

Recommendations to the Medicare Benefits
Schedule Review Allied Health Reference Group

Improving the accessibility and efficiency of allied health services

July 2018



**Allied Health
Professions
Australia**

AHPA interest in this consultation

Allied Health Professions Australia (AHPA) represents 20 national allied health associations who collectively represent some 100,000 allied health practitioner members. As the national voice for allied health, AHPA seeks to represent the roles of the approximately 185,000 allied health professionals who play a vital role in our health, disability and education systems. A key focus for the work of many of those allied health professionals is providing services to people experiencing chronic illnesses such as diabetes, ongoing musculoskeletal health issues and neurological conditions. Many of those practitioners also provide vital support to children with autism and pervasive development disorder. AHPA and its member associations are committed to ensuring that all Australians, regardless of their income, background or location can access safe, evidence-based services to support them to realise their potential for physical, social, emotional and intellectual development and fully participate in life in their community.

This document has been developed in close consultation with our peak association members and with direct input from their individual allied health practitioner members.

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Introduction

Allied Health Professions Australia (AHPA) welcomes the opportunity to support the work of the Medicare Benefits Schedule (MBS) Review Taskforce and, in particular the work of the General Practice Primary Care Clinical Committee and the associated Allied Health Reference Group. This AHPA Framework has been developed to support the work of the Allied Health Reference Group and summarizes the collective views of our member associations with regards to key issues and recommendations.

Our recommendations are split into those that deal with the priority one, in-scope MBS items and those that deal with priority two recommendations for improvement to the Schedule. This Framework document is intended to articulate an overall vision for how AHPA and its members consider the MBS should work to address the four key areas of focus of the Review, which are also referenced in detail below. Our recommendations are dealt with in greater detail in a series of specific supporting position statements that follow on from the Framework and are supplied in conjunction with this document.

AHPA and its members very strongly recommend that each of the three MBS item subgroups is retained. We are aware that data may show underutilisation of some items but note the MBS Taskforce itself has previously recognised that low utilisation data is not a sign of obsolescence but may instead be due to structural issues impeding the use of those itemsⁱ. AHPA and its members contend that there is significant scope to reform current MBS item conditions to improve outcomes for patients and reduce expenditure for the public purse through improved capacity to prevent poor health outcomes and their associated consequences.

Our recommendations are:

- **Subgroup M3 (10951 – 10970). Recommend change to schedule fee, duration, dose and location.** Allied health services belonging to this subgroup require immediate adjustments to the duration and dose of service conditions in order to address issues of accessibility and limited capacity to achieve the consumer health outcomes for which they are intended. We recommend that the Review focuses on the following areas:
 - **Schedule fee:** Align the schedule fee to market rates to reduce out-of-pocket costs for consumers.
 - **Care setting / location of service:** Allow telehealth consultations to increase access to people in rural and remote regions or who might otherwise not be able to access services.
 - **Provider / referrer restrictions:** Allow allied health practitioners to make direct referrals for imaging and pathology services and to other health professionals where appropriate and within their scope of practice. Increase access to professions not currently eligible for rebates but with demonstrated clinical expertise. *This recommendation encompasses additional items and is detailed in our longer-term recommendations.*

- **Service conditions:** Increase the service duration of the first session for each allied health profession to support initial assessment consultations and also increase the subsequent session duration in line with standard practice for the conditions being treated. Increase the total number of annual services that can be accessed to ensure the system has capacity to support higher complexity/risk patients where appropriate.
- **Subgroup M9 (81100 – 81125). Recommend change to rebate structure of group items.** Group allied health services belonging to this subgroup require adjustment to ensure that providers are able to offer group services without undue risk of income loss due to cancellations by participants, an issue that is currently limiting their use. The following areas should be reviewed to ensure that the items can work effectively:
 - **Schedule fee:** Increase the fee for the first four patients or introduce the ability to claim for late cancellations to ensure providers do not risk losing income when delivering services.
 - **Service conditions:** Introduce a final assessment at the end of the program of group services.
- **Subgroup M10 (82005 – 82035). Recommend change to duration and annual limits.** Autism items belonging to this subgroup require adjustments to ensure that they are providing sufficient cover for eligible children and young adults, many of whom will not be deemed eligible for NDIS support.
 - **Service conditions:** Increase the assessment session durations to reduce out-of-pocket expenses for consumers and increase the lifetime limits to ensure children are able to access appropriate care.
 - **Service conditions:** Remove lifetime limits and age limits to align items with appropriate care for children and young adults with ASD/PDD.
 - **Service conditions:** Allow more flexibility in how treatment services are delivered including sessions with just family/carers and group sessions.

It is our position that by implementing these recommendations, the MBS review process will be directly addressing its four areas of focus and overcoming the following current issues and inefficiencies:

- The MBS is currently funding unnecessary gatekeeper services because of inefficient referral processes for both diagnostic services and referrals between health professionals that unnecessarily require the additional involvement of general practitioners. This results in additional health costs and lost productivity for consumers as well as increasing the risk that a person will not follow up on necessary care.
- The MBS is currently failing to adequately fund essential allied health services that prevent deterioration and avoidable complications resulting in far more expensive surgical, other hospital-based interventions, poorer health outcomes that reduce productivity and increase dependence on welfare and other funding. This issue is particularly prevalent in rural and

remote regions where consumers experience higher levels of chronic illness but utilisation of allied health services is significantly lower due to structural barriers.

- The MBS is currently excluding funding for allied health services that are recognised as appropriate care for chronic and complex illnesses (e.g. Orthotist/prosthetist diabetic foot care).
- The MBS is currently failing to fund allied health participation in case conferencing and team care coordination which leaves allied health practitioners unnecessarily siloed and patient care poorly coordinated.
- The MBS is currently applying inconsistent telehealth eligibility to items (i.e. expanding the eligibility of some items such as Better Access to Psychological Care while leaving other items restricted to in-person consultations) leaving rural and remote consumers unable to access care.

It is important to note that the allied health sector strongly supports the essential role of general practice. Many allied health professionals work closely with their general practice colleagues, either in the same location, or through strong collaborative relationships that support patient needs. We recognise that for most consumers, general practices are likely to be the primary point of contact with the health system and they are ideally placed to undertake early diagnosis and screening, identify risk factors, refer patients for further testing, prescribe medications, and ensure patients are referred to the most appropriate other health professionals for additional care. However, we contend it is essential to carefully consider the constraints on what general practices can, and cannot, provide. Similarly, it is also important to carefully consider the primary contact and central, coordinating roles many allied health professionals provide for a range of patient groups including people with ongoing musculoskeletal issues, people with communication difficulties and other functional limitations, as well as for people with mental health issues.

Priority 1 - Current Allied Health Items

The allied health reference group has been tasked with reviewing three key item groups from the Schedule, all of which fall under Category 8 - Miscellaneous Services. The items groups are:

- Subgroup M3 – Allied Health Services
10951 – 10970 (10 items)
- Subgroup M9 – Allied Health Group Services
81100 – 81125 (6 items)
- Subgroup M10 – Autism, Pervasive Developmental Disorder and Disability Services
82005 – 82035 (6 items)

AHPA will provide specific feedback and recommendations for all three areas with our response broadly broken down into chronic disease management and support for children with autism spectrum disorder or pervasive development disorder. Our feedback will broadly reflect the four key

focus areas for the Review:

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system

1.1 Chronic Disease Management

This section deals with the MBS items covered by subgroups M3 and M9. We will argue that these items groups are each essential as the basis for patient access to care and must remain. However, changes to the items are required so they can achieve their intended purpose. Our research and feedback from the community suggests that the MBS allied health items are currently failing consumers in all four goal areas the review is seeking to achieve improvement inⁱⁱ:

- Access to allied health care is not affordable and universally accessible. Current arrangements are inequitable and exacerbate the disparity in health outcomes between those from higher and lower socioeconomic strata. Evidence clearly demonstrates poorer health outcomes for minority or marginalised groups, those experiencing disadvantage, and those in rural and remote regions. Changes will be required to ensure schedule fees and service durations are aligned to consumer requirements and to minimise out-of-pocket expenses.
- The current MBS funds a range of services that have been demonstrated to be ‘low-value’ interventions and fails to fund other services that are recognised as representing best practice. A key example is the continued funding of knee arthroscopy for osteoarthritis while failing to provide appropriate access to proven musculoskeletal allied health care interventions. Annual service limits must be adjusted and referral pathways improved to increase the accessibility and use of best practice interventions.
- The current system is not providing value for patients. The structure of the MBS is such that it disincentivises interventions that are not medical or medications-based by failing to fund these. A key example is that patients with chronic back issues are able to access surgical interventions and pain medications which may be more expensive and less effective than appropriate allied health interventions.
- We will also argue that the health system could get significant value from a more efficient integration of allied health care into patient referral and treatment pathways and could save significantly by realising the potential for avoiding unnecessary health interventions such as expensive amputations for consumers with diabetes.

1.2 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 causeⁱⁱⁱ. Older Australians are impacted most by chronic disease with 78% of people over the age of 65 diagnosed with one or more chronic diseases^{iv}. People living with disadvantage have higher rates of chronic disease^v. These chronic conditions are threatening to overwhelm Australia's health budget, the capacity of health services and the health workforce. They remain the predominant cause of illness, premature mortality and health system utilisation; in fact most of the burden of disease in Australia in 2011 was from chronic diseases, with approximately 66 per cent, or two-thirds, of the total burden of disease resulting from five disease groups — cancer, cardiovascular diseases, mental and substance use disorders, musculoskeletal conditions and injuries. More recent research confirms that more than 1 in 3 potentially preventable hospital admissions in 2013–2014 were due to 8 chronic diseases (arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, cardiovascular disease, diabetes mellitus, or a mental or behavioural condition)^{vi}. The Australian Government also estimates that 70% of the gap in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Australians is attributable to chronic disease^{vii}. The presence of one of these chronic diseases may also signify significantly increased risk factors for other conditions—diabetes is another major underlying cause of death from circulatory and heart disease. People with diabetes are two to four times more likely to develop cardiovascular disease and about two thirds die from it.

Chronic illnesses should be treated primarily within the primary care sector, at least until the deterioration of the illness results in the need for acute interventions. This is both the most effective approach and reflects the typical point of access to the health system for people with chronic illnesses. For example, in two of every five GP encounters at least one chronic problem is managed, with hypertension, non-gestational diabetes, lipid disorders and osteoarthritis among the most frequently managed conditions. For older patients aged 75–84 years, chronic problems are managed in almost nine of every ten GP consultations. This illustrates the depth of chronic health problems that the changes to Medicare policy aim to address.^{viii}

The primary care system is able to provide significantly better value in terms of the cost of supporting people with chronic illnesses. Incorrect management of the consequences of chronic illness are expensive for the health system and lead to poor outcomes for the consumer. Diabetic amputations are a key example with some 4,400 each year, as many as 70 percent of which may be avoidable.^{ix} In Australia in 2004–2005, the average length of hospital stay for people with diabetes requiring lower limb amputations was 26 days. A recent study estimated the cost of lower extremity amputations in Australia to be \$A26,700 per person. Estimated costs for other countries were \$A24,660 for Canada; \$A46,064 for France; \$A31,809 for Germany; \$A14,650 for Italy; and \$A21,287 for Spain. Other direct and indirect economic costs of foot complications, not included in the above data, include the costs of rehabilitation, purchase and fitting of orthotics/prostheses, lost productivity and potential costs associated with disablement.

Addressing chronic disease in the MBS

The Australian Government has introduced a range of initiatives to address the growing need for better support for people with chronic illnesses. These costs are growing--the Commonwealth spent about \$1 billion on chronic illness care in 2013-14 through the Practice Incentives Program, Service Incentive Payments, Health Assessments and chronic disease and mental health management^x. Medicare Benefits Schedule (MBS) payments for Chronic Disease Management (CDM) services (Items 721 to 732) provided by general practitioners grew 36% over the period 2012-2013 and 2014-2015 from \$503.4 million to \$682.7 million^{xi}.

The introduction of the items in subgroups M3 and M9 signaled a recognition that general practices alone cannot provide the necessary care and prevention-focused interventions and needed an avenue to refer patients for additional support with their chronic conditions. Those items have seen increased use with a growth in the MBS payments for subgroup M3 services provided by allied health providers. 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 4.1 million to 5.5 million. In 2014-15, podiatry (45.8%) and physiotherapy (30.5%) were the highest utilised services claimed under individual allied health items^{xii}. The heavy concentration of allied health item utilisation is not consistent with the role many professions have in the care of people experiencing chronic illnesses. Instead these figures suggest that there are systemic issues that are limiting use of the MBS items across the range of professions with clinically appropriate roles in patient care.

Utilisation of subgroup M9 services has also grown significantly during that time. The utilisation of the initial assessment items grew 496% over the ten years from 1,751 in 2007/2008 to 10,440 in 2016/17 while utilisation of the group sessions items grew 803.8% over ten years from 6,095 in 2007/08 to 55,089 in 2016/17.

Despite this increased utilisation of allied health services, the volume of services and the funding provided for allied health services remains small compared to the funding for general practice-based services. In 2012 the Australian Health Survey showed that over 747,000 Australians had known type 2 diabetes (Australian Bureau of Statistics, 2012), and these individuals are entitled to one Medicare funded assessment service per year. However, only 5,536 such services were conducted in 2012, indicating that less than 0.8% of eligible patients were referred for and received this service (Department of Human Services, 2015). This is particularly concerning when research suggests that less than half of people with diabetes seeing Australian general practitioners had recommended levels of blood pressure, blood sugar and cholesterol. A further study of the quality of care for diabetes and heart disease in general practice found that only half had good control of blood sugar levels, just a quarter reached recommended blood pressure levels and less than 20 per cent achieved adequate management of their cholesterol levels.^{xiii} Other studies have shown that only 15 per cent of 7,474 patients with diabetes had recorded all values for glucose and body mass and blood pressure and of those with measurements, 20 per cent had recommended overall outcomes for weight, blood pressure and blood sugar. A study of GP management of heart health found that few patients receive advice or support to address these risks.^{xiv}

Medicare data also shows that many more patients receive GP management plans than team care arrangements. This suggests that the current system of identification and diagnosis by general practice is not leading to the rate of referrals and follow on allied health services that best practice guidelines for many chronic illnesses show are needed to ensure patients are supported to address the risk factors present and to prevent deterioration of health. One reason may be that the current MBS system often focuses on screening rather than intervention. For instance, the 75 + health check may screen for chronic conditions, and an issue such as falls risk may arise during a 75+ health check, but the focus of reimbursement is on the screening task, not on the ongoing management plan.^{xv}

Analysis of the level of expenditure on individual allied health CDM services confirms that it is a fraction of the cost of avoidable hospital admissions. 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. 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^{xvi}. The cost of medications use and unnecessary and potentially ineffective surgical interventions should also be contrasted with increased investment in primary care.

Current failures in the system

Despite the introduction of these items and increased use of multidisciplinary approaches to care, our system is not meeting the needs of consumers. The gaps in our system have been well recognised. The Primary Health Care Advisory Group's December 2015 report to the Australian Government on: *Better Outcomes for People with Chronic and Complex Health Conditions*^{Error! Reference source not found.} states that "Our current health system is not optimally set up to effectively manage long-term conditions." The report also notes that patients often experience providers and services working in isolation from each other rather than as a team and difficulty in accessing services due to lack of mobility and transport, plus language, financial and remoteness barriers.

A 2014 Australian study examined the household economic burden of eating disorders, showing that current models of funding for the treatment of eating disorders do not encourage management of patients in the community or in outpatient settings because the public system offers limited treatment options beyond admission for severe, acute episodes. Private health insurance tends to provide only limited reimbursement outside private hospital admission. This pattern of funding discourages upstream management of illness and does little to prevent escalation. This leads to a model of care based on high cost acute management and creates inequities in access to treatment based on socioeconomic status, access to health insurance and type of condition.^{xvii}

The National Strategic Framework for Chronic Conditions, developed and endorsed by the Council of Australian Governments in 2017, notes the range of barriers people experience in accessing health care stating "*People with chronic conditions can experience cost barriers associated with managing single or multiple chronic conditions, multiple pharmacotherapies, and accessing a range of health services, including those for which there is little or no rebate available.*"^{xviii}

The Framework also notes that the focus of Australia's health system and, by extension, the funding structure that supports it has been on treating illness rather than on preventing it. It states that Australia must adopt a consistent and integrated approach to the effective prevention and management of chronic conditions to improve health outcomes for all Australians and to ease the pressure on the health system. The Medicare Benefits Schedule has the capacity to take on that role but is currently being limited by structural limitations.

Pathways to and from allied health services are inefficient and poorly integrated. Inconsistent and insufficient funding arrangements through the Medicare Benefits Schedule (MBS) mean access to services is severely limited and integration with other parts of the health system does not reflect the role and scope of allied health practitioners. Previous government consultations with the primary care sector noted that "Medicare's structure no longer efficiently supported patients and practitioners to manage chronic conditions [...]". This has also been recognised in a range of research and position papers and in public statements by the Australian Medical Association and the Royal Australian College of General Practitioners.

"[...] although the contribution of AHPs to primary care management of chronic conditions is being recognised, their role is being significantly proscribed. AHPs are being encouraged to contribute to care management and to participate in multidisciplinary team care, but under conditions that do not take maximum advantage of their clinical expertise in tailoring care plans for individuals and facilitating the self-management and behaviour change required."

Barriers to utilisation of the chronic disease management items

A key barrier to the use of allied health services is understanding of the role and benefit of different professions. This applies to both consumers and health professionals. One Australian study found oncology nurses need assistance on knowing where to find evidence-based physical activity resources and hospitals may need to better support these nurses in promoting physical activity to their patients and provide better referral pathways to exercise physiologists and physiotherapists^{xix}.

Chronic diseases require a multidisciplinary approach to provide patients with optimal care in general practice. A 6-month intervention^{xx} consisting of an educational workshop and structured facilitation using specially designed materials, backed up by informal telephone support delivered to 26 practices, found improved professional collaboration among GPs, practice staff, AHPs and patients, increasing understanding and trust and enhancing multidisciplinary teamwork for chronic disease care for patients with diabetes or cardiovascular disease in primary care settings.

GPs reported a greater understanding of the roles of allied health service providers, and of the information that needed to be passed on to them. This flowed through into better patient satisfaction. Doctors talked about the long delay or lack of formal reports by the AHPs after patient referrals, possibly as a consequence of the lack of a MBS code for allied health professionals for case conferencing (including report writing and follow up).

The same study highlighted whilst the Team Care Arrangements are designed to facilitate access to allied health, the current paper-based system is insufficient to build relationships or effectively share roles as part of a patient care team and that active facilitation is the solution.

Another Australian study^{xxi} found two obvious barriers to multidisciplinary care: (i) GPs and allied health providers are seldom co-located, and (ii) practices have little capacity to coordinate care with other services.

Allied health role in prevention

One of the most significant failings of our current system is that it is not taking advantage of opportunities to prevent the development of chronic conditions or to support secondary prevention activities that are likely to reduce the incidence of avoidable negative health outcomes. For example, nutrition interventions can constitute a highly efficient component of a strategy to reduce the growing disease burden linked to over/poor nutrition.^{xxii} Effective integration of allied health interventions once a GP or other health practitioner has identified high levels of risk for the development of Type 2 diabetes, for example, could prevent the development of the illness in the first place. Similarly, the right interventions once the person has developed the illness are likely to reduce further consequences. Exercise and strength training for knee osteoarthritis are highly cost-effective interventions of (< \$5000/QALY). This compares with interventions that have been shown to be ineffective (for example, arthroscopy).^{xxiii} A wide body of evidence shows how exercise can be used to treat many chronic and complex health conditions. Yet Medicare data has shown that less than one percent of patients who are overweight or obese or who had type 2 diabetes were referred to an Accredited Exercise Physiologist for treatment.^{xxiv}

A focus on prevention can save the system significantly. Research by Exercise and Sports Science Australia (ESSA), who commissioned Deloitte Access Economics in 2016 to determine the value of investment of exercise interventions delivered by accredited exercise physiologists. It found these to be both effective and highly cost effective for Australians living with complex chronic disease. For example, the net benefit per person per year, for Type 2 diabetes was \$2,820, for people living with cardiovascular disease or with chronic obstructive pulmonary disease this increased to \$7,606 and \$6,629 respectively.

Research also suggests that effective integration of primary allied health services into the health system can result in a significant decrease in the number of patients needing access to hospital-based services. One study has shown that triage to early podiatry conservative management from the non-urgent category of the waiting list resulted in a reduction across three hospitals of between 23% and 49.7%, increased timeliness and improved patient flows.^{xxv}

Access to allied health care remains dependent on ability to pay privately

One of the reasons our system is not currently realizing opportunities to prevent the development of chronic conditions and associated deterioration is that these systemic and structural funding issues mean that Australian health consumers are left with only limited access to allied health services. Private health insurance is the only other major means of access for most consumers. However private

health insurance rebates are based not on clinical outcomes but rather on the sales of policy products leading to an inconsistent and complex mix of funding that covers only limited professions and treatments. While the Commonwealth provides some \$6bn of funding for private health insurance rebates, access to private health insurance disproportionately favours those with higher incomes and those in metropolitan regions. As a result, private health insurance products are not significantly increasing access to consumers with a need for services. Instead allied health access is heavily dependent on an ability to fund out-of-pocket costs for consumers. People experiencing disadvantage have worse health outcomes. For example, people on lower incomes are much more likely to experience chronic disease than those better off. For example, people in the bottom 20 per cent of incomes are about five times more likely to have cardiovascular disease or diabetes than those in the highest 20 per cent.^{xxvi}

The consequences of high out-of-pocket costs are increasingly being recognised. Recent consultations have found that Australians privately pay approximately 20 percent of total health costs, an amount that is approximately double that of the United Kingdom and some 50 percent higher than Canada and New Zealand, all three of whom have similar government-funded health systems. These costs are increasing too—Medicare data shows that out-of-pocket costs for GP visits have increased by nearly 20% since 2013 despite high rates of bulk billing. This is particularly concerning as out-of-pocket costs and medical gaps vary widely depending on the type of care being accessed and are typically far greater for non-medical services, such as allied health. More importantly, current debates around out-of-pocket costs are focusing on one-off high cost acute episodes which, while important, conceal some of the systemic issues that are failing to support the needs of people with chronic and complex conditions.

The high cost-of-treatment disproportionately impacts people with chronic illnesses, a group that also includes disproportionately high representation by people who experience socioeconomic disadvantage or are Aboriginal or Torres Strait Islander. People living with a respiratory disease, such as chronic obstructive pulmonary disease, experience far higher out-of-pocket healthcare expenditure than those with no health condition, paying \$1640 compared to an average of \$660 per year respectively. Out-of-pocket expense for other chronic health conditions are just as concerning with arthritis, diabetes, cardiovascular disease and mental illness all likely to be double, or more, than average costs for people with no health condition. Adults with asthma, emphysema and chronic obstructive pulmonary disease (COPD) had 109% higher household out-of-pocket healthcare expenditure than did those with no health condition (95% CI: 50-193%); and adults with depression, anxiety and other mental health conditions had 95% higher household out-of-pocket expenditure (95% CI: 33-187%). People with a chronic condition were also more likely to forego care because of cost.^{xxvii}

This was confirmed by a recent Consumers Health Forum of Australia Report 'Out-of-pocket Pain', which survey Australian health consumers and highlighted the particular financial burden faced by those living with a chronic illness. These consumers were found to require frequent out of hospital care specialist consultations with the result that just under one third spending between \$5,000 and \$10,000 in the previous two years.^{xxviii} While allied health costs are far lower than specialist costs, the

overall cost of healthcare treatment is likely to significantly impact on a consumer's ability to access care.

High out-of-pocket costs are known to be a barrier to accessing health services, particularly for people living with a chronic health condition, who are more likely to skip treatment due to cost than other cohorts. People experiencing mental illness are almost eight times as likely to skip treatment. People with depression, anxiety and other mental health conditions had 7.65 times higher odds of skipping healthcare (95% CI: 4.13-14.20), and people with asthma, emphysema and chronic obstructive pulmonary disease had 6.16 times higher odds of skipping healthcare (95% CI: 3.30-11.50) than did people with no health condition.^{xxix} The previous Senate Inquiry into out-of-pocket health expenditure in Australia report noted that:

- Australian Bureau of Statistics show that approximately 1.8 million Australians avoid seeking treatment each year due to cost
- National Health Performance Authority show that between 3–14 % of adults avoid seeking medical treatment due to cost
- Consumers Health Forum of Australia survey results showed that nearly half of Australians identified *cost* as a contributing factor to delays in seeing a medical practitioner.

Speech Pathology Australia has noted that the vast majority of patients incur full (or near to full) out-of-pocket costs of accessing private speech pathology services in Australia. The Dietitians Association of Australia notes that the current limit of five services per annum in total for allied health chronic disease service is too little to achieve adequate health outcomes as demonstrated by an evaluation of the Diabetes Care Project. Despite the research findings showing that greater investment in allied health resulted in better outcomes measured by HbA1c, systolic blood pressure, total cholesterol, LDL cholesterol, waist circumference and depression, no improvements have been made to access to allied health services.

Reduced attendance rates are associated with poorer health outcomes and a greater burden on the Australian economy. This is resulting in an increased rate of avoidable health impacts and costs to the system—data shows that potentially avoidable hospitalisations for asthma and chronic obstructive pulmonary disease (COPD) in Australia are among the highest in the OECD.

In addition to research demonstrating the link between low attendance and poor health outcomes, research also shows that improving access to allied health professionals results in favorable improvements in health outcomes. Victoria's Chief Allied Health Adviser, Kathleen Philip, noted the allied health workforce has the ability to enhance quality of care, improve consumers' experience of primary health care, improve access to primary health care, and reduce the rate of health care expenditure and be used (together with their nursing and medical counterparts) as a greater strategic resource in the effective management of chronic and complex care.

Multidisciplinary care planning and coordination is currently failing due to lack of rebates

Allied health practitioners are well-placed to assist in the development of care plans for people with chronic conditions, having a strong understanding of the range of options available to help consumers maintain and improve their health outside of medical interventions. However, although Team Care Arrangements and multidisciplinary care plans required in Item 10952 appear to acknowledge the need for interdisciplinary collaboration, the current funding arrangements do not remunerate allied health practitioners for case conferences for planning/review purposes, assessment consultations with patients, or communication with GPs. As Foster et al. (2008) write:

“Essentially, this policy forces AHPs to engage in pro-bono work, which is at odds with operating a financially viable small business. The policy reinforces the notion of allied health services being “optional” rather than central to multidisciplinary team care. This may discourage AHPs from participating in more than a minimalist way in multidisciplinary activities, and is likely to reduce the quality and effectiveness of chronic care.”

The low use of case conferencing items compared to other items suggests a systemic failure though it is not clear if this is simply the lack of funding or whether in some cases GPs are less inclined to participate in case conferences compared to health assessments and GP Management Plans.^{xxx}

Medicare statistics indicate that overall uptake by GPs of GPMP and TCA items, required precursors to allied health referrals, is low. The national number of GPMPs prepared in the year to 30 June 2009 was 1.08 million plans, at a cost of AU\$130 million. The average number of GPMPs prepared by each GP nationally was 22, with 25% of GPs preparing six or less and 25% of GPs preparing more than 56 plans over the 12 months. Approximately half were reviewed.^{xxxi}

Experience suggest that this may at least in part reflect the levels of knowledge and experience of the allied health sector of GPs and practice nurses—unless these have a clear idea of the role and benefits of involving allied health professionals (such as speech pathologists, occupational therapists) a referral won't happen and the opportunity for a cost-effective, multidisciplinary intervention will be lost.

Current MBS rebate structures are insufficient and do not account for complexity

MBS CDM funding is currently capped at 20 minutes regardless of the type of consultation or the profession of the treating practitioner. This is out of touch with standard practice for allied health services, which typically involve an initial assessment that would normally take between 45 and 60 minutes. This initial consultation is important in laying the foundation for further treatment and establishing the needs of the particular patient.

Many of the allied health services likely to be delivered as part of chronic disease care are also likely to significantly exceed the 20-minute session currently rebated resulting either in significant out-of-pocket costs for the consumer or services that are unable to sufficiently deal with the patient's health needs. The 20-minute duration also fails to account for the complexity of the health needs of many consumers. Co-morbidity is common among people with chronic illnesses^{xxxii} and 90% of people with

chronic obstructive pulmonary disease (COPD), 85% of people with diabetes, and 82% of people with cancer had two or more chronic diseases.

International research consistently shows that health system costs (including potentially avoidable hospital admissions) are heavily skewed to a comparatively small subgroup of people with chronic disease.^{xxxiii} Studies suggest that as much as 20 per cent of costs are incurred by one per cent of patients, patients who are typically older, with higher risk factors and more advanced disease and comorbidities.^{xxxiv}

However, current payments for chronic disease interventions are restricted to the same durations and annual attendance limits regardless of whether the patient may need intensive case management as a result of high risk factors such as foot ulceration or whether they require only an annual check by several professions to assess risk factors and support ongoing self-management. While so-called high risk clinics may be offered by jurisdictions to address some of this shortfall, the approach is neither nationally consistent, nor likely to be available outside metropolitan centres. Additionally, those clinics are likely to be set up to account for only some forms of complex need and risk.

Occupational Therapy Australia notes that there are a number of services occupational therapists provide in the CDM scheme in more specialized areas such as Acquired Brain Injury, Lymphedema and hand therapy. An initial consultation in these areas can often take 60 minutes or more leading to significant out-of-pocket costs for consumers and resulting in consumers rejecting the service.

A Cairns Occupational Therapy private practice notes:

“We have had many patients decline to make an appointment when they hear about the out-of-pocket expense of \$30, on top of the \$52.95 Medicare rebate. In most cases they have nowhere else to go for this service. Especially given we are in a regional area with limitations on public services.”

A similar experience is common for osteopaths who report that *“In their experience of treating EPC/CDM subsidised patients, 61.2% of osteopaths stated that these patients would require an average of 8-10 consults per annum to provide optimal benefits from osteopathic treatment, and 9.4% said 5-7 consults per annum. The reasons stated are that CDM patients are different from the usual patient group, the most commonly nominated factors were that they are in financial difficulty (50.6%) or have co-morbidities (38.8%)”*^{xxxv}

Similarly audiologists report providing care for patients with chronic conditions and complex care needs (Item 10952), Aboriginal and Torres Strait Islander Peoples (Item 81310), and children with autism, pervasive developmental disorder (PDD) or an eligible disability (Items 82030 and 82035) and having no option for the longer consultations with patients that may be required in some cases. Thus, audiologists may have to set fees for longer consultations which are higher than the Medicare benefit, resulting in significant out-of-pocket costs for the patient and possibly creating disparities in the accessibility of care.

Assessing the evidence base for allied health interventions

AHPA is aware that a key challenge for the MBS Review Taskforce and its associated committees and groups has been assessing the evidence for certain interventions. This is particularly problematic in the primary care space where there is little data available to draw on and there has not traditionally been significant investment in research. AHPA notes that the Taskforce has acknowledged this challenge and has recognised the need to draw on practitioner expertise and other levels of research where appropriate.

We further note that the published NHMRC methods for literature reviews are primarily designed to be applied to assessment of the evidence of the effectiveness of medical interventions and pharmaceutical treatments (primarily relying on randomised controlled trials) or diagnostic tests. In the case of examination of allied health interventions, often there is a notable dearth of evidence from Level I and Level II studies, and much of the scientific evidence is observational, especially from prospective cohort studies. It is rarely possible to conduct blinded intervention studies for such activities as treatments with whole diets or exercise programs in free living populations or where multiple different interventions from different practitioners are required to achieve an outcome, and very few trials are conducted for long enough periods to assess long term health outcomes. In some cases it may even be unethical to require RCT type trials as they could actually cause harm to those in particular groups. Therefore, Level III prospective cohort studies often provide more important evidence for the development of successful interventions than Level I evidence summarising small short-term randomised controlled trials which place individuals in artificial situations which do not mirror daily living with a chronic condition and can skew expected outcomes.

Finally, AHPA particularly notes the broad and non-specific nature of the allied health items, particularly the chronic disease management items, which cover a very broad range of health issues. For most allied health professions, the one item number is intended to cover a very wide range of interventions each of which is likely to have different types of supporting evidence. For example, is the evidence for dietetic intervention in diabetes sufficient to support the retention of the item? AHPA supports longer term changes to improve data gathering for the use of the allied health items, in conjunction with the use of other GP and hospital services, to improve understanding of the use and benefit of the allied health items. However, AHPA also strongly opposes the arbitrary application of unreasonable evidence standards in the review of the allied health items.

1.3 Recommendations for changes to subgroup M3 items (10951 – 10970)

AHPA strongly recommends that subgroup M3 items are retained and expanded. The recommendations put forward by AHPA focus on ensuring that the Chronic Disease Management items are able to support the intentions of the program. AHPA contends that minor reforms would allow the MBS to increase patient access to allied health services that are underpinned by a wide body of research and best practice standards. These reforms are unlikely to significantly increase short-term

costs but have the potential to significantly improve overall patient care and reduce adverse outcomes such as preventable limb amputations for diabetic patients.

Artificial limitations on the annual number of items that can be claimed as well as short service durations are out of line with other similar items and suggest rationing rather than a focus on ensuring universal access to care. Other Schemes supporting clients with similar health issues such as Department of Veteran's Affairs funding as well as other MBS item groups are based on need or episodes of care rather than individual services and allow a far greater and more appropriate number of services. Many chronic conditions are likely to require at least two, possibly even three or four different health professions to provide care. An annual limit of five sessions means that Medicare support is barely adequate for an annual checkup and has no provision for more intensive intervention where greater complexity or risk is demonstrated.

Current Medicare rebates for allied health care are well below the average cost of services and cover only a small proportion of the services most consumers need each year. Many allied health services are consultative in nature and cannot be provided during a 20-minute rebated service. Medicare statistics for the Better Access to Mental Health Care Medicare items, where service delivery for a range of professions is likely to be similar, supports the need for longer consultation rebates with 90% or more of the items accessed by eligible allied health practitioners of one hour duration.

The recommendations for changes are outlined below. Each recommendation is supported by a separate position statement supplied with this document, which provides greater detail and supporting arguments and evidence.

- **Recommendation 1 – Change schedule fees**
Review the schedule fee for allied health services to ensure that these are sufficient to support universal access to allied health services and keep out-of-pocket costs to a reasonable level.
- **Recommendation 2 – Change care setting/location of service**
Changes should be made to the care setting/location of service limitations currently imposed on the subgroup M3 Medicare items to enable remote consultations to be delivered via telehealth for patients living in rural and remote areas defined as being outside of a major city (RA1 using the Australian Standard Geographical Classification - Remoteness Area (RA) classification).
- **Recommendation 3 – Service conditions.**
Urgent adjustments are required to increase both the maximum number of annual services and the duration of services to bring them in line with standard practice. AHPA recommends an initial longer duration assessment is made available annually for each profession included in the management plan. AHPA further recommends that the five annual session cap is increased to ten with additional sessions available to newly diagnosed patients or those displaying higher risk. Access to the additional ten annual items could be via GP prescription as is currently the case with Better Access to Psychological Services items.

- **Recommendation 4 – Service conditions.**

Provide access to services for women with gestational diabetes, who do not currently meet the definitions of chronic disease but demonstrate an important area of need and who are likely to have up to seven times the risk of Type 2 diabetes as a result of the gestational diabetes^{xxxvi}.

1.4 Recommendations for changes to subgroup M9 items (81100 – 81125)

The group items covered by subgroup M9 are structured more effectively than those in subgroup M3 as they include both an assessment item and fund a larger number of individual interventions. Utilisation data suggests that for every assessment conducted, on average, each person attends 5.27 group sessions. As such these items are important to retain.

However, extensive feedback from practitioners suggest that many practitioners may discontinue using them if they are not able to ensure sufficient clients attend each session. The primary issue with the current structure of these items is that the rebates are such that practitioners cannot break even with the minimum number of participating clients. With only two clients participating, the practitioner receives a total rebate of \$34.90 for a session of at least 60 minutes. To achieve a sustainable income, a practitioner is likely to require a minimum of 6-8 clients and has no backup if those clients do not turn up on the day as there is no provision for cancellation fees. This means that the practitioner is exposed to significant risk and is less likely to make use of a service item that is otherwise structured effectively. Feedback suggests that attracting sufficient patient numbers in rural and remote regions is particularly challenging, again exacerbating access issues for people in those regions.

Possible solutions include staggered fees that provide for greater rebate for the first 2-4 clients. This would make smaller sessions viable while still incentivising larger groups. Alternatively, some form of cancellation fee would mean practitioners are exposed to less risk in setting up and running sessions.

A further gap in the structure of this subgroup of items is the lack of a final re-assessment item, which would allow a practitioner to review progress with the client and provide support for ongoing self-management activities.

- **Recommendation 1 – Change schedule fee**

The schedule fee should be reviewed to ensure that it is set at a level to ensure practitioners can reliably and sustainably offer group services without requiring significant co-payments. It may be appropriate to have a cascading fee structure so that remuneration rates are higher for the first 2-4 clients allowing group sessions to be sustainably offered even when there are smaller numbers of clients available to participate but still incentivising the involvement of larger groups of participants.

- **Recommendation 2 – Change service conditions**

The service conditions should be adjusted to provide a rebate for a final re-assessment at the end of the eight sessions.

1.5 Autism Spectrum Disorder and Pervasive Development Disorder

In addition to their important role in support people with chronic health conditions, there is significant evidence showing the important role of psychologists, speech pathologists, occupational therapists and other appropriate allied health professionals in the assessment and treatment of Autism Spectrum Disorder (ASD) and Pervasive Development Disorder (PDD) in children and young adults. The access provided through these items provides vital access to support for many families.

1.6 Recommendations for changes to subgroup M10 items (82005 – 82035)

AHPA contends that the subgroup M10 items must be retained as they provide essential access to assessment and support for children, support that may not be available through other funding methods such as the NDIS or may only be available once initial assessments have been made through the use of the M10 items.

The recommendations for changes are outlined below. Each recommendation is supported by a separate position statement supplied with this document, which provides greater detail and supporting arguments and evidence.

- **Recommendation 1 – Change service conditions (assessment items)**
Changes should be made to the current service duration limits imposed on the subgroup M10 assessment items to align rebates with best practice assessment methods.
- **Recommendation 2 – Change service conditions (treatment items)**
Changes should be made to the current lifetime limits imposed on the subgroup M10 treatment items to ensure consumers who will not be able to access the National Disability Insurance Scheme (NDIS) can access appropriate care at key development stages. Lifetime limits should be replaced by annual limits. Age limits should also be removed.

Priority 2 – Longer-term recommendations to improve the efficiency of the MBS

Considering the focus of this Review, AHPA has focused most of its work on the items determined to be in-scope. Our recommendations have focused on practical changes that would allow those existing items to be more effective. However, even with the implementation of those changes, access issues will remain for many consumers. Opportunities for improved outcomes for patients experiencing a wide range of health conditions, including chronic and complex conditions, will remain underutilised. Similarly, opportunities to reform some of the traditional structures that underpin the current Schedule due more to historical reasons than a recognition of the changing health landscape and the changing needs of consumers will remain unexplored.

Our additional recommendations cover the following key areas:

1. More streamlined referral processes covering both referrals for diagnostic imaging and pathology; and referrals to and from specialist services.
2. Inclusion of allied health professions whose scope of practice means that they would be an appropriate provider of services covered by these MBS subgroup items.
3. Provision for alternate funding structures for allied health services that are outcomes rather than service focused.
4. Support better data collection on patient outcomes across the primary care sector and link this to hospital outcomes.

Alternatives to fee-for-service funding

In addition to these specific recommendations, AHPA understands that the Review is considering options that might bundle payments or more closely mimic managed care options in place in other health systems. AHPA is broadly supportive of the idea of reforming health funding and of a move towards funding outcomes or episodes of care. The fee for service model does not meet the complex needs of people with chronic disease, particularly those who experience a number of health issues and co-morbidities. The Medicare Chronic Disease Items for allied health are insufficient to provide adequate care for the least complex clients, let alone those with greater complexity or the newly diagnosed. The same limitations apply to the support provided by general practice and other parts of the health system. Until more intensive interventions can be applied that focus on the outcomes that are needed for patients with varying needs, our system will continue to fail to prevent unnecessary poor health outcomes, health outcomes that disproportionately impact those who experience disadvantage.

There are a range of options that have been tested or are in place locally and internationally that have demonstrated both improved outcomes and cost efficiency. The Diabetes Care Project was innovative in making available more allied health visits for trial participants and demonstrated that greater investment for lower and higher complexity cases resulted in better outcomes. This experience

suggests that the fee for service model could work, if increased allied health visits were allowed under Medicare Chronic Disease Items and if case conferencing arrangements were extended to allied health. Similarly, the Victorian Hospital Admission Risk Program (HARP) provides specialised client-centred medical and allied health care and care coordination in the community and ambulatory setting through an integrated response of hospital and community services. The project was formally evaluated in 2004-05, and in that 12 month period, HARP clients' experienced 35% fewer emergency department attendances, 52% fewer emergency admissions; and 41% fewer days in hospital. The service delivery model used is based on the Kaiser Permanente Chronic Care framework and the Wagner Chronic Care Model. Internationally a range of medical homes, managed care and other outcomes-focused initiatives have resulted in improvements to health delivery.

A systematic review^{xxxvii} of models of care for musculoskeletal pain conditions, osteoarthritis, rheumatoid arthritis, osteoporosis and musculoskeletal injuries and trauma identified best practice care models around the world. Consistent features of MOCs included primary and secondary, prevention, care coordination, access to a multidisciplinary team to address the biopsychosocial aspects of chronic musculoskeletal conditions and injury and trauma sequelae, self-management support and care planning that is inclusive of patients as equal team members respecting their cultural backgrounds, co-morbidities, mental health and socio-economic status alongside a workforce of adequate volume and competencies.

In one Western Australian model where service delivery for pain (including CMP) management was inverted, inter-professional consumer group education sessions are delivered prior to individual practitioner appointments. The model delivered reduced wait times and costs at public pain medicine units and increased use of active pain management strategies by consumers with fewer requiring individual consultations prior to individual practitioner appointments^{xxxviii}

AHPA contends that any move to introduce and/or trial new funding structures should ensure that they involve the broader health system, including allied health, rather than being limited to one particular professional group. They should also be developed on the basis of careful consultation with the health sector, including allied health and key medical stakeholders. Any changes must involve detailed analysis of the impact on access to services. Constraints must be placed on ensuring that patient care utilises appropriate clinical expertise and is within the scope of practice of the health care professional delivering that care. We note that the current Health Care Homes initiative, while not directly involving allied health practitioners or allied health funding, has shown signs that its implementation may result in a shift from delivery of at least some services from qualified allied health practitioners to medical assistants or other health professionals who do not have the same clinical expertise and training. This may be due to the constraints on the trial and its current lack of involvement of allied health.

We also note the importance of ensuring that approaches are not overly general practice-centric, where there is a risk that this is detrimental to existing services and supports that may exist in a particular area. AHPA recognises the government's desire to build on its heavy and ongoing investment into general practice as well as the benefit many practitioners gain by being co-located

with GPs. However, there is an ongoing risk of market distortion created by the government's investment in general practice technology uptake and staff resourcing that may reinforce treatment options that are not optimal for the patients' health or recovery, while potentially eroding existing allied health practice viability and, consequently, access to appropriate services.

2.1 Streamline referral processes to reduce consumer and system costs

The current structure of many MBS items requires general practices to play an intermediary gatekeeper role between two referral points. This primarily administrative support role adds costs and time delays rather than adding to the quality of care. Current referral requirements fail to recognise the primary contact role of allied health providers, or the expertise of allied health and specialist providers. Simple changes to the service conditions for a range of MBS items would provide significant improvements to the efficiency of our health system and reduce costs.

Key examples of these roles include musculoskeletal interventions where chiropractors, osteopaths and physiotherapists are likely to provide the primary point of contact for patient care. For example, a person who has a sporting or other musculoskeletal injury may seek immediate care from an allied health professional. That allied health professional has the skill, expertise and scope of practice to diagnose the issue and to determine whether additional diagnostic imaging services may be required. Similarly, that health professional may determine that immediate referral to an orthopaedic surgeon is required. However, current MBS service conditions slow down the referral process and add time and financial costs by requiring the consumer to first see a GP for the required referral. By allowing direct referrals to appropriate imaging services as well as to other health professionals, patient care can be significantly improved.

Current requirements regarding referrals that apply to the MBS items for audiologists place unnecessary barriers to the smooth transition of patients along their pathways of care. Under the current system, a patient must be referred to an allied health practitioner by a medical practitioner or specialist. This necessity may increase costs for patients and the health system where a consumer requires an additional GP consultation simply to get a referral. Some common examples include:

- An adult who has their hearing assessed by an audiologist working in a hospital and who is identified as requiring hearing aids will need to obtain a referral from a medical practitioner in order to access the Office of Hearing Services Voucher scheme and will then require a second hearing assessment prior to being fitted with hearing aids.
- An infant who is identified as having a sensorineural hearing loss cannot be fitted with hearing aids without clearance from an ENT specialist. Long waiting times for ENT services in public hospitals can delay the hearing aid fitting with potential adverse consequences for the infant's speech and language development.

- A patient identified by an audiologist as having a disorder that is most appropriately treated by surgery must return to their general practitioner to obtain the required referral to an ENT surgeon.
- A child in a remote community diagnosed with otitis media with accompanying hearing loss and requiring hearing aids by an audiologist requires that the local nurse organises for the child to be seen by the next visiting medical officer so that the medical officer can make a referral to the ENT to obtain clearance to fit the hearing aids. It is not inconceivable that there will be a six to twelve-month delay before the hearing aids are actually fitted.

In each case additional costs are borne by the healthcare system and the patient unnecessarily.

The recommendations for changes are outlined below. Each recommendation is supported by a separate position statement supplied with this document, which provides greater detail and supporting arguments and evidence.

- **Recommendation 1: Allow referrals for imaging services.**
Where clinically indicated as preferable to plain radiography, ultrasound (Group I1, Subgroup 6) is made available for MBS rebates via direct referral from allied health practitioners appropriately trained to diagnose and treat musculoskeletal issues. Expand MBS Schedule 5, Subgroup 1 to provide access to MSK allied health practitioners.
- **Recommendation 2: Allow direct referrals to other health professionals.**
AHPA recommends that the Taskforce supports amendment of Explanatory Note GN.6.16 of the Medicare Benefits Schedule, such that a referral can be made by an allied health professional to specialists and consultant physicians within the allied health professional's scope of practice.

2.2 Inclusion of allied health professions with appropriate training and clinical expertise

AHPA contends that a number of professions with the necessary training and expertise and with an appropriate evidence base to show their role in the delivery of services for particular chronic conditions are currently being excluded from delivering rebatable services. These professions are excluded not on the basis of their qualification to deliver those services but because the original implementation of the Medicare items had errors in its implementation and design.

AHPA contends that a longer term review process should be implemented that allows professions to demonstrate their competence in delivering services under the MBS. This process should have reasonable evidence requirements and reflect the level of evidence available for other funded interventions.

- Recommendation 1: Include orthotics/prosthetics in the professions able to deliver diabetic foot and related care under the MBS.**

Orthotists/prosthetists have specific training and expertise to support care for consumers with diabetic foot issues. Access to appropriate foot care has been shown to significantly reduce the risk of adverse outcomes for consumers, including amputations.
- Recommendation 2: Introduce an MBS rebate for occupational therapy driving assessments.**

Introducing a Medicare rebate for occupational therapy driving assessments would improve road safety and access to transport for consumers, for whom driving can be a key activity of daily living. An occupational therapy on-road driving assessment with a self-navigation component, administered in a standardised format and using objective scoring protocols, has been shown to be a valid and reliable measure of driving ability^{xxxix,xl,xli}. The use of such an on-road protocol provides evidence for the justification and evaluation of driver remediation programs, and furthermore has been shown to be predictive of subsequent crash risk in older drivers.

2.3 Implement processes to track primary care outcomes and utilisation and link with hospital data

Our current health system has no effective means of tracking outcomes for patients or even effectively tracking patient pathways across the primary and acute sectors. The lack of Medicare funding for most allied health interventions and the lack of data collection from primary care providers in general means that there is little opportunity to understand the patient experience in primary care and the connection between primary care interventions and hospitalisations. As a result, we are not effectively able to ask questions such as how often did a patient see a GP or specialist or allied health practitioner and how did this impact their use of medications, rate of hospitalisation and overall health outcomes. This lack of data severely hampers our ability to make outcomes-based decisions about funding interventions and building policy to support the growth and development of our health system. AHPA recommends the review taskforce consider opportunities to better link patient outcomes with utilisation of services.

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