CONSULTATION RESPONSE

Allied Health Professions Australia

Department of Health
Consultation paper: private health insurance reforms – second wave

February 2021

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

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Introduction

Allied Health Professions Australia (AHPA) thanks the Department of Health for the opportunity to provide feedback on its proposals for a second wave of private health insurance reforms. AHPA is the recognised national peak association for allied health professions, collectively representing some 145,000 individual allied health professionals. A significant proportion of those allied health professionals provide services rebated by private health insurers.

Access to government funding for allied health surgical pre-habilitation and rehabilitation services, and to prevent and treat mental ill-health, is highly variable. All Australians are currently able to access 20 annual allied health mental health services funded under Medicare and a total of five annual allied health services relating to chronic disease. Recent and ongoing consultations by the Department of Health, including the Medicare Benefits Schedule (MBS) Review and the work of the Primary Care Reform and Preventive Health Committees have highlighted the inadequacy of these provisions, with discussion and recommendations focusing on the lack of preventive health funding and the limited access to chronic and complex illness-focused allied health services. That recognition led to an increase in the number of mental health items available under the Better Access program from 10 to 20 annual items as well as additional items for older Australians living in residential aged care under a COVID-19 related trial. No current changes have been announced in relation to the chronic disease items for the broader population.

Given the limitations of Medicare funding, many Australians rely on private health insurance to provide access to allied health services. For some Australians, and for some services, that works relatively well. However, there is significant variability across insurers and individual policies in relation to coverage of services provided by allied health professionals and coverage is almost exclusively provided through general treatment policies, which are not a true insurance product. Coverage under general treatment policies is most often limited to musculoskeletal health services and optical equipment. Decisions about what is rebated, including services, rebate levels and total annual limits, is left up to individual insurers with the Australian government providing only limited restrictions or guidance. As a consequence, private health insurance does not currently work effectively as a means of addressing gaps in Medicare funding and other government programs as a means of providing equitable access to care. It also means that there is little interaction between what private health insurers fund, and what clinical guidelines recommend.

Access to mental health and rehabilitative services under most hospital cover policies is extremely limited. A review of current policy offerings, now categorized as Bronze, Silver and Gold resulting from the first wave of reforms, shows that most insurers provide restricted access to allied health services as part of hospital cover policies. That cover is generally limited to hospital based in-patient or admitted day-patient options. This reflects the Department's statement in the consultation paper, which acknowledges that insurers have been able to pay for a range of services outside of hospital since the 2007 Broader Health Cover reforms but that currently only very few services are delivered under these arrangements. It also reflects data collated by Deloitte for AHPA in 2018 which showed that only $0.04 out of every dollar of hospital cover spending went to Chronic Disease Management Programs (CDMP) and $0.03 to hospital substitution services.

This provides a strong foundation for change and AHPA is very supportive of the intention to undertake reform activities in relation to private health insurance funding. The allied health sector welcomes any opportunity to work with government and insurers to address perceived barriers and to develop improved options for consumers to access allied health services.

Unfortunately, AHPA and its members do not consider it likely that the current consultation process will achieve the aim of improving outcomes and choice for consumers. The Department of Health team leading this consultation, in responding to questions during a series of online consultations in late January 2020, stated that the intentions of reforms is primarily to provide increased flexibility for insurers and that there is no intention for government to guide how that flexibility is utilised or to seek to develop agreed models of care that align with best practice guidelines and standards. We note in this context that direct engagement by AHPA with the private health insurance sector indicates that the key focus for the sector is on expanding access to nurses and peer workers, under the CDMP program.

Given these factors, AHPA and its members are concerned that there is unlikely to be any real reform in these proposals, particularly in relation to allied health access under private insurance hospital policies. We are also concerned that the only practical outcome is likely to be the removal of the requirement to use allied health professionals to provide services entirely as currently specified in the CDMP legislation.

This is particularly concerning as the consultation paper misstates the intention of reforms to focus only on expanding the range of eligible allied health services. This is despite nurses and peer workers falling outside the Australian Government's own definition of allied health and an acknowledgement during the online consultation process that the intention is to expand access to non-allied health professions or to entirely remove the list of eligible professions.

The allied health sector objects in the strongest possible terms to the government making legislative changes to the entire CDMP program to increase access to non-allied health services, under the guise of consulting on mental health interventions. We note that the Department of Health has clearly recognised that this is a potential issue as it specifically asks whether legislative changes to the CDMP program should only impact mental health services.

Given that this consultation provides no detail about the potential ramifications for either mental health CDMP or the CDMP program more broadly, AHPA argues strongly for the need to pause any potential legislative change until further consultation has been undertaken. Instead, this consultation should be seen for what it is, a useful information-gathering opportunity that will allow the Department of Health to build on input from providers and insurers as it undertakes further policy work, including an analysis of the workforce impacts, and related regulatory issues that are likely to arise. This in turn provides a solid foundation for the recommendations set out below.

Recommendations

AHPA recommends that the Department of Health:

1. **Halt any legislative changes to the list of eligible non-allied health professions able to deliver CDMP services until a second round of consultation is undertaken, based on an analysis of potential costs, risks and benefits, and outlining likely models of implementation as well as regulation of new workforces.**
2. **Ensure any potential legislative change to the broader CDMP program, in relation to an expanded workforce, is only undertaken after detailed consultation with the sector, including an analysis of potential costs, risks and benefits.**

3. **Convene expert advisory groups for both rehabilitation and mental health as part of additional consultation to support the development of models of care, to review proposals for workforce changes, and to oversee implementation and evaluation of reforms.**

Responses to the consultation paper questions

In responding to the consultation paper, AHPA has limited its responses to those questions of the greatest relevance to the allied health workforce. We encourage the Department to contact us if additional information is sought on any aspects of the proposed reforms.

Consultation 2: Expanding home and community-based rehabilitation care

AHPA strongly supports the proposal to increase access to home and community-based rehabilitation care. Our view is that the private health insurance reforms, focused on increasing access to allied health services as part of hospital cover polices, offers the potential to increase consumer choice and increase access to services that have a demonstrated ability to improve post-surgical recovery and overall outcomes. We would welcome genuine collaboration between the allied health sector, private health insurers, and the Australian Government to design new models of home- and community-based rehabilitation care.

However, AHPA reiterates the concerns raised above about the likelihood that this consultation process will result in much-needed reforms and improved models of care. The limited detail provided in the consultation document does not make clear how the proposed development of a rehabilitation plan will result in increased access to home and community-based care or improved rehabilitation options provided by allied health professionals. The consultation paper also fails to address an inherent conflict between stating that insurers have flagged regulation and funding structures as key barriers to use of home- and community-based rehabilitation while also flagging the findings of the Improved Models of Care Working Group rehabilitation sub-committee, which found that the regulation was in most cases not a barrier.

AHPA argues that no reforms will be achieved without addressing the real or perceived barriers to uptake by insurers. The addition of extra administrative processes, in the form of the requirement to develop rehabilitation plans, may work against the intended aims of these reforms if there is not also careful analysis of what additional time and cost burden this will place on providers and the extent to which it medicalizes the rehabilitation process. The proposals focus heavily on interventions by medical practitioners with little reference to the role and expertise of the allied health professionals likely to provide most rehabilitative care. This is despite quoting the Royal Australasian College of Physicians and Australasian Faculty of Rehabilitation Medicine standards which states that therapy is generally provided by a range of allied health professions.

AHPA argues that to achieve the intended outcomes of these reforms, additional consultation will be required once the Department has undertaken a more comprehensive policy development process, based on information gathered through this first round of consultation. That should include concrete guidance about what models insurers may implement, and how this will benefit consumers as well as impact allied health and other rehabilitation providers.

We strongly recommend that the Health Minister should re-convene a working group consisting of insurers, allied health provider representatives and consumer representatives, to oversee and

evaluate the impact of proposed rehabilitation changes and to provide the Minister with additional information to support any reforms, particularly as they relate to legislative change. In addition to providing initial advice, this group should be called upon to report back to government after an appropriate period with a view to potentially recommending additional reforms and changes.

1. Which procedures and/or MBS item numbers should have a rehabilitation plan?

AHPA argues that any hospital procedure, including non-orthopaedic interventions, would benefit from the development of a rehabilitation plan, in conjunction with appropriate allied health professionals and the patient. Despite the Department's intention to focus initially on orthopaedic rehabilitiation, AHPA recommends a broader approach is taken that seeks to capitalize on opportunities for a range of different rehabilitation types including post-stroke or as part of cardio rehabilitation.

However, while AHPA supports widespread use of rehabilitation plans, we also argue that these should only be introduced in conjunction with work to develop new models of care that increase access to allied health rehabilitation services in home and community settings. It would not be appropriate or effective to add additional administrative requirements without also working on increasing access to appropriate home and community based rehabilitative care for patients with private health cover by developing models and standards that apply across insurance products. We note that there are clear standards about appropriate care on which these should be based and that it would be very achievable for the sector to work with government and insurers to develop standard models for different levels of cover. Insurers could then provide additional information to consumers to help them understand what rehabilitation standards are and what level of rehabilitation services will be funded under a particular policy.

2. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?

AHPA argues that rehabilitation plans should be standardized to a significant extent to ensure consistency with appropriate clinical standards. It may be appropriate to develop standardized templates that can be used by different insurers and providers, and which prompt providers to consider the appropriate range of services. This is particularly important given the proposal to allow medical practitioners such as GPs, who may have only limited direct experience in relation to the development of rehabilitation plans, to develop plans.

However, AHPA argues that while it will be important to outline broad standards about what should be included in a rehabilitation plan, it will be essential to provide sufficient flexibility to allow the allied health professionals providing services the scope to exercise clinical judgement in designing and delivering an appropriate program of care, including an ability to make adjustments as needed. This is particularly important to ensure that the clinician is able to monitor the patient's response to therapy, and their ability to tolerate the prescribed level of therapy and to make adjustments to the program as needed.

3. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?

AHPA proposes that compliance requirements are minimal and subject to normal private health insurer compliance and auditing measures. It may be appropriate to simply require the issuing

practitioner to keep a copy of the rehabilitation plan and a report on the review undertaken at the end of the plan. If treating practitioners are to be required to develop reports as part of the review of the rehabilitation plan, this should be funded by insurers in addition to any time spent on clinical care. Allied health providers of rehabilitation services should be required to maintain records of the treatment provided as per normal practice.

4. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?

AHPA argues strongly that the rehabilitation plan should be available via mechanisms such as My Health Record or via other online platforms that ensure the plan is accessible not only to the patient and the treating practitioners identified in the plan, but also to GPs and other allied health professionals who may provide additional support during the initial rehabilitation phase and potentially at a later stage once formal rehabilitation has ended. We argue that it would be valuable to have not only the plan but also a final review of the patient's recovery available in the same way.

The key principles for sharing of the plan should be robust privacy and security measures, and access to any relevant parties (i.e. practitioners, plan developers and consumers).

5. What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community-based rehabilitation services and oblige insurers to fund these services?

AHPA argues against medical practitioners seeking to identify appropriate home or community-based rehabilitation services. We note that it is not clear how appropriate is being defined, nor is it clear on what basis a medical practitioner would make such a determination. The most likely outcome is that either the medical practitioner will preference services they work more closely with or even have commercial arrangements with, or providers owned by, or with preferred provider arrangements in place with, a health insurer. Neither supports improved patient choice and may disrupt existing relationships between a patient and a practitioner that may have provided therapeutic services before orthopedic surgery was undertaken.

AHPA instead argues that rehabilitation plans should allow the patient to see the provider of their choice. Insurers should only provide information about the rebates available to patients and how these may vary based on their choice of provider, e.g. where there may be differences in out of pocket costs using a provider of their choice versus one with a preferred provider arrangement.

6. What transition arrangements and timeframe would be appropriate to implement this reform?

As it is not clear what the reforms entail, AHPA argues that it is not possible to specify an appropriate timeframe. Instead AHPA argues that implementation should be the subject of additional consultation alongside the proposals above. Any timeframe for implementation should be developed in conjunction with medical and allied health peak associations to support the development and rollout of appropriate guidance material for providers.

7. What are appropriate metrics for measuring the impact of this proposal?

AHPA recommends the following metrics are adopted to evaluate the proposal:

- Proportion of services provided in home or community-based settings compared to baseline

- Cost comparison between home and community-based rehabilitation and hospital-based services
- Patient-reported outcome and experience measures.

AHPA further recommends that these are provided to the steering group proposed above as part of their oversight of the success of the program and development of recommendations for further changes.

8. What is the regulatory burden associated with this proposal?

As it is not clear that the current proposals will result in increased use of home and community-based services or the development of an increased number of rehabilitation plans, AHPA cannot comment on the regulatory burden it will create. However, AHPA argues that consideration of any potential impact on allied health providers of the proposals should be considered alongside an implementation plan as a second round of consultation.

9. Service providers: what services would you deliver under this proposal?

AHPA wishes to flag its uncertainty about the role of this question, and any responses provided by service providers, given that the Department of Health has indicated that it is not seeking to provide guidance about appropriate programs or to provide oversight of any service delivery.

AHPA does reiterate its concerns about this lack of guidance and the potential impact this will have on consistency across policies and insurers, the additional complexity that this creates for consumers and providers, and the lack of focus on ensuring services align with best practice care standards, which have been well-established in the rehabilitation space.

Consultation 3: Out of Hospital Mental Health Services

AHPA supports the proposal to increase access to preventive mental health services as part of a second wave of reforms. We note that there is the potential to align reforms with the recommendations of the Productivity Commission Report on Mental Health, as well as the outcomes of previous inquiries and reviews. However, we also express our strong concern that the current process has little likelihood of achieving meaningful reform. We reiterate our concerns, outlined above, about the lack of detail in the consultation paper, both in relation to outlining potential new models, and in analysing the impact of changing the legislative restrictions on which professions can provide services. There appears to be no consideration of the potential quality impact of introducing access to workforces without consistent education, credentialling or regulatory requirements. There also appears to be little analysis of how the reforms will improve outcomes for consumers. As a result, the current consultation process seems to represent an information-gathering exercise rather than a genuine attempt to work with the sector to create meaningful change.

Given the Department of Health's stated intention to focus only on increasing flexibility for insurers without providing any oversight or guidance about potential new models of preventive care under a more flexible mental health CDMP, it appears clear that the only likely outcome of this process will be legislative change to provide insurers with the ability to provide lower cost mental health services through mental health nurses and peer workers. In the absence of work to analyse the impact of the proposals, and with no engagement with allied health mental health experts about the impact of this proposal outside this consultation, is by no means clear that this will result in positive changes. While AHPA acknowledges that both mental health nurses and peer workers are a valued and

important part of the mental health sector, workforce changes should be underpinned by appropriate policy analysis.

We note in this context that AHPA has flagged its concerns with the Department about its reference to an 'expanded list of allied health services' when what is in fact being considered is an expansion of services beyond allied health professionals to professions such as nursing and peer workers that do not meet any agreed definition of allied health. This is potentially misleading and may impact the accuracy and relevance of feedback to this consultation.

AHPA argues strongly that the current process of reform, and the role of the Department of Health, should be urgently reconsidered. We argue against any legislative changes before there has been genuine consultation. The Department of Health should seek to provide a far more detailed second round of consultation, based on the input and advice provided by respondents to this consultation. This should provide clear guidance about how the addition of new workforces will be managed and regulated, as well as how new models are likely to be implemented by insurers. We reiterate our call for the Minister to re-establish an advisory group to oversee both the finalising of initial reform proposals and subsequent implementation and evaluation.

1. What additional mental health services funded by insurers under this proposal would be of value to consumers?

AHPA argues in support of a more flexible, stepped care model that better supports access to services that align with the level of complexity and need of the person seeking care. These services should seek to integrate with, and complement, existing Medicare-funded services available under the Better Access program. We strongly support an expanded list of health professions, noting that this provides an opportunity to increase access to professions such as exercise physiology, physiotherapy and other professions involved in 'exercise is medicine' interventions that focus on using improved physical health and exercise as a means of addressing mental ill-health. We also argue for the need to consider alternative treatment modalities, such as those delivered by creative art and music therapists, that may be more effective for some patient cohorts or which may provide a valuable complementary intervention in addition to more traditional talking therapy. Both proposed broad intervention types outlined above are well-supported by research as well as by consumers.

For example, there is clear and strong evidence that music therapy provides symptomatic relief for people living with mental health illnesses, including depression[i] and anxiety (the highest source of lost Disability Adjusted Life Years (DALY) in Australia) as well as schizophrenia symptoms[ii]. There is also evidence of its effectiveness in severe mental illness[iii], substance abuse[iv], children with social and emotional behavioural problems[v]. These positive mental health outcomes can be achieved over a modest number of music therapy sessions at minimal to no cost on the Australian health care system. Music therapy is frequently requested by consumers and a range of studies have represented consumers' voices in advocating for their right to access music therapy[vi vii viii], and its effectiveness in prevention[ix x xi].

Physiotherapy offers value across a range of preventive and wellness activities relating to mental health. These include addressing obesity arising from the effects of medication[xii] , the relationship between depression and movement quality[xiii] ;and the relationship between pain, movement and mind[xiv]. Similar evidence exists for the interventions provided by a range of other allied health professions and can be provided on request.

Finally, AHPA also argues that there is considerable evidence that some functional issues, such as communication disorders in young people, can contribute significantly to the development of mental ill-health. As such we argue that some preventive interventions that focus not directly on mental ill-health but rather contributing factors should be considered in scope. To prevent confusion, it may be most appropriate to aim to split interventions into those that directly address mental ill-health, and interventions that address key contributors to mental ill-health.

AHPA argues strongly for the need to standardize access, based on Departmental guidance, across policies and insurers rather than relying on insurers to independently make decisions about which interventions to fund. Improved consistency should be a key foundation for any reforms.

2. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?

AHPA argues in the strongest possible terms that any changes to the list of eligible allied health services should be limited to mental health conditions until there is further consultation on the CDMP program. We strongly reiterate our argument that any introduction of non-allied health professions to the CDMP program for the purpose of providing mental health conditions should be underpinned by robust policy analysis and appropriate consultation. These professions should be listed separately to ensure there is no confusion about which professions are recognised allied health professions.

Any broader change to the CDMP program would be justifiably seen as having been made under false pretenses, particularly in light of the misrepresentation in the paper and online consultations where the Department of Health has referred to changes as an expansion of the allied health workforce. It would be highly concerning if government were to proceed in this manner.

3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

AHPA argues strongly that any professions providing mental health services must have appropriate accreditation with a professional body such as the Australian Health Practitioner Regulation Agency (AHPRA) or by a self-regulating profession with equivalent standards and requirements for minimum education levels and ongoing professional development and clear scope of practice definitions. Those professions should also have robust professional standards, including professional ethics codes, and formal processes allowing complaints about practitioners to be lodged and independently investigated and sanctions introduced where standards breaches have occurred. In addition, membership of those professions should require members to make declarations about their fitness to practise, such as previous criminal convictions, indictment on serious offences or professional misconduct findings or impairment.

AHPA does not consider the Department of Health proposal to only require accreditation where existing accreditation standards exist to be safe or appropriate. People with mental ill-health are potentially vulnerable and should have an expectation that services they access have at least the same level of oversight and regulation as health services. If the Australian Government does choose to expand the list of eligible professions to those without existing accreditation, consistent minimum education levels, and appropriate regulatory mechanisms, funding by insurers should be contingent on the Department of Health working with the sector on short- and long-term measures to develop appropriate accreditation measures and standards.

For example, we note that a scan of current vacancies for mental health nurses shows that the qualifications and experience requirements that eligible applicants may have can vary widely. Most roles allow mental health nurses to be either enrolled nurses or registered nurses as well as allowing previous work in a mental health setting to stand in for actual additional qualifications, despite a range of further study options for mental health nurses. The peer workforce has an even greater range of backgrounds.

4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?

AHPA notes that current expenditure on the CDMP program (based on 2018 data compiled for AHPA by Deloitte) shows approximately 89 percent of total rebates going to coordination and planning, and only 11 percent rebating allied health services. Currently it is not clear what exactly is provided under those definitions and AHPA would like to see a clearer definition of those services, as well as clarification of how they fit into a broader model of care for mental health services. We note that while planning costs per service are lower than allied health services at $126 and $175 respectively, coordination appear to be significantly higher at $353 per service.

Additional work to define coordination and planning will provide greater clarity around how it might fit into a preventive mental health model and how it provides value for money for consumers and government as a major indirect funder of private health insurance.

5. Are there any mental health services insurers should not be permitted to fund?

AHPA argues strongly for the need to ensure that only services provided by appropriate professions are funded. In addition, we argue for the need to recognise the evolving nature of intervention types such as digital mental health and other interventions and programs that may be developed as part of these reforms. An expert advisory group should be convened by the Department of Health with membership from consumers, practitioners, providers and insurers. This group should be tasked with overseeing the safety and quality of proposed insurer programs and interventions types, as well as determining eligible cohorts of practitioners. Where particular risks are identified by an expert group, funders should be required to cease funding services.

6. How should the relevant patient cohort be identified as eligible for services?

AHPA argues that preventive mental health treatments should be available to any holder of an eligible policy. Consumers should be encouraged to self-identify for treatment with ongoing access subject to an assessment by the relevant allied health professional provided to the insurer. AHPA further argues in the strongest possible terms for a consistent set of criteria across all insurance products to avoid further fragmentation of products and additional confusion for consumers. It may be appropriate to use the product tiers implemented in the last wave of reforms as the basis for potential differentiation in the levels of service available.

7. Who should identify relevant patient cohorts, and should insurers set criteria for which members would be eligible?

AHPA argues strongly that patients should be able to self-refer and access an initial assessment by an allied health professional. That assessment would then determine whether the person is eligible for services or if a referral to seek Medicare or other services is more appropriate. The overall criteria to determine whether a policy holder is eligible for services will require more detailed work

to first identify the models of care that will be offered as this will be highly relevant to determining who would potentially receive services. Once some models of service have been established, the expert advisory group, proposed above, should be charged with developing a set of consistent clinical indicators relevant across all insurance products.

8. What are appropriate metrics for measuring the impact of this proposal?

AHPA recommends the following metrics are adopted to evaluate the proposal:

- Data-linking between Medicare Better Access program, public hospital mental health in-patient data and private health insurer funded prevention and hospital service use
- Cost comparison reviewing overall hospital expenditure for patients accessing preventive health programs
- Patient-reported outcome and experience measures.

AHPA further recommends that these are provided to the steering group proposed above as part of their oversight of the success of the program and development of recommendations for further changes.

9. What is the regulatory burden associated with this proposal?

AHPA notes that the proposal as stated provides too little detail to allow a detailed response in relation to its regulatory burden. If the AHPA recommendation to increase access to other allied health professions such as creative arts and music therapists, as well as exercise physiologists and physiotherapists, is implemented, existing regulatory measures will minimize the regulatory burden on insurers, government and providers. However, it is likely that additional regulatory requirements will be imposed on insurers and the Commonwealth if unregulated workforces are to provide services under CDMPs.

10. Service providers: what services would you deliver under this proposal?

Allied health professionals from a broad range of professions including existing mental health professions such as psychologists, mental health occupational therapists and social workers, are trained in providing a wide range of evidence-based, individually tailored mental health therapies to help support people who may otherwise experience a deterioration in mental health. A focus on stepped treatment and prevention would allow a range of additional delivery modalities to support the maintenance and treatment of mental health conditions, including through digital mental health options utilizing apps, online platforms and telehealth treatment options. Ideally, these should be designed to work with Medicare-funded treatments to allow consumers to access treatments that reflect the level of complexity of their mental illness.

Health professionals from other allied health professions not currently funded, as outlined above, would provide targeted interventions in line with the evidence and models of care developed within their professions as a means of targeting mental ill-health.

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