AUSTRALIAN
PHYSIOTHERAPY
ASSOCIATION

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2020-21 pre-budget submission

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INTRODUCTION

The Australian Physiotherapy Association (APA) is pleased to offer solutions to support improvements in the efficiency and sustainability of our world class health system. We welcome the sector wide reform that the government is undertaking and commend the government on recognising the importance of ensuring the allied health sector, representing a third of the workforce is engaged in a meaningful way.

Physiotherapy is Australia's largest allied health workforce, with 31,600 registered physiotherapists working across all areas of the health system.[1] Physiotherapy represents the fourth largest health profession in rural Australia and has the greatest penetration of privately operated allied health businesses.[2]

Physiotherapists are key members of multidisciplinary teams, making an important contribution to health care through health promotion, prevention, screening, as well as triage, assessment and treatment activities. The skills and training of physiotherapists equip them to work across a wide variety of conditions and disabilities to improve the health status of individuals across their lifespan. Physiotherapists also work with groups to deliver improved population health outcomes within their local areas.

Physiotherapists are perhaps best recognised for the treatment of musculoskeletal conditions. They also have a well-established role in the treatment and maintenance of chronic conditions such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes, osteoporosis, arthritis, obesity and hypertension. The educative focus they adopt in areas such as chronic disease management, self-management techniques and lifestyle and physical activity counselling aligns well with the primary health care philosophy of consumer and community empowerment.

Demand for physiotherapy services continues to increase due to the ageing population, population growth, the rising incidence of chronic disease and survival of accidents or illness.

Our recommendations in this submission offer an opportunity to begin further discussions with government on how physiotherapy can help to deliver on Australia's Long Term National Health Plan. We offer solutions that strengthen the primary care sector and improve the affordability of access to multidisciplinary care to all Australians, and address the inequities that exist in pockets of our society.

Australians living in regional, rural and remote Australia rely extensively on services provided by both public and private physiotherapists, and have established strong relationships with these practitioners, who are part of their community. Physiotherapists are an integral part of both private and public systems and work closely with other health professions.

In rural and remote areas there are significantly more potentially preventable hospitalisations than in metropolitan areas.
To reduce the additional burden on expensive tertiary care in rural and remote areas, the introduction of programs to improve the distribution of the physiotherapy workforce and better utilise existing infrastructure is vital.

We offer opportunities to improve efficiencies in the system through the rollout of physiotherapy service provided through telehealth, allowing people all over Australia to access specialist physiotherapy services. This means that the farmer in Walgett can access the same high quality, personalised care, as the lawyer in metropolitan Sydney.

We plan to strengthen primary care by reducing the burden on hospitals and better utilise the

1 & 2 Physiotherapy Board of Australia, Registrant Data June 2019. Accessed 20/08/19 https://www.physiotherapyboard.gov.au/About/Statistics.aspx

existing investments in infrastructure in the physiotherapy sector. We believe there is scope to use our expert diagnostic skills to triage and treat minor injuries, particularly in rural areas and in the after hours period where general practice is already under pressure. This could mean that the parent of a child who has fallen from a bed and injured a wrist, can be safely reassured when an X-ray is not required.

We recognise the barriers of access to care for some patients are predominantly economical and geographical, and we strongly believe that wherever it is possible, these barriers must be removed. We have identified many ways in which we see this can be achieved.

Our profession also wants to engage in health system stewardship in a meaningful way. Our goal in treatment is to deliver recovery with minimum intervention and our expertise and diagnostic skills in treating and managing musculoskeletal disorders means that we know exactly when it is time to refer to a surgeon or to recommend imaging.

We would like to see the weekend soccer player who has come to a physiotherapist for an assessment of their injury, follow a journey that represents best practice - whether that is conservative management, diagnostic imaging or referral to an orthopaedic surgeon. Our digital health environment allows this communication to be fed through to the GP in real time yet our system puts administrative barriers in the way that costs patients in time, money and recovery.

In addition, we would like the government to better understand how the private physiotherapy sector relies on a myriad of complex funding mechanisms for its viability and sustainability, with many practices relying on blended funding from a number of sources such as private health insurance, Medicare, compensable schemes such as WorkCover, the National Disability Insurance Scheme and aged care packages, while also needing to attract and compete for consumer contributions. This means that minor tweaks to policy can have a major impact on an individual practice, which in turn impacts on out of pocket costs to consumers thereby reducing accessibility. For this reason we have made suggestions that support the efficient use of the existing systems with some innovative solutions.

We trust that our recommendations will provide the government with sound, feasible and cost-effective solutions, and that these solutions represent a multidisciplinary, informed, patient-centred approach that supports the implementation of the Long Term National Health Plan.

SUMMARY OF RECOMMENDATIONS

1.0 PRIMARY HEALTH CARE

GOAL: Improve equity of access to primary health care for all Australians through affordable high value physiotherapy

PROPOSED SOLUTIONS:

- Allow direct referral to medical specialists and diagnostic imaging, within individual scope of practice, under a clinical governance framework that recognises the role of physiotherapists as health system custodians in their area of expertise.
  Cost saving: $13.6 million
- Provide funding to pilot the expansion of physiotherapy services, delivered through telehealth to high need consumers, with proven safety and clinical equivalence to standard care, to evaluate cost-effectiveness.
  Cost estimate: $1 million
- Investigate the cost-effectiveness of incentivised private health insurance rebates for physiotherapy services that reduce out of pocket costs to consumers and promote the delivery of outcome driven, high value physiotherapy care.
  Cost estimate: $100,000
- Improve access to After Hours care and reduce emergency department burden by piloting an innovative service model for triaging and treatment of acute musculoskeletal injuries, which utilises the existing physiotherapy sector infrastructure.
  Cost estimate: $1 million
- Improve access to allied health services for people with chronic and complex conditions through the MBS by recognising the current limitations and increasing the number of available consultations and reducing the out of pocket cost to consumers.

SUMMARY OF RECOMMENDATIONS

2.0 PREVENTION

Goal: Enable access to funded prevention strategies where there is evidence supporting both immediate need and cost-effectiveness

PROPOSED SOLUTION:

- Develop a service delivery model that utilises existing physiotherapy infrastructure to improve access to early intervention pain services.
  Cost estimate: $200,000

SUMMARY OF RECOMMENDATIONS

3.0 RURAL AND REMOTE HEALTH

Goal: To bring equity of access to high quality physiotherapy for people in rural and remote locations and areas of workforce shortage

PROPOSED SOLUTIONS:

- Recognise the higher costs associated with rural living and service provision by providing financial support to existing services and support to attract and retain the physiotherapy workforce. **Cost estimate: $3.75 million**
- Promote viable rural markets by redirecting government programs towards enhancing utilisation of existing infrastructure, expertise and relationships, and stop the preferential incentivising of certain sectors, which creates an uneven playing fields, such as the General Practice Workforce Incentive Program. **Cost estimate: neutral**
- Provide ready access to high quality, affordable education and training for both public and private practice to attract and retain the rural workforce. **Cost estimate: $200,000**

SUMMARY OF RECOMMENDATIONS

4.0 ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Goal: To reduce the current underutilisation of physiotherapy services by Aboriginal and Torres Strait Islander peoples

PROPOSED SOLUTIONS:

- Provide funding to trial the impact of embedding appropriately trained, culturally safe physiotherapists into Aboriginal Community Controlled Health services. **Cost estimate: $2.75 million**
- Enhance utilisation of existing Chronic Disease Management items in the Medicare Benefit Scheme, by providing a no gap physiotherapy consultation policy, similar to other Closing the Gap initiatives for Aboriginal and Torres Strait Islander peoples.
- Provide funding for research into an evaluation of the barriers and enablers to appropriate utilisation of physiotherapy by Aboriginal and Torres Strait Islander peoples. **Cost estimate $150,000**

SUMMARY OF RECOMMENDATIONS

5.0 AGED CARE

Goal: To re-orient aged care services to evidence-based early interventions, such as physiotherapy, to improve the quality and safety of care provided

PROPOSED SOLUTIONS:

- ~~Provide a $1000 payment for physiotherapy-led restorative care for all new admissions into residential aged care facilities to improve their independence, reduce frailty and reduce the cost burden on the aged care system.~~
- In the Australian National Aged Care Classification (AN-ACC) system include a new funding layer for consumer directed wellness and reablement care to be delivered by allied health.
- Establish an Aged Care Workforce Steering Committee tasked with commissioning and evaluating research into best practice workforce models to ensure a viable, safe and sustainable aged care workforce.

SUMMARY OF RECOMMENDATIONS

6.0 ALLIED HEALTH LEADERSHIP

Goal: To understand and recognise the contribution of the allied health sector to the health system and facilitate data driven future decision making

PROPOSED SOLUTIONS:

- Develop an Allied Health Workforce Dataset that enables informed decision making and identifies opportunities for better workforce utilisation.
- Appoint a Chief Allied Health Officer to inform decision making within the department.
  Cost estimate: $400,000

1.0 PRIMARY HEALTH CARE

Goal: Strengthen the primary care system and improve equity of access to primary health care for all Australians through affordable high value physiotherapy

PROPOSED SOLUTION: Provide direct referrals for physiotherapist to medical specialists and diagnostic imaging

We believe that to strengthen primary care in Australia, improve efficiencies and enhance access to care for all Australians, all health professionals must take ownership of the sustainability of our health system and should consider themselves custodians, and be empowered to act as such. In a contemporary team based health system, stewardship is not a role that can be designated to a single profession at the exclusion of others. Not only does this suggest that other health professionals are not trusted to make sound decisions that are in the best interest of their patients, but it also reinforces an outdated hierarchy that devalues the contribution of other health providers.

The rationale for retaining general practitioners (GPs) as the primary source of referral has been the importance of continuity of care. However, recent research suggests that a significant proportion of general practice care is delivered away from 'usual' or home practices, with more than one-quarter of the study's sample attending more than one practice in the previous year.[3] This has potential implications for continuity of care.[4]

Within their scope of practice, optometrists, dentists, midwives and nurse practitioners are able to make referrals directly to consultant medical specialists. The same principle needs to apply to physiotherapists.

One in 20 Australians lives in an area with severely reduced access to the services of a GP. In some of Australia's most underserviced areas, only half the number of GP services per person are provided, compared with those provided to people living in metropolitan areas.[5]

This means that the patients of physiotherapists in rural areas, who already have restricted access to consultant medical specialists, have an additional hurdle when accessing suitable medical practitioners.

Allowing for direct physiotherapy referral to specialist medical practitioners will better utilise the existing workforce, cut red tape and free up GPs to dedicate more time to complex clinical care.

For example, the Transport Accident Commission (TAC) in Victoria has a Network Pain Management Program in Victoria that supports the principle of early intervention and enables physiotherapists to refer motor accident patients directly to pain medicine specialists. Benefits of this program include:

- a single approval, which facilitates early access to healthcare
- access to a coordinated team of healthcare professionals, and
- access to pain management usually within 4 weeks of approval.

In contrast, the MBS requires a GP referral to consultant medical specialists, when in selected cases a physiotherapist could safely and appropriately make the referral. This can create a circular referral pattern that delays necessary specialist treatment and generates unnecessary work.[6] The use of interoperable information and communications systems (including My Health Record) overcomes any sense of discontinuity between providers and patients.

3 Haggerty JL Reid RJ Freeman GK et al. Continuity of care: a multidisciplinary review. BMJ. 2003 Nov 22;327(7425):1219-21.

4 Wright M Hall J van Gool K et al. How common is multiple general practice attendance in Australia? AJGP May 2018;47(5):289-96.

5 Duckett S Breadon P Ginnivan L. Access all areas: new solutions for GP shortages in rural Australia, Grattan Institute, Melbourne. 2013.

There is evidence to support that physiotherapists are capable health system stewards in hospital-based orthopaedic screening clinics. In these clinics, musculoskeletal physiotherapists screen patients referred by GPs to an orthopaedic surgeon, filtering and treating patients who could benefit from conservative treatment and reducing the number of appointments on the orthopaedic wait list.

An analysis of physiotherapy-led orthopaedic and neurosurgery screening clinics in Queensland 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.[7]

In 2013, the APA commissioned Griffith University's Centre for Applied Health Economics and the Deeble Institute to conduct an economic evaluation to determine the costs associated with referrals. The research found if physiotherapists were to receive Medicare rebates to directly refer to a range of specialist medical practitioners, there would be substantial savings:

Savings to the MBS:	$13,641,362
Savings to patients:	$2,175,407
TOTAL SAVINGS:	**$15,816,769[8]**

As shown in the figures above, the current referral system can incur additional GP out-of-pocket costs for patients. The imposition of additional costs can lead patients to delay their care, or worse, fail to follow through on treatments, potentially creating a later acute episode. By changing current referral requirements, health policymakers will streamline patient care, facilitating faster diagnosis, improved patient outcomes, quality of life, work productivity and wider community benefits.

A safety and quality framework already exists. The APA Code of Conduct is binding on all members and requires physiotherapists to collaborate with colleagues to promote safe, quality care. This will often involve collaboration with a GP, which is normal practice within the profession.[9]

The Physiotherapy Board of Australia also has a code of conduct that requires physiotherapists to 'recognise and work within the limits of their competence and scope of practice.'[10] This reflects the practice in the profession of referring patients to a GP if the aetiology of the presenting condition is unclear or outside a physiotherapist's scope of expertise. However physiotherapists, as experts in the management of musculoskeletal disorders, are well placed to determine the relevant pathways for patients.

In addition, evidence suggests that physiotherapists are skilled at ordering clinically appropriate imaging. When magnetic resonance imaging (MRI) was used as the gold standard, the diagnostic accuracy of physiotherapists for clients with musculoskeletal injuries was found to be as good as that of orthopaedic surgeons and significantly better than that of non-orthopaedic providers.[11]

- **Proposed Solution:** Allow direct referral to medical specialists and diagnostic imaging, within individual scope of practice, under a clinical governance framework that recognises the role of physiotherapists as health system custodians in their area of expertise.
  Cost Saving: $13.6 million

6 Wright Hall van Gool et al. op cit.

7 Raymer M Smith D O'Leary S. Physiotherapy screening clinic model improves neurosurgery and orthopaedic outpatient services, Queensland Government 2012.

8 Comans T Byrnes J Boxall A et al. Physiotherapist referral to specialist medical practitioners. Final Report. Griffith University Centre for Applied Economics and Deeble Institute. 2 September 2013.

9 Australian Physiotherapy Association (2017). APA Code of Conduct, p4, available at http://www.physiotherapy.asn.au/DocumentsFolder/APAWCM/The%20APA/Governance/Code_of_Conduct_V2013.pdf

10 Physiotherapy Board of Australia (2011). Code of Conduct for Registered Health Practitioners, p2, available at http://www.physiotherapyboard.gov.au/Codes-Guidelines.aspx

PROPOSED SOLUTION: Provide funding for telehealth provided physiotherapy services

We believe there is an opportunity to support the implementation of the Long Term National Health Plan to improve access to services through the rollout of telehealth.

Telehealth is a proven, safe and cost-effective strategy for increasing access to physiotherapy services for all Australians and there is a broad, and rapidly increasing, body of evidence that demonstrates this.

Reports suggest that sufficiently scaled home telehealth implementation is an appropriate and cost-effective way of managing chronic care clients in both urban and rural settings.

A systematic review that assessed the economic value of video communication found that:

- 91% reported telehealth outcomes were at least equivalent or better
- 61% found telehealth to be less costly than the non-telehealth alternative.[12]

Difficulty in accessing physiotherapy services can be a result of multiple barriers, not only geographic. Video-consultations can lower the barriers for patients to receive advice and support. This includes people living in rural locations, those who are homebound and older people with limited capacity to travel to a clinic.[13] Frailty and immobility can reduce access at any distance and should not make vulnerable patients ineligible – therefore we also believe that this has broader application and that the restrictions should be based on clinical need, not geographic location. However, we also recognise that the most immediate access crisis is in rural and remote settings.

There are additional benefits if the patient is in a rural or regional location and the treating practitioner is an urban based specialist who is able to either provide direct patient care, or support the local practitioner to meet patients' needs without the burden of travel.

Given recent technology advancements that have simplified the user experience and reliability, telehealth is now an obvious solution to current access issues and can be effectively used to deliver many services, to review patient progress, ensure effective services are delivered and provide motivation for effective management programs. Telemedicine is also a proven cost-effective strategy for chronic pain management, providing a solution the current opioid dependence epidemic and extended wait lists to access specialist pain services.

We recognise that recommendations for subsidised allied health teleconference consultations has been provided to the MBS Taskforce from the Allied Health Reference Group, and we would like to reinforce the importance of enabling this to begin to address some of the inequities of access that currently occur in our system, particularly for people living in rural and remote areas.

Additional work to further support these services would be welcomed and should focus on the collection of evidence of outcomes to form national minimum data sets.

- **Proposed Solution:** Provide funding to pilot the expansion of physiotherapy services, delivered through telehealth to high need consumers that have proven safety and clinical effectiveness equivalent to standard care and can demonstrate cost-effectiveness.
  Cost estimate: $1 million

11 Daker-White G Carr AJ Harvey I et al. A randomised controlled trial: Shifting boundaries of doctors and physiotherapists in orthopaedic outpatient departments. J Epidemiol Community Health,1999. 53: p. 643-50.

12 Wade VA Karnon J Elshaug AG et al. A systematic review of economic analyses of telehealth services using real time video communication. BMC Health Services Research 2010;10:233

13 Foley & Lardner LLP. 2014 Telemedicine Survey Executive Summary. Executive Summary November 2014. Chicago. USA. https://www.foley.com/files/Publication/0585f5b1-1205-4be7-be5a-4e14602a4fac/Presentation/PublicationAttachment/39c25a9b-5ff1-4ee8-b861-4ea2d71718ae/2014%20Telemedicine%20Survey%20Executive%20Summary.pdf (Accessed 1 October 2017)

PROPOSED SOLUTION: Support the delivery of high value care through incentivised Private Health Insurance rebates

We believe there are opportunities in the current system to encourage consumer choice and support innovation, while ensuring there is a robust public and private health system that delivers high quality care. We would like to see out of pocket costs to consumers reduced so that access is improved, but quality is not compromised.

The health system is under constant pressure to provide more efficient, high quality care. Yet for physiotherapy, and allied health practitioners in general, there is no effective way to either measure this, or provide any incentives at the coal face to extend beyond traditional practices. The ultimate potential of high value care and the link to accurate funding mechanisms to drive this and support preventative health activities is underestimated.

It is now critical that the government acknowledges this gap and develops frameworks that can support the system to identify strengths and weaknesses. We need to be able to understand, and where possible quantify, the quality of the service provided so that we can recognise the provider for delivering cost-effective health care to the system.

It is essential that we identify opportunities within the allied health sector to maximise efficiency, reduce wastage, and identify and remove perverse incentives to over-service. We know that there can be huge variation in practice quality across locations – we need the data to understand this better and the access to resources to change it.

A suggested introductory model, or interim model, is the provision of higher private health insurance rebates for acknowledged skills set or practice standards, which are passed on to the consumer as reduced out-of-pocket expenses, thereby encouraging the consumer to seek out quality care.

This higher level of rebate could occur at two levels:

- Practitioner (i.e. Titled physiotherapists)
- Practice (i.e. Have undergone QIP accreditation)

This is an important point of difference from preferred provider systems, which creates an uneven playing ground, and reduces the incentive for individual practitioners to invest in the system.

It is an opportune time to identify the opportunity for scaling and evaluation. Individual practitioner credentialing already exists and there is precedence for some insurers to recognise this in their rebate structure. Quality assurance recommendations are best developed by the individual peaks, who can inform government and regulators of health service delivery.

We believe this recommendation will support the Private Health Industry, allowing them to develop a system that will engender consumer confidence and improve health outcomes by allowing higher rebates for outcomes based care.

- **Proposed solution:** Investigate the cost-effectiveness of incentivised private health insurance rebates for physiotherapy services that reduce out of pocket costs to consumers and promote the delivery of outcome driven, high value physiotherapy care.
  Cost estimate: $100,000

PROPOSED SOLUTION: Improve access to After Hours care through a pilot triaging model for acute musculoskeletal care

We see an opportunity to address some of the inequities of access to care that currently exist in our system while at the same time strengthening our existing workforce by providing alternative access points that leverage existing infrastructure.

We believe there are opportunities for physiotherapists in rural areas to help reduce the number of unnecessary presentations at emergency departments and the pressure on GPs in rural areas.

We would like the government to trial an after hours model for physiotherapists to use existing infrastructure to provide triaging and treatment for minor injuries, or other Category 4 and 5, presentations.

This could be extended to sociable hours triaging opportunities.

These models have been explored through the Supercare Pharmacies model in Victoria and some other Primary Health Network (PHN) initiatives. These initiatives looked at innovative collaborative models of care to address access to services after hours. Many of the lower category presentations are minor traumas that would be better triaged or managed by a physiotherapist.

Studies in this area may show that rural access issues could also be addressed this way.

There may also be opportunity to provide certainty for local providers that rural practice is both sustainable and represents a sound investment.

Primary Health Networks (PHNs) provide an ideal opportunity to work more closely with rural services and ensure that funding effectively targets areas most in need.

- **Proposed Solution:** Improve access to after hours care and reduce emergency department burden by piloting an innovative service model for triaging and treatment of acute musculoskeletal injuries, using the existing physiotherapy sector infrastructure. **Cost estimate: $1 million**

"Those with existing businesses already have the infrastructure and business structures in place and often just need some support to expand into a multidisciplinary practice model."

APA member

PROPOSED SOLUTION: Improve access to allied health services for people with chronic and complex conditions through the MBS

We are keen to deliver on the nascent value within the Chronic Disease Management (CDM) items in the MBS and to support the goal of the Long Term National Health Plan to guarantee a secure Medicare and a strong primary health sector.

We have a number of concerns about the model for the CDM items as currently enabled in the MBS. Clients often tell our members that they have claimed all but one of their annual allocation of MBS-subsidised consultations with allied health professionals prior to their first visit to this physiotherapist. This creates a material barrier to the clients attending for a sufficient 'episode' of physiotherapy care.

Our members report they are advised by GPs that referral to the physiotherapist is for a single session, as the four remaining sessions available under the MBS are to be used by other allied health professionals (e.g. a dietician or occupational therapist).

They also report that the structure of the CDM items departs materially from their usual practice. Independent research, commissioned by the APA in 2017, indicates that initial consultations last, on average, 40.29 minutes. This is more than twice the threshold length of 20 minutes indicated for the service in the MBS. There is little variation in this reported average length between urban and rural clinics and between sole traders and group practices.

This research also indicated that more than a third of physiotherapists in Australia offer a bulk-billed initial consultation on referral from a GP. Across the states, Western Australian (WA), Queensland (Qld), Victoria (Vic) and the Northern Territory (NT) have the highest rates of offering to bulk bill (respectively). Although the base of respondents in the study was smaller, the Australian Capital Territory (ACT) and Tasmania (Tas) have very low levels of offering to bulk bill. The study showed very little difference between urban and rural clinics and between with sole traders and group practices.

We are aware from other research on the costs of physiotherapy services that the fee/benefit for the CDM items is materially lower than the full average cost of providing the service on a sustainable basis. We anticipate there is an important financial barrier for patients when accessing physiotherapy subsidised by the MBS. This barrier is amplified for people with chronic diseases as they are likely to need an episode of care. Financial barriers are further exacerbated by variable bulk-billing rates.

Our members have stated they do not receive referrals for the same person over multiple years despite the design of the CDM items pertaining to the management of chronic conditions. Our members report that there is a small number of GPs who consistently refer patients who would not, in the view of our members, otherwise be eligible for these services. Our members have been made aware that the decision is that of the GP and the regulatory framework is such that the decision is the GP's.

The APA would welcome a tiered model proposal against current chronic disease items to provide additional allied health visits. This shift aligns with the literature and the need for a long-term multidisciplinary management plan for effective chronic disease management.

- **Proposed Solution:** Improve access to allied health services for people with chronic and complex conditions through the MBS by recognising the current limitations by increasing the number of available consultations and reducing the out of pocket cost to consumers.

2.0 PREVENTION

Goal: Enable access to funded prevention strategies where there is evidence supporting both immediate need and cost-effectiveness

PROPOSED SOLUTION: Enhance access to early intervention pain physiotherapy services

One in five Australians under the age of 65 is affected daily by chronic pain, this rises to one in three in over 65 years of age.[14] Chronic pain costs the Australian economy about $34 billion per year. This is the third most costly health burden in Australia and the leading cause of early retirement and absenteeism in the workplace.[15]

The Productivity Commission has recommended the health sector shifts its focus to integrated and patient centred care. It is estimated this shift could save the economy $140 billion over 20 years.[16]

There is strong evidence that early interventions can result in health system savings and, more importantly, reduce the negative impact of pain on quality of life. We believe there is a missed opportunity to address the gap in service delivery that exists in identifying people at risk of developing persistent pain.

A significant amount of the burden of chronic pain arises from musculoskeletal disorders. For example, the direct costs of low back pain are estimated at $4.8 billion per year in Australia. The indirect costs are estimated at more than $8 billion in Australia.[17]

There are well-defined predictors of pain chronicity in the literature. These include high levels of pain, poor self-efficacy, poor pain-related beliefs and fear avoidance.[18] Early intervention to address these predictors has been shown to reduce the risk of developing chronic pain and may help address the burden of disease and prevent chronicity.[19]

Physiotherapy has been shown to be effective in the early intervention setting and lead to outcomes such as fewer sick days, shorter injury duration and decreased utilisation of the healthcare system.[20] Physiotherapists are well placed to employ a

biopsychosocial approach to educate and promote best-practice approaches to pain including pain education and promotion of healthy movement, as well as being well placed to screen for co-morbid predictors of chronicity. Physiotherapy can help address the domains that are predictors of chronicity.[21]

As a result, it is important for health funding to include services that provide early intervention physiotherapy services for people at risk of persistent pain. The presence of these services provides a routine, accessible option for patients and GPs when the risk of persistent pain is identified.

Rural communities, service and provider deficits, and distance, also factor strongly. Targeted strategies are needed to address access constraints so patients can receive treatment close to home.

MBS pain-related items should be expanded to enable high value care via multidisciplinary, patient-centred approaches to pain management. This expansion could provide an effective and lasting solution to one of the nation's priority health problems. A broad range of interdisciplinary methods including face-to-face, group meetings and telehealth will ensure stronger coverage and support accessibility aims.

A proposed service is described in Appendix 2.

- **Proposed Solution:** Develop a service delivery model that utilises existing physiotherapy infrastructure to improve access to early intervention pain services.
  Cost estimate: $200,000

14 Pain Australia 2018-2019 Pre-Budget Submission. December 2017. http://www.painaustralia.org.au/static/uploads/files/painaustralia-budget-submission-18-19-color-wfbralgwytgq.pdf

15 Productivity Commission 2017, Shifting the Dial: 5 Year Productivity Review, Inquiry Report. https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review.pdf

16 & 17 Productivity Commission 2017. op cit.

18 Picavet HSJ, Vlaeyen JW, Schouten JS: Pain catastrophizing and kinesiophobia: predictors of chronic low back pain. American journal of epidemiology 2002, 156(11):1028-1034.

19 Raymond A, Bouton C, Richard I, Roquelaure Y, Baufreton C, Legrand E, Huez J-F: Psychosocial risk factors for chronic low back pain in primary care—a systematic review. Family practice 2011, 28(1):12-21.

20 Hallegraeff JM, Krijnen WP, van der Schans CP, de Greef MHG (2012) Expectations about recovery from acute non-specific low back pain predict absence from usual work due to chronic low back pain: a systematic review. Journal of Physiotherapy 58: 165–172.

21 Guzman, J., Esmail, R., Karjalainen, K., Malmivaara, A., Irvin, E. & Bombardier, C. (2001). Multidisciplinary rehabilitation for chronic low back pain: a systematic review. British Medical Journal, 322(7301), 1511-1516.

3.0 RURAL AND REMOTE HEALTH

Goal: To bring equity of access to high quality physiotherapy for people in rural and remote locations and areas of workforce shortage

PROPOSED SOLUTION: Recognise the higher costs associated with rural living and service provision by providing support to existing services and to attract a new workforce

We know that the costs of running a business in regional, rural and remote areas is already higher than metropolitan areas. We also know that these practices are committed to keeping the out-of-pocket costs to their community to a minimum.

Rural physiotherapy practices are the backbone of the community, and support provided to those practices will help them thrive and extend their reach. Our members believe that existing practices already have infrastructure and business models in place to expand into a more comprehensive, multidisciplinary practice model.

We have raised our concerns about the Workforce Incentive Program with the Minister for Health, However; we are yet to be reassured that the viability of existing services is being protected, despite the program being scheduled to begin in January 2020.

"If GP clinics are able to claim up to $120,000 per year (depending on location and SWEPI of the clinic) simply to employ a physiotherapist at their clinic, it is very clear that GPs will happily accept this grant and then refer all their usual cases to the "in house" physio. Long term community based physios will no longer have a source of GP referrals that we rely on for our livelihood. The GP clinics will not only receive the WIP grant but the income the in-house physio generates so they are likely to be very happy about this! However, the scenario I can perceive is a new graduate physio could be attracted to take up this position, will have no one to mentor them and consequently have a negative working experience and everyone misses out!"

"Support of existing practices is the only way to keep experienced practitioners in these areas..... the same experienced practices who can mentor and nurture prospective practitioners"

Rural physio practitioner

We understand that the majority of local practices would welcome the opportunity to employ and be able to retain more allied health practitioners, and to provide the professional support that is best provided by peers. A thriving rural practice that can invest in more staff, infrastructure and technology can more easily attract new graduates for training. The capacity to pay competitive rates to attract urban based practitioners is also key.

We also believe, that in an area where there is sufficient workload to support a general practice that is large enough to employ an allied health professional, there is also a viable option to support a new independent allied health practice. This practice, like a general practice is, should be allied health practitioner led.

We believe there are inequities of access in the system for consumers and health care professionals. Government-funded services providing lower cost options is anti-competitive. The higher cost of delivering rural services is recognised for general practices through funding provided by the Department of Human Services and to community pharmacies through the 6th Community Pharmacy agreement. Physiotherapy and allied health services receive no support.

We believe it is time all health providers were recognised for their essential contribution. Department-funded incentive payments must be shared equitably and not just provided exclusively to general practice. There is already significant investment in the allied health infrastructure that does support the "all under the GPs roof" model, yet this is often not mentioned.

Disrupting the delicate ecosystem of local services will result in a reliance on higher levels of ongoing government funding and there are many examples of where this has occurred already. The impact on these communities can be far reaching, with new models exposed to a high risk of failure, and an increasing chance that existing services will relocate to urban areas where costs are reduced and the competition is more equal.

"The most likely people to stay rural and do good things for their communities are those who are already there. These practices should be supported. They are also the best people to train early career therapists."

APA member

There needs to be better collaboration between PHNs and the physiotherapy profession to facilitate a deeper understanding of local service needs, and to be able to provide viable solutions. We believe it is imperative that the government work closely with individual exiting allied health practices to determine a model to support future viability.

> *"In the first four months of this year, I lost out 18 hours' worth of contracts to nearby aged care and public hospitals to two different large health corporations. Our practice had been providing physio services to these sites for many years and now they are being serviced by a rolling series of mostly limited registration physios who have no interest in the local community and are only working out their contract until they pass their exams. This is largely due to the ACFI pain management 4A and 4B funding models that make it very attractive for agencies to employ these corporates in exchange for increased funding but, unfortunately, decreased services and consistency. So I am left in a position of trying to keep my staff still employed with not enough to do and again at great cost to myself. So this may seem slightly contrary to what is perceived as gaps in treatment in rural physio areas. We are actually trying to source more work to keep us all afloat! I am facing the very real prospect of having to downsize my services and staff, which means local physios who are prepared to work in this area are losing jobs to health corporates who have a fiscal bottom line agenda."*

We believe that rural practice is often not recognised for its agility and progressive culture. The lack of administrative red tape that inhibits innovation in metropolitan locations is an opportunity in rural practice. We believe that investments in the development of rural practice will pay dividends at a national and international level. The opportunity to access the support needed to harness this is limited for rural allied health practitioners.

These are examples of rural and remote support that is currently provided to other health professionals that should be open to all health professionals, including allied health:

- HECS Reimbursement Scheme
- Workforce Incentive Program – Practice Stream
- Workforce Incentive Program – Practitioner Stream
- Medicare funded Telehealth consultations
- Rural Pharmacy maintenance allowance
- Rural start-up allowances
- Outreach support
- Better Access to funding such as the MBS and private health insurance to reduce out of pocket costs to consumers
- The PIP-QI
- EHealth incentives
- Relocation costs subsidies
- Rural practitioner loadings
- **Proposed Solution:** Recognise the higher costs associated with rural living and service provision by providing financial support to existing services and support to attract and retain the physiotherapy workforce
- **Proposed Solution:** Promote viable rural markets by redirecting government programs towards enhancing utilisation of existing infrastructure, expertise and relationships. Stop the preferential incentivising of certain sectors, which creates an uneven playing field, such as the General Practice Workforce Incentive Program. **Cost estimate: neutral**

PROPOSED SOLUTION: Provide ready access to high quality, affordable education and training for both public and private practice

We support initiatives to increase access to professional development activities for rural practitioners, particularly programs which recognise the diversity of the skill set, the increased workload, the breadth and depth of practice scope, along with the inevitable decrease in access to highly skilled mentors. We see this as an iterative process that must continue to evolve to keep pace with opportunities that are available in metropolitan locations. The issues are well documented, and we know that if we don't support our rural practitioners, then we will continue to lose them. The pipeline in terms of students, university placements, new graduate positions and clinical supervisor capacity building is a key priority to ensure future workforce distribution matches population need.

Choosing to become a healthcare professional needs to be a practical option for rural students. When students are forced to relocate to meet these needs, the connection is disrupted. Given the current connectivity of the world, and the rate of technology advancement, distance is no longer an argument for variations of either standard or opportunity. We need to keep pace with other industries and ensure that health uses data informed distribution of funding to ensure equivalent standards for the provision of training and education in rural and metropolitan Australia.

- **Proposed Solution:** Provide ready access to high quality, affordable education and training for both public and private practice to attract and retain the rural workforce.
  Cost estimate $200,000

3.0 ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Goal: To reduce the current underutilisation of physiotherapy services by Aboriginal and Torres Strait Islander people

PROPOSED SOLUTION: Trial the impact of embedding appropriately trained physiotherapists into ACCHs

The APA supports the core premise that there is not currently the access to culturally safe and affordable physiotherapy and other allied health services that there should be.

For physiotherapists, there remains significant financial and structural impediments to providing care. A broader population health policy framework is required that recognises the role of primary care, prioritising allied health in addressing health disparities. The recommendations outlined here move us closer to addressing key access constraints enabling physiotherapists to provide the best possible care for Aboriginal and Torres Strait Islander people.

In recognising the importance of culturally appropriate healthcare, the APA is heavily invested in delivering a Reconciliation Action Plan (RAP), working alongside Aboriginal and Torres Strait Islander people. Our RAP delivers on culturally appropriate physiotherapy services to all people. But while we know that all allied health services must be culturally safe, and we are committed to achieving this, we also know, through experience, that this is a process that will not occur overnight, and that physiotherapy utilisation by Aboriginal and Torres Strait Islander people remains starkly below non-indigenous rates.

We believe that community-controlled health service provision plays a critical role in helping Aboriginal and Torres Strait Islander people identify a recognised culturally safe service. And we think that inside that safe space should be a team that can service the needs of each person.

Physiotherapy plays an essential role in improving health outcomes for Aboriginal and Torres Strait Islander people, including in managing chronic diseases such as cardiorespiratory disease and chronic pain. However we are concerned that in addition to the well-recognised financial barriers, there is a lack of understanding of the role of allied health providers and difficulty in identifying culturally safe providers. And therefore, people choose to not use physiotherapy as a way to reduce their burden of disease and instead suffer for longer, and put themselves more at risk of poorer outcomes.

Strengthening the cultural competency of the allied health professions and building the indigenous allied health workforce are key shifts required in making health services work for Aboriginal and Torres Strait Islander people. In the meantime we need to understand if we can impact outcomes by placing the person at the centre of how they choose to receive their care, and ensure that all ACCHS have access to at least one culturally safe physiotherapist.

- **Proposed Solution:** Provide funding to trial the impact of embedding appropriately trained, culturally safe physiotherapists into Aboriginal Community Controlled Health services.
  Cost estimate: $2.75 million

PROPOSED SOLUTION: Increase access to CDM items by providing a no-gap service for physiotherapy

We believe that the bulk-billing incentive is a step toward addressing the issue of out-of-pocket costs for some Aboriginal and Torres Strait Islander people. However, the scheduled fee would also need to be increased to adequately reflect the true costs to service providers to ensure that all Aboriginal and Torres Strait Islander people have access.

We call on the government to adopt the same model applied to other Closing the Gap initiatives, such as access to pharmaceuticals, where there should be a no-gap model for all services. Increasing the scheduled fee to an appropriate level to enable all practices to utilise the bulk-billing incentive, which may then enable this to occur without incurring a loss.

Five appointments across all allied health services is insufficient for people with a chronic disease or at risk of chronic disease. Increasing the number of appointments for Aboriginal and Torres Strait Islander people who already carry a higher burden of care will go some way toward closing the gap. We acknowledge that further research needs to be done to determine the appropriate number of allied health sessions.

In the interim, we recommend that all limitations be removed and access to allied health services for Aboriginal and Torres Strait Islander people is uncapped and based on clinical need. We recommend the determination of clinical need is made by the treating allied health provider.

- **Proposed Solution:** Enhance utilisation of existing Chronic Disease Management items in the Medicare Benefit Scheme, by providing a no-gap physiotherapy consultation policy, similar to other Closing the Gap initiatives for Aboriginal and Torres Strait Islander people

PROPOSED SOLUTION: Research into underutilisation

It is clear there is a correlation between cost impacts and the utilisation of allied health services for those most in need, however there are multiple determinants, beyond cost, driving the inequity and gap.

We believe that high out-of-pocket fees associated with MBS allied health items, combined with low access to culturally safe service, underpins low utilisation. However, this area warrants further research to ensure future changes achieve the desired impact.

While there is a strong understanding of the barriers to accessing mainstream services such as general practice, it is less well understood for physiotherapy and other allied health services. Investments in further research are required to enable fully informed solutions to be developed and implemented.

We call on the government to further investigate the reasons for the low utilisation to ensure a comprehensive solution to fully address these barriers and improve access to vital allied health services. We recommend further economic modelling be undertaken to enable a fee schedule that truly represent the costs of high-quality service delivery.

- **Proposed Solution:** Provide funding for research into an evaluation of the barriers and enablers to appropriate utilisation of physiotherapy by Aboriginal and Torres Strait Islander people. **Cost estimate $150,000**

5.0 AGED CARE

Goal: To re-orient aged care services to evidence-based early interventions, such as physiotherapy, to improve the quality and safety of care provided

PROPOSED SOLUTION: Development of a 'train the trainer' model for Residential Aged Care providers

The Australian Pain Society report (2018) talks to the increasing burden of pain among elderly people in Australian residential aged care facilities (RACF), that pain is under-diagnosed and inadequately managed in RACF's and that pain is unnecessary and leads to serious decline in quality of life.

The National Pain Management Strategic Action Plan includes the following action item, under Goal 3: *To Develop a 'train the trainer' model for Residential Aged Care providers and distribution and dissemination of the existing guidance and management strategy documents.*

With appropriate funding the APA can develop a 'train the trainer' program for physiotherapists working in RACF's to upskill staff and carers in the complexity of chronic pain and effective prevention, diagnosis and management of pain.

The goal is to upskill Aged Care workers to recognise and properly assess the signs of pain, provide safe manual handling, posture and positioning and supervision of exercise programs. In addition, training would be provided to family and carers of residents to empower them to support and facilitate effective pain management techniques and to recognise pain and advocate for the resident in relation to their need for pain management.

It is anticipated that training is offered via face-to-face or video-link across all states and territories. There is also an option of videoconference training for physiotherapists in rural and remote services.

Proposed Solution: The Australian National Aged Care Classification (AN-ACC) system includes a new funding layer for consumer directed wellness and reablement care to be delivered by allied health

A number of systematic failures in the current aged care system are contributing to poor quality and safety for older people. These failures include, but are not limited to, inadequate funding for high quality care, including restorative and reablement care.

There is opportunity to improve the quality of care provided to older people by embedding restorative and reablement care as a key support service. The very nature of aged care support is that they must be considered in the broader social, economic, environmental and physical attributes of the individual's life – a key pillar of physiotherapy care.

We believe that an aged care model focussed on reablement, preventive and restorative care reflects safe, high quality and best practice care.

Reablement care focuses on strategies that maintain or improve functional ability and independence, through maximising an individual's intrinsic capacity and the use of environmental modifiers. Currently lacking in the Australian policy context is a true reablement focus and supporting best practice and quality outcomes for older Australians.

Physiotherapists consistently tell us that the current Aged Care Funding Instrument (ACFI) precludes physiotherapists from using funding for activities that will provide the best long term outcome (best value) for an older person.

We acknowledge that the proposed AN-ACC model is an improvement on the ACFI, which contains a perverse incentive for people to experience greater pain, disability and frailty to gain additional funding.

However, we are concerned that without a carved out financial incentive for preventive, reablement and restorative care in the AN-ACC, this vital component of quality care will not occur.

We believe the proposed AN-ACC funding model does not include adequate direct incentive to work with the older person to improve their ability and quality of life.

Reablement and restorative care should not be considered a 'nice to have' addition in the variable or fixed component of the funding model. Rather, it should be considered as an integral part of the proposal.

Physiotherapists working to the full scope of their practice, which includes restorative and reablement care, provide not only financial value, but also high quality care and improved life outcomes for the consumer.

In a consumer directed care model, where quality of life and wellbeing of an older person are at the centre, funding for restorative and reablement care is vital to ensure the best outcomes for each older person.

- **Proposed solution:** In the Australian National Aged Care Classification (AN-ACC) system include a new funding layer for consumer directed wellness and reablement care to be delivered by allied health.

Proposed Solution: Establish an Aged Care Workforce Steering Committee tasked with commissioning and evaluating research into best practice workforce models to ensure a viable, safe and sustainable aged care workforce

The APA is calling on substantial investment into workforce research to ensure the long term sustainability of the aged care workforce.

A sustainable workforce with the right skills mix to assess, care for, monitor and respond to the needs of ageing Australians is one of the keys to ensuring a safe and high quality aged care system. A holistic approach is required that addresses ageism, perceptions of working in the aged care sector, identifying best practice workforce models, ensuring career pathways and specialist geriatric training.

A workforce that is appropriately recruited, trained, remunerated and receives ongoing professional development, career advancement and recognition throughout their tenure will not only improve workforce satisfaction and lower staff churn, but also increase quality care delivered to older people.

There is no "one size fits all" model that can meet the diverse needs of our ageing population across our diverse communities. Tailored, flexible approaches addressing different cultures, backgrounds, health conditions and individual consumer desires are needed.

However, before these approaches are developed, the sector must share an understanding of best practice drawn from the in-depth data about appropriate skills mixes and staffing ratios that is currently lacking.

It is clear that there is little available data about best practice models and it is imperative that this shortfall in research is addressed.

At the APA we have implemented a number of peer and professional regulatory tools to support the profession in delivering high quality and safe care, such as the APA Code of Conduct. We want to see further expansion of resources such as these across service providers to prevent the mistreatment of people living in the community and residential aged care facilities.

It is likely that the true demand for the aged care workforce is yet to be realised nationally, as population demographics shift across Australia. We foresee an increasing demand for the aged care workforce in coming years, as the aged care sector responds to the challenges of changing consumer expectations, technologies and social circumstances.

As aged care demand increases, we are concerned that the aged care sector has been unable to achieve the creation of a stable 'backbone' of experienced staff.

There is an opportunity for the Government to develop a predictive model for aged care workforce supply and consumer demand. This would include differentiating consumer demand in residential aged care facilities and home and community care.

A transparent online data capture system that articulates rates of home care package use and fund utilisation would create a clearer picture of workforce supply and demand.

A map of the workforce 'market', including workforce distribution, skills and experience across Australia, charted against older demographics may help to address issues of the accessibility, timeliness, and availability of aged care workers.

Clearly articulating supply and demand for the workforce will help to improve system efficiency and, importantly, transparency for consumers and service providers, and improve the quality and level of support made available to older Australians based on their personal circumstances.

It is acknowledged that the aged care workforce is under resourced in a variety of ways, including staffing levels. This directly impacts the capacity across all care environments, including residential aged care facilities, community care providers and flexible care (such as Short-Term Restorative Care – provided in the community or residential

environments) to deliver preventive, restorative and reablement care.

As part of care delivery and planning, a sustainable workforce cannot be overlooked.

The aged care workforce must have an appropriate level of knowledge, skills and experience to appreciate the complexity of the people in their environment and provide support services appropriately.

Perception of the aged care workforce is important for decision making. New graduates will not be attracted to work with older people - it is generally believed to offer few development opportunities, even if this is not the case.

We know that working in aged care can be an immensely rewarding career choice. However, for this to be more broadly understood, it is critical that the aged care workforce is recognised professionally and financially for their contribution, and that these positions are sought after for these reasons.

- **Proposed solution:** Establish an Aged Care Workforce Steering Committee tasked with commissioning and evaluating research into best practice workforce models to ensure a viable, safe and sustainable aged care workforce.

2.0 ALLIED HEALTH LEADERSHIP AND INNOVATION

Goal: To understand and recognise the contribution of the allied health sector to health system and facilitate data driven future decision making

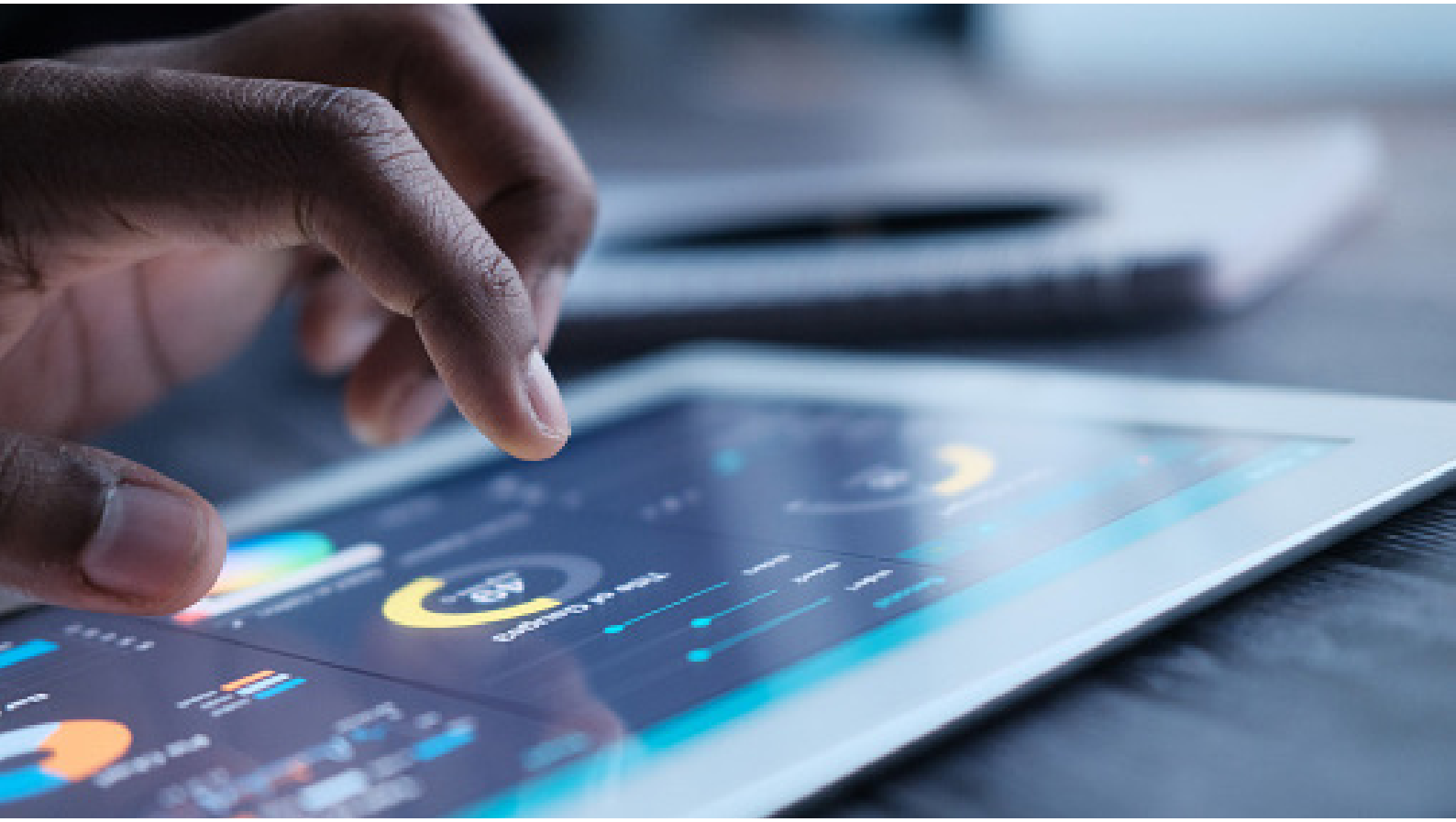
PROPOSED SOLUTION: Developing an Allied Health Workforce Dataset

A national allied health dataset will enable better workforce planning, could be used to identify areas of acute need, and will support economic analysis to provide transparency of value for funding and service delivery. It may also assist in directing the location of training hubs student clinical placements to shift distribution.

This will help to deliver health services where most needed, encourage the development of digital health solutions and is essential to underpin effective allocation of resources.

This data has a broader application and could also be used to identify a national minimum service access standard to enable Australians access to allied health professionals regardless of where they live.

- **Proposed Solution:** Develop an Allied Health Workforce Dataset that enables informed decision making and identifies opportunities for better workforce utilisation



Proposed Solution: Appointment of a Commonwealth Chief Allied Health Officer

We strongly support the recommendation of a dedicated Chief Allied Health Officer. We consider the positioning of this role within the Department to be critical, and include the need for a dedicated program of work with adequate resourcing to sit within the remit of the Chief Allied Health Officer.

We know the shortage of physiotherapists is a significant problem across the spectrum of primary, secondary and tertiary health services in rural and remote areas. Given there are significantly more preventable hospitalisations than in metropolitan areas, the introduction of programs to improve the distribution of the physiotherapy and allied health workforce is vital.

- **Proposed Solution:** Appoint a Chief Allied Health Officer to inform decision making within the department. **Cost $400,000**

APPENDIX

1.0 Early intervention physiotherapy services for people at risk of persistent pain

This service will be provided to a person by an eligible physiotherapist if:

- the service is provided to a person who has pain lasting less than 6 weeks
- the person is being managed by a medical practitioner who has identified that person as showing risk factors associated with prediction of non-recovery (high VAS, DASS or OMPQ scores)
- the person is referred to an eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and
- the person is not an admitted patient of a hospital nor enrolled in a pain management program at a tertiary institution; and
- the service is provided to the person individually and in person or via video consultation for rural and remote patients
- The initial consultation is of at least 45 minutes duration and includes:
- Use of psychosocial screening tools – Site specific outcome measures (e.g. DASH), PSFS, OMPQ
- Functional measures to demonstrate progression such as patient specific functional scales
- The follow-up consultations of at least 30 minutes duration and includes:
- Pain education
- Interventions targeted at addressing the barriers to recovery identified at the initial assessment
- Active strategies that encourage self-management
- after the first five (5) services, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c) outlining the baseline measures of biopsychosocial and functional parameters and provides written demonstration of how the barriers to recovery have been addressed, as well as progressions in these measures over time
- the person has been shown to have made demonstrable progress in the report mentioned in paragraph (g) but has not yet shown complete resolution, a further 5 sessions may be recommended by the medical practitioner mentioned in paragraph (c)
- In the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

These planned services are time limited being deliverable in up to ten planned sessions in a calendar year. Claims for this service may not exceed this maximum limit.

APPENDIX

2.0 Establishment of a pilot to evaluate the effectiveness of Medicare funded Telehealth consultations between medical specialists and physiotherapists in rural areas

The APA applauds the Australian Government's implementation of the telehealth scheme to help rural people access specialist care. Telehealth services have immense potential to overcome such barriers to treatment as physical distance from health facilities, lack of clinicians or specialists in a geographic area and lack of transportation.

Medicare funding is vital to make this type of consultation an accepted alternative to face to face services, and the APA believes more can be done to ensure that all patients needing specialist medical attention can access these consultations.

Despite having a distinct affinity with a number of medical specialists, physiotherapists are not eligible under Medicare rules to assist patients in consultations with such specialists as orthopaedic surgeons, or sport and exercise medicine specialists. The APA has already been told by rural members that metropolitan medical specialists have requested they consult via telehealth – specifically in the fields of orthopaedic surgery and paediatrics.

SOLUTION

In order to establish the scientific evidence base for the effectiveness and need for specialist medical services facilitated by physiotherapists, the APA proposes the establishment of a pilot program. 25 sentinel physiotherapy practices should be recruited to participate in a pilot. Grant funding should be provided to conduct the research, with a competitive tendering process used to establish the most clinical and cost effective procedure for the pilot.

KEY FEATURES

- Patients and physiotherapists located in ASGC-RA Categories 2 -5
- Patients of participating physiotherapists should be eligible to claim for Medicare items 2126, 2143, and 2195
- Patients eligible to claim Medicare as necessary on referral from the physiotherapist
- The type of medical specialists referred to by physiotherapists must be within their sphere of expertise. The APA expects that most commonly this will include but will not necessarily be limited to:
  - Orthopaedic Surgeons
  - Pain Specialists
  - Rehabilitation Physicians
  - Sports and Exercise Medicine Specialists
  - Neurologist
  - Paediatricians

COST

To ensure that the data collected is of high quality and is empirically relevant, the APA recommends that a pilot run for two years.

While growing, these costs are relatively low, and the APA estimates that the costs of a physiotherapy pilot to Medicare would be minimal, not exceeding $200,000 in the first year. In addition to the cost to Medicare for the telehealth item numbers the cost to run the evaluation project would be $1 Million.

OUTCOME

Telehealth consultations save time and money for patients in rural areas, and contribute to improved outcomes through earlier expert medical intervention. The pilot program will provide clear empirical evidence of the safety, efficacy and need for physiotherapists to support specialist telehealth consultations.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

The APA is the peak body representing the interests of Australian physiotherapists and their patients.

It is a national organisation with state and territory branches and specialty subgroups.

The APA represents more than 27,000 members who conduct more than 23 million consultations each year.

To find a physiotherapist in your area, visit **www.choose.physio**

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