POSITION STATEMENT

Improving access to allied health services through increased annual Chronic Disease Management item limits and service durations

This position statement has been developed by Allied Health Professions Australia (AHPA) and its member associations to support the work of the Medicare Benefits Schedule (MBS) Review Allied Health Reference Group. We particularly acknowledge the work of Exercise & Sports Science Australia (ESSA) in the development of this statement.

1. Introduction

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 for whom the ability to self-fund their care is limited. 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]. People living with disadvantage are also consistently found to have higher rates of chronic disease[iii].

Current restrictions on the annual Chronic Disease Management (CDM) items are insufficient to meet the needs of many people with chronic health issues, particularly where consumers have more complex health issues or display higher risk factors. These annual service limits increase out-of-pocket costs and care avoidance, both of which are already exacerbated by the low schedule fee and service duration limits. By limiting access to those people with the least capacity to fund services, who experience the greatest need for care, our system is directly contributing to poor health outcomes and significant additional, avoidable costs to the health system.

2. Recommendations

Despite the current limitations on the CDM items, AHPA strongly recommends that as a bare minimum, they remain in their current form. However, we propose that minor adjustments to annual limits and service durations are likely to significantly increase their effectiveness in meeting the needs of patients and our health system.

Recommendation 1: Annual session limits

AHPA recommends that the annual limit of five sessions is adjusted to allow for a higher session limit where this may be required. AHPA proposes that the basis for these additional sessions could be either financial disadvantage or where the person is assessed as having a higher degree of complexity or risk of adverse outcomes. The latter in particular provides a strong argument for more intensive intervention and investment in prevention of more acute health interventions such as limb amputation.

AHPA contends that the criteria for additional sessions under Group M7, the Better Access to Psychological Services, whereby the treating allied health practitioner makes a recommendation back to the general practitioner, could be a model for managing appropriate access to additional care.

- **For patients with complex conditions including co-morbidities (possibly defined by a range of simple physiological measures easily measured by a GP), patients may be referred by their GPs for a further treatment cycle of up to 10 sessions after the assessment of the initial 10 sessions (for a total of 20 sessions per annum).**

Recommendation 2: Service duration

AHPA notes that current service duration limits are not in line with standard practice and result in significant out-of-pocket costs for consumers.

- **AHPA recommends the introduction of an initial allied health assessment service of 45 minutes in length to mirror the availability and duration of an assessment service under the Group M9 Allied Health Services for People with Type 2 Diabetes. This assessment item would be available to each allied health profession providing chronic disease management services and identified in the team care arrangement.**

- **AHPA further recommends that the service duration for standard Group 3 Allied Health Services is increased to 30 minutes.**

3. Rationale

Managing chronic diseases is 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 items has grown at a similar rate, but costs remain comparatively low compared to general practice and hospital-based services. Payments 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[vi]. Further analysis from 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[vii].

More recent research confirms that more than one in three 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)[viii].

The four major disease groups (cardiovascular diseases, cancers, chronic obstructive pulmonary disease and diabetes) account for 75% of all chronic disease deaths. All are linked to the four main

behavioural risk factors (smoking, physical inactivity, poor nutrition and harmful use of alcohol)[ix]. These factors disproportionately impact people experiencing disadvantage.

Helping consumers to reduce these risk factors requires behavioural change and is likely to require ongoing support and management, particularly where a person experiences multiple comorbidities. This type of support is often likely to be best delivered by an allied health professional such as a dietitian or diabetes educator, an exercise physiologist, or a psychologist.

The current restriction of five individual allied health sessions over a twelve-month period does not adequately allow for the treatment of chronic conditions using evidence-based, best practice clinical guidelines. Some patients may require multiple sessions with one or more allied health professionals in order for their care needs to be properly assessed and managed. Most people will need more than one allied health session – one to assess and a minimum of one but generally more to provide an intervention. For example, at least four audiology consultations under Item 10952 allows for best practice assessment and treatment for a patient. This would enable fitting of a hearing device if required, post-fitting care and device maintenance, aural rehabilitation and consultation.

For dietary interventions, 14 on-site, high-intensity sessions in a six-month period is regarded as best clinical practice by the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society for comprehensive weight loss[x]. Seven individual nutritional consulting sessions delivered by a clinical dietician or the treatment of major depressive episodes was found to be an efficacious and accessible treatment strategy, the benefits of which could extend to the management of common co-morbidities[xi].

Six lifestyle intervention sessions (an initial assessment, four individual consultations with a dually qualified dietitian and exercise physiologist, and a final assessment) for General Practitioner (GP) referred patients with a mental illness showed that cardiovascular fitness, muscular endurance, and psychological well-being improved in 80% of those who completed the program.[xii]

The current five-session limit frequently results in patients not being able to progress to a point where they are in a position to self-manage their conditions. When combined with the impact of high out-of-pocket costs and resulting care avoidance, the risks of this structure are that the burden of care is shifted to the hospital system when conditions become acute.

The effectiveness of allied health interventions as a means of preventing hospital admission have been widely demonstrated. In a tertiary teaching hospital in outer Melbourne, preliminary screening by experienced physiotherapists of waitlist patients with non-urgent musculoskeletal conditions resulted in 63% of patients being assessed appropriate for non-surgical management. These patients then received early alternative treatment effectively reducing waitlists for orthopaedic and joint replacement surgery, allowing for relevant patients to be managed conservatively, and enhancing the efficiency of the waitlist system, thus reducing costs[xiii]. The hospital redesigned its referral process to allow GPs to refer directly to the physiotherapist-led screening clinic.

Rehabilitation services for stroke patients, which are mostly delivered by AHPs (speech pathology, physiotherapy, occupational therapy, medical nutrition therapy, psychological counselling, and social work intervention), have a profound effect upon patient function and independence[xiv].

AHPA supports the 2016 recommendation from the House of Representatives Standing Committee on Health “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.[xv]"

Over 300 consumers who responded to the consultation process for the development of an Interim Report[xvi] 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.

4. References

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[iv] Swerissen, H., Duckett, S., and Wright, J., 2016, Chronic failure in primary medical care, Grattan Institute, p28.

[v] Ibid.

[vi] Swerissen, H., Duckett, S., and Wright, J., 2016, Chronic failure in primary medical care, Grattan Institute, p16.

[vii] Ibid.

[viii] Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/chronic-disease/overview Accessed 30 May, 2018

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[xv] 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.