AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

9 May 2014

Our ref: 140506-MR MATT

Mr Matt Crawshaw
Secretary
Community Affairs References Committee (Committee)

Via email: community.affairs.sen@aph.gov.au

Dear Mr Crawshaw

Re: Inquiry into the out-of-pocket costs in Australian healthcare

Thank you for the opportunity to comment on the terms of reference for the inquiry into the out-of-pocket costs in Australian healthcare.

The Australian Physiotherapy Association (APA's) response to the full terms of reference is included below:

(a) the current and future trends in out-of-pocket expenditure by Australian health consumers;

The APA acknowledges that there are a number of variables that impact on consumers' out-of-pocket expenses, including the type of cover, the actual fee for service and contractual arrangements between the provider and insurer. The table below compares the percentage change in fees for physiotherapy services, with CPI indexing for the thirteen year period from 2000 to 2013.

Year to	Average amount paid by patients for service	Percentage increase	Average rebate (payment by insurer) to patients per service	Percentage increase	Total cost per service	Percentage increase	Health CPI Index
Dec-00	$15.56		$23.65		$39.21		
Dec-01	$15.94	2.45%	$24.72	4.52%	$40.66	3.7	2.60%
Dec-02	$16.52	3.64%	$25.52	3.23%	$42.04	3.39%	6.60%
Dec-03	$17.38	5.20%	$25.19	-1.27%	$42.58	1.27%	6.90%
Dec-04	$19.22	10.56%	$25.54	1.37%	$44.76	5.12%	5.00%
Dec-05	$20.66	7.49%	$25.58	0.16%	$46.24	3.31%	4.20%
Dec-06	$22.20	7.45%	$26.15	2.22%	$48.35	4.56%	5.30%
Dec-07	$24.02	8.21%	$26.66	1.95%	$50.68	4.83%	4.10%
Dec-08	$25.79	7.36%	$27.36	2.61%	$53.14	4.86%	4.90%
Dec-09	$27.24	5.65%	$27.91	2.02%	$55.15	3.78%	4.70%
Dec-10	$28.29	3.86%	$28.48	2.04%	$56.77	2.94%	5.00%
Dec-11	$29.71	5.01%	$29.54	3.74%	$59.25	4.37%	3.60%
Dec-12	$31.28	5.28%	$31.28	5.89%	$62.56	5.59%	7.70%
Dec-13	$32.45	3.74%	$32.67	4.44%	$65.12	4.09%	4.40%

Table 1: *Percentage increase in physiotherapy rebate fees, average gap payments and costs 2000-2013 (PHIAC data).*

Table 1 demonstrates that total fees charged for physiotherapy services have steadily increased for the period 2000 to 2013. The incremental increase in patient out-of-pocket fees from year to year has been steady, with an average increase of 5.8% for the period. *This is really important*

It must be noted further that whilst the total cost per service for physiotherapy treatments has steadily continued to increase, the average rebates paid by insurers to patients has remained fairly constant in comparison. This trend is further evidenced by the data depicted in Figure 1 below.

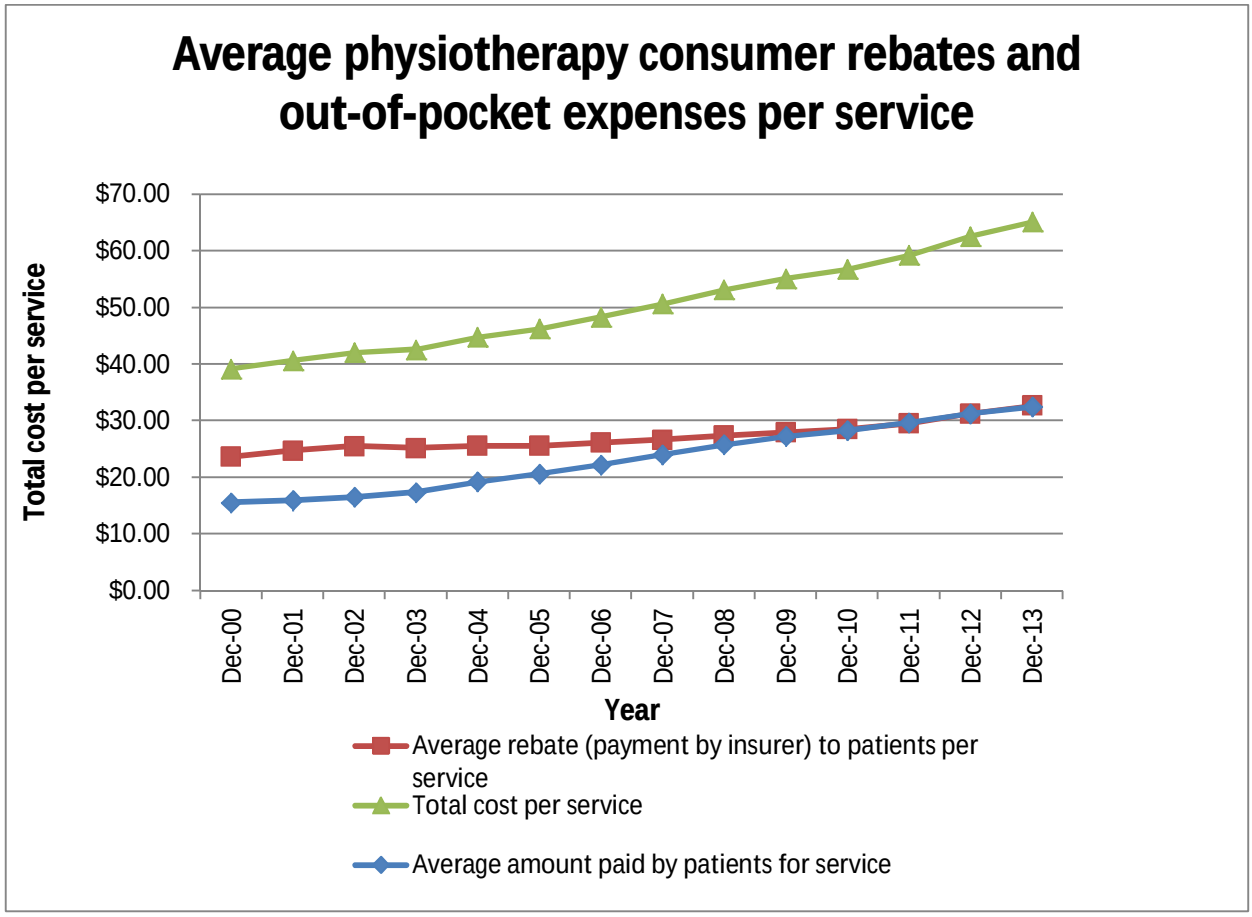

Figure 1: *Graph of average physiotherapy consumer rebates per total number of services and average out-of-pocket expenses (PHIAC data).*

The PHIAC data includes all private health insurers, including the rebates paid for patients to see the preferred providers of Medibank Private and BUPA. The majority of physiotherapists in private practice are not preferred providers of these funds. Consumers who are members of these two funds and who choose not to use or do not have access to these preferred providers have suffered a massive increase in gap payments over the past decade. A small survey of rebate and data conducted by the APA reveals that the average gap payment for services provided by non-preferred providers has more than doubled over the past decade. This is due to the average rebate increasing minimally for those patients who see non-preferred providers.

Over the past 13 years private health insurance rebates have failed to keep up with the cost of physiotherapy services. This trend is significantly worse for members of the major funds seeing non-preferred providers.

(b) the impact of co-payments on:
(i) consumers' ability to access health care, and
(ii) health outcomes and costs;

The APA understands that the Federal Government proposes to introduce a $6 co-payment to Medicare rebates for GP, pathology, diagnostic imagining and optometry services. In various media reports, this proposal is expected to save the Government in the vicinity of $1.7 billion per year.[i] Most recently, the National Commission of Audit has recommended a $15 co-payment for GP visits and Medicare services, which is estimated to generate up to $70 billion in annual savings.[ii]

A $6 co-payment would likely bring the Medical Benefits Schedule (MBS) more into line with the co-payments that apply for the Pharmaceutical Benefits Scheme (PBS). For PBS-listed medications, non-concession card holders pay $36.90 per script and concession-card holders pay $6 per script.

The APA is concerned however that the proposal might undermine the MBS rebate on GP items, as well as undermine the incentives for GPs to bulk-bill. Any co-payment (whether $6 or $15) would apply to comparatively minor and lower-cost health services such as GP visits but the APA is concerned that this measure could potentially restrict access to GP services for very vulnerable people, such as low-income families or Australians with chronic and complex conditions.

A GP can refer patients with a chronic or complex condition to a physiotherapist under Medicare's Extended Primary Care (EPC) plan for 5 visits a calendar year. A visit to an allied health provider such as a physiotherapist can cost between $80 and $100 per treatment session, on average. A patient is entitled to claim a partial Medicare refund for these visits. The APA believes that 5 treatment sessions for people with chronic and complex needs is woefully inadequate. In particular, rural and remote persons have poor access to the Medicare items as there is a dearth of private practitioners in these areas.

The APA believes that persons with complex and chronic conditions should receive lower levels of subsidised health care in the long term than persons with minor or short-term conditions. This results in an inequitable allocation of healthcare resources and there is nothing to suggest that introducing co-payments would lead to better health outcomes for Australians overall. Moreover, the APA is concerned that co-payments might perversely disadvantage those most in need of ongoing healthcare who incur crippling costs in the long run to fund necessary healthcare treatments.

(c) the effects of co-payments on other parts of the health system;

As above.

(d) the implications for the ongoing sustainability of the health system;

The APA believes that introducing co-payments would further increase consumer out-of-pocket costs. Though recent media reports estimate that this measure is expected to save the Government in the vicinity of $1.7 billion per year – the APA believes that the increased costs to the consumer outweigh the potential cost-savings to Medicare. The APA contends that there are more effective ways to save costs to Medicare than to introduce either a $6 co-payment or the astronomically high $15 co-payment.

The APA recently commissioned The Deeble Institute to produce an economic report that shows the cost savings associated with a potential change in the MBS to provide rebates for medical specialist consultations on referral from a physiotherapist.

The report details significant savings to Medicare and identifies out-of-pocket savings for ordinary Australians.

When a physiotherapist is presented with an injury, condition or co-morbidity that is outside their scope of practice, or with a patient who needs ongoing care and management, they refer the patient to a GP. Patients referred to their GP are supported by MBS funding.

Physiotherapists also see patients with conditions that are within scope of the physiotherapy profession but whose condition is such that consultation with a medical specialist is needed.

Due to funding barriers within the MBS, physiotherapists often need to refer to a GP even when they have assessed that a medical specialist is the most suitable health professional. The physiotherapist will ask the GP to fill out a referral form for the relevant medical specialist. This necessitates a GP consultation that is driven purely by funding structures.

This can delay specialist treatment, utilises the time of busy GPs and costs the MBS scheme millions of dollars. The patient and the MBS would be well-served if the patient received a rebate for referral directly to the most appropriate medical practitioner, be it a GP or a medical specialist.

The APA believes that it is entirely appropriate that GPs are the primary source of referrals to medical specialists. They are the group that see the vast majority of patients, and they are the practitioners

who are highly trained in generalist medical treatment. The physiotherapy profession does not claim to have this broad ranging training but the APA contends that physiotherapists are experts in their field of practice.

Unfortunately, the lack of recognition of this expertise through the MBS is costly to the Federal Government and to patients.

The Deeble Institute concluded that if patients directly referred to specialist medical practitioners by all physiotherapists could receive Medicare rebates, the cost-savings would be as follows:

Savings to Medicare:	$13,641,362
Savings to patients:	$2,175,407
Total savings:	$15,816,769

To ensure the best use of physiotherapists within the health system, the MBS should be changed to facilitate referral to medical specialists within the physiotherapist's scope of practice. A change to the MBS requirement for a GP referral would allow physiotherapists to directly refer to the most suitable medical practitioner and would be safe, cost-effective and reduce red tape for patients, physiotherapists and GPs.

(e) key areas of expenditure, including pharmaceuticals, primary care visits, medical devices or supplies, and dental care;

No comment.

(f) the role of private health insurance;

As outlined at point (a) above, consumer out-of-pocket expenses have increased over the past decade. The APA believes that the introduction of co-payments would only serve to increase the existing burden of out-of-pocket expenses for consumers.

The APA is aware that private health funds generally pay below market rates for initial and standard consultations and that some health funds do not allow for complex or extended consultations. If a particular health fund refuses to recognise an extended consultation and a patient presents with multiple injuries or a particularly complex condition, the physiotherapist has no option but to ask such a patient to attend twice for a standard consultation. It is the only way to treat a patient of complex needs, if extended consultations are not permitted under the fund rules. Seeing a patient twice and charging a standard consultation should not present a problem specifically if one standard consultation appointment could be booked within a day or two of the next standard consultation. In reality however, a busy practice often does not permit for such neat scheduling and two standard consultations may be spaced quite far apart, creating a hiatus in treatment and impairing early recovery.

The scenario described in the paragraph above is clearly not ideal, as the patient has to pay twice to attend an allied health practitioner's office and incurs further out-of-pocket expenses. If co-payments are introduced on top, patients would face increasing out-of-pocket costs for treatment services not covered by private health insurance. This is especially of concern if a patient elects to see a non-preferred provider because the patient already incurs higher out-of-pocket costs for seeing a provider of their choice.

Private health insurance policies often contain limitations on rebates for primary healthcare, and this increases out-of-pocket expenses. The APA submits that any co-payments would only increase the existing burden of out-of-pocket expenses for consumers.

(g) the appropriateness and effectiveness of safety nets and other offsets;

The Medicare Safety Net provides an additional benefit for eligible services, in addition to the standard Medicare benefit, once patients reach the threshold. The advantage of the safety net is that doctor visits and various ultrasounds, tests and biopsies could cost patients less once they reach the Medicare Safety Net threshold. The safety net covers a range of out-of-hospital doctor visits, such as GP and specialist consultations and tests listed on the MBS including blood tests, CT scans, tissue biopsies, ultrasounds and x-rays. Physiotherapy services are not covered under the MBS.

The APA submits that there is little evidence that the safety net has resulted in a reduction in consumer out-of-pocket expenses. The Extended Medicare Safety Net (EMSN) review report of 2009 reported that for every dollar spent on the EMSN in 2008, providers received 43 cents and patients received 57 cents. In some specialty areas 78 percent of total funding for the safety net was paid out in doctor's income, as doctors increased their fees leaving consumers with only 22 percent of benefits.[iii]

The safety net does not cover physiotherapy services. This is because Medicare-funded access to physiotherapy is limited to people with complex and chronic diseases. The APA submits that an effective safety net should cover all forms of health care and not just those services provided by medical doctors. The APA submits that there needs to be a single and comprehensive safety net for all health care expenses which should include physiotherapy and other allied health services. Patient attendance at a physiotherapist may be necessary for recovery, compared with the startling statistic that over 30% of the funding for the EMSN is used on private obstetric services.[iv] Obstetric services represent a once-off expense and there is a public hospital alternative to attending a private obstetrician. Clearly, funding could be better used to cover necessary allied health services and the APA suggests that it may be even extended to essential health care devices and non-prescription medicines.

The APA submits that the Medicare safety net should provide a comprehensive safety net for all health care expenses, including allied health services that target persons most in need of assistance and access to healthcare.

(h) market drivers for costs in the Australian healthcare system; and

No comment.

(i) any other related matter.

No comment.

Yours faithfully,

Marcus Dripps
President

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[i] Canberra Times. (2014). Co-payment plan is no mortal blow against Medicare (article dated 12 March 2014). Available at: http://www.canberratimes.com.au/comment/copayment-plan-is-no-mortal-blow-against-medicare-20140311-34klc.html

[ii] Medical Observer. (2014). *$15 co-payment recommended by Commission of Audit report (article dated 1 May 2014).* Available at: http://www.medicalobserver.com.au/news/15-copayment-recommended-by-commission-of-audit-report

[iii] Centre for Health Economics Research and Evaluation. (2009). Extended Medicare Safety Net: Review Report 2009, page 6 (VI). Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/Review_%20Extended_Medicare_Safety_Net/$File/ExtendedMedicareSafetyNetReview.pdf

[iv] Ibid.