



**SARRAH**

Services for Australian  
Rural and Remote Allied Health



# Medicare Benefits Schedule Review Taskforce: Final Report of the Allied Health Reference Group

## **Consultation Response**

7 June 2019

## OUR PERSPECTIVE

Services for Australian Rural and Remote Allied Health (SARRAH) is nationally recognised as the peak body representing allied health professionals (AHPs) working in rural and remote Australia. For twenty five years SARRAH has sustained a strong reputation for representing the issues facing rural and remote allied health professionals and the communities they serve.

Our members come from a range of allied health disciplines including but not limited to Audiology, Chinese Medicine, Chiropractic, Dental And Oral Health, Dentistry, Dietetics And Nutrition, Diabetes Education, Exercise Physiology, Genetic Counselling, Medical Imaging, Nuclear Medicine, Radiation Therapy, Health Promotion, Occupational Therapy, Optometry, Orthoptics, Orthotics, Osteopathy, Paramedics, Pharmacy, Physiotherapy, Podiatry, Prosthetics, Psychology, Speech Pathology, Social Work and Sonography.

We support AHPs that work across the public, private and community health sectors who confidently deliver safe and culturally sensitive services in rural and remote communities. AHPs play a vital role in primary health care and have a significant role in the health, welfare, education, and disability sectors. They are critical for the prevention, management and treatment of chronic disease and complex care needs. SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health services are basic and core to Australians' health care and wellbeing.

***SARRAH has developed this submission which draws upon the collective experience of our members, partners and previous work on issues around access to Medicare for allied health services.***

## INTRODUCTION

SARRAH thanks the Medicare Benefits Schedule (MBS) Review Taskforce Reference Groups, in particular the Allied Health Reference Group (AHRG) for their work in reviewing the allied health MBS items and for developing the recommendations contained in their final report. The recommendations acknowledge the need to update and improve the efficacy of the allied health items, have the capacity to improve access to allied health services and better support communities in rural and remote Australia.

We endorse all recommendations contained in the report and see them as a strong step towards improving access to allied health services. However, there are still a number of areas which require further attention. In particular, models of care based on telehealth, building an evidence base for allied health and improving data collection on the utilisation of allied health services across Australia.

Given that the MBS Review Taskforce was convened in 2015 and has reviewed over 5700 items on the MBS, it is our view that implementation of the recommendations presented in the final report are prioritised for the immediate and near term by the recently re-elected Coalition Government.

We stress that the recommendations have received significant attention through the work of the MBS Review Taskforce and its consultation with the sector. Delaying implementation of the recommendations due to further review processes and other administrative arrangements is unwarranted at this late stage and will adversely impact health consumers, particularly those consumers who live in rural and remote communities.

If material is required after reading this consultation response, we invite the MBS Review Taskforce to contact SARRAH for further information.

## GENERAL COMMENTS

Rural and remote communities face a host of challenges that are not experienced by people living in major cities, particularly in relation to accessing MBS services.

Maldistribution of the allied health workforce and market failure in rural and remote communities limit access to allied health services either directly or through a Chronic Disease Management Plan (CDM plans) / General Practitioner Management Plan (GP Management Plans).

Maldistribution of the allied health workforce, and market failure in rural and remote communities, limit access to allied health services for rural and remote Australians. The following table illustrates the geographic distribution and practitioner to population ratios of a selection of allied health professions compared with medical practitioners, nurses and midwives.<sup>1</sup>

**Table 1: Rate of Full Time Equivalent AHPs per 100,000 population by remoteness areas (2016)**

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
<b>Allied Health Professions</b>	No of FTE professionals per 100,000 population				
Medical Radiation Practitioners	54.93	43.22	30.90	25.19	12.35
Oral Health Practitioners*	82.20	60.42	53.82	42.21	21.74
Occupational Therapists	62.18	47.43	46.52	38.13	22.73
Optometrists*	19.74	15.85	11.46	9.19	3.95
Osteopaths*	7.96	6.17	2.30	NP	NP
Pharmacists	99.35	78.07	78.01	74.89	45.95
Physiotherapists	103.78	66.30	55.44	43.91	40.51
Podiatrists	17.72	17.21	10.97	10.55	5.93
Psychologists	103.17	61.25	45.84	35.40	20.75
<b>Other Health Professions</b>					
Medical Practitioners	440.88	302.44	284.73	331.90	220.34
Nurses and Midwives	1157.15	1105.59	1099.88	1304.78	1192.12

Source: Australian Government Department of Health, 2018

The rural health picture is worse than it should or needs to be. Current service systems are fragmented and, in combination with existing funding models and program-centric (rather than patient or community-centric) contract and service models do not adequately support the provision of allied health services in rural and remote areas, meaning “market failure” is a feature of many contexts where community need, demand and eligibility could otherwise support viable local services and sustainability.

In light of this, it is reassuring that the AHRG agreed that ‘improving access to allied health for rural and remote populations’ be one of the main themes for the report. It is

<sup>1</sup> Battye, K., Roufeil, L., Edwards, M., Hardaker, L., Janssen, T., Wilkins, R. (2019). Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review. Services for Australian Rural and Remote Allied Health (SARRAH), page 10.

clear that a number of the recommendations seek to improve access to allied health services in rural and remote communities.

It is SARRAHs view however that a greater emphasis needs to be placed on access to telehealth based allied health service delivery and building an evidence base relating to the efficacy and value of allied health interventions and their capacity to effectively prevent, manage and treat chronic illness.

Further delays or inaction with improving access to telehealth services or building a more robust body of evidence, particularly in respect to recommendations 13 and 14, will continue to have a negative impact on health outcomes in the regions where people will continue to receive limited access to the health services they need.

### **Prioritising allied health research and building an allied health evidence base**

Between 2015 and 2016 SARRAH released two reports which investigated the efficacy and value of allied health services. The first report, 'The impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke' looked at eight key interventions and identified significant potential budget savings which could be achieved by increasing access to key services such as diabetes education, foot care interventions, stroke programs and speech pathology services<sup>2</sup>.

The second report, 'Addressing Diabetes-Related Foot Disease in Indigenous NSW: A Scan of Available Evidence' looked at the efficacy of increasing access to podiatry services in rural and remote NSW<sup>3</sup>. It showed that greater access to programs to prioritise foot care for people living with diabetes showed significant reductions in lower extremity amputations and other complications associated with diabetes related foot disease.

These are but two examples of research contributing to building an evidence base that assesses the efficacy and value of allied health services. However, they were either completed internally through pro-bono support or commissioned by state governments with no underlying national research strategy focused on building an allied health evidence base. In the 2018-19 Corporate Plan of the National Health and Medical Research Council (NHMRC) has not placed any prioritised allied health and building the evidence base around its efficacy<sup>4</sup>.

In fact, according to a search of the NHMRC website only 9 publications investigate 'efficacy' and none of these relate to allied health interventions<sup>5</sup>. It is well past due that

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<sup>2</sup> Adams, J., Tocchini, Lucas. Novartis Pharmaceuticals. *The impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke*. Research report prepared for Services for Australian Rural and Remote Allied Health by pro-bono arrangement. 2015.

<sup>3</sup> Services for Australian Rural and Remote Allied Health. *Addressing Diabetes-Related Foot Disease in Indigenous NSW: A Scan of Available Evidence*. Research report prepared for NSW Ministry of Health, Workforce Development and Planning Branch. 2016.

<sup>4</sup> National Health and Medical Research Council. *NHMRC Corporate Plan 2018-2019*. <https://www.nhmrc.gov.au/file/9236/download?token=i-m9ICz8>. Accessed 04/06/2019.

<sup>5</sup> National Health and Medical Research Council. *Website search for publications containing 'efficacy'*. [https://www.nhmrc.gov.au/search?search=efficacy&field\\_publication\\_date=&field\\_publication\\_date\\_1=&content\\_type\\_filter=2](https://www.nhmrc.gov.au/search?search=efficacy&field_publication_date=&field_publication_date_1=&content_type_filter=2). Accessed 04/06/2019.

the NHMRC prioritise building an evidence base on the efficacy of allied health services in the management of chronic disease, mental health issues, and preventative health.

Given that allied health has the potential to provide significant savings to both Federal and State healthcare budgets and have a positive impact on the private health insurance premiums it is important that this research work take place sooner than later. It will enable policy makers in Government to make informed decisions and ensure that access is fair, equitable and meets the needs of everyone who lives in Australia including in rural and remote communities.

### **Removing barriers to access by improving support for telehealth based services**

It is clear that people living in regional, rural, remote and very remote areas face significant barriers to accessing allied health services compared to people living in metropolitan areas. However, as technology and infrastructure has improved, SARRAH has seen telehealth as a key enabler for greater access to allied health services in rural and remote communities.

In 2012, SARRAH released a position statement on using telehealth as a mechanism to deliver allied health services<sup>6</sup>. In the position statement SARRAH states:

" Health consumers in remote, regional and outer metropolitan areas face greater barriers to accessing specialist services than those in city areas. Remote and small rural communities do not necessarily have the population critical mass to support all or any allied health services to be located within their local community. Consequently access to services delivered by the different allied health professions is limited. This is particularly true where the allied health service may be a specialty area within a profession, for example paediatrics, neurology, rheumatology or diabetes. Telehealth can assist health consumers to overcome these barriers; enabling access to specialist services sooner with lower travel costs and better continuity of care." (SARRAH, 2012, p2.)

With telehealth being rolled out for people in rural areas to improve access to psychological services<sup>7</sup>, it is clear that the value of telehealth for rural and remote communities continues to be recognised.

Telehealth has the capacity to dissolve barriers to access and the work identified in recommendation 14 should be prioritised for implementation concurrently with recommendations 1 - 12. This will allow for the creation of new proposed MBS items that enable increased access to telehealth in rural and remote areas.

Lastly, the interim creation of an MBS item covering the "provision of telehealth services for patients consulting with an allied health professional via teleconference" proposed in recommendation 14 should be expanded cover Modified Monash Model (MMM) Areas 3 – 7. Whilst MMM 3 areas have a population size between 15,000 and 50,000, it is clear from the maldistribution of the allied health workforce detailed above, that these

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<sup>6</sup> Services for Australian Rural and Remote Allied Health. *Position Paper: Telehealth and Allied Health*. [https://sarrah.org.au/sites/default/files/docs/allied\\_health\\_and\\_telehealth\\_final\\_-\\_19.10.12.pdf](https://sarrah.org.au/sites/default/files/docs/allied_health_and_telehealth_final_-_19.10.12.pdf). Accessed 04/06/2019.

<sup>7</sup> Department of Health. *Better Access Telehealth Services for People in Rural and Remote Areas*. <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-telehealth>. Accessed 04/06/2019.

centres still see a significant drop off in access to AHPs. As such people living in MMM area 3 may continue to experience significant barriers in access.

Whilst SARRAH wants to see more immediate action on recommendations 13 and 14 as detailed above, we endorse and support all recommendations included in the report by the AHRG. Particularly, we want to highlight the recommendations that consider comprehensive initial assessments, expanded team care arrangements and group therapy arrangements. All these changes have the capacity to improve health outcomes and support greater access to services in rural and remote communities.

In the appendix attached, we have responded against each recommendation contained in the final report.

## APPENDIX: RESPONSE TO INDIVIDUAL RECOMMENDATIONS IN THE AHRG FINAL REPORT INCLUDING LONG-TERM RECOMMENDATIONS

### **Recommendation 1: Encourage comprehensive initial assessments by allied health professionals**

SARRAH is highly supportive of this recommendation as it acknowledges that initial assessments are standard practice for allied health professionals. It will ensure that they receive a rebate in line with the level of care provided by allied health professionals and addresses a key issue around the cost faced by health consumers when undergoing an initial assessment. This issue is especially prevalent in rural and remote areas where consumers may have a limited capacity to absorb out of pocket costs.

### **Recommendation 2: Expand allied health involvement under team care arrangements**

This recommendation is essential and is one that needs to be taken up by the Federal Government. It has the capacity to significantly improve health outcomes across the country and particularly those of health consumers who reside across rural and remote Australia. Furthermore, it addresses two major issues faced in rural and remote communities:

1. It gives health consumers greater access to allied health services so they can more readily treat medical conditions and proactively manage their health and wellbeing.
2. It will contribute to breaking down barriers faced by allied health professionals operating in the regions who may be impacted by market failure as a result of health consumers not receiving sufficient access to health services.

### **Recommendation 3: Improve access to orthotic or prosthetic services**

SARRAH supports appropriate access to care through the proposed Medicare item numbers will support health consumers with limb difference, amputation and orthotic needs. However, there is still a need to manage chronic conditions such as diabetes related foot disease, arthritis or stroke, then the limit of one visit per year is insufficient. Given the size of the workforce and low expected service volumes, SARRAH suggests that the number of services available per calendar year be increased.

### **Recommendation 4: Incentivise group therapy for chronic disease management**

SARRAH supports this recommendation which has the capacity to improve health outcomes in rural and remote communities which statistically experience higher rates of chronic illness such as diabetes. Addressing the fixed costs and logistics faced by allied health professionals running group therapy sessions may improve viability of the services as well as potentially reduce incidence of market failure. However, it is important that the incentive payment is rural proofed as there are significant additional costs in a rural context. This is especially the case for outreach services which incur significant costs associated with travel, accommodation and time away from their home clinic.

An alternative approach may be looking at introducing Medicare items for telehealth based group therapy services for diabetes education and dietetics services. This would enable remote delivery of services which may limit travel and accommodation costs associated with delivering group therapy sessions as part of an outreach service.

### **Recommendation 5: Understand the effectiveness of group allied health interventions**

As with recommendation 4, SARRAH supports conducting a systematic review into the efficacy of group allied health interventions. SARRAH calls for this research to be prioritised by the NHMRC within the current term of parliament. The systematic review should also pay particular attention to rural and remote communities where this has the greatest potential to make an impact. Furthermore, attention should be given to the capacity for group allied health interventions to make an impact on preventable hospitalisations, end point procedures and placing downward pressure on the health care budget. To this effect, health economists should be involved in the systematic review.

### **Recommendation 6: Improved access to paediatric allied health assessments**

SARRAH supports improving access to paediatric allied health assessments, particularly for conditions that have a higher prevalence in rural and remote communities.

### **Recommendation 7: Improve access to complex paediatric allied health assessments**

SARRAH supports improving access to complex paediatric allied health assessments to ensure that ASD and other eligible disabilities are detected early so that access to the National Disability Insurance Scheme (NDIS) can occur at the earliest possible opportunity.

### **Recommendation 8: Encourage multidisciplinary planning for children with a potential ASD or eligible disability diagnosis**

SARRAH supports multidisciplinary planning for children with a potential ASD or eligible disability diagnosis and the introduction of case conferencing as part of the assessment process.

### **Recommendation 9: Improve access to M10 treatment items as group therapy**

SARRAH supports expanding M10 treatment items to be delivered as group therapy under the HCWA program. This will ensure that families receive access to social and support networks.

### **Recommendation 10: Improve access to M10 items for patients with severe speech and language disorders**

SARRAH supports extending the list of disabilities eligible to access M10 items to including stuttering, childhood apraxia of speech, developmental language disorder and phonological disorder to ensure that assessment and treatment can occur as soon as the condition is able to be diagnosed.

### **Recommendation 11: Improve access to the ASD and eligible disability assessment to people under 25**

SARRAH supports increasing the age limit of items for ASD and eligible disability assessment to 25 years of age and modifying the item descriptions to include young adults within the scope of the relevant items.

### **Recommendation 12: Improve allied health collaboration during Assessments**

SARRAH supports introducing inter-disciplinary referrals between allied health professionals during the assessment phase of eligible disabilities including ASD.

## **Longer-term Recommendations**

### **Recommendation 13: Support the codifying of allied health research and evidence**

SARRAH supports codifying allied health research and evidence. Additional information is contained in the body of SARRAH submission.

### **Recommendation 14: Improve access to allied health services via telehealth**

SARRAH supports improving access to allied health services via telehealth. Additional information is contained in the body of the SARRAH submission.

### **Recommendation 15: Pilot non-fee-for-service allied health payment models**

SARRAH supports research and work that explores blended funding and non-fee-for-service models as this would go a long way to addressing some of the underlying causes of market failure in rural and remote health settings.

Any pilot undertaken should take into account rural and remote services including community controlled health organisations and aboriginal community controlled health organisations. We also agree that any pilot should preserve the autonomy of allied health professionals and be voluntary for health consumers.

### **Recommendation 16: Enhance communication between patients, allied health professionals and GPs**

SARRAH supports the recommendation to improve communication between patients, allied health professionals and GPs, particularly with respect to cultivating shared decision-making and focusing on patient centred care. An education campaign that educates allied health professionals, GPs and primary health organisations including Primary Health Networks (PHNs) will be key to implementing changes to CDM plans / GP Management Plans and improving appropriate access to allied health services.

### **Recommendation 17: Allow non-dispensing pharmacists to access allied health items**

SARRAH supports the recommendation to add an item that enables pharmacists to cater to the complex care requirements of health consumers through providing medication management services. However, the two item limit seems somewhat

restrictive. An expansion of annual item limits that is based on recommendation 2 would address this issue.

### **Recommendation 18: Expand the role of allied health in the Australian public health care system**

SARRAH supports expanding the role of allied health in the Australian public health care system, especially in rural and remote communities where an allied health professional may be the first point of contact for patient burdened with a chronic illness.

Allied health professionals can play a key role in minimising the burden of chronic disease through early interventions such as diabetes education, more immediate access to speech pathology and occupational therapy services following stroke, and propose lifestyle modifications to reduce the incidence and severity of chronic heart disease.

The impact of these early interventions have the potential to not only improve health outcomes, particularly in rural and remote communities, but also place significant downward pressure on the health care budget of the state and federal government. This is due to reducing the number of preventable hospitalisations, reducing the incidence of preventable end point procedures and the preventable dispensing of medications to manage late stage chronic illness.

It is important however, that implementation of this recommendation acknowledge the work involved on the part of the allied health professional and that this is factored into streamlining CMP plans / GP Management Plans, referrals and case conference processes.