CONSULTATION RESPONSE

Allied Health Professions Australia

Medicare Review General Practice Primary Care Committee

Response to the Phase Two Report

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Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback on the General Practice Primary Care Committee's Phase Two Report. AHPA is the national peak body representing Australia's allied health professions. We have 20 individual member associations, and a further six organisational friends who represent allied health professions or professions closely aligned with the allied health sector. The AHPA membership represents some 93,000 allied health professionals working across a wide range of settings and sectors. Our friend organisations represent a further 5,400 professionals.

A significant proportion of those allied health professionals provide essential care to Australians seeking primary health care, either in conjunction with a treating GP and other health professionals or independently as part of their primary contact role. AHPA and its member associations are committed to ensuring that all Australians, regardless of their background, socioeconomic status or age, can access safe, evidence-based services to support wellness, reablement and maintenance of functionality so that they can live life as fully as possible.

This submission has been developed in consultation with AHPA's allied health association members.

Introduction

Allied Health Professions Australia (AHPA) welcomes the release of the Phase 2 Report from the General Practice and Primary Care Clinical Committee (GPPCC) and its recommendations for changes to a range of item categories as part of the broader Medicare Benefits Schedule (MBS) Review. Given the close interaction between general practice and allied health in the primary care space, and the range of structural challenges limiting the effectiveness of a multidisciplinary allied health care team for consumers, the recommendations in this report are of significant interest to AHPA and its members.

Not all of the recommendations in the report impact on allied health service delivery and access. As such we have deliberately kept the commentary in this report focused on the items that are of the greatest relevance to allied health practitioners supporting general practice and primary contact patients. We note that AHPA and its members created a comprehensive series of position statements outlining our own recommendations for reform that were provided to the allied health reference committee. Those recommendations remain highly relevant and we encourage the Taskforce to revisit those in the context of the GPPCC recommendations, noting that for many patients, good outcomes depend on access to appropriate follow-on allied health care after they've been diagnosed and referred by a GP. That follow on care is currently not universally accessible and remains heavily dependent on an ability to pay privately.

Responses to the individual recommendations

The AHPA response addresses the following recommendations made in the Phase Two report of the GPPCC.

1. Move to a patient-centred primary care model supporting GP stewardship
3. Introduce flexible access linked to voluntary patient enrolment
4. Combine GP Management Plans (GPMPs) and Team Care Arrangements (TCAs) and strengthen GPMPs
5. Link allied health items to GPMPs
6. Equalise the rebate for GPMPs and GPMP reviews
7. Increase access to care facilitation services for patients
8. Activate and engage patients in their own care planning
9. Rebate participation in case conferencing for non-GP health professionals
11. Delete Health Assessments less than 30 minutes and expand the at-risk groups who are eligible for Health Assessments
16. Increase access to primary health care in Residential Aged Care Facilities

Recommendation 1 – A patient-centred primary care model

AHPA supports the Committee's vision for the future of primary health care in Australia as one that provides continuing care for the person rather than episodic treatment for illness, emphasises prevention and health promotion in addition to disease management, focuses on outcomes rather

than process, and provides collaborative team based care integrated into the larger health system. This vision is one that aligns with a growing recognition by policymakers and health stakeholders that fee for service approaches are leading to less efficient care and less effective outcomes.

We agree that a greater integration of care will be required, with much more efficient collaboration between the health professionals providing care. We also acknowledge that in a majority of cases, GP stewardship is likely to be the most appropriate approach. However, we also note that in some cases, a move to allow genuine patient-centred care may involve a patient taking advantage of primary contact access to allied health services rather than requiring a GP referral to trigger access.

Similarly, some patients in some situations may be best placed to have a coordinating role provided by an allied health practitioner. For example, a person with ongoing chronic musculoskeletal health issues may wish to have a musculoskeletal health professional such as a chiropractor, physiotherapist, or osteopath coordinate their care with an emphasis on reablement and non-surgical or medication-focused interventions. We argue that a contemporary health system should be designed carefully with a focus on patient needs and the full involvement of both medical and non-medical health professionals. Any potential reforms in this area must be co-designed with the involvement of the allied health sector.

Recommendation 3 - Flexible access to care

AHPA supports a move to greater flexibility in how care is delivered, noting that telehealth (also referred to as telepractice) is supported by a wide body of evidence showing that it can be effective. In addition to supporting increased access to general practice services, AHPA argues that a more consistent approach to telehealth access should be applied across the Medicare Benefits Schedule (MBS) as access issues apply to consumers regardless of whether they are accessing specialist, general practice or allied health services.

While supporting this change, we note that recent adjustments to programs such as Better Access to Psychological Services have initially implemented mechanisms aimed at protecting local services by requiring initial face-to-face consultations before eligibility for telehealth access. While AHPA strongly supports the need to have sustainable businesses in rural and regional areas, we argue that these mechanisms are ineffective (as demonstrated by low levels of uptake and the subsequent drought adjustments) and that most consumers will have a preference for engaging with local services except where there may be an intention to discuss sensitive information with someone not part of a local community. As such we argue against constraints on who can provide teleservices.

Recommendations 4 and 5 - Merging General Practice Management Plans and Team Care Arrangements

AHPA supports any attempt to streamline the current process for accessing allied health services. While the exact cause is not evident, as a sector we have significant concerns about low levels of referral for allied health services in cases where we believe that best practice would dictate allied health care. A key example is the low rate of referral for musculoskeletal problems, where we note

that a 2017 RACGP report showed that only 6.8% of all musculoskeletal problems managed by a GP were referred to a physiotherapist.[i]

While we acknowledge that only some of these issues will have been chronic and eligible for Medicare rebates, and that including chiropractic and osteopathy will increase that rate slightly, we argue that appropriate care for musculoskeletal issues should involve much higher rates of referral to allied health services. The low rate of referral is particularly concerning given high rates of opiate addiction connected to chronic musculoskeletal health issues.

We similarly note that referrals for psychological services are consistent low and much lower than medical prescription rates. The AIHW 2016 Survey of Health Care noted that "of those who spoke to a GP for their emotional or psychological health, almost half (48%) reported being prescribed medications, two in five (39%) reported being provided with counselling and just over one quarter (29%) reported being referred to a psychologist, psychiatrist or counsellor."[ii]
It is our hope that the implementation of this recommendation and a resulting reduction in administration for GPs will support higher levels of referral to allied health services. We recognise that a streamlining of administrative processes is only one element of increasing access to, and use of, appropriate allied health services.

AHPA also wishes to highlight in this context the issue of high rates of non-use of referred allied health services when patients have a Team Care Arrangement (TCA) plan in place. The report notes "some TCAs are claimed for patients who do not use the associated allied health services: 30% of patients who claimed a TCA did not use any allied health services that calendar year."

AHPA argues that there are significant issues that require further examination if almost a third of patients with TCAs are not utilising the allied health service for which they were referred. These issues are not simply due to administrative burden and addressed by the deletion of the TCA Medicare items. We argue that this is most likely due to access issues related to the design of the allied health items and the limitations of those items. Addressing those issues will be essential to support follow-on care prescribed by a GP.

Recommendation 6 – Changes to GPMP descriptor, explanatory note and schedule fee

While AHPA supports the streamlining of items 721 and 732, we note that the proposed wording change removes the current requirement under item 732 to:

> *"a. consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the general practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan."*[iii]

While we recognise the burden this places on practitioners, we also note that coordinating services from the earliest possible point in the patient journey is likely to have benefits for consumers and the health system. As such we argue for consideration of aligning the development and

management of a GP management plan with the case conferencing item, particularly for patients with risk factors. We would suggest and support the addition of a requirement for a case conference within the first three months of the establishment of a GP management plan to support better coordination and patient care.

Recommendation 7 - Increase access to care facilitation

AHPA acknowledges the important role of care facilitation and we support reforms to the current Medicare system to increase access to facilitation services for consumers with chronic and complex health needs. However, we are extremely concerned about the recommendation to fund access to care facilitation by drawing on the current, limited number of allied health items. Adding care facilitation into the already limited pool of annual sessions for non-allied health services would reduce access to already limited care and spreads further the number of services funded under this group of items.

As such AHPA argues that this option would be inappropriate unless the service was provided by an allied health practitioner, or aboriginal health worker, and that the addition of this category of services to the group of allied health items was accompanied by an increase in the annual limits on the allied health items as recommended by AHPA for patients with higher level needs. AHPA considers a minimum of 2-3 sessions per year are likely to be the minimum required for care facilitation and notes that care facilitation can only be effective if consumers can be referred for appropriate and financially accessible care. This necessitates a larger pool of allied health items.

AHPA also argues that while nurses play a very important role in modern general practice, they may not represent the most appropriate set of professions with care coordination expertise. In the case of a range of different chronic health conditions, an allied health professional may be best placed to provide care coordination due to their understanding of the patient's needs and expertise in that condition. This may include a diabetes educator or dietitian for a person with diabetes or a musculoskeletal health professional for a person with back pain.

Finally AHPA argues that a fee-for-service approach may not be effective and appropriate for care facilitation noting that a care facilitation role is likely to require regular contact with flexibility in the length of the service provided as well as the ability to undertake non-face to face activity. Instead we believe a block-funded or PHN-led approach may be most appropriate. The advantage of a PHN-led approach is that it may support alternatives to a purely general practice-based approach such as for people with mental ill health. We also argue that a PHN is likely to have a better understanding of the range of services available in a region and could utilise that expertise to support the work of staff with a care facilitation role.

Recommendation 8 - Activate and engage patients in care planning

AHPA supports the proposal to develop advice and support mechanisms to activate and engage patients in their own care planning, including assessment and support of patient health literacy. It is our experience that patient health literacy can play a vital role in helping patients understand what

health services they may require and which health professionals to involve in their care. Health outcomes are often better for patients with the right knowledge and ability to self-advocate. One reason may be that those patients may be more likely to understand the need to be actively involved in their own health, are more likely to request referrals for health services that may not be automatically provided, or argue for alternative methods such as non-medication based approaches.

We strongly argue that any work undertaken to develop mechanisms and resources must involve the allied health sector. We note that the allied health sector is experienced and trained in approaches that work with the patient meaning that allied health practitioners can provide valuable input. We also note that allied health practitioners are likely to be important members of the broader care team for many patients and should thus be involved in the design of these mechanisms ensuring that they reflect the work and practice of those practitioners.

Recommendation 9 - Case conference items for non-doctor health practitioners

AHPA and its members were extremely pleased to see a recommendation for changes to case conferencing and strongly support the recommendation to:

> '*Create three new items to rebate attendance at a case conference by non-doctor health practitioners, one for 15-20 minutes to align with item 747, and one for 20-40 minutes to align with item 750, and one for >40 minutes to align with item 758.'.*

The allied health sector has long argued for the need for remuneration for other participating practitioners as part of a case conference as the basis for effective care for consumers with complex needs requiring the involvement of multiple health professions. We have strongly argued that this change will make significant improvements to better linking the allied health sector to general practice and support genuine multidisciplinary approaches. In conjunction with enhanced communication and information-sharing through other initiatives such as My Health Record, this change has the potential to significantly improve patient care and the effectiveness and efficiency of our health system.

Recommendation 11 – Health Assessment changes

AHPA supports the recommendation to include a requirement that the GP must *"personally explain the findings and implications of the Health Assessment to the patient and agree with the patient a plan for health promotion and disease prevention based on these findings."* We would additionally suggest that there is an additional requirement to develop a GP management plan with appropriate referral to services where indicated by the results of the health assessment.

We argue this on the basis of Medicare data showing a current relative lack of correlation between health assessment items and use of GPMPs and TCAs, despite evidence of the rates of chronic and complex illness in many of the cohorts eligible for health assessments. We further argue that without appropriate follow on care and, where appropriate, behavioural change, patient health

outcomes are unlikely to be improved. This may contribute to the lack of correlation between current health assessments and improved health outcomes.

A wide body of evidence shows that many people need additional support to achieve the behavioural and other changes needed to address their health issues. In many cases, allied health practitioners such as diabetes educators, dietitians, exercise physiologists and physiotherapists are well-placed to provide this support. AHPA supports the recommendation that health assessments should generally be undertaken by the patient's 'usual doctor'. We believe that continuity of care is essential to achieving good outcomes.

Recommendation 16 – Increase access to primary health care in Residential Aged Care Facilities

AHPA supports any initiatives to increase access to primary health care for people living in residential aged care facilities. We note that a range of reports have noted the disparity in access to mental health and allied health services for older people in residential aged care, despite evidence of high rates of mental ill health and chronic illnesses in aged care residents. The same access issues do not exist for general practice services and PBS-funded medications.

It is likely that there is a strong correlation between the rates of over-medication of older people in residential aged care and lack of access to a broader range of appropriate primary care services. As such it is disappointing that the recommendation outlined in the report while referring to primary health care, only focuses on access to general practice. AHPA argues that urgent work is required to investigate the effectiveness and appropriateness of the new program of mental health services funded in the 2018 Federal Budget and to more broadly review access to appropriate primary care services for residents of aged care facilities.

We further argue that any genuine attempt to address access to primary health care services must be undertaken with the involvement of a broader range of primary health care providers including allied health.

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[i] https://www.racgp.org.au/afp/2017/june/who-do-australian-general-practitioners-refer-to-physiotherapy/
[ii] From New joint AIHW-ABS publication: 4343.0 Survey of Health Care, Australia, 2016 [20 September 2017]).
[iii] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=732