Exercise & Sports Science Australia submission to the Senate Standing Committees on Community Affairs

Value and affordability of PHI and out-of-pocket medical costs

Alex Lawrence
Policy and Advocacy Officer
Exercise & Sports Science Australia

Anita Hobson-Powell
Chief Executive Officer
Exercise & Sports Science Australia

28th July 2017

Thank you for the opportunity to submit feedback to help inform the *Senate inquiry: Value and affordability of PHI and out-of-pocket medical costs.* Exercise & Sports Science Australia (ESSA) is a professional association representing over 6,000 members, including university qualified accredited exercise scientists, accredited sports scientists and accredited exercise physiologists (AEPs). AEPs are recognised allied health professionals who provide clinical exercise interventions aimed at primary and secondary prevention; managing sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness. The following comments are for your consideration and address the following Terms of Reference:

1. The effect of co-payments and medical gaps on financial and health outcomes

The link between cost, attendance and poorer health outcomes

It is well acknowledged that cost-of-treatment is a barrier to accessing health services regardless of health status[1]; however, people living with a chronic health condition are more likely to skip treatment due cost than other cohorts[1]. Increasing out-of-pocket expense results in reduced attendance rates, which is associated with poorer health outcomes and a greater burden on the Australian economy[2].

ESSA recommends that decision-makers, where possible, adopt a position to reduce out-of-pocket expenses for those who are socioeconomically disadvantaged.

Cost. High out-of-pocket expense is a problem in Australia. For example, people living with a respiratory disease, such as chronic obstructive pulmonary disease, experience 109% higher out-of-pocket healthcare expenditure than those with no health condition, $1640 compared to $660 per year respectively[1]. Out-of-pocket expense for other chronic health conditions are just as concerning[1]:

Chronic disease	Average out-of-pocket expenditure per year
Arthritis	$1220
Cancer	$810
Mental illness	$1350
Diabetes	$1220
Heart disease	$890
Hypertension	$1030
High cholesterol	$1420

Attendance. Simply put, the higher the associated out-of-pocket expense for treatment, the more likely people are to forego healthcare. Highlights from a recent senate inquiry into out-of-pocket health expenditure in Australia included:

- the Australian Bureau of Statistics reports that approximately 1.8million Australians avoid seeking treatment each year due to cost
- the National Health Performance Authority reports that between 3–14% of adults avoid seeking medical treatment due to cost
- according to the Consumers Health Forum of Australia nearly half of Australians identified *cost* as a contributing factor to delays in seeing a medical practitioner[2].

Health outcomes. While there is a significant amount of research supporting the link between low attendance to general practice appointments and poor health outcomes (similar findings also exist for medication adherence)[3], comparative research for allied health professionals is missing. However, there is a myriad of research that supports improving access to allied health professionals results in favorable improvements in health outcomes[4].

The financial and economic implications

A significant proportion of Australians (75%) experience financial hardship while managing their illness, including being unable to pay for medical or dental expenses, medication, rent/mortgage and utility bills[5].

ESSA recommends that when unavoidable, out-of-pocket expense should be *invested* in evidence-based care.

In 2016, ESSA commissioned Deloitte Access Economics to identify the financial investment associated with engaging the AEP workforce from the perspective on the consumer[6]. Deloitte Access Economics identified that exercise interventions delivered by AEPs are efficacious and highly cost effective for Australians living with complex chronic disease. The net benefit per person per year, include:

- **$2,820** for people living with type 2 diabetes
- **$5,467** for people living with depression
- **$7,606** for people living with cardiovascular disease
- **$6,629** for people living with chronic obstructive pulmonary disease
- **$241** for people living with asthma.

On average the overall benefit for consumers receiving AEP exercise interventions is estimated to be $6,562, with a net benefit of $5,938 (overall benefit minus the cost of treatment), benefit to cost ratio of 10.5 (for every AUD spent the consumer will receive a $10.5 return) and approximately 25% of direct out-of-pocket expenses saved[6].

In addition to consumer savings, improving access to AEPs has significant implications for the Australian economy. A summary of the benefits and costs of AEP interventions per person, for the conditions analysed by Deloitte in their 2015 report are outlined in the table below. Deloitte also identified that clinical exercise interventions were also cost effective for chronic back pain, osteoarthritis and rheumatic diseases[7].

Estimated benefits and costs of AEP interventions per person						
Condition	**Benefits ($)**				**Costs ($) (E)**	**BCR**
	Health system (A)	**Productivity & other financial (B)**	**BoD (C)**	**Total wellbeing (D=A+B+C)**		
Pre-diabetes	1,977	1,520	2,617	6,115	580	6.0ˆ
Type 2 diabetes	5,107	NE	2,860	7,967	580	≥8.8 ˆ
Mental health (depression)	330	1,909	NE	2,239	824	2.7 ˆ
Chronic disease (cardiovascular)	NE	NE	11,847	11,847	1,903	6.2

Note: BoD is 'burden of disease', NE is 'not estimated due to lack of available data', ˆ BCRs (Benefit to Cost Ratio) for pre-diabetes, type 2 diabetes and mental health (depression) are reported as the ratio of financial benefits (health system and lost productivity savings) to costs. The BCR for chronic disease is relative to the burden of disease. BCRs which contain NE elements are reported on a 'greater than or equal to' basis, as it is assumed that the NE components would add to the benefits. Source: Deloitte Access Economics (2015)

2. Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements

Misrepresentation of services

Presently, many private health insurance policies commonly—and incorrectly—categorise AEP services as a sub-category of natural/alternative therapy.

In 2006, AEPs were included by Medicare Australia as an allied health provider under the Enhanced Primary Care Program (now the Chronic Disease Management Program). AEPs have since become the fifth most utilised AHP—a testimony to the recognition of AEP interventions as a cornerstone of the allied health sector [8], the high benefit to low risk associated with exercise[9], and exercise being an acceptable (little stigma associated with exercise) intervention to consumers[6-7].

Furthermore, in 2007 the Department of Health and Ageing released the Quality Assurance Requirements for Privately Insured Services[10]. The framework identified that "the exercise physiology industry meets all of the requirements of an allied health profession that is eligible for the provision of health insurance benefits"[10].

AEPs are acknowledged as an allied health profession in section 12 of the Private Health Insurance (Health Insurance Business) Rules 2013[11]. Yet several private health insurance policies catagorise exercise physiology under naturopathic, alternative or complementary therapies, this is misinformative and misrepresentative.
ESSA recommends that **AEPs should not be classified in the natural, alternative or complementary therapies. Many complementary therapies have limited evidence for the efficacy of their treatments, which is not the case for exercise physiology.**

Product design and exclusions

Managed-care remains a real problem within PHI extras policies. For example, the scope of benefits available to PHI members represent "general-consumer-demand" as opposed to letting individuals decide for themselves. As a result, PHI members are often required to purchase more comprehensive cover to meet their basic needs.

Exercise is fundamental to chronic disease prevention and management, yet AEPs (i.e. professionals with the highest level of training for prescribing exercise) are frequently under-represented or excluded in PHI polices, lack parity with other AHPs and are inappropriately classified under "naturopathic" and "alternative" therapies. Research supporting AEP interventions, as appraised by the National Health and Medical Research Council (NHMRC) evidence hierarchy rating, is available for the following conditions:

- cardiovascular disease (ischemic heart disease[9,12], post-acute myocardial infarction[9, 12], chronic heart failure[13], peripheral arterial disease[14], hypertension[15])
- pulmonary disease (asthma[16], chronic obstructive pulmonary disease[12], cystic fibrosis[17])
- metabolic disease (diabetes mellitus[18], dyslipidemia[12], impaired glucose tolerance[12] obesity[19])
- musculoskeletal disease (arthritides[18-21], osteoporosis/osteopenia[22-23], acute and/or chronic musculoskeletal injury)
- neurological disease (acquired brain injury, multiple sclerosis[24], Parkinson's disease[25], spinal cord injury[26], stroke[27], cerebral palsy[28])
- mental health[9]
- cancer[29]
- aged care[30]
- kidney disease[31].

Access to evidenced-based health services—such as AEPs—should be a basic health right and not restricted to only those that can afford top tier policies.

ESSA recommends PHI follow contemporary patient-driven models of care and empower their members to choose the services they need. This can be achieved by regulating the total annual limits across each level of cover, but removing any restriction on the type of service someone can access.

References

1. Callander, E.J., Corscadden, L., and Levesque, J.F. (2016) Out-of-pocket healthcare expenditure and chronic disease: do Australians forgo care because of the cost? *Australian Journal of Primary Health, 23*(1) 15-22.
2. Parlemant of Australia (2014) Out-of-pocket costs in Australian healthcare. Retrieved 14/06/2017, from http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare/Report
3. Williamson, A.E., Ellis, D.A., Wilson, P. (2017) Understanding repeated non-attendance in health services: a pilot analysis of administrative data and full study protocol for a national retrospective cohort. *British Medical Journal*, 7.
4. Services for Australian Rural and Remote Allied Heath (2015) The impact of allied health professionals in improving health outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke. Retrieved 14/06/2017, from http://sarrah.org.au/search/node?page=1
5. Jeon, Y., Essue, B., Jan, S., Wells, R., and Whitworth, J.A. (2008) Economic hardship associated with managing chronic illness: a qualitative inquiry. BMC Health Services Reseaerch, 9(182).
6. Deloitte Access Economics. (2016). Value of accredited exercise physiologists to consumers in Australia. Canberra.
7. Deloitte Access Economics. (2015). Value of Accredited Exercise Physiologists in Australia. Canberra.
8. Medicare Australia Item number Statistics (http://www.medicareaustralia.gov.au/statistics/mbs_item.shtml)
9. Soan, E.J, Brownie, S.M., Hills, A.P. (2014). Exercise physiologists: essential players in interdisciplinary teams for non-communicable chronic disease management. Journal of Multidisciplinary Healthcare, 7: 65-68.
10. Private Health Insurance (Health Insurance Business) Rules 2013. Retrieved from http://www.comlaw.gov.au/Details/F2013L02159/Html/Text#_Toc372124281
11. Commonwealth Department of Health and Ageing. Private Health Insurance: Proposal for Quality Assurance Requirements for Privately Insured Services. http://www.pandoleon.com/massageaustralia/documents/features3rdcol/PrivateHealthInsuranceComplete.pdf
12. US Department of Health and Human Services. (2015). Physical Activity and Health A Report of the Surgeon General Executive Summary. Atlanta, Georgia.
13. Pederson, B.K., & Saltin, B. (2006). Evidence for prescribing exercise as therapy in chronic disease. Scandinavian Journal of Science and Medicine in Sport, 16(1): 3–63.

14. Selig, S.E., Levinger, I., Williams, A.D., Smart, N., Holland, D.J., Maiorana, A., Green., D.J., & Hare., D.L. (2010). Exercise & Sports Science Australia Position Statement on exercise training and chronic heart failure. Journal of Science and Medicine in Sport, 13: 288–294

15. Askew, C.D., Parmenter, B., Leight, A.S., Walker, P.J., & Golledge, J. (2014). Exercise Sports Science Australia (ESSA) position statement on exercise prescription for patients with peripheral arterial disease and intermittent claudication. Journal of Science and Medicine in Sport, 17 (6): 623–629.
16. Sharman, J.E., & Stowasse, M. (2009). Australian association for exercise and sports science position statement on exercise and hypertension. Journal of Science and Medicine in Sport, 12(2): 252-257. doi: 10.1016/j.jsams.2008.10.009.
17. Bradley, J., & Moran, F. (2008). Physical training for cystic fibrosis. Cochrane Database Systematic Review, 23(1). doi: 10.1002/14651858.CD002768.
18. Hordern, M.D., Dunstan, D.W., Prins, J.B., Baker, M.K., Singh, M.A., & Coombes, J.S. (2012). Exercise prescription for patients with type 2 diabetes and pre-diabetes: a position statement from Exercise and Sport Science Australia. Journal of Science and Medicine in Sport, 15(1): 25-31.
19. Shaw, K.A., Gennet, H.C., O'Rourke, P., & Del Mar, C. (2006). Exercise and overweight and obestity. Cochrane Database Systematic Review, (4), Art No. CD003817.
20. Bennell, K.L., & Hinman, R.S. (2011). A review of the clinical evidence for exercise in osteoarthritis of the hip and knee. Journal of Science and Medicine in Sport, 14: 4–9.
21. Fransen, M., McConnell, S., Harmer, A.R., Van der Esch, M., Simic, M., & Bennell, K.L. (2014). Exercise for osteoarthritis of the knee. Cochrane Database Systematic Review.
22. Nikander, R., Sievänen, H., Heinonen, A., Daly, R.M., Uusi-Rasi, K., & Kannus, P. (2010). Targeted exercise against osteoporosis: A systematic review and meta-analysis for optimising bone strength throughout life. BioMed Central, 21(8): 8-47.
23. Howe, T.E., Shea, B., Dawson, L.I., Downie, F., Murray, A., Ross. C., Harbour, R.T., Caldwell, L.M., & Creed, G. (2011). Exercise for preventing and treating osteoporosis in postmenopausal women. Cochrane Database Systematic Review, 6(7). doi: 10.1002/14651858.CD000333.
24. Rietberg, M.B., Brooks, D., Uitdehaag, B.M., & Kwakkel, G. (2005). Exercise therapy for multiple sclerosis. Cochrane Database Systematic Review, 25(1).
25. Prodoehl, J., Rafferty, M.R., David, F., Poon, C., Vaillancourt, D.E., Comella, C.L., Leurgans, S.E., Kohrt, W.M., Corcos, D.M., & Robichaud, J.A. (2015). Two-year exercise program improves physical function in Parkinson's disease: the PRET-

PD randomized clinical trial. Nurorehabilitation and Nural Repair, 29(2):112-122. doi: 10.1177/1545968314539732.

26. Neekfkes-Zonneveld, C.R., Bakkum, A.J., Bishop, N.C., Van Tulder, M.W., & Janassen, T.W. (2015). Effect of Long-Term Physical Activity and Acute Exercise on Markers of Systemic Inflammation in Persons With Chronic Spinal Cord Injury: A Systematic Review. Physical Medicine and Rehabilitation, 96(1): 30–42.
27. Saunders, D.H., Sanderson, M., Brazzelli, M., Greig, C.A., & Mead, G.E. (2011). Physical fitness training for stroke patients. Cochrane Database Systematic Review, 9(11). doi: 10.1002/14651858.CD003316
28. Maltais, D.B., Wiart, L., Fowler, E., Verschuren, O., & Damiano, D.L. (2014). Health-related physical fitness for children with cerebral palsy. Journal of Child Neurology, 29(8): 1091-100. doi: 10.1177/0883073814533152.
29. Speck, R.M., Courneya, K.S., Mâsse, L.C., Duval, S., & Schmitz, K.H. (2010). An update of controlled physical activity trials in cancer survivors: a systematic review and meta-analysis. Journal of Cancer Surviv.orship, 4(2): 87-100. doi: 10.1007/s11764-009-0110-5.
30. Paw, M.J., van Uffelen, J.G., Riphagen, I., & van Mechelen, W. (2008). The functional effects of physical exercise training in frail older people : a systematic review. Sports Medince, 38(9): 781–793.
31. Smart, N.A., Williams, A.D., levinger, I., Selig, S., Howden, E., Coombes, J.S., & Fassett, R.G. (2013). Exercise & Sports Science Australia (ESSA) position statement on exercise and chronic kidney disease. Journal of Science and Medicine in Sport, 16(5): 406-411.