Allied Health Professions Australia

Treasury

Pre-budget submission 2021-22

January 2021

Allied Health Professions Australia
Level 1, 530 Collins Street
Melbourne VIC 3000
Email: office@ahpa.com.au
Website: www.ahpa.com.au

Advocating on behalf of Australia's allied health professions to create a fairer and more equitable health system

Introduction

Allied Health Professions Australia (AHPA) thanks the federal government for the opportunity to contribute to the federal budget planning process for 2021-22.

The last twelve months presented Australia with an unprecedented health and economic challenge. The COVID-19 pandemic meant that the Australian government needed to move quickly to meet the demand for a range of new supports and services. While that response was highly effective, it also revealed vulnerabilities in our system, which particularly impacted some members of the community such as older Australians and Australians with disability. Importantly, the response to these challenges has left all Australian governments with significant pressures in relation to current and future budgets. That makes efficient use of increasingly scarce health dollars more important than ever.

AHPA argues strongly that this federal budget provides an important and necessary opportunity to begin realising government health reform goals. We note and commend the significant investment made in the last budget focused on improving the accessibility of mental health services. Similar sensible and pragmatic investments focused on improving access to allied health care for people with chronic and complex illness, based on the extensive work already undertaken to substantiate and propose solutions to allied health access issues, will significantly improve the Australian primary care system. Allied health services are a crucial part of the health system and a key link between different parts of our system including primary and preventive health, acute care, rehabilitation, community and inpatient mental health, disability, aged care, education, social services and justice. Allied health interventions are particularly relevant as we begin to grapple with some of our greatest health burdens, many of which cannot be tackled through medical interventions alone. Allied health services are highly cost-effective, as both a supplement and alternative to medical interventions, particularly primary care.

Yet access to allied health services for many of our most vulnerable consumer cohorts remains a major issue, particularly community-based and primary allied health services. This budget presents an opportunity to begin addressing those access issues. The proposals below are realistic and achievable and will ensure that our health system is better equipped to meet the current and future needs of our community.

About AHPA and the allied health sector

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 130,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, providing services including diagnostic and first-contact services, preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

Recommendations

AHPA calls on the federal government to use the 2021/22 federal budget to commit funding to the following proposals:

1. **Fund an expansion of the Medicare Benefits Schedule (MBS) Chronic Disease Management Program, as recommended by clinical working groups, with an increase in annual session limits and an introduction of initial assessment items for an initial period of 24 months. Ongoing access should be subject to evaluation and consideration of the introduction of alternative models of funding.**
   Cost: $421.4 million per annum

2. **Fund a series of targeted pilot programs trialling models of primary care funding of allied health services, based on multidisciplinary interventions and including telehealth models, across a series of metropolitan and regional/rural sites.**
   Cost: $8 million over three years.

3. **Undertake a detailed review of the Chronic Disease Management Program (CDMP) available through private hospital cover policies, in conjunction with allied health sector and industry representatives, to identify opportunities to increase access to prevention- and maintenance-focused allied health services for Australians with private health insurance.**
   Cost: Up to $200,000 but potentially cost-neutral if able to be funded from existing Departmental resourcing.

4. **Increase health peak body funding provided to AHPA to better align with funding provided to other recipients and to support the sector and the Australian government's policy agenda as it relates to reforms of allied health services in primary care, aged care and disability.**
   Cost: Additional $1.2 million over four years.

Recommendation 1: Expand access to allied health MBS-funded care

Background

Chronic diseases are Australia's leading cause of illness, disability and death with 90% of all deaths in 2011 having a chronic disease as the underlying cause[i]. Chronic diseases disproportionately impact people who have limited ability to self-fund their care. Older Australians are impacted most by chronic disease with 78% of people over the age of 65 diagnosed with one or more chronic diseases[ii]. Rural and remote Australians also experience significantly higher rates of chronic disease and have significantly lower rates of private health insurance coverage for allied health services. People living with disadvantage are also consistently found to have higher rates of chronic disease[iii].

The management of those chronic diseases is extremely costly—the Commonwealth spent about $1 billion in 2013-14 to address chronic health issues through the Practice Incentives Program, Service Incentive Payments, Health Assessments and chronic disease and mental health management[iv]. These costs are growing with MBS payments for Chronic Disease Management (CDM) services provided by general practitioners (Items 721 to 732) growing 36% over the period 2012-2013 and 2014-2015 from $503.4 million to $682.7 million. Utilisation of allied health CDM items has grown at a similar rate, though costs remain comparatively low compared to general practice and hospital-based services. Payments for allied health services increased 33% between 2012-2013 and 2014-2015 ($219 million to $293.5 million) with the number of individual allied health services increasing 34% over the same period from to 4.1 million to 5.5 million. Those services are primarily delivered by two allied health professions: in 2014–15, podiatry (45.8%) and physiotherapy (30.5%) were the highest utilised services claimed under individual allied health items[v].

In 2010-11, approximately $2 billion was spent on Ambulatory Care Sensitive Condition-Chronic Diseases (ACSCCD) which was 3% of all hospital admissions, and 5.1 % of bed days. The same study showed hospital costs due to Avoidable Admissions of 2 (AA2) days or less for lower severity admissions for diabetes complications alone was $77 million[vi]. More recent research confirms that more than 1 in 3 potentially preventable hospitable admissions in 2013-2014 were due to eight chronic diseases (arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, cardiovascular disease, diabetes mellitus, or a mental or behavioural condition)[vii]. The four major disease groups (cardiovascular diseases, cancers, chronic obstructive pulmonary disease and diabetes) account for 75% of all chronic disease death while lower back pain is the second largest overall disease burden[viii].

Allied health professionals are key providers of services to address and manage chronic conditions. Yet unlike access to medical services, access to Medicare-subsidised services is limited to five annual 20-minute services across all allied health professions, regardless of the complexity of the condition or if a person experiences multiple comorbidities. Guidelines for most chronic conditions recommend involving at least two different allied health professions in appropriate team care arrangements. For example, a person with type 2 diabetes would generally be referred to a diabetes educator, a dietitian, and an exercise physiologist or physiotherapist. The five-session limit means that consumers can only access 1-2 sessions per profession, which is less than evidence-informed recommendations for maintenance care and significantly under the number of services required where a person has multiple chronic conditions, has been recently diagnosed, or is having difficulties managing their condition. Yet unmanaged condition have clear downstream costs to the health system.

AHPA estimates that some 20 percent of patients are likely to be high risk. An easily identified example is diabetic foot lesions and the high annual rate of preventable amputations resulting from improper care. While we expect some limited increase in utilisation for this cohort, appropriate

design of the item extension and stewardship by GPs will ensure that any increased costs associated with these additional items is directly preventing additional costs to the health system and broader economy.

AHPA notes that the MBS Review Allied Health Reference Group found that 20-minute sessions were significantly shorter than standard follow-up sessions and well below the length of initial assessment services. The impact of the lower rebates was that most consumers are likely to need to pay gap fees. Work undertaken by AHPA and by the expert group suggested that gap fees are likely to be the major contributor to underutilisation of services and care avoidance. As such the group recommended introducing rebates for initial appointments of at least 40 minutes.

A proposal for both of these changes was put forward by the government-appointed, multidisciplinary team with extensive clinical experience as part of the MBS Review, based on a review of MBS data, clinical knowledge and consideration of other government schemes. Over 300 consumers who responded to the consultation process for the development of an Interim Report[ix] from the MBS Review Taskforce highlighted the difficulties they faced once their annual allocation of five sessions per calendar year for allied health services under chronic disease management plans was used. In 2016, the House of Representatives Standing Committee on Health recommended "that the Australian Government investigate expanding the number of allied health treatments that can attract a Medicare Benefits Schedule rebate (MBS items 10950 to 10970) within a year, on the proviso that the patient has the relevant General Practitioner Management Plan and Team Care Arrangements in place."[x] In proposing these changes, we note that the Ministers for Health and Aged Care recently announced similar temporary measures for older Australians living in residential homes.

Recommendations

- **Introduce an initial assessment of 40 minutes duration with a limit of one assessment item per profession, per year for each patient.**
- **Increase the number of allied health appointments under team care arrangements by stratifying patients to identify those with more complex care requirements, including recently diagnosed consumers and those that show signs of not managing their condition. Provide up to an additional five sessions for these patients with an additional GP referral.**
- **Both changes are to be introduced for a period of 24 months with access beyond then to be subject to evaluation of the impact of changes by the Department of Health, alongside evaluation of alternate models of allied health primary care funding.**

Cost estimate

AHPA has undertaken an initial analysis of potential costs below, noting that the federal government is likely to have access to more detailed data for more accurate costing.

- ***Introduction of initial assessment items for CDM services.***
  Medicare data from 2017/18 shows that a total of 6,776,000 individual claims were made against the MBS CDM program. Data supplied by the Department of Health during the MBS Review indicated an average of 3 uses per patient, suggesting an estimated 2,260,000 unique users of the CDM program. Based on most patients accessing two unique professions per patient, per year, this suggests a potential budget impact of $281,370,000.

- ***Introduction of expanded annual limits for some patient cohorts.***
  AHPA estimates that up to 20 percent of eligible chronic disease patients may present as high risk and be given an additional referral for services by their GP. Based on a cohort of some 450,000 consumers (see above for calculation), this would result in an estimate budget impact of $140,000,000 based on full use of the additional five items. For an individual patient, this would represent an annual investment of an additional $311.25 and contrasts with the cost of amputation of a diabetic foot of around $23,555, and an additional annual spend of $6,065 every year afterwards.

Recommendation 2: Trialling alternate models of multidisciplinary allied health care

Background

Australian health policymakers are increasingly recognising the limits of fee-for-service funding as a means of addressing some of Australia's biggest health burdens. Many of these are chronic and complex conditions such as lower back pain. Fee-for-service models reward higher use of systems rather than more effective care, an approach that can drive overuse of services, particularly where access is uncapped. Local and international evidence is emerging showing the benefit of, and need for, alternative models of funding which support practitioners and health providers to provide additional coordination and support to patients. Alternate funding models have also been shown to be necessary in regions with lower population density. Australians living in rural and remote areas are particularly impacted by a lack of access to services, including primary health care services as well as more specialised aged care and disability-focused services. This lack of access, when combined with the MBS funding issues outlined in Recommendation 1 and in a range of AHPA submissions to government, leads to the wide disparity in health outcomes between metropolitan-based Australians and those living outside major cities[xi].

The need to identify and trial alternate models of care has been well established and has been flagged as a priority by both the Department of Health and the Health Minister. The current Primary Care 10-year plan process has involved some initial discussion of policy options, and the Department of Health has commenced limited trialling of alternate models of care, through the Health Care Homes project and the more recently announced Voluntary Patient Enrolment measure. Both measures focus exclusively on general practice and have not sought to integrate allied health services. Additional rural trials are also scheduled to commence in rural NSW, focused on multidisciplinary models using general practitioners and nurses. Only one of the trial sites identified is likely to involve allied health.

This is a critical failure in current reform activities if the government indeed wishes to improve equity and access for consumers which is its stated aim. Allied health practitioners represent Australia's second largest health workforce after nurses and must be prioritised in the work being undertaken by government. Appropriate interventions for many of our largest disease burdens require allied health interventions, as part of coordinated multidisciplinary program of care involving multiple allied health professions, medical specialists and general practitioners. Allied health providers also represent a more complex and heterogenous group than general practitioners, typically working under a range of funding programs and in a range of different settings and operating environments. Understanding how to integrate those allied health services into a coordinated response to consumer needs can only be achieved through dedicated trials, focused on allied health interventions.

AHPA argues strongly for the funding of a number of allied health-focused trials covering both rural and metropolitan sites and testing a range of funding models including capitation and block-funding

options. Unlike other initiatives, these trials should focus on multidisciplinary allied health care addressing key health burdens, such as diabetes and lower back pain. The Department of Health should establish an expert advisory group, led by allied health professionals, that works with a departmental team to identify appropriate models and sites. Local implementation would be undertaken by Primary Health Networks (PHN) in conjunction with allied health and other providers. AHPA notes that the chosen PHNs will likely need to build internal allied health expertise and should have increased involvement in governance by allied health representatives.

AHPA argues that an important component of the proposed allied health trials will be considering the role of direct referrals between medical specialists and allied health professionals. We note the proposals of the MBS Review Allied Health Reference Group and the Specialist and Consultant Physician Clinical Committee in relation to direct referrals, both of which noted the evidence supporting current clinical pathways that do not involve general practice and where the requirement for GP referrals is adding costs to the system and slowing down access to appropriate care. Health cost analyses, such as those commissioned by the Australian Physiotherapy Association, show the potential for significant cost savings to consumers and the health system by improving referral pathways[xii].

AHPA further argues for the need to trial alternate models of funding for telehealth. While the recent introduction of temporary COVID-19 pandemic measures significantly expanded access to allied health telehealth services, services were limited to a replacement of face-to-face care delivery. There is a need to test the viability of telehealth funding models that incorporate asynchronous care delivery, online platforms and other contemporary technology as part of a program of care that more effectively meets the needs of consumers.

Recommendations

- **Fund the development planning of six allied health-led trial sites, across regional/rural and metropolitan locations, focused on testing capitation and block-funding models, incorporating face-to-face and telehealth delivery modalities.**
- **Fund establishment and running of funding models across six trial sites for a period for 24 months.**
- **Undertake evaluation of funding models as a foundation for scaling up of funding approaches nationally.**

Cost

Implementing a series of allied health-led trial sites will require a multi-year funding approach that covers planning, implementation and evaluation. Funding will need to be split between the Department of Health project management team, the PHNs, the local providers implementing the model, and relevant allied health peaks.

- *Stage 1: Model development, trial site identification and planning - $1.5 million in 2021–22*
- *Stage 2: Implementation - $6.0 million in 2022–24*
  Note: some of this funding may potentially be drawn from existing funding sources such as Medicare and private health insurance as per the Health Care Homes trial.
- *Stage 3: Research and evaluation - $0.5 million in 2023-24 financial year.*
- *Total: $8 million*

Recommendation 3: Review Private Health Insurance Chronic Disease Management Program legislation and program design

Background

The Australian government recently announced as part of the October 2020 federal budget that it was commencing the second wave of reforms to private health insurance with the aim of improving the affordability, value, and attractiveness of private health insurance, particularly for younger Australians. Under the plan outlined in the Commonwealth Department of Health's current public consultation document, proposed changes focus on out-of-hospital rehabilitation for physical conditions following orthopaedic surgery. The proposed mental health changes are more wide-ranging as they aim to provide an opportunity to deliver preventive mental health interventions. They also propose legislative changes to the Chronic Disease Management Program (CDMP) guidelines, a program which provides physical health care in addition to mental health care. The current consultation does not address the impact of legislative changes on non-mental health CDMP services, nor does it provide an opportunity to consider the opportunities and failures of the CDMP.

The CDMP is part of reforms that were introduced in 2007 as part of the Broader Health Cover[xiii] initiative. The intention of the CDMP is to allow insurers to fund services that are preventative in nature and can assist in improving the management of chronic illnesses and reducing avoidable hospitalisations and health decline. The design of the program appears to provide an effective means of supporting the MBS CDM program by providing access to appropriate allied health services for eligible holders of private health insurance policies. Yet data collated for AHPA by Deloitte in 2018 shows that use of the CDMP is declining and represents only a tiny fraction of insurer expenditure. Data shows that for every $1 spent on in-hospital treatment, only $0.04 were spent on CDMP and $0.03 on hospital substitution programs. The CDMP has also provided little funding of allied health interventions, with data showing that 58 percent of the total CDMP expenditure was spent on planning services with a further 31 percent spent on coordination. Only 9 percent of spending went to allied health services. Coordination and planning services were both significantly more expensive than allied health service delivery.

While AHPA welcomes the reform intentions of government, and the focus on expanding access to community-based rehabilitation and preventive mental health services, we argue that CDMP represents an urgent focus for dedicated work to improve the model of service delivery and to consider which services should be funded and how.

Recommendations

- **Fund work by the Department of Health to undertake a dedicated review of the Chronic Disease Management Program with a dedicated advisory group established to oversee evaluation of the current program and a public consultation with recommendations to go to government in time for the 2022/23 federal budget.**
- **Commit to an implementation of a third wave of reforms, focused on CDMP, aimed at expanding access to allied health services funded under private health insurance hospital cover for eligible policy holders.**

Cost

Funding required for this initiative is expected to be minimal with a significant proportion of costs potentially able to be covered by the existing Department of Health budget. Some additional secretariat support, in addition to sector and/or external consultant support, may be required as will

support to cover participation by relevant medical and allied health professionals. Possible budget of $100,000-200,000.

Recommendation 4: Increased peak body funding for allied health sector

Background

AHPA is the recognised national peak association for the allied health sector, working on behalf of the allied health professional workforce. At over 200,000 health professionals, this is Australia's second largest healthcare workforce. Those professionals work across an extremely diverse range of settings, sectors, and geographic locations. The diversity of the sector makes the provision of accurate and timely advice to government extremely important. That diversity also increases the complexity of the task as AHPA needs to work with a range of Commonwealth and jurisdictional departments and agencies to fulfill its role effectively. AHPA is currently involved in active and ongoing work with the Australian Commission for Safety and Quality in Health Care, the Australian Digital Health Agency, the Australian Institute of Health and Welfare, multiple areas of the Department of Health, the Department of Social Services, the National Disability Insurance Agency, the NDIS Quality and Safeguarding Commission, the Royal Commissions into disability, aged care and mental health (Victoria) as well as a range of funding bodies, parliamentary committees and more.

The ongoing COVID-19 pandemic has also demonstrated a significant need to support governments in navigating the challenge of border closures, lockdown and transition plans. That additional work is likely to be required for some time yet as Australia continues to respond to the pandemic and the longer-term health and rehabilitation needs of those that have experienced COVID-19. All governments have relied heavily on the allied health sector, and on AHPA, for advice, support and implementation of guidance and standards and will continue to do so as we work through the current pandemic and plan for the future.

However, AHPA receives the lowest amount of funding of any HPAB recipient organisation, a level of funding that is significantly out of proportion to the size and complexity of the sector. We note by way of contrast that the Australian Pharmaceutical Society, which represents some 18,000 representatives from a single profession, receives almost two and a half times the support from the Commonwealth. The Australian Association of Practice Managers with some 2,600 members receives over a third more funding. Both of those organisations also work with a far less diverse membership base or range of operational settings.

AHPA has undertaken significant work in relation to the specific needs of people with disability and the providers that support them during the pandemic. AHPA has expanded on the already significant body of work it undertakes with the NDIS Commission, the National Disability Insurance Agency, Department of Social Services (DSS) and individual jurisdictions and stakeholders throughout the pandemic. AHPA continues to do so at our own cost, as advice after formal approaches to the DSS grants team and the Ministers for the NDIS and Social Services have stated that AHPA is not eligible to receive funding under the Department of Social Services National Disability Representative Organisations program. AHPA and its members have significant concerns about how this reflects on the importance of engaging with the allied health sector in relation to disability-related policy, particularly in light of current work on an NDIS Workforce Strategy and the introduction of major reforms to the NDIS that directly involve the allied health sector through the introduction of Independent Assessments.

To address these resourcing gaps, AHPA proposes a modest four-year increase in funding to allow the organisation to increase its resourcing and to support government reform projects across aged

care, disability, primary care, mental health and rural health. We further recommend building in a review mechanism to account for the likely growth in government work relating to allied health, particularly in the aged care sector.

Recommendations

- **Fund an immediate increase to the annual amount provided to AHPA under the Department of Health HPAB grant programme of $300,000 per annum over four years.**
- **Undertake evaluation of funding after two years with the potential to increase funding further if additional need can be demonstrated.**

Cost

Additional investment in the allied health sector represents an important foundation for improved research and policy engagement in support of a range of current and future government reform programs.

- *Total cost of $1,200,000 over four years in addition to current HPAB funding.*

References

[i] Key indicators of progress for chronic disease and associated determinants: data report. Cat. no. PHE 142. Canberra: AIHW.
[ii] Australian Institute of Health and Welfare (2014) Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW, page 8.
[iii] Australian Institute for Health and Welfare (2012) Social distribution of health risks and health outcomes, Australian Institute for Health and Welfare
[iv] Swerissen, H., Duckett, S., and Wright, J., 2016, Chronic failure in primary medical care, Grattan Institute, page 28.
[v] Ibid.
[vi] Ibid. Page 16.
[vii] https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/chronic-disease/overview.
[viii] https://www.aihw.gov.au/getmedia/0d9f8959-2a1c-4c99-8c7e-0c8a878f4d6c/Back%20problems.pdf.aspx?inline=true
[ix] https://www1.health.gov.au/internet/main/publishing.nsf/Content/MBSR-closed-consult
[x] The Parliament of the Commonwealth of Australia, House of Representatives Standing Committee on Health, "Inquiry into Chronic Disease Prevention and Management in Primary Health Care", May 2016, page 69.
[xi] https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary
[xii] https://ahpa.com.au/advocacy/mbs-review-position-statement-direct-referrals/
[xiii] https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/ChronDisease