Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Feedback on the Discussion Paper Better Outcomes for People with Chronic and Complex Health Conditions through Primary Health Care

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Executive Summary

The discussion paper *Better outcomes for People with Chronic and Complex Health Conditions through Primary Health Care*, outlines seven guiding principles that a sustainable primary health care system for patients should feature. The APA supports these principles, and makes the following comments on the need for re-design of the primary health care system to support care for people with chronic conditions.

- The APA believes that current funding models do little to support people with chronic conditions. These funding models are largely responsible for pushing people who cannot afford to pay for primary care therapies not funded by Medicare (such as most physiotherapy services) into the more expensive tertiary sector.
- People with chronic and complex disease have publicly funded access to allied health services mainly through the Chronic Disease Management (CDM) program. There are significant problems with the limited nature of these items.
- Providing coordinated primary care for people with chronic and complex diseases who live in rural and remote areas is particularly difficult. There is a dearth of allied health private practitioners in most rural and all remote areas, and more needs to be done to address this imbalance.
- The current primary care system does little to encourage health practitioners to work to the top of their scope. Requirements for GP referrals for imaging, pathology, the prescription of medications and referral to medical specialists frustrate physiotherapists, and don't allow them to work to scope (as in the case of imaging and medical specialists) or to extend their scope towards areas such as prescribing of medications and the ordering of pathology tests.
- The APA believes that many conditions are most suitably managed by a general practitioner however there are some circumstances where it would be appropriate to base a 'health care home' with a physiotherapist. That is why the APA supports a healthcare home that is not restricted to medical practices or practitioners, but that gives patients the choice to base their 'health care home'
- Technology will provide the way to better connect Australia's primary care system, but to facilitate this, government must support allied health practices to upgrade their systems to the extent of GP practices.
- The APA supports the use of evidence based outcome measures to evaluate patient outcomes. Such measures should integrate with existing clinical workflows to ensure that reporting requirements do not constitute an additional burden on healthcare providers.
- The APA supports the view that fee-for-service model may not always be the best funding model for the management of people with chronic and complex conditions. It does remain a good way to fund treatment for many acute or well self-managed chronic conditions. Publicly funded access to physiotherapists should be available on a primary contact basis. This would facilitate early intervention and reduce the instances of acute injuries developing into a chronic pain condition.
- Capitated funding models could form the basis for care packages for people with chronic conditions and should be based on clinically assessed need, rather than occasions of services. Funding should allow practitioners to individually assess a patient's needs, not be based on a set number of sessions with particular health practitioners. Packages could fund care co-ordination and should travel with the patient, rather than be based with a care provider, or with a 'health care home'. This avoids the inherent conflict in health care providers managing a pool of funding on behalf of a patient, from which they pay themselves.
- Patients with chronic conditions should be enabled to manage their own care if they are willing and competent to do so.
- Total knee replacements arising from osteoarthritis cost more than $7.6 billion per year in Australia. If even a small proportion of total knee replacements for osteoarthritis were

prevented, then the savings would be in the hundreds of millions, or even billions of dollars each year.

About the APA

The Australian Physiotherapy Association (APA) is the peak body representing the interests of over 19,000 physiotherapists and their patients. APA members are registered with the Physiotherapy Board of Australia, have undertaken to meet the APA Code of Conduct, are expected to use the latest research in practice and often have further and/or expert qualifications.

The APA sets a high standard for professional competence and behaviour and advocates best practice care for clients. It is our belief that all Australians should have access to high quality physiotherapy to optimise health and wellbeing.

Vision

That the whole community recognises the full benefit of physiotherapy

Belief

That all Australians should have access to high quality physiotherapy to optimise health and wellbeing

Purpose

To leverage our global leadership position for the benefit of physiotherapy and consumers

Utilising physiotherapy's potential to increase the care of people with chronic health conditions

Principles underpinning the primary care system

The discussion paper *Better outcomes for People with Chronic and Complex Health Conditions through Primary Health Care,* outlines seven guiding principles that a sustainable primary health care system for patients should feature. The APA supports these principles, and makes the following comments.

1. Engage patients and carers as active partners in decisions about their health and wellbeing.

Patients managing their own care

Physiotherapists are experts in empowering their patients to take a more active approach to manage their own chronic conditions. They are primary contact professionals with excellent communication skills, and are well placed to promote physical activity guidelines and healthy lifestyle.

The APA believes that with the support of primary care health professionals including physiotherapists and other allied health care professionals, many patients with chronic conditions would be capable of managing their own care. Those who are capable and wish to, should be empowered to manage their own care by a well-functioning primary health care system.

2. Ensure service and payment models are based on best practice to maximise patients' health improvement, service safety and quality, and allow flexibility.

Flexibility to consult the most appropriate health care provider

Flexibility is one of the key principles that will facilitate our primary health care system to foster innovation and connected models of care. These flexible systems must be wrapped around the patient, rather than being based on the needs of administrators in the primary health care system.

A flexible primary health care system would help patients to access the most appropriate clinician at the most appropriate location at the most appropriate time. This would see patients able to access physiotherapists and other allied health practitioners early enough to avert preventable hospital admissions. It would particularly benefit patients with chronic conditions such as chronic lower back pain, osteoporosis, and osteoarthritis, who could avoid expensive procedures such as hip and knee arthroplasty, or spinal surgery.

It is also vital to ensure that out of pocket expenses in primary care are minimised for people with chronic conditions, as this acts as a deterrent for the most vulnerable members of society from seeking early intervention for chronic conditions.

3. Deliver efficient health care, eliminating waste and duplication.

Remove the gate keeper to save time and money

The GP as gatekeeper for other primary care services is inefficient, and an enormous waste of scarce health care resources.

The system can eliminate waste and duplication by supporting physiotherapists to refer to medical specialists within their scope of practice. This will save the system nearly $16,000,000 each year. This change to the Medicare rules would also reduce the instances of physiotherapists writing a detailed letter to the patient's GP outlining the intervention and response and recommending that the patient be referred to a specific medical specialist. The GP will then fill out a referral form for the relevant medical specialist. This necessitates a GP consultation that is driven purely by funding structures, and removing this requirement would save significant time for the GP, the physiotherapist and the patient. Rather than funding a GP consultation specifically for administrative purposes,

Medicare should require that physiotherapists communicate with the GP to notify them of a specialist referral. This practice is already well entrenched in the health care system. The APA supports that GPs need to be aware of an appropriate referral to a medical specialist, but not that a GP needs to be the health practitioner who actually makes all referrals.

4. Ensure potentially avoidable hospitalisations are minimised.

Access to conservative physiotherapy treatment can prevent surgery

The results of physiotherapists performing triage roles in hospital outpatient settings show the enormous potential of physiotherapists to reduce unnecessary surgical intervention. In these screening clinics, patients are taken from the waiting list for orthopaedic or neurosurgery and suitable candidates are provided with conservative physiotherapy treatment.

An analysis of physiotherapy led orthopaedic and neurosurgery screening clinics in Queensland has found that 58% of the patients referred by a GP did not require surgical consultations at all and 83% were referred for conservative physiotherapy management rather than surgery. The same review found that patients, GPs and medical specialists had high levels of satisfaction with the clinics.[1]

Accessing physiotherapy services in the community before referral to surgery is vital to significantly reduce preventable hospital admissions. Such a move has the potential to make considerable savings, given that just one total knee replacement surgery can cost in excess of $23,000 in the public setting.[2] This figure is for surgery only, and does not include extended lengths of stay, complications arising from surgery, rehabilitation or other out-patient costs.

5. Facilitate integration and coordination of patient care across care settings and support health care professionals to work as multidisciplinary teams.

Effective multidisciplinary teams are vital

Patient care can be co-ordinated by a range of appropriate health professionals. In many cases the GP will be the most appropriate coordinator, however physiotherapists may be best placed to manage appropriate care, and a high functioning primary health care system must support this flexible approach to care co-ordination.

6. Encourage all primary health care professionals to work to their full scope of practice.

Remove the gatekeeper to allow full scope of practice care

The APA believes that GPs as gatekeepers discourage physiotherapists and other allied health professionals from working to their full scope of practice. Funding barriers discourage full utilisation of diagnostic imagining and bar appropriate referral to medical specialists and other allied health providers. GPs are also prevented from working to their scope, with too much of their time taken up with the gatekeeper role allocated to them via Medicare. The APA supports that physiotherapists must communicate with the GP and other health providers on the care they provide, and any referrals that they make.

7. Support the collection, reporting and use of primary health care outcome information to promote continuous quality improvement.

The APA supports the establishment of mechanisms to support improved outcome data collection, based on appropriate clinical outcome measures.

Responses to specific questions within the discussion paper

What is the problem?

What aspects of the primary health system work well for people with chronic and complex health conditions? What is the most serious gap in the primary health care system currently provided to people with chronic and complex health conditions?

Barriers to accessing allied health services

The APA believes that current funding models do little to support people with chronic conditions. These funding models are largely responsible for pushing people who cannot afford to pay for primary care therapies not funded by Medicare (such as most physiotherapy services) into the more expensive tertiary sector.

People with chronic and complex disease have publicly funded access to allied health services mainly through the Chronic Disease Management (CDM) program.

There are significant problems with these items:

- The program is overly focused on restrictive and complex paperwork, and relies on GPs to work outside of their scope by deciding on the type and number of allied health services required. The APA believes that GPs should be a facilitator, not a barrier to co-ordinated care.
- The program lacks flexibility because:
    - Only a GP practice can write a plan, despite the suitability of other primary contact health practitioners to do so. For example a physiotherapist for an older person who has had falls due to osteoarthritis, or a paediatrician for a child with cerebral palsy.
    - Care plans need not be complex for all situations, and plans are difficult to change once they have been written, despite the propensity for patients to improve or decline depending on their circumstances.
- The CDM program allows for just five allied health services per year, more than a patient who is motivated to self-manage their condition might need, but far less than a truly complex patient requires.
- GPs are compensated well for their role in managing care and completing Medicare paperwork, but physiotherapists and other allied health professionals are not acknowledged or paid for writing mandatory reports or coordinating care.
- Communication lines are vital for connection of care, and two way communications are not a feature of the CDM program.

Case Study - Justin's occupational therapy

"Recently my youngest son Justin was referred to an occupational therapist and it was suggested that a CDM plan would be helpful. My wife took him to a GP who did not know about or wasn't interested in setting up the plan. She tried a second GP who said they didn't know how to do it, but made an appointment for my wife and son to see a practice nurse the following day.

"My wife (who is a speech pathologist working with children with a range of disabilities in a primary care setting) had to talk the nurse through completion of the form. It is frustrating that the process took three Medicare funded visits, hours of my wife's time, and Justin got no clinical

benefit from his three visits to the medical practices. His appointment with the occupational therapist was also delayed because of Medicare's paperwork requirements."

Justin was in an ideal position for his mother to coordinate his care with support from the occupational therapist. Medicare made payment for two doctors' visits and for the practice nurse to write the care plan. In addition, Justin's family were subject to out of pocket costs from one of the GP practices.

An effective primary health care system would have funded the occupational therapist to complete a simple CDM plan, assess the child's clinical needs and start treatment immediately.

Primary care for people in rural and remote areas

Providing coordinated primary care for people with chronic and complex diseases who live in rural and remote areas is particularly difficult. There is a dearth of allied health private practitioners in most rural and all remote areas, and more needs to be done to address this imbalance.

Unlike medical general practice, there are virtually no government incentives or support for private physiotherapy practitioners to set up practice in rural and remote areas, despite almost complete failure of the market for primary health services.

In very small communities, eligible public health services are able to provide some Medicare funded services under what is known as a section 19(2) exemption. This is a clause in the *Health Insurance Act 1973* that allows eligible services to receive both public funding and Medicare rebates. Just 60 health services around Australia have had this exception granted,[3] however in Western Australia there are significant problems with providing allied health services under this exemption due to problems with the allied health industrial instrument.

Case study - Lucy's parents

"My parents are elderly and are ageing in place in their home in regional NSW. I see duplication and ineffectiveness of services at home as a major problem for them. Mum and dad have access to DVA and Medicare funding and local health services but the different providers do not collaborate, despite the cost savings and improvement to care that could be achieved.

"Three different nurses can turn up on any one day; two OTs can come from different agencies but can't collaborate because they are engaged by two different government departments. Mum and dad rarely see the same physiotherapists or occupational therapist twice. This is in an area where each health professional might be travelling more than 25km each way just to provide a home visit. Complications caused by geographical locations need to be addressed if we are to have an effective primary care system for people with chronic and complex conditions."

In Aboriginal communities, poorly co-ordinated care from different health services is also a dire problem. In a remote part of the Kimberley in WA, one Aboriginal Medical Service (AMS) reported that there is virtually no coordination between different health services' provision of staff in the community they service. For example a local hospital funded a medical specialist to visit the local school, but failed to notify the AMS, meaning a lost opportunity for other local community members to access care. Because of the nature of ad hoc arrangements and the lack of communication with local service providers, arrangements for appropriate follow up care were also impossible to make.

There are also supply problems with allied health providers including physiotherapists in these rural and remote communities. Providers visit infrequently, despite the benefits they could provide to Aboriginal and Torres Strait Islander communities with incredibly high rates of chronic conditions.

Physiotherapists working to the top of scope

The current primary care system does little to encourage health practitioners to work to the top of their scope. Requirements for GP referrals for imaging, pathology, the prescription of medications and referral to medical specialists frustrate physiotherapists, and don't allow them to work to scope (as in the case of imaging and medical specialists) or to extend their scope towards areas such as prescribing of medications and the ordering of pathology tests.

Also, GP referral requirements for CDM or Department of Veterans Affairs (DVA) funding provide disincentive for physiotherapists to work as independent primary care health professionals under these systems. Such referrals are not required in the private health system, or under many workers compensation and third party motor accident schemes.

Conversely, there are many outstanding physiotherapy programs in the hospital sector that are achieving outstanding results to keep people out of hospital, provide excellent care and encourage physiotherapists to work to the top of scope. The APA believes that some of these programs should be adapted to suit the primary healthcare setting.

There is robust evidence that physiotherapists working to their scope of practice in these programs:

- Reduce hospital admissions and elective surgery waiting lists
- Reduce costs in the system
- Provide high levels of patient satisfaction
- Increased accuracy and reduction of adverse events

Reducing hospital admissions and elective surgery waiting lists

Positioning musculoskeletal physiotherapists where they are able to screen patients referred for orthopaedic surgery has been shown to dramatically reduce demand on the services of orthopaedic surgeons. Oldmeadow et al[4] found that there were excellent results when patients referred by GPs to orthopaedic surgeons for knee and hip replacements were first screened by an experienced musculoskeletal physiotherapist with post-graduate qualifications. The service at Northern Hospital (the subject of Oldmeadow's study) successfully provided conservative physiotherapy treatment to nearly two thirds of the people on the waiting list.

Reducing costs in the system

Physiotherapy referral to medical specialists would have significant cost savings for both the MBS and for consumers. The Deeble Institute and Griffith University's Centre for Applied Health Economics published a report into the economic cost of physiotherapy referral to medical specialists in 2013. The following is an extract of the report's findings:

• An estimated net saving to the Medicare Benefits Scheme of more than $13.6 million per year
• A reduction in the number of GP visits by around 737,000 per year
• An increase in specialist medical practitioner consultations by 55,521

The report's economic analysis concluded that the following savings would be made:

Savings to Medicare: $13,641,362

Savings to patients: $2,175,407

Total savings: $15,816,769[5]

For more information on physiotherapy referral to medical specialists, see the APA's 2015-16 Pre-budget submission at
http://www.physiotherapy.asn.au/APAWCM/Advocacy/Campaigns/APAWCM/Advocacy/Campaigns/prebudget2014.aspx

Providing high levels of patient satisfaction

Research has consistently found that primary contact physiotherapy services in the Emergency Department and Orthopaedic and Neurological screening clinic achieves excellent patient satisfaction results.[6 7 & 8]

Increasing accuracy and reduction of adverse events:

Physiotherapists are increasingly acting as primary contact practitioners in the hospital emergency departments, independently managing caseloads of minor trauma. A study published in 2015 made a remarkable finding that the primary-contact physiotherapy service, had *no adverse events* or *misdiagnoses*. It found that:

> …the primary-contact physiotherapy service identified and managed a clinical caseload without any identified adverse events or misdiagnoses. This is a critical outcome to support the safety of implementing such a service in the emergency department. The study also suggests that for an ICD matched cohort, patients managed by the physiotherapy service had a reduced length of stay and fewer X-ray, CT and ultrasound imaging requests than those managed by the medical staff.[9]

Future-proofing the primary health care system – physiotherapy prescribing

In the UK, physiotherapists are able to complete postgraduate qualifications and practical training that allow them to prescribe medications to their patients. The APA has recently put forward its case for Australian physiotherapists to become prescribers of medications, and expect Australian physiotherapists to be enabled to prescribe in the coming years.

Empowering physiotherapists to deliver safe, appropriate and timely care to patients by extending prescribing responsibilities promotes:

Better health outcomes

- supports patient centred care
- promotes better clinical outcomes and supports evidence based practice
- ensures consumers have appropriate and timely access to the medicines they need
- improves the patient experience
- reduces health inequalities
- reduces delays in treatment
- improves access and choice
- decreases unnecessary use of medicines

Better healthcare pathways

- improves the quality, efficiency and continuity of care
- avoids administrative visits to a GP for certain prescriptions
- builds care pathways that are cost-effective and sustainable
- creates new ways of working across historical professional boundaries
- suited to self-referral pathways
- improves the transition from acute to community care
- reduces avoidable admissions to hospital and promotes lower cost community care

Better use of resources

- makes better and more flexible use of existing workforce resources
- reduces costs for the patient or taxpayer
- helps recruit and retain the best physiotherapists to maximise access to physiotherapy
- reduces pressure on GPs
- Potential savings from prescribing responsibilities for physiotherapists:

Savings from time efficiencies:	**$3,246,094**

Savings from avoided GP visits and ED attendances: $3,196,411

Savings from reduced private practice consultations: $2,354,411

It is important that the primary health care system is flexible enough to allow patients to benefit from developing scopes of practice across the professions, and to allow the primary health care system to benefit from the reduction in costs that physiotherapy prescribing will bring.

Theme 1 – Patient care

Do you support patient enrolment with a health care home for people with chronic and complex health conditions? What are the key aspects of effective coordinated patient care?

Enrolling patients in a primary care facility could help co-ordination of care, but funding must be flexible enough to support enrolment in a physiotherapy practice.

The APA believes that many conditions are most suitably managed by a general practitioner however there are some circumstances where it would be appropriate to base a 'health care home' with a physiotherapist. That is why the APA supports a healthcare home that is not restricted to medical practices or practitioners, but that gives patients the choice to base their 'health care home' with a physiotherapy practice or practitioner. This would allow a person with one or more chronic conditions the choice and flexibility to enrol in a practice to best suit their needs.

Enrolment with a physiotherapist as the base for a 'health care home' would allow a physiotherapists to provide a coordinated approach to care, without taking away from the role of a general practitioner. Physiotherapists are used to working with GPs, and the wider adoption of My Health Record as it is rolled out as an opt out system will facilitate good two way communication between all healthcare providers.

It is not unusual or new for physiotherapists to be primary contact professionals. Only about a third of the patients in a general physiotherapist practice are referred from a GP. Most of the other two thirds are primary contact patients, self-referring under private health insurance, or paying privately for their treatment.

Physiotherapists are trained to recognise red flags that indicate the need for medical intervention, and are accustomed to referring these people to their GP for conditions that are out of their scope of practice. This recognition of the limits of their training would ensure that physiotherapists did not enrol inappropriate patient cohorts, instead would refer them on to a medical practice.

The APA believes that physiotherapy may be the most appropriate place for a 'health care home", particularly for complex musculoskeletal conditions. Physiotherapists must be included in any plans for re-imbursement for care management that would otherwise be available for another care coordinator where a patient chooses a physiotherapy practice for their 'health care home'.

The APA firmly believes that to support an effective primary care system, service provision must be based on the needs of the patient, not on the needs of health care funders. This may necessitate some additional resourcing of the primary care sector, but this will be recouped through significantly reduced costs in the far more expensive tertiary healthcare sector.

To support these changes, funding models must allow physiotherapists to refer to medical specialists and for appropriate diagnostic testing within their scope of practice.

Theme 2 – Use of technology

How might the technology described in Theme 2 improve the way patients engage in and manage their own health care? What enablers are needed to support an increased use of the technology described in Theme 2 of the Discussion Paper to improve team based care for people with chronic and complex health conditions?

Physiotherapists must be supported to upgrade their IT systems and have writable access to My Health Record

Technology will provide the way to better connect Australia's primary care system, but to facilitate this, government must support allied health practices to upgrade their systems to the extent of GP practices.

For many years, the government supported GP practices to upgrade their IT infrastructure through the Divisions of General Practice. IT continues to be supported through the Practice Incentives Program for GP practices. Allied health practices have received no such support from governments, and as a result are not equipped to the same level as GPs for the fast changing IT environment in which they are expected to perform.

Other important issues that need resolution are:

- Physiotherapists and other allied health providers cannot currently enter data into My Health Record. This is a major barrier to better communication between health providers, and this must be changed, or the record will be of extremely limited benefit to help connect care and improve primary care coordination for people with chronic disease.
- Use of My Health Record must be incentivised at the same level for all providers, regardless if they are allied health or medical providers.
- Government agencies must work with the vendors of physiotherapy clinical record keeping and practice management software to incentivise the integration of My Health Record into current workflows.

Using the My Health Record or other electronic systems to connect care between providers will negate the need for GPs to act in a gatekeeper role for allied health. Treatments will be transparent and providers will need to be accountable for inputs and outcomes to all health practitioners and consumers involved in the care of a patient.

To date, registering for a My Health Record (formerly the PCEHR) has been a complicated and confusing process for consumers, resulting in a pitifully small number of Australians with a record. To address this issue, and make the record a useful and meaningful way to facilitate communication between health professionals, as well as to patients and their carers, the APA supports an opt-out model for My Health Record.

Technology in the form a central and accessible database of outcome measures that are linked to ongoing funding and accessible health information are important components of a technology based health system.

Theme 3 – Evaluating system performance

Reflecting on Theme 3, is it important to measure and report patient health outcomes? To what extent should patients be responsible for their own health outcomes?

It is vital that agreed upon outcome measures be used to evaluate the performance of the primary health system

The APA supports the use of evidence based outcome measures to evaluate patient outcomes. Such measures should integrate within existing clinical workflows to ensure that reporting requirements do not constitute an additional burden on healthcare providers.

Patients who are capable of taking responsibility for their own health outcomes should be enabled to do so, with the support of health literacy resources, and of their health providers.

Physiotherapists are experts in empowering people to self-manage their condition or conditions and connections across care providers, as well as access to a greater range of health providers has been linked to the capacity to build more effective self management techniques and accountability in people with chronic conditions.[10] For example there is evidence that people with heart failure enrolled in programs that feature multidisciplinary team care have shorter inpatient stays and lower rates of re-hospitalisation.[11]

Physiotherapists have the appropriate skills to empower people to participate in their own healthcare, thus are well placed to assist people to self manage chronic conditions. They are experienced in pain management techniques and have a thorough understanding of the biopsychosocial influences that are important in long-term conditions - all factors important to enable self-care for chronic conditions.[12 & 13]

Theme 4 – Payment Systems

How should primary health care payment models support a connected care system? What role could Private Health Insurance have in managing people with chronic and complex health conditions in primary health care?

Care packages could enable connected care for people with chronic and complex conditions

Fee for service and care packages

The APA supports the view that fee-for-service model is not always the best funding model for the management of people with chronic and complex conditions. It does remain a good way to fund treatment for many acute or well self-managed chronic conditions. Publicly funded access to physiotherapists should be available on a primary contact basis. This would facilitate early intervention and reduce the instances of acute injuries developing into a chronic pain condition.

Capitated funding models could form the basis for care packages for people with chronic conditions and should be based on clinically assessed need, rather than occasions of services. Funding should allow practitioners to individually assess a patient's needs, not be based on a set number of sessions with particular health practitioners. Packages could fund care co-ordination and should travel with the patient, rather than be based with a care provider, or with a 'health care home'. This avoids the inherent conflict in health care providers managing a pool of funding on behalf of a patient, from which they pay themselves.

Patients with chronic conditions should be enabled to manage their own care if they are willing and competent to do so.

Private Health Insurers

The APA believes that private health insurers have a role to play in connecting care for their members and there are some interesting programs that insurers are running for fund members with chronic conditions. For example Medibank's Integrated Care for Chronic Conditions, which aims to deliver integrated medical and allied health service, improve health outcomes, and reduce potentially preventable hospitalisations.

The APA's experience has been that in some instances, large for-profit insurers have used their market power to pressure health providers to provide fewer and shorter services than is clinically appropriate. They have also used their relatively powerful position to pressure physiotherapists to sign restrictive contracts without providing any flexibility to account for variations in levels of expertise in specific areas of physiotherapy practice. These types of practices are not in the best interests of a high quality service for patients, and safeguards must be put in place to prevent such behaviour.

The APA is also concerned that legislation prevents general benefits private health insurance products from covering treatment that assists in the prevention of chronic conditions. For example a supervised group exercise program could reverse a state of pre-diabetes for a person with increased risk of developing diabetes, however exercise interventions that target such a group are increasingly being seen as 'wellness' treatment by health funds, for which they may not provide funding. This is despite the obvious economic and social benefits of the prevention of chronic conditions such as diabetes.

Public private partnerships will be important into the future to assist publicly funded patients to benefit from R&D within the private system; however safeguards and good governance practices must be put in place. This is important as many insurers are for profit organisations, whose primary purpose is to return profits to investors.

The drive to find more cost-effective ways to provide health services has the potential to benefit primary care, and to find innovative ways of doing things. Cost shifting between primary care funded by the Commonwealth and the hospital sector funded by the State is well acknowledged, and such cost shifting does not necessarily affect the private health insurance industry.

Researchers, peak bodies and private health insurance partnering to provide best practice care for people with knee osteoarthritis

Knee osteoarthritis (OA) is the 11th highest contributor to global disability and a partnership with Medibank private has been formed to run a telephone-delivered exercise behaviour change support program for self-management of knee OA in the community.

Exercise is the recommended first line treatment for people with knee OA, yet more than half of people do not receive appropriate healthcare management[14].One tertiary hospital in NSW reported that people with hip and knee OA referred to an orthopaedic surgeon, only 30% have seen a physiotherapist, and even less had tried supervised exercise to manage their condition[15]. Given that knee and hip arthroplasty is only indicated when conservative management is no longer effective, this represents a significant waste of resources and lack of knowledge of correct care pathways.

This kind of partnership can help to increase connected care in the community for people with chronic disease.

Case study - Reducing cost through a reduction of preventable hospital admissions for people with knee osteoarthritis

The efficient price for a non complex knee arthroplasty is $19,671[16], and there were 38,679 performed on people with knee OA in 2012-13[17]. If all of these surgeries were non-complex, then the efficient cost would have been $7.6 billion. This is an extremely conservative estimate, which does not take into consideration more complex patient presentations (which have an efficient cost of $23,813) pre- or post-surgery costs including surgeon consultation fees, more expensive prostheses, post-surgical rehabilitation, extended length of stay, adverse events or higher costs in rural and regional areas.

While it is difficult to determine exactly how many of the nearly 40,000 knee replacements are caused by OA could have been avoided were they managed in the primary care system, there are specific factors that indicate that this figure might be substantial. Management in the primary care sector, including physiotherapy, is sorely lacking, with less than 30% following clinical guidelines recommending non-drug, non-surgical manage management of knee osteoarthritis[18].

With such a poor rate of adherence to clinical guidelines and a huge bill for knee arthroplasty, it is likely that significant savings could be made.

If even a small proportion of knee replacements for osteoarthritis were prevented, then the savings would be in the hundreds of millions, or even billions of dollars each year.

Summary

Australia needs a redesigned primary health care system to provide better care for people with chronic conditions. The system must:

- Put the patient at the centre of care and facilitate self-management of chronic conditions.
- Be flexible enough to allow funding to support access to the most appropriate health practitioner.
- Use technologies to ensure that all care providers are able to communicate seamlessly, and to feed into the My Health Record.
- Utilise physiotherapists and other allied health professionals to prevent unnecessary hospitalisations for conditions such as osteoarthritis, lower back pain and osteoporosis.
- Allow people with chronic conditions choice in the type of health practice they enrol in as their 'health care home'.
- Remove GPs as gatekeepers to physiotherapists and other allied health providers, while increasing two way communication.
- Retain fee for service for people acute or well self-managed chronic conditions.
- Use capitated funding models to form the basis for care packages for people with chronic conditions. These should be based on clinically assessed need, rather than occasions of services.
- The funding of packages must allow practitioners to individually assess a patient's needs, not be based on a set number of sessions with particular health practitioners.
- Packages should fund care co-ordination and to travel with the patient, rather than be based with a care provider, or with the 'health care home'.
- Enable patients with chronic conditions to manage their own care if they are willing and competent to do so.
- Facilitate private/public partnerships to better deliver primary care.

In order to increase efficiencies within the health system, it is important that allied health providers are enabled to provide health care for people at risk from or with chronic and complex diseases.

References

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[2] This information is taken from http://ihpa.gov.au/internet/ihpa/publishing.nsf/Content/nep-determination-2015-16-html~2-nep~2-3-ABF-price

[3] See http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/COAG_Improving_Access_to_Primary_Care_Services_in_Rural_and_Remote_areas-s19_2_Exemptions_Initiative for more information on exemptions.

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