1 May2019

Primary Care Reference Groups Consultation
Allied Health Reference Groups
Medicare Review Unit, Medical Benefits Division
Australian Government Department of Health

Sent via email: MBSReviews@health.gov.au

Re: Submission in response to the Allied Health Reference Group Report

Dear Allied Health Reference Group,

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide a submission in response to the Allied Health Reference Group Report.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

AHHA supports the Medicare Benefits Schedule (MBS) Review Taskforce's commitment to providing recommendations to the Minister for Health that will see the MBS deliver:

1. Affordable and universal access
2. Best practice health services
3. Value for the individual patient
4. Value for the health system

To achieve a healthy Australia supported by the best possible healthcare system, AHHA recommends Australia reorientate the healthcare system over the next 10 years by enabling outcomes-focused and value-based healthcare. This requires:

1. A nationally unified and regionally controlled health system that puts patients at the centre;
2. Performance information and reporting that is fit for purpose;
3. A health workforce that exists to serve and meet population health needs; and
4. Funding that is sustainable and appropriate to support a high-quality health system.

AHHA's *Healthy people, healthy systems* is a blueprint with a series of short, medium and long-term actions to achieve this goal. I have attached a copy of *Healthy people, healthy systems* along with this submission, and it is also available online at www.ahha.asn.au/Blueprint. Equally available are a series of Australian case studies, exemplify these recommended actions in practice.

We are committed to a strong primary healthcare system which aims to reduce unnecessary and preventable hospitalisations, and includes a workforce where clinicians are funded and authorised to work to the top of their licence.

PO Box 78 Deakin West ACT 2600 Unit 8, 2 Phipps Close Deakin ACT 2600
T. +61 02 6162 0780 F. +61 02 6162 0779 E. admin@ahha.asn.au W. www.ahha.asn.au
ABN 49 008 528 470

While the recommendations from the Allied Health Reference Group Report are broadly supported in principle for providing improved continuity of care and better management of chronic conditions, we also note that a number of recommendations would be associated with a potentially significantly increased cost to the MBS. While the rationales provided to support the recommendations are generally *prima facie* tenable, evidence to support these recommendations has not been provided in many instances.

Changes to the MBS must improve continuity of care and management of chronic conditions, and must take into account the financial impacts for patients and clinicians providing services. Any changes associated with a significantly increased cost to the MBS must be supported by evidence.

AHHA therefore asserts that there must be a transparent independent review and evaluation within 12 to 24 months of any change to the MBS to ensure that the proposals are delivering value for money and improved patient care. This must also involve the collection of appropriate baseline data before a change is made to the MBS to ensure that this independent review and evaluation can be validly conducted. AHHA acknowledges that reviews are proposed in rationales for some of the report's recommendations, however these proposals should be included in the recommendations to Government, rather than in the rationales.

AHHA also strongly encourages the Government to consider the merits of including a sunset clause on the costlier proposals made by the MBS Review Taskforce. This particularly relates to:

- Recommendation 1 where, if schedule fees are increased compared with current individual service fees for initial assessments undertaken by allied health under chronic disease management plans through the introduction of a new MBS item, the MBS expenditure associated with these services will increase significantly.
- Recommendation 2 where, if the number of allied health appointments under team care arrangements is increased for those patients identified as having more complex care needs through stratification, the MBS expenditure associated with these services will increase significantly.

If the proposed recommendations do result in improved patient care where the benefits exceed the cost, then this would represent a valuable investment in the health of all Australians. However, where for example similar services are being provided but at a recommended significantly higher cost to the MBS, the evidence needs to be established that this represents value in patient care and to the health system.

AHHA submits the following with regards to the 18 recommendations made within the Allied Health Reference Group Report.

1. Introduce initial assessment appointments (of more than 40 minutes) for allied health professionals.

AHHA supports this recommendation in principle, while noting that the quantum of the increase in the schedule fee for an initial assessment item has not been specified.

AHHA is supportive of the Allied Health Reference Group's recommendation in the rationale that the use of this item should be reviewed in 12 to 24 months so that any abnormal claiming patterns can be analysed. AHHA also asserts that this review should assess the effectiveness of these initial assessments to ensure that the proposal delivers value for money and improved patient care.

2. Increase the number of allied health appointments under team care arrangements (TCAs; item 721 and 723) by stratifying patients to identify those with more complex care requirements.
AHHA supports this recommendation in principle, while noting that identification of patients via a stratification tool will require a suitable and valid tool to be developed and trialled.

AHHA notes that the Allied Health Reference Group propose a study to review health outcomes of patients in this trial compared with a sample group not involved in the trial. Consideration of which health outcomes will be measured and how they will be collected is necessary. AHHA recommends aligning outcomes measurement with work being undertaken or planned to be undertaken by the AIHW on the Primary Health Care Data Asset to ensure data standards are nationally consistent to better inform system performance.

3. Introduce a new item for orthotic or prosthetic services under the MBS.
AHHA supports the introduction of a new item for orthotic or prosthetic services provided by appropriately trained orthotists or prosthetist under the MBS.

4. Introduce a practice incentive payment for allied health professionals who provide group therapy under items 81105, 81115 and 81125.
AHHA supports this recommendation in principle for items 81105 and 81125, where there has been a fall in the annual average growth of services over the five year period to 2016–17, while noting that the quantum of the practice incentive payment has not been specified.

AHHA recognises barriers to some allied health professionals running group therapy sessions, particularly where the inherent risks associated with fixed costs for providing group therapy sessions are borne by the health care provider. AHHA acknowledges that MBS reimbursement should reflect the cost of delivering services to ensure access for patients to MBS services.

5. Conduct a systematic review of the evidence for group allied health interventions to inform future models of care.
AHHA supports this recommendation. However, it is not clear what funding outside of the MBS is envisaged in 5(c)(ii) of the recommendation.

6. Update the M10 descriptor to encompass Autism Spectrum Disorder, Complex Neurodevelopmental Disorder and Disabilities.
AHHA supports this recommendation.

7. Increase the number of assessment items available for children with a potential ASD, CND or eligible disability diagnosis.
AHHA supports this recommendation.

8. Allow up to two assessment items to be used for case conferencing for children with a potential ASD, CND or eligible disability diagnosis.
AHHA supports this recommendation.

9. Allow M10 treatment items to be delivered as group therapy under the Helping Children with Autism (HCWA) program.
AHHA supports this recommendation in principle. However, the Allied Health Reference Group report should clarify the permissible claiming practices for the delivery of M10 treatment items when delivered as group therapy. This should include any adjustment to the MBS item fee related to efficiencies in providing simultaneous care to multiple patients.

10. Include patients with severe speech/language disorders in the list of eligible disabilities under M10 items.
AHHA supports this recommendation.

11. Increase the ASD, CND and eligible disability assessment and treatment age to 25.

AHHA supports this recommendation in principle. However, it is noted that only very limited peer-reviewed clinical evidence is provided to support this recommendation with no independent evidence to support the proposed age cut-off of 25 years. AHHA therefore believes that if the recommendation is implemented, then the use of this item should be reviewed in 12 to 24 months so that any inappropriate claiming patterns can be analysed.

12. Allow inter-disciplinary referral between allied health professionals during the assessment phase for eligible disabilities, CND and ASD.
AHHA supports this recommendation.

13. Build an allied health research base.
AHHA notes that the Allied Health Reference Group propose a study to review health outcomes of patients in this trial compared with a sample group not involved in the trial. Consideration of which health outcomes will be measured and how they will be collected is necessary. AHHA recommends aligning outcomes measurement with work being undertaken by the AIHW on the Primary Health Care Data Asset to ensure data standards are nationally consistent to better inform system performance.

AHHA supports this recommendation in principle, however this work should be part of a comprehensive national health workforce strategy.

There are joint roles and responsibilities between the Commonwealth Government and state and territory governments relating to the health workforce and their education and training requirements[1, 2].

At both Commonwealth and state and territory levels, there is significant focus on the number and distribution of health professionals regulated under the Health Practitioner Regulation National Law Act 2009 (the National Law), in particular medical professionals and nurses. However, data do not currently capture information about accessibility, responsiveness, acceptability, quality and appropriateness. Further, data on numbers and distribution need to be interpreted in terms of evolving and innovative changes in scopes of practice and models of care, particularly with growing evidence of the comparative cost-effectiveness of allied-health-led care and multidisciplinary involvement in models of care across the patient journey[3]. Data related to scopes of practice and use of the non-registered workforce are also unavailable.

---

[1] Council of Australian Governments (COAG) 2012, *National Health Reform Agreement*, viewed 1 November 2017, http://www.publichospitalfunding.gov.au/national-healthreform/agreement.
[2] Council of Australian Governments (COAG) 2017, *Schedule I – Addendum to the National Health Reform Agreement*, viewed 1 November 2017, http://www.federalfinancialrelations.gov.au/content/npa/health/other/Addendum_to_the_National_Health_Reform.pdf.
[3] Office for Professional Leadership 2015, *Demonstrating the value of allied healthcare in SA Health*, SA Health, Adelaide, viewed 1 November 2017, http://www.sahealth.sa.gov.au/wps/wcm/connect/f9a86700476e95d5ada7bfdd1460951d/Demonstrating+the+Value+of+Allied+Health+Care+Fin al+20.02.15.pdf?MOD=AJPERES&CACHEID=f9a86700476e95d5ada7bfdd1460951d.

The development of a National Allied Health Minimum Dataset will be important for understanding the contribution and costs of this workforce, provided it is linked with outcomes[4].

The Productivity Commission noted 'Labour costs comprise a large share of health expenditure, and so making better use of health workforce skills and competencies could lead to large efficiency gains. There is evidence that some tasks that are currently the exclusive responsibility of particular professionals could be performed just as effectively by others, without compromising patient safety or the quality of care. Carefully relaxing some specific regulations affecting scopes of practice could allow workers to be better allocated to tasks where they can add the most value, and reduce the labour resources needed to effectively deliver specific health care services (freeing up workers to deliver more services and potentially improving patients' access to health care)'[5].

The former Commonwealth entity Health Workforce Australia reported that a 'business as usual' approach to the health workforce is not sustainable, with a need for coordinated, long-term reforms by government, professions and the higher education and training sector for a sustainable and affordable health workforce. The main policy levers required for change were innovation and reform, immigration, training capacity and efficiency, and workforce distribution, with innovation and reform measures identified as the area of most promise[6].

While the National Law has an objective 'to enable the continuous development of a flexible, responsive and sustainable Australian health workforce', there is no shared vision documented for what such a workforce would look like. Further, there are limited mechanisms to ensure a match between health professional education and training which is controlled nationally, and the workforce needs of the largely state-controlled healthcare organisations[7]. The review of the National Registration and Accreditation Scheme (NRAS) identified that an improved mutual understanding about the future agenda in workforce reform was needed. Submissions to the review showed an almost universal agreement on the importance of developing national workforce policy guidance that can be acted upon by all entities and processes within, and interdependent with, NRAS—consumers, employers, professional associations, education providers, National Boards and government departments[8].

Clinical training and experience, particularly clinical placements, are a critical component in preparing health professionals for practice. The quality of and time in pre-registration placements has been recognised as one of the main influencing factors in determining career destinations for

---

[4] Stephens, C & Erven, J 2015, Presentation: *Developing a National Allied Health Dataset*, Queensland Government Department of Health, viewed 1 November 2017, http://abfconference.com.au/cms/wp-content/uploads/2015/06/3-1415-Stephens-L2-Thurs.pdf.

[5] Productivity Commission (PC) 2015, *Efficiency in health*, Australian Government, Canberra, viewed 1 November 2017, http://www.pc.gov.au/research/completed/efficiency-health.

[6] Health Workforce Australia (HWA) 2013, *Health Workforce 2025- summary*, Australian Government, Adelaide, viewed 1 November 2017, http://www.health.gov.au/internet/publications/publishing.nsf/Content/workreview-australian-government-health-workforceprograms-toc~appendices~appendix-ii-healthworkforce-2025-summary.

[7] Leggatt, S 2014, *Changing health professionals' scope of practice: how do we continue to make progress*, Deeble Institute Issues Brief no. NLCG-4, viewed 1 November 2017, https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_nlcg-4_changing_health_professionals_scope_of_practice.pdf.

[8] Woods, M 2017, *Australia's Health Workforce: strengthening the education foundation. Independent review of accreditation systems within the National Registration and Accreditation Scheme for health professions*, Australian Health Ministers' Advisory Council, viewed 1 November 2017, http://www.coaghealthcouncil.gov.au/Portals/0/Accreditation%20Review%20Draft%20Report_U.pdf.

health professionals[9]. Support and incentives for placements are critical in terms of rural and remote distribution, but should also be considered in terms of areas of public need and service models.

With drivers to shift care from hospital to primary and community care sectors, there need to be similar drivers supporting clinical training/placements in the latter settings, including primary healthcare, disability care, aged care and mental health. Without sufficient exposure to healthcare settings outside of public hospitals, the choice to practise in other settings (and their readiness to do so) is reduced.

Promoting efficient and sustainable use of limited clinical training resources is of value and benefits all stakeholders. While IHPA is designing a nationally consistent method of classifying teaching and training activities and the associated costs to inform activity-based funding (ABF) in public hospitals, consideration of, and responsibility for, placements beyond the hospital environment needs attention.

14. Expand the role of telehealth in allied health care.
AHHA supports flexible access including non-face-to-face access (for example: telephone, email, videoconsulting, telehealth, etc.) for consumers facing difficulties in accessing face-to-face consultations (for example: remote, rural, disabled) be made available as soon as possible. AHHA also supports the gathering of national evidence on the highest-value opportunities for telehealth integration into allied health care.

However, it is noted that for some patients access to allied health professionals may not only be restricted by geography. For example, public transport may be inadequate or the patient may have other personal mobility restrictions. It is also noted that the recommendation only envisages the provision of telehealth services which achieve the same outcomes via teleconference as in face-to-face consultations and where there is no compromise in service delivery or the standard of care. Finally, allied health services funded through the MBS can only be provided in circumstances consistent with the criteria specified in the Schedule.

If comparable care is being provided at the same or lower cost, the issue is one of access to allied health services for any patient in circumstances where they are eligible for these services under the MBS.

AHHA therefore believes that access to allied health telehealth interventions in the manner described in the recommendation that are demonstrated to be at least as cost effective as face-to-face consultations should be open to all eligible patients, and not restricted to people living in Modified Monash Model Categories 4–7 and at least 35 kilometres by road from the allied health professional.

It is also noted that the MBS items for medical practitioner telehealth attendances use a criterion of being at least 15 kilometres by road from the practitioner, rather than a distance of at least 35 kilometres by road as recommended in the Allied Health Reference Group report. If a distance is to be specified in any expansion of telehealth MBS items for allied health then consistency would be recommended.

[9] Universities Australia 2017*, Submission: Department of Health Medical Workforce Assessment*, viewed 1 November 2017, https://www.universitiesaustralia.edu.au/research-innovation-workforce/Research-andInnovation-Submissions-Reports-and-Studies/Research-Innovation-Workforce-SubmissionsReports-and-Studies.

15. Pilot non-fee-for-service allied health payment models.
Consideration must be given to how funding for value and outcomes can be achieved either through the MBS or alternative funding arrangements to support more the effective and efficient provision and coordination of patient-centred and team-based primary care services. Services provided in this manner are a critical component of a comprehensive health system which can improve health outcomes and reduce overall healthcare costs and out-of-pocket expenses.

AHHA agrees that reforming payment models in relation to the care and support needed in the community should form part of a modern and responsive health system. This was a key finding at the AHHA's September 2015 think tank on health funding[10] and from AHHA's paper on the role of bundled payments in Australian primary healthcare[11].

AHHA notes that the Allied Health Reference Group propose a study to review health outcomes of patients in this trial. Consideration of which health outcomes will be measured and how they will be collected is necessary. AHHA recommends aligning outcomes measurement with work being undertaken by the AIHW on the Primary Health Care Data Asset to ensure data standards are nationally consistent to better inform system performance.

AHHA supports the rationale for piloting a non-fee-for-service allied health payment model to improve incentives for delivering high value care.

Value in health care has been defined as the health outcomes that matter to patients relative to the resources or costs required[12]. The concept of value is not a simple equation.

Health outcomes that matter to patients are multi-dimensional. The focus is not only traditional clinical indicators, but also broader factors such as the patient's quality of life and ability to work, and over a full cycle of care[13]. No single indicator captures the outcome of care (Porter 2010), and to be truly indicative of what matters to patients, patient involvement in the design and development of measures is essential[14].

Similarly, the resources or costs must reflect the actual costs of the care delivered to a patient over a full cycle of care. These costs are often distributed across many providers (and divisional units within providers) as well as the patient and their family or carers.

In a universal health care system, the concept of social value or the price governments are prepared to pay for health care, may also be a defining feature of value.

It is important in the development of any pilot that patient reported health outcomes and the full costs of care are genuinely measured and evaluated.

---

[10] Australian Healthcare and Hospitals Association (AHHA) 2015, *Think tank on Sustainable Funding of Public* Hospitals, Australian Healthcare and Hospitals Association, Canberra, https://ahha.asn.au/think-tank-sustainable-funding-public-hospitals-0.
[11] Dawda P 2015, *Bundled payments: Their role in Australian primary health* care, Australian Healthcare and Hospitals Association, Canberra, https://ahha.asn.au/sites/default/files/docs/policy-issue/bundled_payments_role_in_australian_primary_health_care_0.pdf.
[12] World Economic Forum (WEF) 2017, *Value in healthcare: Laying the foundation for health system transformation*, viewed 31 January 2019 http://www3.weforum.org/docs/WEF_Insight_Report_Value_Healthcare_Laying_Foundation.pdf.
[13] *Ibid*
[14] Wiering, B, de Boer, D & Delnoij, D, 2017, 'Patient involvement in the development of patient-reported outcome measures: a scoping review', *Health Expect*, vol. 20, no. 1, p. 11–23.

16. Enhance communication between patients, allied health professionals and general practitioners (GPs).
AHHA supports the expansion of My Health Record to provide enhanced capacity for secure communication and provision of referrals by general practitioners, allied health professionals and other healthcare, aged care and disability services.

AHHA supports the recommendation in principle for providing incentives to general practitioners and allied health providers to set up secure messaging services while noting that the quantum of the incentive payment has not been specified. AHHA therefore asserts that there must be a transparent independent review and evaluation within 12 to 24 months after implementation of these changes to ensure that the proposal is delivering value for money and improved patient care. This must involve the collection of appropriate baseline data before a change is made to ensure that an independent review and evaluation can be validly conducted.

17. Add non-dispensing pharmacists to the list of eligible allied health professionals under the MBS.
AHHA supports appropriately trained non-dispensing pharmacists to be included in the list of eligible allied health professionals under the MBS.

18. Expand the role of allied health in the Australian public health care system.
AHHA supports a patient-centred, team-based primary care model. However, AHHA stresses that any model of patient-centred primary care should not exist to support allied health professionals as providers but should exist to support patients to receive the right care, at the right place by the most appropriate service provider practising to the top of their licence. The MBS Review is an opportunity to examine how to develop the MBS funding model to better capitalise on the capacity of the total health workforce.

Patient-centred and team-based primary care should assist in providing continuity of care, coordinated services and a team-based approach according to the needs and wishes of the patients. This should build on the efforts of Primary Health Networks (PHNs) who are already developing such services in their areas.

AHHA supports the identifiable risk factors for chronic disease including tobacco use, high Body Mass Index, alcohol use, physical inactivity and high blood pressure for eligibility to access MBS items for allied health services in complex and chronic disease items. AHHA also supports greater commitment to primary prevention. However, it is noted that there is no cost estimate specified in the recommendation or rationale and this needs to be better understood before a broad opening of the MBS to these types of services.

AHHA therefore contends that there should be an initial pilot study conducted on this recommendation similar to that outlined for Recommendation 2.

Conclusion
There is a clear need for an ongoing and transparent review of MBS items to ensure they are evidence-based, fit-for-purpose, reflect contemporary practice and offer value for money.

Changes to the MBS must improve continuity of care and management of chronic conditions, and must take into account the financial impacts for patients and clinicians providing services. Any changes associated with a significantly increased cost to the MBS must be supported by evidence.

AHHA supports the establishment of sunset clauses to remove the necessity of exhaustive review processes every few decades and to strengthen the ongoing sustainability of the Medicare Benefits

Scheme, as well as rapid reviews to allow the Medicare Services Advisory Committee to speed up some applications to add new services to the MBS.

Reforming payment models in relation to the care and support needed in the community should form part of a modern and responsive health system.

Collaboration between primary care, local hospitals and health networks (public and private) can support population health planning and reduction of inequities in health service access and health outcomes. We support the role of Primary Health Networks in facilitating this collaboration, and note the key role the primary health workforce must play in shaping collaboration.

Collaboration should include opportunities to pool funding, particularly to address preventable hospitalisations and to promote innovative models of care. AHHA has made a number of recommendations regarding health system governance in our *Healthy people, healthy systems* blueprint, available online at www.ahha.asn.au/Blueprint.

While primary care and greater system integration are part of the solution to better patient care, we must also acknowledge and address health and social inequalities, better utilise data and technology, promote better engagement between clinicians and patients, increase attention on transitions of care, focus more on advanced care planning and shift the system toward value-based care that is focused on patient outcomes.

Reducing preventable hospitalisations in order to improve health outcomes and reduce unnecessary healthcare system costs is a longstanding concern, and finding solutions will require effort, investment, research and system redesign. Allied health practitioners must be engaged in this redesign, together with patients, other primary health providers, the acute care sector and policy makers.

Achieving and evaluating these goals will take both time and investment, and will challenge existing models of care and practices to enable all care providers to work to the top of their licence.

Sincerely,

Alison Verhoeven
Chief Executive
Australian Healthcare and Hospitals Association

Attachment: *Healthy people, healthy systems*