9 June, 2000

Ms Shelley McInnis
Inquiry Secretary
Family & Community Affairs Committee
Room 1 – 106
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Ms McInnis

**House of Representatives Standing Committee on Family & Community Affairs.**
**Substance Abuse in Australian Communities**

The Inner Eastern Melbourne Division of General Practice is pleased to make this submission to the Committee on what is clearly an important matter for the community and of great significance to General Practitioners (GPs) in Australia.

Our submission addresses the role of the GP in the management of people with addictive disorders, in general, and specifically addresses the last term of reference of the committee regarding 'health care costs'. Three areas of the costs of providing services are identified that require specific consideration.

## The Inner Eastern Melbourne Division of General Practice

Inner Eastern Melbourne Division of General Practice (IEMDGP) is one of 31 Divisions of General Practice in Victoria funded by the Commonwealth Department of Health and Aged Care. IEMDGP represents 325 General Practitioners who live and work in the Inner Eastern parts of Melbourne.

Our role is to provide services to GPs; assist GPs to service their patients better and thereby improve Population Health. Continuing Medical Education is a key part of our role. The Division has portfolios in Adolescent Health, Aged Care, Cardiovascular Disease, Immunisation, Mental Health, and in Substance Abuse and Addictive Disorders and uses a multi-disciplinary approach to achieve demonstrable outcomes.

IEMDGP works collaboratively with a number of allied health providers and other Divisions across the eastern region to achieve its goals which include:

- Maintain the pivotal role of General Practice in the Health system.
- Optimize the GPs role as primary advocates for their patients.
- Ensure that the division's activities improve the health of the community.
- Identify what GPs need to function effectively.
- Enhance General Practice as a vocation and profession.

IEMDGP achieves these goals by encouraging GPs to work together and link with other health professionals to upgrade the quality of health service delivery at the local level.

**The Division's Interest & Experience in drug & alcohol matters**

The Division has a broadly stated mission to assist its members in a variety of ways to improve the health outcomes of the local population.

Given the prevalence of addictive disorders in all communities, the interest in these matters and the central role for GPs in both the treatment and prevention of addictive disorders, the Division has given considerable emphasis to these issues as part of its ongoing role.

In particular, the Division has:

1. Established a Substance Abuse and Addictive Disorders Committee. The Terms of Reference are attached.

2. Conducted a Methadone Maintenance Treatment Training Course for 11 GPs and developed a mentoring process for these GPs.

3. Collaborated with local service clubs and Eastern Drug & Alcohol Services (EDAS) in establishing a specialized methadone clinic in the City.

4. Participated on relevant local organizations / committees e.g. ACCESS Shared Care Project, City of Boroondara Drug Action Plan.

5. Promoted community education in drug and alcohol issues at its display at the Kew Festival, 2000.

6. Collaborated with EDAS in mounting a public forum on drug and alcohol issues with Professor David Penington.

**Why GPs are central to the management of drug & alcohol problems in the Australian Community.**

We see the role of the local GP as being integral to the management of the majority of addictive disorders in the Australian Community. While there are a variety of professional and peer groups concerned with patient care, and GPs will always wish to integrate their core services with these groups, GPs are in a unique position to influence the health care of patients with addictive disorders and as a consequence, have a significant impact on the total costs of health care to this population;

**1 Addictive disorders are chronic and relapsing conditions.**

Many patients will require numerous interventions over the years for the management of the effects of their addictions. GPs are the central focus of the Australian health care system and are in a strategic position to manage and coordinate the episodic nature of the management of the patients and provide a central focus for the coordination of their care. With coordination, there is a reduction in the duplication of both medical and non-medical services and a reduction in the costs of a chaotic, non-coordinated approach.

**2 GPs are family focussed.**

A particular strength of General Practice in Australia is its focus on the management of families throughout the life cycle. Given the etiology of addictive disorders and their impact on family life, GPs are in a strong position to limit the immediate impacts of addictive disorders on the family, to put in place preventative strategies, to identify families 'at risk', and to help put in place early intervention strategies. This approach is of particular relevance to patients and their carers with 'dual diagnoses'. Early intervention, facilitated by GPs, not only reduces the distress of the addicted patient, but may also help to reduce the overall costs to the community of the addictive disorders. Models of early intervention in psychotic illnesses, for example, indicate better outcomes for patients and their carers as well as reducing institutional admissions and subsequent costs to both the public and private sectors.

**3. Patients with addictive disorders have concurrent medical problems.**

In addition to patients with 'dual diagnoses', most patients will have concurrent medical problems of varying levels of severity. GPs are ideally placed to manage these conditions according to acceptable 'benchmarks', eg. guidelines have been published for the management of Hepatitis C by GPs. With this approach, only appropriate patients will need to be referred to highly specialised medical services. Again the 'gate keeper' role of GP into the tertiary (and expensive) health system is reinforced.

**4. Many patients with addictive disorders have relatively minor problems that can be Identified at an early stage by GPs.**

In particular, the management of depression and anxiety, that may be compounding the patient's (and their carer's) problems, but may not be life threatening, is ideally managed by GPs using both medication and psychological supports. GPs are very aware of the containment of costs of the Pharmaceutical Benefit Scheme and the coordinated, GP focused approach argued for in this submission is congruent with other health care primary policies that aim to contain costs associated with prescription medications.

**5. Historically, GPs in Australia have been interested in the addictive disorders and managing their impacts on individuals and families.**

Recently, this traditional clinical interest has been expanded to include for GPs, a concept of the population health aspects of addictives and an evolving interest by GPs to become involved in health education and health promotion aspects of addictive disorders. In general, the GP has high credibility in the eyes of the public in these matters and is ideally placed to work with colleagues in developing effective education and early intervention strategies.

**6. GPs work in the primary care sector, which includes drug and alcohol services.**

A traditional role for GPs in Australia has been as an 'interface' between the primary care medical system and community agencies concerned with a comprehensive psycho-social approach to health care. The management of patients (and families) with addictive disorders is a natural extension of the GPs role in working collaboratively with others. Many patients expect their GP to facilitate their entry into the broader system at a level appropriate to their medical needs and psycho-social situation. A 'seamless' transition from medical services to other health care services reduces the stress for patients and families and contains unnecessary costs associated with the provision of inappropriate care.

**7. GPs normalise issues concerned with addictions.**

By seeing the assessment, diagnosis, management and rehabilitation of the addicted person as a normal part of family practice, GPs can go a long way in reducing the stigmatisation of the patient and family with an addictive disorder. Australia's approach to the management of AIDS/HIV has clearly illustrated that a process of normalisation of a serious medical problem means that patients seek care earlier and that the possibilities for early intervention (both clinically and educationally) are reinforced. The ongoing role of the GP in the management of addictions as part of a comprehensive medical service to Australian families, should ensure a similar outcome for this population. In the long term, earlier identification, intervention and rehabilitation means better outcomes for patients and with the expectation of the containment of health care costs.

### 8. GPs role in new treatments.

Significant advances are being made in the pharmacological management of both alcohol and opiate dependent patients. New and effective therapies are being promoted to GPs for the management of their patients in the primary care setting. It is likely that the appropriate use of these medications, by GPs, will reduce the overall burden of the impact of these disorders on the costs of Australian health care, and on the productive capacity of the community.

## Some specific Issues:

Having argued for the ongoing role of GPs in Australia in the management of addictive disorders, we believe that the following specific matters should be addressed:

### 1. Cost of Methadone Maintenance Programs.

The international literature is clear that methadone is the treatment of choice for a significant proportion of the opiate dependent population. However, in Victoria, methadone is dispersed with a fee of $5 - $6 per dose per day. There is an argument that methadone as a prescription medication should be included in the Pharmaceutical Benefit Scheme to remove a barrier to the successful compliance with methadone programs.

### 2. Ongoing training for GPs in drug and alcohol management.

Given the central role of GPs in these matters and the demands on their services, attention needs to be given to their ongoing training and professional development needs. While there are a variety of models to achieve this outcome, IEMDGP experience suggests that Divisions are well placed to provide this training and experience. Pilot projects could be funded to explore these possibilities. Our Division is well placed to participate in such a pilot.

### 3. Costs of vaccination against Hepatitis A and Hepatitis B.

Many injecting drug users – with or without concurrent infection with Hepatitis C – are at risk of acquiring Hepatitis A and B with significant implications for their care and the costs of ongoing management. While there are effective vaccines available to prevent Hepatitis A and B, the costs of these vaccines are often prohibitive for individual patients or their families. Major opportunities to effect the outcomes of preventable epidemics of Hepatitis are being missed, with long term implications for the infected population and the Australian community. Alternative approaches to the provision of these vaccines for the affected population should be considered.

## Conclusion

The Inner Eastern Melbourne Division of General Practice is pleased to make this submission to highlight the central role for GPs in the management of addictive disorders. Our experience shows that Divisions, as credible organisational entities, can influence GP behaviours in the management of addictive disorders, hopefully, with improved outcomes for the population.

There is merit in considering models for the roles of Divisions in this area of family practice.

Finally, we have alerted your enquiry to two aspects of funding ancillary services for addicted populations that should be considered to improve the overall effectiveness of medical interventions.

We look forward to providing additional information and discussing our submission as appropriate.

Yours sincerely

**Dr John McEncroe**
**Chairman**