Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Private Health Insurance Consultation

Submission by the Australian Physiotherapy Association

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

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AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Executive Summary

The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the consultation on private health insurance.

We recognise the major challenge of providing Australians with sustainable access to safe, high quality services at an affordable price.

Australians can 'miss out' on care they need or they experience of lack of continuity in that care because the complexity of the structures and responsibilities in health. To address this we recommend that a whole-of-health-system perspective be taken when proposing improvements to private health insurance.

Physiotherapy can be a cost-effective choice for consumers. To achieve sustainability, we support directing resources to the services/areas that produce comparatively greater benefits. We recommend that therapies with low levels of evidence for their benefit be excluded from attracting government subsidies.

Consumers have raised concerns about perceived reductions in subsidies for cost-effective modes of care such as group physiotherapy. We recommend that the Private Health Insurance Code of Conduct be reviewed to determine whether the definition of 'detrimental changes to policies' covers the events that policyholders would characterize as such.

We need to strengthen consumers' ability to be fully informed about private health insurance products and recommend that the Australian Government continue to fund PrivateHealth.gov.au, including providing funding for its promotion.

We recommend that the Private Health Insurance Code of Conduct be provided in a range of languages spoken commonly in Australia, other than English and includes a commitment to provide consumers with an accessible and consistent range of information in forms that are meaningful to this audience.

Our consumers who use private health insurance are making increasingly astute choices in their health care. The products, however, appear to behind this ability. Although there is some recognition that a historical model that focused on acute episodes needs to be complemented with arrangements that support non-acute care, further adjustment of the models is needed.

Preventative care provides substantial benefits to consumers. The *Private Health Insurance Act 2007* provides for general treatment to prevent a disease, injury or condition and also allows for pilots. In this context, we recommend that models of funding primary prevention interventions in physiotherapy be piloted in the near future.

We recommend that the Private Health Insurance (Risk Equalisation Policy) Rules be reviewed to reward the adoption of evidence-based prevention measures. Alternatively, we recommend that post-equalisation arrangements be made to ensure prevention is rewarded.

We are concerned about the impact of program structures, especially annual benefit caps, on people with chronic conditions. We recommend pilots of new models that explore longitudinal

funding that facilitates cost-effective secondary prevention (e.g. a 'course of treatment rather than a single visit). For similar reasons, we recommend that pilots of funding models for policyholders needing tertiary prevention. The aim should be to test whether approaches such as 'carving out' the subsidies for a chronic condition are suitable to the Australian private health insurance environment.

We are concerned that the Health Industry Claims and Payments Service (HICAPS) codes fail to reflect appropriate diversity in service provision for our consumers, and recommend that they be reviewed.

Innovation is essential and must be rewarded. We recommend that, for the purposes of physiotherapy care subsidised by private health insurance, the definition of attendance be broadened to include synchronous audio-visual communication other than 'in-person' attendance (e.g. telehealth). We recommend that mechanisms that facilitate prompt and rigorous adoption and evaluation of new digital technologies be built into a refined private health insurance system.

We support the use of outcome measures and clinical review. Regardless of the particular path taken, it will be essential that data collection, the use of outcome measures and review processes are feasible, relevant to the context and accepted by our profession.

Our feedback suggests that the lack of sophistication in clinical information systems will be an impediment to widespread adoption. Adoption of software platforms that allow meaningful, flexible and efficient reporting requires investment. An approach to such investment is found in the Practice Incentive Program for general practice, funded by the Commonwealth Government.

We recommend that PHIs consider an incentive program that supports the adoption of software systems in physiotherapy that will allow reporting on outcomes and support clinical review.

Preferred provider arrangements are the subject of ongoing concern to consumers and physiotherapists. The problems with preferred provider arrangements need to be resolved. We recommend that preferred provider schemes allow for exceptions to fee levels for complex presentations. We also recommend that preferred provider schemes be precluded from areas of comparatively low physiotherapist to patient ratios.

The APA is committed to facilitating improvements in the private health insurance system. This submission reflects its willingness to collaborate with the people involved to embed safe, cost-effective, high quality practice and support innovation.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

1 Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the consultation on private health insurance (the Consultation).

We recognise that the major challenge facing modern health systems internationally is how to ensure that quality services are available to all citizens at an affordable price.[1] We also recognise that fiscal sustainability is a concern for health insurance schemes across Australia.

A pillar of our work is that we provide members with access to the highest quality knowledge, resources and research to keep their skills current and relevant. We pursue high levels of professional conduct.

2 We need enhanced coordination between private health insurance and other insurance arrangements

We believe that all Australians should have access to safe, high quality physiotherapy in order to optimise the health and wellbeing of individuals, families, communities, and the nation as a whole.

Private health insurance arrangements are one way in which some Australians access physiotherapy. General cover (often called ancillary and/or extras cover) is, for example, integral to the primary health care sector.

The Medicare Benefits Schedule (MBS), the programs of the Department of Veterans Affairs, state-coordinated community health services and the compensable insurance schemes of WorkCover[2] and the Transport Accident Commission[3] also facilitate access to physiotherapy services.

However, the complexity of the structures and responsibilities in health create circumstances in which Australians 'miss out' on care they need or they experience a lack of continuity in that care.

We recognise that the Commonwealth Government has embarked on a number of reviews of aspects of the health system, including a review of the MBS and the work of the Primary Health Care Advisory Group (PHCAG).

Recommendation 1:

We recommend that a whole-of-health-system perspective be taken when proposing improvements to private health insurance so that Australians in need of physiotherapy services do not 'fall through the gap' between the elements that comprise the system as a whole.

3 We need to grasp the opportunity offered by physiotherapy to enhance the sustainability of the health system

Physiotherapy can be a cost-effective choice for consumers. Despite this, PHIs appear to be pursuing models of cost containment in physiotherapy services that are less likely to achieve long term sustainability of the private health insurance system.

3.1 Physiotherapy is cost-effective

One study reported that physiotherapy management of female stress urinary incontinence (FSUI) cost $302.40, on average, while surgical management costs were between $4,668 and $6,124.[4]

Arthritis Australia recently provided the House of Representatives Standing Committee on Health with another example. Arthritis Australia gave evidence that at least 10 per cent of joint replacements in Australia are avoidable.[5] In this example, Arthritis Australia estimated that a reduction in government expenditure of around $200 million per annum could be made by providing a multidisciplinary program for people with hip and knee osteoarthritis. Arthritis Australia also estimated this sort of program could be delivered for around $750 per person, compared to a joint replacement, which costs $25,000.

Later sections of this submission will detail other illustrations of the cost-effectiveness of physiotherapy.

3.2 We need to allocative funding efficiently

Allocative efficiency is about directing resources to the services/areas that produce comparatively greater benefits, rather than those that provide marginal or no health benefit for the same investment. Key elements of allocative efficiency include priority setting among areas (will we get more benefit from funding orthopaedic or cardiac services) and within areas (we will get more benefit from preventative versus curative treatments).

We are concerned that PHIs are still too reliant on cost containment and cost-shifting as mechanisms to pursue sustainability.

PHIs appear to be reliant on shifting costs to the consumer, by limiting access to services which are funded by private health cover; and/or by setting subsidy/fee levels at a level that triggers the charging of a co-payment by the physiotherapy service.

An illustration of this is the offering of products with exclusions and restrictions. This approach can result in consumers purchasing products yet still funding elements of care they require. Around 30 per cent of policies now have important exclusions such as joint replacement costs and cardiac treatments.[6]

In addition to exclusions and restrictions, PHIs have shifted costs by insisting that some treatment modalities, like groups and classes, be funded under Health Management Programs. Under this arrangement, where benefits are usually capped at $150 to $200, policyholders quickly run out of cover and are discharged from physiotherapy, even if there is a need for ongoing clinical care. This

approach can also lead to shifting costs to other providers through earlier discharge of policyholders to community services. It can also create a perverse incentive to provide policyholders with one-to-one treatments outside the Health Management Program.

A combination of physiotherapy interventions has been shown to be effective in producing functional and symptomatic improvement in people with chronic low back pain. This combination includes:

- manual therapy
- specific exercise training, and
- education focusing on the neurophysiology of pain.[7]

Intensive rehabilitation programs led by physiotherapists have shown to be as effective as spinal surgery in improving outcomes for people with chronic low back pain (LBP) and are associated with lower costs. Exercise therapy has also shown to be effective for people with sub-acute (6–12 weeks) and chronic (> 12 weeks) low back pain[8].

There is also evidence to support specifically water-based exercise therapy, which has been shown to be effective in treatment of rheumatic conditions and chronic low back pain, as it improves function, self-efficacy, joint mobility, strength and balance[9].

Reconsideration of the way resources are allocated, especially at program level, could facilitate effective care in low back pain at lower cost. This illustrates the opportunity of changing priorities in funding health services.

Compared with other insurance schemes (e.g. compensable schemes), PHIs also appear to be willing to stint on subsidy levels, both for an individual service and at program level. This is evident in the fees/subsidies for physiotherapy services being below those of other insurance schemes (e.g. compensable schemes).

Recommendation 2:

We recommend a reconsideration of the focus on investment in clinical services, with a view to improving the allocative efficiency of the investments.

The available evidence fails to demonstrate that homeopathy is an effective treatment for any of the clinical conditions for which it has been examined.[10] From the viewpoint of allocative efficiency, therapies such as homeopathy, which have lower level evidence for their benefit, should have lower funding priority.

Recommendation 3:

We recommend that therapies with low levels of evidence for their benefit be excluded from attracting government subsidies.

3.3 Physiotherapy groups and classes assist in achieving sustainability

Physiotherapy has an extensive history of providing services through group modalities (e.g. hydrotherapy). It is increasingly recognised that groups can provide the additional benefit of peer support to people with health issues.[11] Additionally, some models of groups can be cost-effective as a part of an overall approach to staying/becoming healthy.

Similarly, classes delivered by a physiotherapist can be cost-effective as a component of an approach to maintaining or achieving good health.

Our National Physiotherapy Service Descriptors include both groups and classes, and define their characteristics. However, groups and classes need to be appropriately subsidised if they are to achieve their benefits for policyholders.

We are concerned that:

- PHIs underestimate the value of groups and classes
- PHIs misunderstand the different roles of groups and classes
- PHIs subsidise groups and classes at an unsustainably low level given their value and role in health care.

We have had reports that new HCF consumers can only access physiotherapy groups under HCF's Health Management Program, from a benefits pool of $150-$200 cover, rather than from general cover.

Rebates for groups for new policyholders will also come under HCF's wellness cover. HCF health fund members may exhaust the $150-$200 pool more quickly or be unable to access groups because of concurrent use of other services.

This is a significant departure from existing HCF health fund policies that allow existing HCF health fund members to claim for a group session under general cover.

Recommendation 4:

We recommend that the Private Health Insurers reconsider their approach to subsidising physiotherapy groups and classes.

4 We need to strengthen the ability of consumers to be informed

We support the making of informed choices by consumers of physiotherapy services. We are aware of the Private Health Insurance Code of Conduct (the Code) and support its use. The Code includes a commitment by PHIs to provide clear and complete policy documentation.

4.1 Information on private health insurance products needs to be more transparent and accessible

A recent report found that consumers overwhelmingly felt that it was difficult to know if a private health insurance policy is good value for money before using it.[12] Comparator websites were seen to compare insurers based on price and not value for money, mainly due to value being unique and specific to the individual.

Policyholders tell us, for example, that they are often faced with product exclusions which lead to an increased risk of unexpected out-of-pocket costs. They also tell us that products that appear to be similar can be quite different (e.g. different caps, exclusions and impacts of preferred provider arrangements). They tell us that this makes it hard for them to make comparisons and understand the implications of switching insurers.

Policyholders continue to tell us that they are confused by the very large number of products available in the private health insurance market.

In the case of the changes to HCF's approach to classes and groups we have had reports of inconsistent information being provided by HCF customer service staff. Inconsistent and asymmetric information is confusing to consumers and reduces the confidence of consumers that they can choose the policy which best meets their needs.

Our consumers are asking for:

- decision-making tools (including tables, diagrams and images) to guide them through the process of deciding which cover is most appropriate to meet their health needs
- decision-making tools that explain the operation of general cover, hospital cover, chronic disease management programs and other arrangements
- explanations of common terms such as 'premium', 'out-of-pocket', 'exclusion' and 'cap'
- concrete and familiar examples of common terms accompanying their definitions
- all PHIs to provide information that is materially consistent (e.g. 'comparison rates')
- all of the information to be accessible in a single place.

Information on private health insurance products needs to be more transparent and accessible.

We are aware of attempts such as the creation of websites such as i-Select and PrivateHealth.gov.au, to help consumers compare the products. Product disclosure statements need to be available in the same location as other comparative information such as pricing.

Arguably, if 'like for like' comparisons for a product cannot be made, the product offering is too complex for consumers to understand and the offering of the product needs to be simplified.

Recommendation 5:

We recommend that the Australian Government continue to fund PrivateHealth.gov.au and provide funding for its promotion.

Recommendation 6:

We recommend that the Private Health Insurance Code of Conduct be provided in a range of languages spoken commonly in Australia, other than English.

Recommendation 7:

We recommend that the Private Health Insurance Code of Conduct be enhanced to include a commitment to provide consumers with a consistent range of information in forms that are meaningful to this audience.

Recommendation 8:

We recommend that the Private Health Insurance Code of Conduct be enhanced to include a commitment to providing a consistent range of consumer information through a single outlet/website (in the current context, PrivateHealth.gov.au).

4.2 Consumers need fair warning of product changes

In the past few months, our consumers have raised concerns about what they see as PHIs increasingly varying existing policies and restricting the level of cover without warning. These restrictions have been in the form of lower rebates and a reaching the 'cap' in their cover more rapidly.

This suggests that there are problems with either the definition of 'detrimental changes to policies' in the industry's Code and/or non-compliance with the Code.

We understand that there is also a difference in the notice period given for detrimental changes to hospital cover compared with that given for general cover. For policyholders managing chronic conditions effectively through planned use of general cover, the justification for this difference in notice periods is unclear.

Recommendation 9:

We recommend that the Private Health Insurance Code of Conduct be reviewed to determine whether the definition of 'detrimental changes to policies' covers the events that policyholders would characterise as such; and the Code be amended to achieve consistency with consumers' reasonable expectations.

Recommendation 10:

We recommend that the Private Health Insurance Code of Conduct be reviewed to require the notice periods for 'detrimental changes to policies' to be of the same length, regardless of the program cover.

5 We need to support astute choices by consumers using private health insurance

Consumers are making increasingly astute choices in their health care. The products, however, appear to be lagging behind in their ability to facilitate these choices.

5.1 Private health insurance needs to cover the diversity of disease trajectories

Funding structures and programs in the private health insurance arena continue to evolve. There has been some movement from the 'old' model which focused on acute episodes. Further adjustment is needed so that arrangements that support non-acute care are optimised.

5.1.1 Primary prevention

Primary prevention seeks to prevent the onset of specific diseases by reducing risk (e.g. by altering behaviours or exposures that can lead to disease, or by enhancing resistance to the effects of exposure to a disease agent).

As primary contact professionals with excellent communication skills, physiotherapists can focus on early intervention to flag preliminary signs of chronicity and to prevent acute and sub-acute conditions from developing into chronic pain.[13]

Sections 121-10 of the *Private Health Insurance Act 2007* makes provision for general treatment to manage or **prevent** a disease, injury or condition.

Despite this, PHIs appear to subsidise physiotherapy only in the presence of an *existing* clinical condition or diagnosis.

It has been estimated that 25% of incident symptomatic knee osteoarthritis (OA) in men and 14% in women could be prevented by preventing knee injuries.[14] Additionally, neuromuscular conditioning programs are effective in reducing knee and ankle injuries.[15] However, the private health insurance arrangements prevent us from pre-emptively targeting high-risk groups/policyholders, such as adolescents and young adults who play sport which involves pivoting.

Recommendation 11:

We recommend that private health insurers pilot models of funding cost-effective primary prevention interventions in physiotherapy for a small range of high risk policyholders/groups.

5.1.2 Secondary prevention

Secondary prevention is concerned with detecting a disease in its earliest stages, before symptoms appear, and intervening to slow or stop its progression – the idea of "catch it early."

Physiotherapists see a wide range of acute conditions, such as joint injury, which respond to a short period of physiotherapy, and where functional capability is regained with no ongoing problem.

However, we also see a wide range of conditions where the presenting problem may have resolved, but where on-going monitoring and/or care is required to maintain function, good health and wellbeing, and to prevent/minimise subsequent deterioration.

In some contexts we are concerned that referral from general practice occurs too late or does not occur at all.

Where secondary prevention is occurring, we are concerned that an 'all-or-nothing' assumption appears to underpin PHI arrangements.

Resolution of the presenting problem in these situations, appears to trigger a requirement to 'discharge' the patient. We routinely hear that PHIs advise that this is required because the legislation precludes 'preventative care'.

It also appears to be underpinned by ideas such as:

- the ability of all people to self-manage unaided, and
- the absence of degenerative or potentially degenerative condition(s).

The term 'maintenance' appears to have crept into common usage amongst the PHIs in these situations. 'Maintenance' appears to designate situations in which the PHI(s) have concluded there is no additional benefit in further treatment, or that the additional benefit is marginal and not cost-effective to subsidise. On some occasions, the implication is that the physiotherapy service is acting in a fraudulent manner. Some PHIs insist that they will not fund 'maintenance' under general cover and insist that the policyholder be discharged from care. PHIs will often refer to the *Private Health Insurance Act 2007* and their fund's rules which impose requirements about the conduct of health insurance business. They stipulate that private health cover should only be claimed where there is a presenting clinical condition.

The implication is often that the person is capable of maintaining their health with respect to the presenting issue unaided; and in practical terms that all people are capable of this.

Alternatively should a person seek physiotherapy to prevent health decline, services cease when the policyholder's subsidies reach the 'cap' of their general cover.

A more nuanced approach is required.

When physiotherapists speak of 'maintenance', they refer to something active and beneficial to their patient. Intervening is purposive. It aims to stop or slow progression of a condition. Physiotherapists put their mind to the effectiveness, and especially the cost-effectiveness of the activity (such as the likelihood of preventing high-cost care including hospitalisation).

Astute choices by patients to maintain 'light-touch' contact with physiotherapy because they need support to maintain their health, rather than see their health decline, are impeded. Astute choices

by physiotherapists to assertively outreach to patients with a high likelihood of ceasing health maintenance activities or with a condition likely to be degenerative, are impeded.

Some PHIs have outreach programs and established evidence of their benefit, yet physiotherapy services seeking to adopt the same principles of 'light-touch', differentiated support appear to be prevented from doing so by the legislation, regulation or fund rules.

Best clinical practice should be the guiding principle that underpins physiotherapy in the maintenance phase of treatment, rather than funding rules.

Recommendation 12:

We recommend that private health insurers pilot longitudinal funding models that facilitate cost-effective secondary prevention (e.g. a 'course of treatment rather than a single visit).

5.1.3 Tertiary prevention

Once a condition has developed and has been treated in its acute phase, tertiary prevention seeks to reduce the impact of the condition on the person's function, longevity, and quality of life. Tertiary prevention can include modifying risk factors, such as assisting a person with a cardiovascular condition to lose weight.

It is clear that PHIs understand the importance of tertiary prevention as PHIs offer Chronic Disease Management (CDM) Programs to a range of members. We are keen to support enrolment into CDM Programs for appropriate policyholders.

We are aware of PHI-run elements of CDM Programs, such as help-lines and assertive phone outreach. We understand that these elements are continuous throughout the year.

In contrast, policyholders tell us that physiotherapy support can be discontinuous and disrupted because of caps on subsidies. This can lead to a 'peak-trough' approach of effective function followed by declines in function that are ameliorated when the new funding year begins.

Recommendation 13:

We recommend that private health insurers pilot funding models for policyholders needing tertiary prevention occur, with a view to testing whether approaches such as 'carving out' the subsidies for a chronic condition are suitable to the Australian private health insurance environment.

5.2 We need to revise the service descriptors used in private health insurance

The scope of physiotherapy practice is quite broad and physiotherapists have the expertise to manage the care of clients at various stages of the chronic disease continuum.

Physiotherapists also manage a diversity of conditions and presentations, including people with chronic lung diseases, including asthma, through exercise prescription and cardio-pulmonary rehabilitation. People with complications from cancer surgery, like lymphoedema, are treated by

physiotherapists using complex physical therapy (CPT)[16], and physiotherapists prescribe exercise therapy to improve glucose control in people with, or at risk of developing diabetes.

Physiotherapy can include cardiac rehabilitation programs for people with various forms of heart disease[17] and the rehabilitation of elderly people after a stroke.[18] Physiotherapists also provide interventions, including therapeutic exercise, to reduce the risk of osteoporotic fracture, and physiotherapy is effective in helping people manage osteoarthritis.[19]

The Health Industry Claims and Payments Service (HICAPS) codes, used to facilitate electronic claiming of private health insurance rebates, however, reflect a presumption of homogeneity. They are less differentiated than the National Physiotherapy Service Descriptors, for example.

We recently worked with Private Healthcare Australia on a revision of the (HICAPS) codes. Although some improvements occurred, the resulting HICAPS codes continue to be an inadequate list of services, given the range of physiotherapy services. They are insufficiently nuanced.

We understand the importance of a list of services which has low transaction costs and is transparent to consumers, providers and insurers.

We are keen to achieve consistent classification of service types, or 'model rules', underpinning the way that physiotherapy interventions are delivered through the MBS, compensable schemes and private health insurance. A 'middle ground' between the range of services on the HICAPS list and differentiated items for each clinical domain is desirable.

Recommendation 14:

We recommend that the Health Industry Claims and Payments Service (HICAPS) codes be revised to better reflect the National Physiotherapy Service Descriptors and allow for effective data capture on the presenting issues triggering care.

5.3 Member turnover policies need to support preventative care

In the private health insurance arena, investments in prevention and innovations in care are usually premised on the reaping of subsequent tangible and intangible benefits.

We are aware of concerns about the ways in which 'hit-and-run' behaviour by policyholders could dampen innovation and improvement.

As we understand the issue, the central concern of investing in some activities is threefold:

- The reliability of the benefit being accrued
- The length of time between making the investment and reaping the benefit
- The potential for member turnover shifting the benefit from the PHI making the investment to another PHI which reaps the benefit.

We believe that the available evidence, and judicious selection of policyholders for key initiatives will address the first concern.

The second and third concern are interrelated – the longer the time between making the investment and reaping the benefit, the more likely that member turnover will adversely affect the achievement of net benefit.

5.4 Risk equalisation policy needs to support preventative care

In addition to the disincentive for preventative activities that have delays before reaping the benefit, the perceived impact of the risk equalisation policy is commonly raised. As we understand it, PHIs whose membership base is comparatively low cost effectively subsidise PHIs with a greater proportion of high cost members.

We support risk equalisation as a means to maintain community rating.

The apparent disincentive is that is that investment in prevention reduces the costs of some high-cost policyholders, compared with other funds, and this reduction creates a situation where a fund investing in prevention is subsidising a private health insurer which is not.

It is clear that the private health insurance system needs powerful incentives to invest in prevention to increase its sustainability. As a result, risk equalisation needs review.

In addition, a post-equalisation adjustment that creates incentives for prevention may need to be considered.

Recommendation 15:

We recommend that the Private Health Insurance (Risk Equalisation Policy) Rules be reviewed to reward the adoption of evidence-based prevention measures. Alternatively, we recommend that post-equalisation arrangements be made to ensure prevention is rewarded.

6 Innovation is essential and must be supported

The PHIs need to keep pace with evidence-based practice and incorporate emerging practices and technological innovation in physiotherapy to be sustainable.

6.1 Safe, reliable emerging technology needs to be adopted

The Discussion Paper for the Primary Health Care Advisory Group (PHCAG)[20] points to the importance of advancing health technologies, including software, smart phone applications, self-testing and point of care testing, as ways to improve quality and reduce unnecessary costs.

This paper signals that:

- software compatibility across health care providers remains a challenge
- education is required to ensure testing and monitoring devices are appropriately used, and deliver value for money, and
- the storage and communication of health information with new devices is secure and compatible with national standards.

An immediate challenge is the requirement for personal attendance in order for a physiotherapy service to attract a subsidy. The requirement can prove a barrier to consumer choice, continuity of care, and access to particular expertise where the person is in a rural or regional location or the person is otherwise isolated.

In circumstances where a physiotherapist is satisfied that a synchronous audio-visual communication other than 'in-person' attendance is safe and clinically appropriate, this would improve access to care. This change reflects the rapidly changing digital landscape, especially for Australians, both consumers and health professionals, in rural and regional locations.

Recommendation 16:

We recommend that, for the purposes of physiotherapy care subsidised by private health insurance, the definition of attendance be broadened to include synchronous audio-visual communication other than 'in-person' attendance (e.g. telehealth).

Physiotherapists also foresee distributed digital technologies (e.g. devices in their homes) allowing people to report on outcomes remotely. For example, there is already a device with advanced personal activity monitoring, cloud based analytics and reporting that provides information about trends in activity that might signal improvement or deterioration in wellbeing.

The current policy settings for PHIs appear to dampen the adoption of such innovation.

Recommendation 17:

We recommend that mechanisms that facilitate prompt and rigorous adoption and evaluation of new digital technologies be built into a refined private health insurance system.

6.2 The use of health outcome measures and review needs support

The principles of modern regulation need to guide the data collection, collation and analysis and subsequent improvement strategies.

We need to supplant a legal model of surveillance where PHIs focus on procuring compliance with existing rules with an expert model of surveillance where PHIs focus on quality improvement and profession-supported models of influencing action.[21]

In achieving this, we recognise the importance of data collection, including the use of outcome measures and review.

The *Early Intervention Physiotherapy Framework* (EIPF) used by the Victorian Traffic Accident Commission may provide a useful reference point.[22]

Regardless of the particular path taken, it will be essential that data collection, the use of outcome measures and review processes are feasible, relevant to the context and accepted by our profession.

Our feedback suggests that the lack of sophistication in clinical information systems will be an impediment to widespread adoption. Adoption of software platforms that allow meaningful,

flexible and efficient reporting requires investment. An approach to such investment is found in the Practice Incentive Program for general practice, funded by the Commonwealth Government.

Recommendation 18:

We recommend that PHIs consider an incentive program that supports the adoption of software systems in physiotherapy that will allow reporting on outcomes and support clinical review.

7 Problems with preferred provider arrangements need to be resolved

7.1 Preferred provider schemes can adversely impact on the quality of care

Preferred provider schemes provide a higher subsidy/benefit to policyholders compared with visiting a non-preferred physiotherapist. However, preferred provider schemes can place restrictions on fees charged to the policyholder.

Where co-payments are restricted, a number of consequences may follow.

A physiotherapy service may stint on time with the person to ensure that the treatment fits within affordable parameters, or may stint on related activities such as clinical record keeping. Neither is appropriate in the context of providing safe, high quality care.

Particularly in the case of complex presentations such as people with multiple injuries or social and/or emotional health issues, the physiotherapist may seek to break the treatment into shorter, more frequent visits. This creates time costs to the policyholder and increases the rate at which they reach caps in the insurance products. PHIs may also characterise such activities as 'over-servicing'.

Recommendation 19:

We recommend that preferred provider schemes allow for bilateral agreement with physiotherapy services on exceptions to fee levels for complex presentations.

7.2 Preferred provider schemes need to be constrained as market capture increases

We understand that the Australian health care system operates, in part, as a market. However, it is a 'failed market' and thus requires some regulation to reduce the adverse impacts of market failure.

South Australia offers an interesting example of market penetration by PHIs. The BUPA group has control of a significant proportion of the market in South Australia. The 2014 State of the Health Funds Report reported that

- BUPA's market share in South Australia was 52.4%

- Medibank was the next closest contender for market share, with a 23.63% of fund market share
- The next largest market share for an open fund was 7.6%.[23]

An argument is often put forth that practitioners have a choice to partake in a preferred provider scheme, on the proviso that they accept any drawbacks that come with scheme participation. However, there are often competitive and restrictive market forces that operate which make it very difficult to decline scheme membership.

In addition to the safety and quality problems described above, we are concerned that some PHIs are starting to restrict the number of physiotherapists on their preferred provider schemes in South Australia. Some physiotherapists attempting to join a preferred provider scheme have reported being put on an indefinite waiting list or told that they must be 'invited' to join a scheme. These restrictions may limit the entry of physiotherapists into the South Australian market and inhibit consumer choice of provider.

Recommendation 20:

We recommend that the Private Health Insurance Ombudsman investigate reports that physiotherapists in South Australia have been put on an indefinite waiting list or told that they must be 'invited' to join a preferred provider scheme.

Recommendation 21:

We recommend that consideration be given to precluding preferred provider schemes in areas of comparatively low physiotherapist to patient ratios.

8 Conclusion

The APA is committed to helping to improvement the private health insurance system. This submission reflects its willingness to collaborate with the people involved to embed safe, cost-effective, high quality practice and support innovation.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Australian Physiotherapy Association

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups. The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 12,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and its current submissions are publicly available via the APA website www.physiotherapy.asn.au.

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[1] Gray. G. (2005, February 18). "Health Policy in Australia." Retrieved from: http://apo.org.au/commentary/health-policy-australia (Accessed 30 November 2015)

[2] Called WorkSafe in VIC, ACT and NT.

[3] Called by different names across Australia, including: the Motor Accident Insurance Commission (MAIC) in QLD; the Insurance Commission of Western Australia (ICWA); the Motor Accident Commission (Allianz) in SA; the Motor Accidents Authority (MAA) in NSW; the Treasury Department in the ACT; the Territory Insurance Office (TIO) in the NT and the Motor Accidents Insurance Board (MAIB) in Tasmania.

[4] Neumann, P. B., Grimmer, K. A., Grant, R. E., & Gill, V. A. (2005). The costs and benefits of physiotherapy as first-line treatment for female stress urinary incontinence. *Australian and New Zealand journal of public health*, *29*(5), 416-421.

[5] Proof Committee Hansard, Australia (2015, November 18) Standing Committee on Health: Chronic disease prevention and management in primary health care. Retrieved from: http://parlinfo.aph.gov.au/parlInfo/download/committees/commrep/c86874f7-5e8f-4195-99e4-cc9b5a485a0c/toc_pdf/Standing%20Committee%20on%20Health_2015_11_18_4011.pdf;fileType=application%2Fpdf#search=%22Standing%20Committee%20on%20Health,%20chronic%20disease%20prevention%20and%20management%20in%20primary%20health%20care%22 (Accessed 1 December 2015)

[6] Private Health Insurance Administration Council. 2014. Operations of the Private Health Insurers Annual Report 2013–14. Retrieved from: http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Operations-of-PHI-Annual-Report-2013-141.pdf (Accessed 1 December 2015)

[7] Moseley, L. (2002). Combined physiotherapy and education is efficacious for chronic low back

pain. *Australian Journal of Physiotherapy*, *48*(4), 297-302.

[8] Smidt, N., de Vet, H. C., Bouter, L. M., & Dekker, J. (2005). Effectiveness of exercise therapy: a best-evidence summary of systematic reviews. *Australian Journal of Physiotherapy*, *51*(2), 71-85.

[9] Geytenbeek, J. (2002). Evidence for effective hydrotherapy. *Physiotherapy*, *88*(9), 514-529.

[10] Australian Government Department of Health. (2015) Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance. Retrieved from: http://www.health.gov.au/internet/main/publishing.nsf/Content/0E9129B3574FCA53CA257BF0001ACD11/$File/Natural%20Therapies%20Overview%20Report%20Final%20with%20copyright%2011%20March.pdf (Accessed 1 December 2015)

[11] Sandhu, S., Veinot, P., Embuldeniya, G., Brooks, S., Sale, J., Huang, S. & Bell, M. J. (2013). Peer-to-peer mentoring for individuals with early inflammatory arthritis: feasibility pilot. *BMJ open*, *3*(3), e002267.

[12] Colmar Brunton (2015). Australian Competition and Consumer Commission. Consumer Survey – Private Health Insurance. Full Report Prepared for the Australian Competition and Consumer Commission. Retrieved from: http://www.accc.gov.au/system/files/ACCC%20Consumer%20Survey%20Private%20Health%20Insurance%20Final%20Report.pdf (Accessed 1 December 2015)

[13] Australian Physiotherapy Association. (2012, February). "Position Statement on Pain Management." Retrieved from: http://www.physiotherapy.asn.au/DocumentsFolder/Advocacy_Position_Pain_Management_2012.pdf (Accessed 1 December 2015)

[14] Hunter, D.J. (2011). "Osteoarthritis". *Best Practice & Research Clinical Rheumatology – Musculoskeletal Science*, *25*(6), 801-814

[15] Hunter, D. J. (2011). Lower extremity osteoarthritis management needs a paradigm shift. *British journal of sports medicine*, *45*(4), 283-288.

[16] McCallin, M., Johnston, J. & Bassett, S. (2005). How effective are physiotherapy techniques to treat established secondary lymphoedema following surgery for cancer? A critical analysis of the literature. *NZ Journal of Physiotherapy*, *33*(3), 101-112.

[17] Jolliffe, J., Taylor, R., & Ebrahim, S. (2000). *National Service Framework Coronary Heart. A report on the clinical and cost effectiveness of physiotherapy in cardiac rehabilitation.* London: Chartered Society of Physiotherapy.

[18] Forster, A. & Young, J. (2002). *The clinical and cost effectiveness of physiotherapy in the management of elderly people following a stroke.* London: Chartered Society of Physiotherapy.

[19] Bennell, K., & Hinman, R. (2005). *Evidence-based clinical statement: Knee joint osteoarthritis*. Australian Physiotherapy Association, St Kilda (Vic.)

[20] Department of Health, Australia (2015 August). Better outcomes for people with chronic and complex health conditions through primary health care. Retrieved from: http://www.health.gov.au/internet/main/publishing.nsf/Content/2D8BCF439DE725CACA257E93001B462A/$File/discussion.pdf

[21] Sparrow MK. Joining the regulatory fold. Criminology and Public Policy 2012; 11(2): 345-59.

[22] Early Intervention Physiotherapy Framework – Guidelines for physiotherapists who provide services to injured workers under the framework. Retrieved from: http://www.worksafe.vic.gov.au/__data/assets/pdf_file/0016/130840/290615-EIPF-Policy-WorkSafe-Final.pdf (Accessed 1 December 2015)

[23] Private Health Insurance Ombudsman, Australia (PHIO). (2014, March). State of the Health Funds Report 2014. Retrieved from: http://www.phio.org.au/downloads/file/PublicationItems/SOHFR2014.pdf (Accessed 1 December 2015)