CONSULTATION RESPONSE

Allied Health Professions Australia

Medicare Review Specialist and Consultant Physician Consultation Clinical Committee

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Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback on the Medicare Benefit Schedule Review's Specialist and Consultant Physician Consultation Clinical Committee. AHPA is the national peak body representing Australia's allied health professions. We have 20 individual member associations, and a further five affiliate members who represent allied health professions or professions closely aligned with the allied health sector. The AHPA membership collectively represents some 120,000 allied health professionals working across a wide range of settings and sectors.

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, re-ablement 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 report from the Specialist and Consultant Physician Consultation Clinical Committee and its recommendations for a range of changes as part of the broader Medicare Benefits Schedule (MBS) Review. A number of the Committee's recommendations will directly impact allied health professionals and are of significant interest to the sector. Several recommendations also reflect common themes across the reports presented by other clinical committees and working groups that have been part of the MBS Review. Our responses to those recommendations are structured on that basis. Despite the wide range of different clinical areas those different stakeholder groups work in, there is a clear recognition that the current Medicare structure could better support consumers in key areas such as telehealth. We argue that these areas should be addressed consistently, regardless of the individual item or profession covered.

Please note that in responding to the recommendations of the allied health reference group, AHPA has not sought to revisit the detailed position put forward in our previous submissions to the MBS review, which provided detailed arguments in support of the majority of the recommendations in this report. We are aware that evidence provided previously has been considered and remains available for consideration. Should clarification or additional evidence be required, we encourage the Taskforce to contact AHPA for further information.

As a final note, we wish to highlight that aspects of the Specialist and Consultant Physician Consultation Clinical Committee's work directly impact allied health professionals, but no allied health professionals were included in the Committee's membership. While we very much support the work of the Committee, we do have concerns about the impact of that lack of input. Recommendation 19 in particular could have been further refined and more achievable in the short term with allied health involvement. We recognise the practical need to constrain the scope and membership of different review groups and committees, but this has meant that allied health professionals participating in the review did not have the opportunity to provide detailed feedback about case conferencing and referral processes, two areas of very significant relevance to allied health professionals and the consumers they support.

We note this with the hope that the Taskforce will recognise this gap and consider carefully how progress might still be achieved on the basis of the discussions that took place and the feedback provided by stakeholders such as AHPA and its members.

Responses to the individual recommendations

The AHPA response provides specific feedback on the following recommendations:

- Recommendation 7 – A new framework for telehealth
- Recommendation 8 – Reinvest in telehealth
- Recommendation 10 – Introduce case conference items for allied health professionals (AHPs) and nurse practitioners
- Recommendation 12 – Establish a minimum data set to inform evidence-based clinical practice and inform patient choice
- Recommendation 19 – Introducing a new AHP pathway

Recommendation 7 – A new framework for telehealth

AHPA strongly supports the Committee's recommendation to streamline access to telehealth-based specialist services for consumers. We argue that for clinicians and consumers to benefit from access to telehealth, access should be simple and mirror standard consultation items so as to minimise the complexity of billing. It is our view that a consistent approach to telehealth items needs to be applied across the Schedule. A wide range of committees and working groups have noted the importance of providing rebates for telehealth-based services and we won't revisit the strong clinical basis for those recommendations. However, we will note that despite agreement on the need for telehealth access, the recommendations vary in key aspects such as in the potential restrictions placed on use (e.g. distance, requirement for initial face-to-face consultations). We are concerned that this variation across the Schedule adds unnecessary complexity to the system for government, providers and consumers.

Our view is that a standard process should be introduced by which any appropriate MBS item can be reviewed to determine if there is evidence for the effectiveness of an alternative telehealth-based intervention. If there is such evidence, then the guidelines for the item should be expanded to add telehealth modality as an option within the existing item. Given the strong preference for face-to-face care in the research literature, we argue that imposing restrictions on access only limits consumers without adding additional safeguards. In the case of the items already addressed by various committees and working groups, the evidence for effectiveness has already been provided and it is now a matter of applying a consistent approach to implementation.

We strongly support the need to undertake an evaluation of the changes to the telehealth items in order to identify their effectiveness and any unintended issues that may arise. We argue that any evaluation should be undertaken across the Schedule with the aim of a systematic review of the uptake and effectiveness of telehealth interventions.

Recommendation: streamline specialist telehealth items in the context of a broader Schedule-wide process for providing telehealth access for consumers. Evaluate the take-up and effectiveness of changes.

Recommendation 8 – Reinvest in telehealth

AHPA strongly supports the recognition that increasing access to care through use of telehealth will require more than just relaxing or expanding the delivery criteria for different MBS item groups. There is currently no consistent training or infrastructure for consumers and providers to support the use of telehealth. In the absence of these, uptake of telehealth has been much slower than would be suggested by demand, and many providers and consumers who could benefit from use of telehealth are not doing so. AHPA is concerned that without a targeted program to support use of telehealth, telehealth rebates will not significantly improve access.

We support the Committee's recommendation that Primary Health Networks (PHNs) are a key mechanism for local support and training. This approach fits well with the remit of PHNs to improve access to services. We also support the need to engage other groups such as colleges and peak associations as well as non-government organisations as these will play an important role in ensuring that consumers and non-GP health professionals are reached in cases where PHNs are not well connected to the broader health workforce.

AHPA also argues that there should be strong consideration given to the development of consistent guidance about how to use telehealth, including practical considerations such as which hardware and software is appropriate and accessible for the majority of consumers and providers. We also argue for the need for national infrastructure such as a telehealth directory to support consumers to identify services that may meet their needs. This may build on existing infrastructure such as the National Health Services Directory. We recognise that this is not something that would be directly funded through individual items and instead would likely need to be funded as a separate Department of Health work program.

AHPA argues that this approach is one that should be applied consistently across all health professional groups and the consumers they support, as part of a Schedule-wide approach to supporting effective use of telehealth.

Recommendation: support uptake of telehealth items across the MBS by implementing a program of education and support that involves PHNs, colleges and peak associations as well as relevant NGOs representing consumer groups.

Recommendation 10 – Introduce case conference items for allied health professionals (AHPs) and nurse practitioners

AHPA very strongly supports the recommendation that access to rebates for case conference participation is introduced for allied health professionals and nurse practitioners. Our previous submissions to the MBS Review have highlighted the importance of case conferencing access as part of effective multidisciplinary care and there is widespread recognition by medical practitioners of the need to fund participation by allied health professionals. We are pleased to see that both this Committee and the General Practice Primary Care Committee (GPPCC) in its Phase Two report (Recommendation 9) support the introduction of case conferencing items. The allied health

reference group's terms of reference limited its ability to directly address case conferencing, so we consider it all the more important that the recommendation is recognised as being very strongly supported by the allied health sector.

Both this report and the GPPCC reports provide strong arguments from the perspective of medical practitioners supporting the need for these items. Given the strong agreement on the need for this change, AHPA argues that government should move quickly to implement a new item. While we support a quick implementation, we caution that an opportunity for consultation with the sector must be provided in finalising the item descriptor, to ensure that the allied health practitioners that will claim the case conferencing items can provide practical input into their design.

Recommendation: introduce case conferencing items for allied health professionals and nurse practitioners. Undertake a short, focused consultation with the allied health sector to provide opportunity for practical input into item wording from practitioners.

Recommendation 12 – Establish a minimum data set to inform evidence-based clinical practice and inform patient choice

AHPA is very supportive of the development of minimum data sets to inform clinical practice, patient choice and health policy. We note that there has been strong recognition across various review committees and groups that there is still little in the way of outcomes data in many areas of health intervention. We also note there is an increasing understanding that undertaking traditional research trials such as randomised control trials may often not be appropriate or achievable given their cost. We argue that a focus on increasing data collection from areas such as primary and specialist care where there is currently only very limited data available is essential.

This has been recognised by a number of clinical review committees and working groups. AHPA argues that a Schedule-wide approach should be undertaken, which seeks to determine where minimum data sets may be required and funds their development. As recommended by this committee, that could be undertaken in conjunction with the Australian Commission on Safety and Quality in Health Care as well as the Australian Institute of Health and Welfare (AIHW). We note that the current primary care data asset project being undertaken by AIHW has a direct potential connection to this recommendation. That project is currently limited by the lack of minimum data sets and data gathering initiatives in key parts of the primary care system and a consistent approach to this issue would provide significant health system benefits.

In responding to this recommendation, we recognise that the Committee has focused its recommendations on a more limited use case than the one we address. AHPA broadly supports the recommendations of the Committee but suggest our broader view is appropriate. We argue for specific work to be undertaken that addresses broader potential challenges and opportunities while still addressing the concerns of this committee: i.e. protecting consumer and practitioner privacy.

Recommendation: undertake a broad, Schedule-wide review of where the development of minimum data sets would support better health outcomes and health policy development as well as informing patient choice. Support development of data sets and data collection.

Recommendation 19 – Introducing a new AHP pathway

AHPA strongly supports the recommendation by the Specialist and Consulting Physician Committee to develop a new allied health professional pathway that will allow direct referrals from consultant specialists to allied health professionals. AHPA and its members have made submissions to the MBS review specifically addressing this. We welcome the recognition that consumers need better and more direct access to allied health services through Medicare and that there are significant structural limitations on this access including referral processes and the current chronic disease-focused nature of the allied health items. Our own submissions to the Review as well as work by organisations such as the Australian Physiotherapy Association have shown that referral processes are adding significant time and cost to patients as well as the broader health system. This report states:

> *"Consultant specialists can already refer to AHPs, but the patient will not have access to a rebate. This opens up a means-based pathway to patients who can afford to pay for AHP. For patients to access a rebate, they must be assessed by their GP for eligibility and development of a GP Management Plan (item 721). If granted, the patient can access up to five AHP visits with a rebate. This is inconvenient for patients, adds an additional cost of visiting their GP, and increases the likelihood of the intervention not taking place."*

AHPA strongly argues for the need for the Taskforce to carefully consider the impact these access issues have on patient care. AHPA argues that it would have been appropriate for a more immediate review of allied health referral processes to be properly integrated into the current MBS review. We recognise that as this has not happened and further work is required. That work should not be delayed as it represents a significant gap in the current MBS Review.

Despite our support for the work of the Committee in terms of an allied health pathway, the lack of consideration of the cost efficiencies of direct referrals is concerning, particularly given that the specialist report referred to concerns about the economic impact to Medicare of implementing this change. We are particularly concerned about the reference to cost-shifting between private health insurance and the Medicare system. We argue that this represents a significant misunderstanding of how our health system should be functioning and doesn't consider the inequity of private health insurance access. A range of expert commentators and reviews have shown that the general treatment component of private health insurance is not in fact an insurance product, and that access to allied health services through general treatment cover is highly variable and dependent on the insurance product offered rather than the health needs of consumers. Access to private health insurance is not universal and that those with the highest need for allied health services are also those with the least capacity to purchase private health insurance products. AHPA argues that the community is not likely to accept a government position based on the current inequitable access to services that arises from private health insurance-based rebates and further work will be necessary to revisit this recommendation.

A review of allied health referral processes should carefully review not only this particular referral pathway but also additional referral processes such as allied health practitioners referring to specialists or allied health practitioners referring for diagnostic imaging services. The same inefficiencies exist for both referral pathways and the initial AHPA submission provided clear evidence that direct referrals were more cost-effective and well within the scope of the allied health professional. The AHPA submission similarly outlined the obvious inefficiencies in current referral pathways for imaging and a review would provide capacity to show that there are significant benefits to consumers and the health system by increased access to appropriate diagnostic services for consumers accessing primary contact allied health services.

As a final note, we wish to state our support for and recognition of the essential role of general practitioners in patient care. However, we argue that it is not necessary to protect this role through the current referral gatekeeper function. Instead, AHPA supports processes by which reports are still provided to the primary GP, potentially through emerging digital health systems such as My Health Record, to ensure that the GP has access to information about their patient.

Recommendation: initiate an immediate review of allied health processes, covering both direct referrals between allied health professionals and specialists in both directions, and referrals for diagnostic imaging. This review must include strong allied health representation.