Integrating Complementary and Mainstream Medicine

7th August 2011

Re: PSR senate enquiry 2011

The Australasian Integrative Medicine Association (AIMA) is pleased to contribute to the PSR senate enquiry with concerns raised by a number of our members.

About the AIMA

The AIMA is an independent not for profit organisation of individual medical practitioners seeking to provide whole person medical care by integrating evidence-based complementary medicine into mainstream practice. AIMA is supported by its membership and governed by a Board of voluntary doctors and academic leaders in the field of integrative medicine. According to a national survey of Australian GPs by the National Prescribing Service in 2009, there is rising number of Australian GPs, over 30%, who describe themselves as practising Integrative Medicine (IM) and CMs and the majority of doctors (>80%) surveyed requested more education in IM and CM.[1] This survey indicates that a large proportion of our GP peers are integrating complementary medicine into their clinical practice.

Since its inception in 1992, AIMA has grown to be the leading voice for integrative medical practitioners, the majority of whom are GPs. AIMA has forged relationships with key organisations such as the RACGP, TGA and AMA as well as other professional bodies with an interest in integrative therapies. Currently AIMA is recognised as a special interest group and works closely with the RACGP via a Joint Working Party and through the Integrative Medicine Network. AIMA values its work with the RACGP in setting standards in this area and creating training and education programs for GPs to learn about CM and IM. This is supported by the RACGP. Please refer to the RACGP-AIMA Joint Position Statement of the RACGP and AIMA, and the IM Curriculum Statement posted on the RACGP website. [2], [3] AIMA hopes to improve the understanding of CMs by medical practitioners.

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[1] Brown J, Morgan T, Adams J, Grunseit A, Toms M, Roufogalis B, Kotsirilos V, Pirotta M and Williamson M. Complementary Medicines Information Use and Needs of Health Professionals: General Practitioners and Pharmacists. National Prescribing Service, Sydney, December 2008 http://www.nps.org.au/research_and_evaluation/research/current_research/complementary_medicines/complementary_medicines_report

[2] RACGP-AIMA Joint Position Statement of the RACGP and AIMA, Complementary Medicine, 2004 http://www.racgp.org.au/Content/NavigationMenu/Advocacy/RACGPpositionstatements/2006compmedstatement.pdf

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AIMA seeks to ensure both practitioners and consumers have access to the best available knowledge about the benefits and risks of these modalities so that optimal patient care and good health can be achieved and maintained, and to ensure proper informed consent for use of these therapies.

AIMA works with medical practitioners, medical students and complementary therapists to:

- Promote the practice of evidence based integrative medicine
- Act as a peak peer body for medical practitioners with an interest in integrative medicine
- Maintain the role of the medical practitioner as the primary care provider whilst working in a multidisciplinary team of other health providers
- Collect and circulate research and other information relating to the mainstream and complementary medicine profession to members
- Encourage the practice of ethical non-pharmaceutical approaches when appropriate
- Act as an advisory body to government and medical bodies in the formation of policies relating to integrative medicine
- Promote improvements or changes in the law relating to medical practice where appropriate
- Provides support for Medical Student Associations with an interest in Integrative Medicine.

In addition, the AIMA provides its members with regular Journals, as well as hosting the annual Integrative Medicine Conference. AIMA is responding to the increasing demand by the community and the body of general practitioners to learn more about evidence-based complementary medicine. AIMA's membership continues to grow and our role becomes ever more important.

Senate enquiry report from AIMA

AIMA acknowledge the continued efforts of Medicare and PSR to provide a safeguard for the public and patients against inappropriate medical practice in Australia and their efforts in working with GP stakeholder groups. In a letter from Dr Tony Webber, director of the Professional Services Review dated 6 August 2007, it was acknowledged that the RACGP and AIMA are regarded as the peer reference group bodies for general practitioners who practice in the area of IM and CM.
However, as AIMA members are more likely to do more longer consults to provide lifestyle advice and comprehensive care, particularly for patients with chronic diseases, and some are more likely to do testing for nutritional deficiencies such as iron and vitamin D and for celiac screening, they are a high risk for auditing by Medicare and subsequent referral to the PSR. AIMA are grateful to Medicare and the PSR for recent discussions to help address these issues, however, our members continue to be audited with subsequent referral to the PSR. Consequently it is for this reason AIMA is submitting a report into the enquiry as these issues are relevant to members of AIMA.

Yours faithfully,

Prof Kerryn Phelps
President AIMA

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[3] Integrative Medicine Statement. See Statement Chapters in RACGP Curriculum for Australian General Practice. http://www.racgp.org.au/curriculum

Professional Services Review enquiry

The following points summarise AIMA's concerns with our current PSR system denying natural justice to our members. We have also covered concerns by our current MEDICARE system that subsequently leads to referral to the PSR.

1. **Medicare auditing for longer consultations**

   Auditing GPs who use more item numbers for longer consultations (e.g. item 36/44) by Medicare is a disincentive to do more long consults, when the evidence supports the benefits of long consultations in improving clinical outcomes for patients, particularly for those with chronic diseases. AIMA are aware that some doctors are using items 23 in place of item 36 or 44, despite spending the extra time with patients who suffer a number of diseases or difficult, chronic diseases, to avoid being audited by Medicare. The current Medicare system financially rewards shorter consultations and there is no evidence to suggest that shorter consultations provide better clinical care. In fact the evidence is to the contrary. Longer consults are preferred by patients and can improve clinical outcomes particularly for patients with chronic diseases. There is also no evidence to suggest doctors doing quicker consults such as 6-10 minute consults, fulfil the item 23 Medicare requirements with good notes, adequate history taking and physical examination, more so than doctors who do longer consults.

   Using more longer consultation item numbers such as item 36 and 44 are an indicator for Medicare auditing and AIMA believe this is unfair. Why are doctors not being audited for doing more 6-10 minutes which is much more costly to Medicare? What is the evidence that suggests doing more 6-10 minute medicine provides better quality care than GPs who do 30-60 minute medicine?

   GPs that see more patients with chronic diseases are more likely to use longer consult item numbers but also, more likely to use the Enhanced Primary Care item numbers. This too is also a trigger for Medicare auditing.

2. **Medicare auditing creates stress and anxiety**

   Medicare auditing and referral to the PSR creates undue stress for GPs. AIMA members who have been through Medicare auditing and referral to the PSR have experienced extreme anxiety and stress as result of the process despite whatever the outcome has been i.e. whether they were referred to the PSR or not.[4] Recently the MJA highlighted research that has shown "audit anxiety" is one of the major reasons for a drop in level C and D consultations in preference of the shorter level A and B consults.[5]

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[4]Scott Masters: Medicare needs an audit. Posted 29 November 2010. http://www.mjainsight.com.au/view?post=scott-masters-medicare-needs-an-audit&post_id=1872&cat=comment

[5] Taylor MJ, Horey D, Livingstone C, Swerissen H. Decline with a capital D: long-term changes in general practice consultation patterns across Australia. MJA 2010 Jul 19;193(2):80-3.

"The decline in the use of Level C and D consultations in recent years has been dramatic and accompanied by an increase in use of Level A consultations. While the use of special items has offset the decline in long consultations, this compensating effect has weakened in the past 2 years. This pattern is at odds with health policy objectives that rely on long consultations to provide preventive care and chronic disease management."[5]

Consequently one million less long consultations occurred due to GPs concerns about being targeted by Medicare and subsequent referral to the PSR – this does not bode well for people with chronic health problems and contradicts the Health Minister Nicola Roxon's stated aim of increasing the length of consultation time with patients.

AIMA believe increased transparency and review of the Medicare audit process, with more debate about the assumptions used in the audit process especially that all GPs are the same, is urgently required. AIMA appreciates recent efforts consisting of meetings and email correspondence with senior staff of Medicare to address some of these issues.

3. GPs with a special interest in certain fields

It is our experience that GPs that specialise in certain fields such as counselling, hypnosis, acupuncture, musculoskeletal or nutritional medicine are often targets for Medicare auditing and referred to the PSR. Yet, it is not uncommon for Medical Specialists to move into sub-specialty areas. For instance, gynaecologists who solely practice in the field of doing just gynaecological ultrasounds alone, dermatologists who only practice cosmetic surgery or have an interest in skin cancer, cardiologists who have a particular interest in hypertension. Like Medical Specialists, GPs may develop an interest in a particular field during their working life and should be valued as contributing to the overall health care system. It is of interest that Medical Specialists are responsible for more than 50% of Medicare expenditure yet account for less than 5% of referrals to the PSR. The Medicare and PSR need to acknowledge the growing number of GPs who, like Medical Specialists, specialize in particular fields and that they too constitute part of the peer body of GPs. They need to be adequately represented by peers with similar interests for Medicare auditing and if necessary on the PSR panel.

4. **Lack of True Peer representation on the PSR panel**

The AIMA are a special interest group of the Victorian AMA and have representation on the Victorian AMA council and close links to the federal AMA. By not consulting with AIMA and the AMA to appoint appropriate peer representation on the PSR panel, denies the right of our members to have true and appropriate peers to fairly assess their clinical work. AIMA believe improved transparency of the PSR referral process is required.

5. Lack of procedural fairness of the PSR process

Apart from lack of true representation and peers on the panel, currently there is no practical appeal mechanism.

6. Growing body of scientific evidence in Integrative Medicine

There is a growing body of scientific evidence for some areas of Integrative Medicine including acupuncture, musculoskeletal medicine, nutritional and some areas of herbal medicine. If PSR panellists are not familiar with the evidence in these areas, then how are

they to fairly understand the work of the GP who are working and specialising in these fields?

7. **Role of pathology testing for chronic disease management and referral to the PSR**

   The level of pathology testing, such as for Vitamin D and Coeliac screenings, above the general body of peers, are indicators for auditing by Medicare and potential referral to the PSR. Consequently GPs who see more patients with concerns in these areas are likely to be audited. Yet, there are Nutritional medical specialists who are not likely to be subjected to the same auditing for excessive testing in these areas as are GPs. In fact, Medical Specialists are rarely likely to be subjected to excessive testing as it is a part of their standard practice. Vitamin D testing is supported by a growing body of convincing research particularly in high risk groups such as dark skinned people, elderly in institutions and those who avoid the sun, and in people who live in high risk areas (especially lower latitudes of Australia).Vitamin D testing is supported by leading experts in the field as vitamin D plays an important role for the prevention of diseases such as multiple sclerosis, osteoporosis and falls in elderly, and deficiency is a risk factor for the development of diseases such as depression, cardiovascular disease, lowered immunity, Parkinson's disease, allergies and some cancers.
   It would be of interest to examine the TOTAL cost to Medicare for integrative medical practitioners (i.e. total cost of consultation rebates, referral to specialists, referral for imaging, prescriptions as well as pathology) and how this compares with that of our 'peers' should anyone be flagged for any audit process in the first place.

   It would also be useful for Medicare to provide statistics to every doctor annually or maybe each triennium so that our members can compare with our peers.

8. **Privacy issue**
   The recent legislative changes to the Health Act that allows Medicare non-medical bureaucrats' access to patient files without the patient's permission is a great concern to AIMA.