Submission to the Australian Government – Department of Health

Consultation paper: Private Health Insurance reforms – second wave

8 February 2021

Emma Gainer
Policy and Advocacy Advisor
Exercise & Sports Science Australia
emma.gainer@essa.org.au

Anita Hobson-Powell
Chief Executive Officer
Exercise & Sports Science Australia
Anita.Hobson-Powell@essa.org.au

1.0 About Exercise & Sports Science Australia

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing over 7,500 members, including university qualified Accredited Exercise Physiologists (AEPs), Accredited Sports Scientists (ASpSs), Accredited High-Performance Managers (AHPMs) and Accredited Exercise Scientists (AESs).

AEPs are recognised allied health professionals (AHPs) who provide clinical exercise interventions aimed at primary and secondary prevention; managing acute, sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness. Exercise physiology is a recognised and funded profession under compensable schemes such as Medicare Benefit Services (MBS), Department of Veteran Affairs (DVA), the National Disability Insurance Scheme (NDIS), private health insurance, and state and territory-based workers' compensation schemes. AEPs are four-year trained university professionals.

Accredited Sports Scientists (ASpSs) and Accredited High-Performance Managers (AHPMs) work predominately in high performance/elite sport specialising in applying scientific principles and techniques to assist coaches and athletes to improve their performance, either at an individual level or within the context of a team environment. ESSA is recognised by the Australian Institute of Sport and Sport Australia as the peak accrediting body for physiology/recovery, biomechanics, performance analysis and skill acquisition support personnel working in Australian sports science.

Accredited Exercise Scientists apply the science of exercise to design and deliver physical activity and exercise-based interventions to improve health, fitness, well-being, performance and assist in the prevention of injury and chronic conditions. They coach and motivate to promote self-management of physical activity, exercise and healthy lifestyles and work in the National Disability Insurance Scheme (NDIS) as personal trainers and allied health assistants (AHAs), in fitness businesses, for sporting bodies, in corporate health and as AHAs for exercise physiologists and other allied health professionals. AESs are three-year trained university professionals.

2.0 Introduction

ESSA welcomes the opportunity to respond to the Consultation Paper on the Private Health Insurance Reforms – second wave. ESSA supports the Australian Government's vision for the provision of health services that ensure consumers can access affordable, quality and timely treatment alongside universal access to Medicare, including sustainable Private Health Insurance that provides greater choice and value for health consumers and is sustainable.

Please accept ESSA's response to the questions and recommendations on the development of the proposed reforms:

- Consultation Two: Private Health Insurance – Expanding home and community-based rehabilitation care.
- Consultation Three: Private Health Insurance – Expanding funding to at home and community based mental health care.

3.0 Summary of Recommendations

Consultation Two: Private Health Insurance – Expanding home and community-based rehabilitation care recommendations:

Recommendation 1: ESSA recommends that rehabilitation plans be given for all procedures and admissions which impact an individual's functional capacity, exercise capacity and quality of life.

Recommendation 2: ESSA recommends that rehabilitation plans should specifically detail the type of care that is required by service providers to meet the individual needs of the health consumer.

Recommendation 3: ESSA recommends that criteria be established to assess individual suitability for rehabilitation plans to be effectively and safely delivered in the home and community environment.

Recommendation 4: ESSA recommends that rehabilitation plans include exercise interventions delivered by an AEP to build an individual's functional capacity, exercise capacity and quality of life.

Recommendation 5: ESSA recommends that outcome measures are developed to assess and monitor health consumer progress, with the implementation of electronic recalls and reminders to comply in a timely manner.

Recommendation 6: ESSA recommends that financial incentives for case conferencing are provided to facilitate timely and cohesive communications between multi-disciplinary team members.

Recommendation 7: ESSA recommends that shared access to health consumer records should be available for all members of the multi-disciplinary team to enhance health consumer health outcomes.

Recommendation 8: ESSA recommends that all rehabilitation providers, the health consumer and carer/s are involved in developing the plan and all parties have continued access to health consumer records throughout the treatment period.

Recommendation 9: ESSA recommends that the medical practitioners, along with rehabilitation providers participate in training to deliver rehabilitation model/s prior to official launch.

Recommendation 10: ESSA recommends that all potential rehabilitation providers are accredited with relevant accrediting bodies and listed on a directory accessible to health professionals developing rehabilitation plans.

Recommendation 11: ESSA recommends that the following arrangements be implemented to oblige insurers to fund rehabilitation services including:

a) Educating insurers on the cost effectiveness of delivering rehabilitation in community and home environments.
b) Promoting the benefits of 'health consumer choice' (by providing the option of home-based rehabilitation where applicable) within marketing and promotion for membership and sales.
c) Providing the option to run a pilot and assess the outcomes.

d) Legislation by government to mandate that the choice for home and community rehabilitation be offered to eligible health consumers.

Recommendation 12: ESSA recommends that telehealth and other additional resources be provided for locations disadvantaged by the geographic distribution of workforce to align with changing population demographics and health needs.

Recommendation 13: ESSA recommends an expert advisory group is formed to guide the development and implementation of the proposal.

Recommendation 14: ESSA recommends that a pilot is implemented to test transition arrangements.

Recommendation 15: ESSA recommends a minimum time frame of at least 12 months is required to implement this reform.

Recommendation 16: ESSA recommends that Health consumer Reported Outcome Measures and Health consumer Reported Experience Measures, should be utilised to measure and substantiate impact, in addition to evidence based clinical outcome measures.

Recommendation 17: ESSA recommends that benchmarking evaluation is required to compare outcomes between regular hospital rehabilitation services and community and home rehabilitation.

Recommendation 18: ESSA recommends that consideration is given to using the quadruple aim model for measuring impact.

Recommendation 19: ESSA recommends that the proposal utilise existing administrative processes where possible to reduce the regulatory burden on providers.

Recommendation 20: ESSA recommends that extensive stakeholder consultation be undertaken to assess the extent of potential regulatory burdens.

Recommendation 21: ESSA recommends that pilot testing of regulatory processes be undertaken to identify areas of improvement prior to broader implementation.

Recommendation 22: ESSA recommends that exercise as a treatment provided by an AEP is added to the services offered to people with mental health conditions.

Consultation Three: Private Health Insurance – Expanding funding to at home and community based mental health care Recommendations:

Recommendation 23: ESSA recommends that the listing of allied health professionals remains unchanged in rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2017*.

Recommendation 24: ESSA recommends that the list of chronic diseases remains unchanged in rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2017*.

Recommendation 25: ESSA recommends any changes to the broader CDMP requires further in-depth consultation and investigation.

Recommendation 26: ESSA recommends that the extended list should not be for mental health conditions only. This limits and removes access to services for health consumers with co-morbidities and other chronic conditions such as asthma, cancer, cardiovascular illness, diabetes mellitus, arthritis and musculoskeletal conditions.

Recommendation 27: ESSA recommends that all professions eligible for direct CDMP related funding must have regulatory oversight from a relevant accrediting body. Where regulatory oversight doesn't exist for a profession, then that professional body should be encouraged to become a member of NASRHP.

Recommendation 28: ESSA recommends that all professions eligible for direct CDMP related funding must have a tertiary qualification at a minimum.

Recommendation 29: ESSA recommends that in addition to newly diagnosed health consumers, individuals at risk of admission or readmission to hospital should be targeted for CDMP and treated by the multi-disciplinary team of health professionals.

Recommendation 30: ESSA recommends the development of a mental health expert advisory group to further investigate eligibility and risk stratification for funding.

Recommendation 32: ESSA recommends that an expert advisory group made up of the key rehabilitation providers (including AEPs) should develop the framework to identify relevant health consumer cohorts.

Recommendation 33: ESSA recommends a pilot to test proposed changes.

Recommendation 34: ESSA recommends that PROMs and PREMs, in addition to evidence based clinical outcome measures are utilised to measure impact.

Recommendation 35: ESSA recommends the inclusion of financial incentives for reporting and data entry to facilitate provider compliance to regulatory processes.

Recommendation 36: ESSA recommends the implementation of an electronic mechanism for provider reporting.

4.0 Consultation Two: Private Health Insurance – Expanding home and community-based rehabilitation care

4.1 Which procedures and/or MBS item numbers should have a rehabilitation plan

Any procedure or admissions that impact an individual's functional and/or exercise capacity should have a rehabilitation plan.

This should include pre- and post- surgery health consumers, or any admitted health consumers with an injury or chronic disease (e.g. cancer, diabetes and obesity). Admitted health consumers who have encountered acute issues that require rehabilitation, for example stroke, fall, traumatic brain injury (TBI) all benefitfrom a

rehabilitation plan. Those people who have been infected with COVID-19 requiring hospitalisation will also need a rehabilitation plan.

ESSA recommends private health insurance rehabilitation plans be given for the following conditions/injuries:

- Orthopaedic (e.g. before and following a joint replacement / reconstruction, back surgery or a fracture)
- Falls (e.g. following discharge)
- Neurological (e.g. post-stroke, traumatic brain injury [TBI], multiple sclerosis [MS], or Parkinson's disease [PD])
- Cardiac (e.g. following heart surgery or a heart attack)
- Pulmonary (e.g. exacerbation of a chronic respiratory condition)
- Multi-trauma (e.g. following a car accident or workplace accident)
- Viral infections (e.g. COVID-19 or influenza).

ESSA notes in the model proposed that rehabilitation plans may be developed prior to surgery. If the use of exercise-based intervention is commenced before surgery as 'prehabilitation', this has been shown reduce recovery time [1].

Recommendation 1: ESSA recommends that rehabilitation plans be given for all procedures and admissions which impact an individual's functional capacity, exercise capacity and quality of life.

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

Clinical judgement is critical in assessing an individual health consumer's needs and focusing on health outcomes. This includes using evidence-based assessments and implementation of best practice rehabilitation plans for the delivery of care services.

Evidence based assessments of health consumers will need to consider the complexity of condition/s and suitability of an individual to receive a rehabilitation program delivered in the community or home.

Identification criteria to screen for a health consumer's suitability for community and in-home rehabilitation care should include:

- Ability for the health consumer to self-care
- Access to carer support
- Appropriate and safe physical and social home environment.

If a health consumer is unable to meet the above criteria at a minimum, exemptions should be made, and hospital-based interventions offered. Further items to be addressed in order to identify exemptions include safety considerations to reduce the risk of readmission to hospital or complications/deterioration.

The use of community and home rehabilitation must not be inferior to in-hospital rehabilitation and individuals should be made exempt if deemed unlikely to achieve the required health outcomes otherwise received in hospital.

Engagement and coordination of a professional multi-disciplinary team including allied health professionals will be critical to achieving effective outcomes of a rehabilitation plan. The use of case/care coordinators will be required to ensure appropriate care is delivered and communicated; and that progress is meeting health

consumer needs, ensuring equivalence to in health consumer care. Allied Health Professions Australia describe how allied health professionals are essential providers of cost-effective rehabilitation services [2].

For older people leaving hospital, rehabilitation plans should focus on a program of short-term restorative care (STRC) which can be delivered at home or in a residential aged care facility.

Feedback from ESSA members involved in STRC indicates that a 'Care Coordinator' role overseeing the multi-disciplinary team is key to positive health consumer outcomes. ESSA Accredited Professionals have identified that this integral role drives the individual's rehabilitation plan and facilitates communication between the health providers. This care coordinator role is in addition to the role of the general practitioner (GP) / Rehabilitation Physician.

Ideally, a program should consist of 8-12 weeks of services from a multidisciplinary care team and help to:

- Prevent or reduce any problems with completing daily tasks
- Improve health and wellbeing
- Avoid long-term or high levels of care.

The Australian Government Department of Health outlines details of the STRC Program including a manual [3].

A similar model of care would prove advantageous for private health providers to adopt with studies depicting the positive impact of reablement for older adults, especially on health-related quality of life and service utilisation [4]. Rehabilitation plans should include referral to AEPs to provide adequate access to resistance and/or weight bearing plus balance exercises to ensures rehabilitation can improve physical health and independence of age, level of disease or disability. Research confirms that exercise interventions are effective in achieving outcomes for both home-based [5] and clinic-based delivery [6].

Studies on home-based rehabilitation services have been shown to be as effective in the home for cardiac conditions, [7] pulmonary conditions [8] and hip fracture [9] when compared to hospital based rehabilitation.

There is a large body of evidence to support the **use of exercise-based interventions** in rehabilitation for:

- Post-myocardial infarction (MI) – exercise based cardiac rehabilitation reduces mortality and the risk of another MI [10]
- Hemiparetic stroke – adaptive physical activity is considered effective and safe in a community setting [11]
- Hip Fracture – home based rehabilitation has several positive effects including better mobility and physical function several months after surgery [12].
- MI, exacerbation of chronic obstructive pulmonary disease or dysregulated diabetes mellitus - the use of multidisciplinary teams for rehabilitation in community settings for the aged leads to improved mobility three months after health consumers are discharged from hospital and is not associated with a lower risk of unplanned hospital readmission within three months of discharge. This rehab included exercise therapy. [13]
- Cancer – exercise has an important role in cancer rehabilitation as stated in the Exercise & Sport Science Australia Position Statement, Titled 'Exercise medicine in cancer management' [14]. The Clinical Oncology Society of Australia outlines the benefits accrued through exercise following a cancer diagnosis [15]. This is particularly important for prehabilitation.

Exercise based intervention in rehabilitation is not limited to face-to-face consultations only. There is clear evidence demonstrating that telehealth consultations provided by AEPs via both video and/or by telephone are clinically effective [16]. Telehealth consultations are effective for many kinds of rehab including, but not limited to cardiac rehabilitation [17] , stoke rehabilitation [18], cancer rehabilitation [19], and pulmonary rehabilitation [20].

In relation to COVID-19, the Agency for Clinical Innovation in NSW has also produced a document titled, Rehabilitation following COVID-19 in the pulmonary rehabilitation setting [21]. This includes guidelines for the delivery of exercise-based interventions which should be incorporated into a rehabilitation plan for health consumers recovering from COVID-19.

In May 2020, NSW Ministry of Health (NSW Health) conducted a rapid evidence check on the rehabilitation needs of post-acute COVID-19 health consumers. The rapid evidence check found **post COVID-19, exercise interventions were one of the keys to recovery** [22]. Furthermore, ESSA conducted two Rapid Reviews on the benefits and requirements of exercise interventions as rehabilitation following COVID-19 [23]. ESSA foreshadows that AEPs will be integral in supporting the recovery of post-acute COVID-19 health consumers.

ESSA's scope of practice of an AEP [24] clearly outlines the services delivered in relation to rehabilitation noting that the role includes:

> "Provision of exercise-based rehabilitation and advice for health consumers in the acute/sub-acute stage of injury, surgical intervention, or during recovery to restore functional capacity and well-being."

AEP scope of practice includes: functional testing; clinical exercise prescription and supervision; physical activity education and counselling; and outcomes analysis to prevent or manage chronic disease or injury, and assist in restoring optimal physical function, health, and wellness [24] all of which are key to effective health consumer outcomes through rehabilitation.

The inclusion of exercise-based interventions delivered by AEPs has been shown to be cost effective – refer to Table 1.1 below [25].

Table 1.1: Estimated benefits and costs of accredited exercise physiologist interventions, per person, 2016

Condition	Benefits ($)				Costs ($)	BCR
	Health system	Productivity & other financial	Wellbeing	Total benefits		
Pre-diabetes	1,977	1,520	2,617	6,115	580	6.0^
Type 2 diabetes	5,107	NE	2,860	7,967	580	≥ 8.8^
Mental health (depression)	330	1,909	NE	2,239	824	2.7^
CVD	NE	NE	11,847	11,847	1,903	6.2#

Note: NE is 'not estimated due to lack of available data', ^ BCRs for pre-diabetes, type 2 diabetes and mental health (depression) are reported as the ratio of financial benefits (health system and lost productivity savings) to costs. # the BCR for chronic disease is relative to the wellbeing gains. BCRs which contain NE elements are reported on a greater than or equal to basis, as it is assumed that the NE components would add to the benefits.
Source: Deloitte Access Economics (2015).

Recommendation 2: ESSA recommends that rehabilitation plans should specifically detail the type of care that is required by service providers to meet the individual needs of the health consumer.

Recommendation 3: ESSA recommends that criteria be established to assess individual suitability for rehabilitation plans to be effectively and safely delivered in the home and community environment.

Recommendation 4: ESSA recommends that rehabilitation plans include exercise interventions delivered by an AEP to build an individual's functional capacity, exercise capacity and quality of life.

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

There are several different mechanisms that should be put in place to ensure compliance in developing and reviewing a rehabilitation plan. These include:

- Establishment of a recall period for review, based on the expected length of the treatment required and what the evidence/guidelines recommend.
- Participation in case conferences by all service providers to report on progress and recommend further interventions or discharge.
- Reporting requirements to document interventions delivered with mechanisms for accessing health consumer treatment notes/progress reports by the multi-disciplinary team.
- Financial incentives for the multi-disciplinary team to participate in case conferences.

- Electronic systems to identify when review is overdue (compliance).
- Peer review system published to measure success and provide comparison.

Recommendation 5: ESSA recommends that outcome measures are developed to assess and monitor health consumer progress, with the implementation of electronic recalls and reminders to comply in a timely manner.

Recommendation 6: ESSA recommends that financial incentives for case conferencing are provided to facilitate timely and cohesive communications between multi-disciplinary team members.

Recommendation 7: ESSA recommends that shared access to health consumer records should be available for all members of the multi-disciplinary team to enhance health consumer health outcomes.

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

It is expected that all parties will be involved in the development of a rehabilitation plan including the GP, other members of the treating multi-disciplinary team, the health consumer and carer/s. Rehabilitation plans and health consumer data can then be loaded to My Health Record with the ability for all parties to access plans throughout the treatment period.

ESSA members involved in home based multi-disciplinary rehabilitation have provided feedback that in-home rehabilitation plans should be regularly reviewed for the appropriateness of treatment across the multi-disciplinary teams involved. Health consumers have previously expressed that they have been overloaded with too many services visiting. Health consumer feedback will therefore be also critical in monitoring progress.

Recommendation 8: ESSA recommends that all rehabilitation providers, the health consumer and carer/s are involved in developing the plan and all parties have continued access to health consumer records throughout the treatment period.

4.5 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?

To assist medical practitioners, it is important that multidisciplinary allied health teams are identified and engaged at the outset with appropriate mechanisms available to support this initial step in developing a rehabilitation plan. For example, one mechanism could be that eligible providers are required to be registered with a directory to deliver services which made available for medical practitioners. An already established database such as the National Health Services Directory | healthdirect may be suitable for this purpose. This is where co-ordination will be key, with strong communication between the multi-disciplinary team members for the best outcomes. Medical practitioners, along with other 'registered' healthcare providers will require training in the delivery of this model prior to official involvement.

With a high proportion of AEPs working in sectors outside of the public health system, the AEP profession is an easily accessible and effective allied health option to support the delivery of the rehabilitation model proposed. In 2019, only 4 % of AEPs were employed in public hospital services [26], leaving the remaining 96% (5,477) to work across the private sectors within private health, DVA, aged care and Medicare.

Furthermore, the numbers of available AEPs are continuing to grow proportionally with an increase of between 10-15% each year since 2016 [26]. This growth highlights the long-term accessibility and sustainability of utilising AEPs within this rehabilitation model.

This growth has largely occurred as a result of the recognition of the role exercise therapy in supporting:

- an ageing population in wellness and reablement; and falls prevention/rehabilitation
- people with mental health conditions, especially those with co-morbidities like obesity
- National Disability Insurance Scheme clients
- preventing and managing chronic and complex diseases in areas such as cancer and cardiac care, pain management, diabetes, chronic obstructive pulmonary disease and respiratory rehabilitation.

The following arrangements will assist insurers to make decisions to fund these rehabilitation services:

1. Educating insurers on the cost effectiveness of delivering rehabilitation in community and home environments.
2. Promoting the benefits of 'health consumer/consumer choice' (by providing the option of home-based rehabilitation where applicable) within marketing and promotion for membership and sales.
3. Providing the option to run pilots and assess the outcomes.
4. Legislation by government to mandate that the choice for home and community rehabilitation be offered to eligible health consumers.

Workforce planning needs to be considered and arrangements put in place to assist medical practitioners to access trained staff and co-ordinate rehabilitation services. There are challenges to access services in rural and remote areas. The final *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* highlighted that [27]:

> "**Allied health professionals are essential to the physical, social and psychological wellbeing of people living in rural and remote Australia.** They are **integral to the care of rural and remote communities, whose capacity to achieve optimal health outcomes is limited by inequitable access to appropriate health services**. They are also integral to the economic development of rural and remote populations particularly in relation to workforce participation and educational outcomes.
>
> **There is both an undersupply and a maldistribution of allied health services in rural and remote towns of less than 30,000 people** that can be addressed by an integrated service and learning pathway linked to more and better structured jobs, greater participation of Indigenous Australians, improved access to workforce data and through national allied health leadership."

The recent launch of new temporary physical therapy Medicare items (exercise physiology, occupational therapy and physiotherapy) for people in residential aged care facilities and group exercise session funding via PHNs will also assist in the recognition of the value of exercise physiology services and drive further growth in aged care.

Recommendation 9: ESSA recommends that the medical practitioners, along with rehabilitation providers participate in training to deliver rehabilitation model/s prior to official launch.

Recommendation 10: ESSA recommends that all potential rehabilitation providers are accredited with relevant accrediting bodies and listed on a directory accessible to health professionals developing rehabilitation plans.

Recommendation 11: ESSA recommends that the following arrangements be implemented to oblige insurers to fund rehabilitation services including:

e) **Educating insurers on the cost effectiveness of delivering rehabilitation in community and home environments.**
f) **Promoting the benefits of 'health consumer choice' (by providing the option of home-based rehabilitation where applicable) within marketing and promotion for membership and sales.**
g) **Providing the option to run a pilot and assess the outcomes.**
h) **Legislation by government to mandate that the choice for home and community rehabilitation be offered to eligible health consumers.**

Recommendation 12: ESSA recommends that telehealth and other additional resources be provided for locations disadvantaged by the geographic distribution of workforce to align with changing population demographics and health needs.

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

An integral transition arrangement for implementation includes the establishment of an expert advisory group to develop a framework that is clinically safe and meets the required health consumer outcomes. Importantly, this group should comprise of the key rehabilitation providers including AEPs.

A pilot to test the draft framework is an important quality assurance process to be followed, with the pilot being supported by the establishment of electronic data collection systems in order to evaluate effectiveness.

A minimum time frame of at least 12 months preparation would be required to enable the development of systems for referral, registration of providers, reporting, claiming, incorporation into insurance policies, education of insurers, and education of providers.

Recommendation 13: ESSA recommends an expert advisory group is formed to guide the development and implementation of the proposal.

Recommendation 14: ESSA recommends that a pilot is implemented to test transition arrangements.

Recommendation 15: ESSA recommends a minimum time frame of at least 12 months is required to implement this reform.

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

Measuring impact should include, but not be limited to measures such as quality of life, functional capacity, satisfaction with service, cost utilisation, provider utilisation and referral efficiency.

This data can be collected utilising Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) in addition to clinical evidence-based testing protocols. Aiming to improve quality care and capturing useful consumer feedback and data, PROMs and PREMs are useful tools which are increasing in popularity due to the ease of assessing health consumers' perceptions of their health and experiences during care and intervention [28].

Consideration should be given to using the quadruple aim which represents a model for high-performing patient care. The model seeks to drive healthcare redesign in order to:

- improve the health of the population
- improve the patient experience of care
- reduce healthcare costs
- improve the work life of health providers [29] [30].

Establishment of a peer review mechanism may also assist in support individual rehabilitation providers.

Impact evaluation must include the comparison between in hospital rehabilitation services and community home models.

Recommendation 16: ESSA recommends that Health consumer Reported Outcome Measures and Health consumer Reported Experience Measures, should be utilised to measure and substantiate impact, in addition to evidence based clinical outcome measures.

Recommendation 17: ESSA recommends that benchmarking evaluation is required to compare outcomes between regular hospital rehabilitation services and community and home rehabilitation.

Recommendation 18: ESSA recommends that consideration is given to using the quadruple aim model for measuring impact.

4.8 What is the regulatory burden associated with this proposal?

Ensuring rehabilitation providers comply with newly implemented processes will be the biggest burden associated with this proposal. Time and cost required for travel, cross-provider collaboration, telehealth opportunities along with mandated reporting and uniform processes will all prove to be a compliance burden for providers.

Building financial incentives for reporting, data entry, travel, and formal multi-disciplinary communication will facilitate provider compliance to regulatory processes and decrease the burden of both the provider and insurer.

The implementation of an electronic mechanism (including existing administrative processes where possible) and innovations to report on these areas would be vital to ensure consistent operating procedures, uniform data entry and operational efficiencies.

Recommendation 19: ESSA recommends that the proposal utilise existing administrative processes where possible to reduce the regulatory burden on providers.

Recommendation 20: ESSA recommends that extensive stakeholder consultation be undertaken to assess the extent of potential regulatory burdens.

Recommendation 21: ESSA recommends that pilot testing of regulatory processes be undertaken to identify areas of improvement prior to broader implementation.

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

In line with their current professional scope of practice [24] AEPs are best placed to be the provider of evidence-based exercise intervention within all rehabilitation programs outlined above in 4.1 & 4.2.

5.0 Consultation Three: Private Health Insurance – Expanding funding to at home and community based mental health care.

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

The importance of including exercise as a cornerstone of effective mental health care has been well-established in clinical research. ESSA notes there is a growing body of evidence supporting the role of exercise in managing and preventing mental illness, as outlined below:

- Decrease symptoms of depression, anxiety, stress and schizophrenia [31] [32] [33] [34] [35]
- Decrease social isolation [36]
- Improve sleep quality [37] [38]
- Increase engagement with treatment and service utilisation [39] [40]
- Reduce cravings and withdrawal in substance use disorders (SUD) and alcohol addiction [41] [42] [43]
- Increase self-esteem [44]
- Improve quality of life [31] [45] [46]

Further to this, recent evidence guides published by the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Commission of NSW recommend referral to, or engagement with dedicated allied-health professionals with expertise in exercise prescription, specifically AEPs, to promote improved health outcomes of people living with a mental illness [47]. To assist with appropriate referral to exercise physiology for mental health, ESSA has developed a Consensus Statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: A Guide for mental health professionals [48].

Recommendation 22: ESSA recommends that exercise as a treatment provided by an AEP is added to the services offered to people with mental health conditions.

5.2 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?

The current list of allied health services outlined as part of a PHI Chronic Disease Management Program (CDMP) is helpful and clearly understood, refer to part 3, item 12. Private Health Insurance (Health Insurance Business) Rules 2017 (legislation.gov.au)

Expansion to this list of allied health professionals should only be made where professions have regulatory oversight and can demonstrate safe and effective evidence-based care within chronic disease management as an allied health professional. There is validity in expanding the list, but changes to the broader CDMP requires further in-depth consultation and investigation and should therefore remain unchanged until this quality assurance process is undertaken.

Consideration should be given to expanding the range of allied health professions to include those recognised by the Australian Government in the Mason report.

At some future stage, it is anticipated that National Allied Health Advisors and Chief Officers committee (NAHAC) will develop an agreed list of recognised allied health professionals which could also guide the inclusion of additional professions.

Additions to this list of allied health professionals should only be made with evidence of benefit in chronic disease management. The introduction of other providers where evidence is lacking in the delivery of CDMPs creates unnecessary risk for health consumers and is not recommended.

The restriction to only providing the extended list of services for mental health conditions is limiting and removes access to services for health consumers with co-morbidities and other chronic conditions such as asthma, cancer, cardiovascular illness, diabetes mellitus, arthritis and musculoskeletal conditions. This restriction risks a deterioration in health for people with these chronic conditions and could potentially contribute to increases in avoidable hospital admissions.

Recommendation 23: ESSA recommends that the listing of allied health professionals remains unchanged in rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2017*.

Recommendation 24: ESSA recommends that the list of chronic diseases remains unchanged in rule 12 of the *Private Health Insurance (Health Insurance Business) Rules 2017*.

Recommendation 25: ESSA recommends any changes to the broader CDMP requires further in-depth consultation and investigation.

Recommendation 26: ESSA recommends that the extended list should not be for mental health conditions only. This limits and removes access to services for health consumers with co-morbidities and other chronic conditions such as asthma, cancer, cardiovascular illness, diabetes mellitus, arthritis and musculoskeletal conditions.

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

A tertiary qualification should be the minimum requirement for direct CDMP related funding from insurers. In relation to allied health professionals, attainment of a tertiary qualification ensures that standards and competencies have been met for the delivery of services within a scope of professional practice.

ESSA supports access to all professions providing evidence based mental health services that benefit health consumers.

It is acknowledged that the COAG (Council Of Australian Governments) Health Council communique' (2018) [49] recognises the National Registration and Accreditation Scheme (NRAS), and those regulated by other means. Professions that deliver evidence based mental health services, but not currently subject to a regulatory process should consider membership of National Alliance of Self-Regulating Health Professionals (NASRHP).

Recommendation 27: ESSA recommends that all professions eligible for direct CDMP related funding must have regulatory oversight from a relevant accrediting body. Where regulatory oversight doesn't exist for a profession, then that professional body should be encouraged to become a member of NASRHP.

Recommendation 28: ESSA recommends that all professions eligible for direct CDMP related funding must have a tertiary qualification at a minimum.

5.4 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?

In this context, care **coordination** and planning are the process of helping a person with a **mental illness** to access a range of different services in a way that helps them to achieve better health outcomes. It involves interactions between different **health** care providers, the individual, their carers, family members and other significant persons. These should be expanded to best support non-MBS mental health services by identifying the gaps that exist in current service provision and coordinating delivery of services to meet needs.

In addition to health consumers newly diagnosed with a mental health condition, individuals at risk of admission or readmission to hospital should be targeted for CDMP and treated by the multi-disciplinary team of health professionals.

Recommendation 29: ESSA recommends that in addition to newly diagnosed health consumers, individuals at risk of admission or readmission to hospital should be targeted for CDMP and treated by the multi-disciplinary team of health professionals.

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

The establishment of a mental health expert advisory group could develop a framework for risk stratification and distinguish services unfit for funding.

Recommendation 30: ESSA recommends the development of a mental health expert advisory group to further investigate eligibility and risk stratification for funding.

5.6 How should the relevant health consumer cohort be identified as eligible for services?

Similar or slightly broader criteria to the criteria used for the MBS Better Access program could be used to determine the relevant health consumer cohort.

Diagnostic and Statistical Manual of Mental Disorders (DSM) is the American Psychiatric Association 's standard reference for psychiatry which includes over 450 different definitions of mental disorders.

Recommendation 31: ESSA recommends utilising a similar criteria to that used for the MBS Better Access program.

5.7 Who should identify relevant health consumer cohorts, and should insurers set criteria for which members would be eligible?

Establishment of an expert advisory group made up of the key rehabilitation providers (including AEPs) could develop the framework to identify relevant health consumer cohorts. This group should made up of experts who would develop criteria based on clinically safe best practices and health consumer outcomes. This criteria should not be left for the individual insurers to make.

A pilot could be used to test the draft framework as an important quality assurance process prior to implementation.

Recommendation 32: ESSA recommends that an expert advisory group made up of the key rehabilitation providers (including AEPs) should develop the framework to identify relevant health consumer cohorts.

Recommendation 33: ESSA recommends a pilot to test proposed changes.

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

Measuring impact should include, but not be limited to quality of life, functional capacity, satisfaction with service, cost utilisation, provider utilisation, referral efficiency.

This data can be collected utilising Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) in addition to clinical evidence-based testing protocols. Aiming to improve quality care and capturing useful consumer feedback and data, PROMs and PREMs are useful tools with increasing popularity due to the ease of assessing health consumers' perceptions of their health and experiences during care and intervention [28].

Recommendation 34: ESSA recommends that PROMs and PREMs, in addition to evidence based clinical outcome measures are utilised to measure impact.

5.9 What is the regulatory burden associated with this proposal?

Ensuring allied health providers comply with the newly implemented processes will prove to be the biggest burden associated with this proposal.

Building financial incentives for reporting and data entry will facilitate provider compliance to regulatory processes and decrease the burden upon both the provider and insurer.

The implementation of an electronic mechanism (including existing administrative processes where possible) and innovations to report on mandated provider areas will provide an important aspect in eliminating this burden.

Recommendation 35: ESSA recommends the inclusion of financial incentives for reporting and data entry to facilitate provider compliance to regulatory processes.

Recommendation 36: ESSA recommends the implementation of an electronic mechanism for provider reporting.

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

In line with the current professional scope of practice [24] AEPs are best placed to be the provider of evidence based exercise intervention for health consumers diagnosed with a mental health condition.

References

1. Santa Mina, D., et al., *Effect of total-body prehabilitation on postoperative outcomes: a systematic review and meta-analysis.* Physiotherapy, 2014. **100**(3): p. 196-207.
2. Allied Health Professions Australia. *Rehabilitative Care*. [cited 2021 February 1]; Available from: https://ahpa.com.au/key-areas/rehabilitation/.
3. Australian Government Department of Health, *Short-Term Restorative Care Programme Manual*. 2020.
4. Tessier, A., et al., *Effectiveness of reablement: a systematic review.* Healthcare Policy, 2016. **11**(4): p. 49.
5. Lewin, G.F., H.S. Alfonso, and J.J. Alan, *Evidence for the long term cost effectiveness of home care reablement programs.* Clinical interventions in aging, 2013. **8**: p. 1273.
6. Liu, C.-J. and N. Latham, *Can progressive resistance strength training reduce physical disability in older adults? A meta-analysis study.* Disability and rehabilitation, 2011. **33**(2): p. 87-97.
7. Clark, A.M., *Home based cardiac rehabilitation*. 2010, British Medical Journal Publishing Group.
8. Horton, E.J., et al., *Comparison of a structured home-based rehabilitation programme with conventional supervised pulmonary rehabilitation: a randomised non-inferiority trial.* Thorax, 2018. **73**(1): p. 29-36.
9. Levi, Y., et al., *Intensive inpatient vs. home-based rehabilitation after hip fracture in the elderly population.* Frontiers in medicine, 2020. **7**.
10. Lawler, P.R., K.B. Filion, and M.J. Eisenberg, *Efficacy of exercise-based cardiac rehabilitation post–myocardial infarction: A systematic review and meta-analysis of randomized controlled trials.* American heart journal, 2011. **162**(4): p. 571-584. e2.
11. Stuart, M., et al., *Community-based adaptive physical activity program for chronic stroke: feasibility, safety, and efficacy of the Empoli model.* Neurorehabilitation and neural repair, 2009. **23**(7): p. 726-734.
12. Wu, D., X. Zhu, and S. Zhang, *Effect of home-based rehabilitation for hip fracture: a meta-analysis of randomized controlled trials.* Journal of rehabilitation medicine, 2018. **50**(6): p. 481-486.
13. Verweij, L., et al., *Effects of postacute multidisciplinary rehabilitation including exercise in out-of-hospital settings in the aged: systematic review and meta-analysis.* Archives of physical medicine and rehabilitation, 2019. **100**(3): p. 530-550.
14. Hayes, S.C., et al., *The Exercise and Sports Science Australia position statement: Exercise medicine in cancer management.* Journal of science and medicine in sport, 2019. **22**(11): p. 1175-1199.
15. Cormie, P., et al., *Clinical Oncology Society of Australia position statement on exercise in cancer care.* Medical Journal of Australia, 2018. **209**(4): p. 184-187.
16. Australia, E.S.S., *ESSA Briefing Paper prepared for Private Healthcare Australia on the clinical effectiveness of Exercise Physiology Teleconsultations*. 2020.

17. Huang, K., et al., *Telehealth interventions versus center-based cardiac rehabilitation of coronary artery disease: A systematic review and meta-analysis.* European journal of preventive cardiology, 2015. **22**(8): p. 959-971.
18. Tchero, H., et al., *Telerehabilitation for stroke survivors: systematic review and meta-analysis.* Journal of medical Internet research, 2018. **20**(10): p. e10867.
19. Cheville, A.L., et al., *Effect of collaborative telerehabilitation on functional impairment and pain among patients with advanced-stage cancer: a randomized clinical trial.* JAMA oncology, 2019. **5**(5): p. 644-652.
20. Tsai, L.L.Y., et al., *Home-based telerehabilitation via real-time videoconferencing improves endurance exercise capacity in patients with COPD: the randomized controlled TeleR Study.* Respirology, 2017. **22**(4): p. 699-707.
21. Agency for Clinical Innovation NSW Health, *Rehabilitation following COVID-19 in the pulmonary rehabilitation setting*. 2020, NSW Government.
22. NSW Health, *Evidence Check: Rehabilitation needds of post acute COVID-19 patients*. 2020, NSW Government.
23. Exercise & Sports Science Australia, *ESSA COVID-19 Rapid Review: Exercise rehabilitation for clients following COVID-19 infection*. 2020.
24. Exercise & Sports Science Australia, *Accredited Exercise Physiologist Scope of Practice*. 2018.
25. Deloitte Access Economics, *Value of Accredited Exercise Physiologists in Australia,*. 2015.
26. Australia, E.S.S., *ESSA Future Workforce Report 2019*. 2019.
27. Emeritus Professor Paul Worley National Rural Health Commissioner, *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*. 2020.
28. Kingsley, C. and S. Patel, *Patient-reported outcome measures and patient-reported experience measures.* Bja Education, 2017. **17**(4): p. 137-144.
29. Bodenheimer, T. and C. Sinsky, *From triple to quadruple aim: care of the patient requires care of the provider.* The Annals of Family Medicine, 2014. **12**(6): p. 573-576.
30. The Royal Australian College of General Practitioners, *Vision for general practice and a sustainable healthcare system*. 2019: East Melbourne, Vic.
31. Rosenbaum, S., et al., *Physical activity interventions for people with mental illness: a systematic review and meta-analysis.* The Journal of clinical psychiatry, 2014. **75**(9): p. 964-974.
32. Stanton, R. and P. Reaburn, *Exercise and the treatment of depression: a review of the exercise program variables.* Journal of Science and Medicine in Sport, 2014. **17**(2): p. 177-182.
33. Firth, J., et al., *A systematic review and meta-analysis of exercise interventions in schizophrenia patients.* Psychol Med, 2015. **45**(7): p. 1343-1361.
34. Stanton, R., B. Happell, and P. Reaburn, *The mental health benefits of regular physical activity, and its role in preventing future depressive illness.* Nursing: Research and Reviews, 2014. **4**(1): p. 45-53.
35. Stanton, R. and B. Happell, *Exercise for mental illness: a systematic review of inpatient studies.* International Journal of Mental Health Nursing, 2014. **23**(3): p. 232-242.
36. Richardson, C.R., et al., *Integrating physical activity into mental health services for persons with serious mental illness.* Psychiatric services, 2005. **56**(3): p. 324-331.
37. Youngstedt, S.D., *Effects of exercise on sleep.* Clinics in sports medicine, 2005. **24**(2): p. 355-365.

38. Rethorst, C., et al., *Does exercise improve self-reported sleep quality in non-remitted major depressive disorder.* Psychol Med, 2013. **43**(4): p. 699-709.
39. Curtis, J., et al., *Evaluating an individualized lifestyle and life skills intervention to prevent antipsychotic-induced weight gain in first-episode psychosis.* Early intervention in psychiatry, 2016. **10**(3): p. 267-276.
40. Vancampfort, D., et al., *Promotion of cardiorespiratory fitness in schizophrenia: a clinical overview and meta-analysis.* Acta Psychiatrica Scandinavica, 2015. **132**(2): p. 131-143.
41. Wang, D., et al., *Impact of physical exercise on substance use disorders: a meta-analysis.* PloS one, 2014. **9**(10): p. e110728.
42. Giesen, E.S., H. Deimel, and W. Bloch, *Clinical exercise interventions in alcohol use disorders: a systematic review.* Journal of substance abuse treatment, 2015. **52**: p. 1-9.
43. Glass, T.W. and C.G. Maher, *Physical activity reduces cigarette cravings.* British journal of sports medicine, 2014. **48**(16): p. 1263-1264.
44. Krogh, J., et al., *The effect of exercise in clinically depressed adults: systematic review and meta-analysis of randomized controlled trials.* The Journal of clinical psychiatry, 2010. **72**(4): p. 529-538.
45. Vancampfort, D., et al., *Health-related quality of life and aerobic fitness in people with schizophrenia.* International journal of mental health nursing, 2015. **24**(5): p. 394-402.
46. Schuch, F., et al., *Exercise and severe major depression: effect on symptom severity and quality of life at discharge in an inpatient cohort.* Journal of psychiatric research, 2015. **61**: p. 25-32.
47. Australian, R. and N.Z.C.o. Psychiatrists, *Keeping body and mind together: improving the physical health and life expectancy of people with serious mental illness*. 2015: The Royal Australian and New Zealand College of Psychiatrists Melbourne.
48. Lederman, O., et al., *Consensus statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: a guide for mental health professionals.* Australasian Psychiatry, 2016. **24**(4): p. 347-351.
49. Council of Australian Governments Health Council, *Purpose of the National Registration and Accreditation Scheme*. 2018.