



Feedback Survey

Application 1405 - MBS Item Number for Pulmonary Rehabilitation

Thank you for taking the time to complete this feedback form on a draft protocol to consider the options by which a new intervention might be subsidised through the use of public funds. You are welcome to provide feedback from either a personal or group perspective for consideration by the Protocol Advisory Sub-Committee (PASC) of MSAC when the draft protocol is being reviewed.

The data collected will be used to inform the MSAC assessment process to ensure that when proposed healthcare interventions are assessed for public funding in Australia, they are patient focused and seek to achieve best value.

This feedback form should take 10-12 minutes to complete.

You may also wish to supplement your responses with further documentation or diagrams or other information to assist PASC in considering your feedback.

Responses will be provided to the MSAC, its subcommittees and the applicant with responses identified unless you specifically request deidentification.

While stakeholder feedback is used to inform the application process, you should be aware that your feedback may be used more broadly by the applicant.

Please reply to the HTA Team

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*Your feedback is requested by **13 November 2015** to enable the collation of responses to be provided to PASC to consider during its deliberations.*

PERSONAL AND ORGANISATIONAL INFORMATION

1. What is your name?

Alex Lakani

2. Is the feedback being provided on an individual basis or by a collective group?

Collective group. Specify name of group (if applicable)

Australian Physiotherapy Association

3. What is the name of the organisation you work for (if applicable)?

N/a

4. What is your e-mail address?

alex.lakani@physiotherapy.asn.au



5. Are you a:
- a. General practitioner
 - b. Specialist
 - c. Researcher
 - d. Consumer
 - e. Care giver
 - f. Other (please specify)

Professional Association

MEDICAL CONDITION (DISEASE):

Patients with chronic lung disease

PROPOSED INTERVENTION:

A pulmonary rehabilitation (PR) program and pulmonary maintenance exercise (PME) program.

CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

- 1) Describe your experience with the medical condition (disease) and/or proposed intervention relating to the draft protocol?

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

Physiotherapists are trained to work with people with Chronic Obstructive Pulmonary Disease (COPD), bronchiectasis, interstitial lung disease, and lung cancer. These conditions reduce lung capacity, leave the large numbers of people with these serious, long term conditions feeling breathless. This in turn impairs quality of life and ability to stay physically active.

PR is vital in improving quality of life, managing symptoms, and reducing hospital admissions of patients with these chronic lung diseases.

The APA sets a high standard for professional competence and behaviour and advocates best practice care for clients. Physiotherapists are experts in assisting their patients to take an active approach to manage their rehabilitation and chronic conditions. They are primary contact professionals with excellent communication skills, and are best placed to provide PR and promote physical activity guidelines in a PME program.



- 2) What do you see as the benefits of this proposed intervention for the person involved and/or their family and carers?

Increasing access to PR programs will improve health outcomes

PR services that are available are provided primarily through the public sector in hospital out-patient and community health settings. Waiting lists can be high, understandably, people with severe conditions are prioritised. It has been reported to the APA however, that this has disadvantaged people with mild or moderate chronic lung disease as there is a paucity of programs available. Even on the more severe end of the scale, only 5-10% of patients COPD had accessed PR services and a majority of PR programs having waiting periods greater than 4 weeks and 37% greater than 2 months.

There has previously been no uniform provision and funding of these services in private practice and the APA firmly believes that the proposed listing of PR and PME programs on the MBS will significantly improve access to PR.

In addition to the access barriers created by waiting lists and scarcity of programs, only a very small number of people with chronic lung disease have a PR program close to their residence.

Increasing access to PR programs in primary care would reduce transport issues and help to improve compliance.

The MBS funding for PR in the primary setting will mean better patient management in a community setting with less reliance on hospital resources. Increasing access to PR for people with mild to moderate chronic lung conditions will increase the number of people who can benefit significantly.

PR is effective and has the potential to reduce the use of health resource

Benefits of Pulmonary Rehabilitation include^{1, 2}:

- Increases quality of life and Functional Exercise Capacity
- Reduces breathlessness
- Improves symptoms of anxiety and depression
- Decreases hospital admissions and length of stay
- Reduces hospital re-admissions post exacerbation
- Reduces mortality

There is a strong evidence-base which has been established by controlled clinical trials for effectiveness in improving quality of life, for example Puhan et al 2011, Cochrane systematic review on PR³.

Moreover, controlled trials have shown a decrease in health care resource use after rehabilitation, indicated by reduction in the number of hospitalisations and emergency department or doctors' visits in people with chronic lung disease. Both these outcomes are very important to patients and carers.



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- 3) What do you see as the disadvantages of this proposed intervention for the person involved and/or their family and carers?

The APA foresees no clinical disadvantages with the proposed intervention for the patients or their family and carers. An appropriate fee for the MBS service item numbers for PR and PME should improve overall access to this intervention which is a major barrier to its effectiveness.

If the rebate is set at an amount that is not sustainable in private physiotherapy practice however, a possible disadvantage for patients is the potential for the service to attract an unaffordable out of pocket cost.

Patients who would benefit from the proposed items are extremely sensitive to out of pocket costs. Because of this, it is extremely important that the level of the Medicare rebate be enough to make the provision of services financially sustainable in the private community setting.

- 4) How do you think a person's life and that of their family and/or carers can be improved by this proposed intervention?

In addition to the improved health outcomes as discussed above, the APA believes that the proposed Medicare items would allow for the establishment of a substantial number of services provided through private physiotherapy establishments.

A person's life and that of their family and/or carers would be improved by this intervention through better access to community-based programs which may be closer to patient's residence which in turn would help patients and carers access PR and PME.

- 5) What other benefits can you see from having this proposed intervention publicly funded on the Medicare Benefits Schedule (MBS)?

Pulmonary Rehabilitation will reduce potentially preventable hospital admissions^{4,5}

The proposed intervention will provide better access to evidence-based health care. There is a potential to decrease the pressure on the hospital based PR programs. It will also lead to reduced overall healthcare costs due to reduced hospital admissions.

A Western Australian study found that not only were hospitalisations reduced by 46% for patients admitted with a COPD exacerbation, the total length of stay was reduced by 62%.⁶

Another small study in a rural location had even more striking results. In this study, COPD patients who had undertaken a PR program had reduced hospital admissions and ED presentations by 95%, and also resulted in a 99% reduction in length of stay. These savings were the result of hospital admission reductions in just 29 COPD patients, saving the health service \$122,500 in a 12 month period.⁷



INDICATION(S) FOR THE PROPOSED INTERVENTION AND CLINICAL CLAIM

Flowchart of current management and potential management with the proposed intervention for this medical condition can be found on page 24.

6) Do you agree or disagree with the eligible population for the proposed intervention as specified in the proposed management flowcharts?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Why or why not?

The management flowchart for the proposed care of patients eligible for PR program group exercise is suitable. There is strong evidence for effectiveness of pulmonary rehabilitation for patients with these conditions, particularly for COPD, bronchiectasis and interstitial lung disease and growing evidence for lung cancer.

7) Do you agree or disagree with the comparator for the proposed intervention as specified in the current management flowchart?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Why or why not?

The comparator is reasonable as it reflects the current situation which is the absence of an available PR or PME program. There is a large unmet demand for PR program services due to the limited availability of programs, and the MBS support will fill a gap and provide access to a large number of potential patients.

8) Do you agree or disagree with the clinical claim (outcomes) made for the proposed intervention?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

Why or why not?



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The clinical claim demonstrates that the comparative effectiveness and safety of PR and PME compared to best care delivered by a GP. Strong evidence from Cochrane systematic reviews shows PR and PME programs^{8, 9, 10}:

- improve quality of life
- exercise capacity
- reduce hospital admissions and bed days
- decrease mortality.
- improved exercise capacity and tolerance
- reduced frequency of exacerbations
- Pulmonary rehabilitation has also been shown to be safe.

9) Have all associated interventions been adequately captured in the flowchart ?

- Yes
 No

If not, please move any misplaced interventions, remove any superfluous intervention, or suggest any missing interventions to indicate how they should be captured on the flowcharts. Please explain the rationale behind each of your modifications.

ADDITIONAL COMMENTS

10) Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed intervention?

Rebates must be sustainable

The APA emphasises that rebates must be at a level that is sustainable for physiotherapy private practices to deliver the proposed intervention.

Each year the APA conducts market research into the average cost of physiotherapy services in private practice. The latest research was conducted in 2014, and benchmarked mean, median and mode costs for an initial physiotherapy consultation and standard physiotherapy consultation. The full report is available from the APA, and can be provided on request.

The APA strongly recommends that the fee for the Medicare item for a Physiotherapy Assessment Consultation be based on this average rate charged for in private practice. This rate in 2014 was \$86¹¹, and should be increased in line with health inflation at the date of launch of PR and PMR rebates.

Patients who would benefit from the proposed intervention are extremely sensitive to out of pocket costs. Therefore, it is important that the level of the Medicare rebate be enough to make the provision of services financially sustainable in the private practice setting.



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The APA is also concerned that the fee for PME group service is very low, despite the physiotherapist being required to provide a similar service to the PR group service. In order to ensure that delivery is sustainable, the fee for this item should be at the same level as PR group service, i.e. raised from \$12.85 to \$25.00.

Accreditation of providers

The APA strongly agrees with the proposal that providers of the proposed intervention be currently registered with the Australian Health Practitioner Regulation Agency. This requirement along would ensure that the provider have current public liability insurance and scope of practice to provide exercise training and testing in the community.

Flexible training options are necessary

The APA agrees that the training requirements to deliver PR and PMR programs are appropriate.

We believe that restricting requirements to a particular program is problematic. To future proof this item we suggest the addition of wording that allows physiotherapists to complete other appropriate professional development that may be developed.

Entry points to PR must be appropriate

The APA strongly disagrees with the wording on the item stating the person is being “managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician)”.

This wording requires a patient to be managed by a general practitioner, and excludes the patients of respiratory physicians, rehabilitation physicians, general physicians and surgeons.

This exclusion places a significant barrier to access PR in the community, and the APA recommends that the wording be revised to say “referred by a specialist, consultant physician or GP” with referral forms amended to reflect this change.

11) Do you have any comments on this feedback form and process? Please provide comments or suggestions on how this process could be improved.

The APA has no comment on this question

Thank you again for taking the time to provide your valuable feedback.

If you experience any problems completing this on-line survey please contact the HTA Team

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References

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- ¹ Lacasse, Y., Goldstein, R., Lasserson, T. J., & Martin, S. (2006). Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochrane Database Syst Rev*, 4(4).
 - ² Nici, L., Donner, C., Wouters, E., Zuwallack, R., Ambrosino, N., Bourbeau, J., ... & Troosters, T. (2006). American thoracic society/European respiratory society statement on pulmonary rehabilitation. *American journal of respiratory and critical care medicine*, 173(12), 1390-1413.
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 - ⁵ Cecins, N.1., Geelhoed, E., & Jenkins, S.C., (2008) Reduction in hospitalisation following pulmonary rehabilitation in patients with COPD. *Australian Health Review* ;32(3):415-22.
 - ⁶ Ibid
 - ⁷ Rasekaba, T.M.1., Williams, E., Hsu-Hage, B. (2009) Can a chronic disease management pulmonary rehabilitation program for COPD reduce acute rural hospital utilization? *Chronic Respiratory Disease*. 6(3):157-63.
 - ⁸ Nici, L., Donner, C., Wouters, E., Zuwallack, R., Ambrosino, N., Bourbeau, J., ... & Troosters, T. (2006). American thoracic society/European respiratory society statement on pulmonary rehabilitation. *American journal of respiratory and critical care medicine*, 173(12), 1390-1413.
 - ⁹ Lacasse, Y., Goldstein, R., Lasserson, T. J., & Martin, S. (2006). Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochrane Database Syst Rev*, 4(4).
 - ¹⁰ Puhan, M. A., Gimeno-Santos, E., Scharplatz, M., Troosters, T., Walters, E. H., & Steurer, J. (2011). Pulmonary rehabilitation following exacerbations of chronic obstructive pulmonary disease. *Cochrane Database Syst Rev*, 10(10).
 - ¹¹ Millward Brown Australia (2014). Assessment of Market Rates for Physiotherapy Services. Melbourne, Australia.