstances, where there is uncertainty in relation to the clinical or cost-effectiveness of a service, under which interim public funding of a service should be supported for a specified period, during which defined data collections under agreed clinical protocols would be collected to inform a re-assessment of the service by MSAC at the conclusion of that period;
- other matters related to the public funding of health services referred by the Minister.

Advise the Australian Health Ministers' Advisory Council (AHMAC) on health technology assessments referred under AHMAC arrangements.

MSAC may also establish sub-committees to assist MSAC to effectively undertake its role. MSAC may delegate some of its functions to its Executive sub-committee.

12. Linkages to other documents

MSAC's processes are detailed on the MSAC Website at: www.msac.gov.au.