EXERCISE & SPORTS SCIENCE AUSTRALIA

ESSA Submission:

Senate Select Committee on Health Terms of Reference

"Australia needs to expand its allied health workforce and improve access to services that provide physical activity, weight loss and healthy nutritional advice and support."
National Preventative Health Task Force, 2014.

04 September, 2014
Contact: Katie Williams (ESSA Industry Development Officer)

EXERCISE & SPORTS SCIENCE AUSTRALIA

1. The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

The Australian hospital health system is under substantial pressure and must undergo significant transformation to meet rapidly rising population healthcare demands. Increasing access to acute hospital services, particularly for individuals with chronic and complex conditions, is not sufficient to address this problem[1]. Rather, purchasing framework priorities need to facilitate increased support of chronic disease management within the hospital setting.

Evidence supports the role of Accredited Exercise Physiologists (AEPs) in tertiary and community health settings as allied health professionals and experts in exercise prescription for the prevention and management of many chronic diseases and injuries. AEP interventions achieve significant cost savings through accelerating patient flow, reducing avoidable hospitalisations and readmissions, increasing self-management and improving continuity of care. However, currently the specialties of the AEP workforce are not being engaged to its full potential.

KEY POINT: The Commonwealth must increase focus on addressing key modifiable determinants of avoidable hospitalisation and readmission. Increased engagement of allied health professionals (AHPs), such as AEPs, within the hospital system will optimise patient care and achieve significant Commonwealth cost savings.

2. The impact of additional costs on access to affordable healthcare and the sustainability of Medicare

It is well documented that people with lower socio-economic status are at increased risk of chronic disease, largely attributed to a lack of health education and increased lifestyle risk factors. ESSA is very concerned that introducing GP co-payments will negatively impact patient access to affordable healthcare, particularly for low income earners and patients with chronic disease.

It has already been widely reported that introduction of co-payments will result in patients significantly reducing visits to their General Practitioner due to the increased out of pocket expense. We anticipate that this will result in a significant increase to the burden of chronic disease in Australia, resulting from more patients failing to receive required health care, exacerbation of existing health conditions and comorbidities, and more high risk patients not being identified until their health has deteriorated to disease state. This may also increase potentially preventable hospital admissions and patient presentation to hospitals for non-urgent care.

KEY POINT: ESSA acknowledges the current Commonwealth health system costs are unsustainable, and opportunities for cost-savings must be sought. However, we contend that introducing GP co-payments is not the answer. Rather, significant cost savings can be achieved through improving integration and coordination of Medicare services (see point 6).

3. The impact of reduced Commonwealth funding for health promotion, prevention and early intervention

The World Health Organisation predicts by the year 2020 chronic disease will account for almost three quarters of all deaths[19]. People with chronic health conditions often develop multiple co-morbidities, using health services and medicines frequently and over extended periods of time. Increasing Commonwealth investment in health promotion, primary health care and prevention is critical in order to reduce hospitalisations, readmissions and patient length of stay, reducing the unsustainable rate of healthcare spending.

In Australia, chronic disease is the leading cause of morbidity. Approximately 48% of Australians have at least one chronic health condition, attributing to more than half of all potentially preventable hospitalisations (PPHs)[2]. The absence of evidence-based preventative measures or lack of timely access to primary health care can precipitate acute exacerbation of chronic health conditions resulting in PPHs[3].

Furthermore, ~32% of Australia's total burden of disease can be attributed to modifiable risk factors[4]. Specifically, low cardiorespiratory fitness, due to inadequate physical activity, has the greatest contribution to all-cause mortality over and above obesity, hypertension, smoking, high cholesterol and diabetes[5].

KEY POINT: ESSA requests greater Commonwealth focus on well-planned and funded health promotion and disease prevention programs to address population risk factors, such as physical inactivity and overweight/obesity.

KEY POINT: ESSA requests re-instatement of funding for Accredited Lifestyle modification programs (LMP) that ceased in 2011.

The LMP allowed at-risk people access to a Medicare rebateable health intervention to prevent development of Type 2 Diabetes. ESSA requests this program expands to allow LMP referral for all people at-risk and with chronic health conditions. Evidence unequivocally demonstrates the power of group services in the ability to change behaviour and facilitate lifestyle modification.

Australia is facing a health crisis, whereby 3.3 million Australians are expected to have Type 2 Diabetes by 2031 [6] and health expenditure for Type 2 Diabetes is projected to increase by 520% between 2003-2033[7].

Current eligibility criteria for the 'Medicare Allied Health Group Services for patients with type 2 diabetes' requires disease diagnosis. However, by this stage individuals are reliant on pharmaceutical intervention, and have many associated co-morbidities including cardiovascular and peripheral vascular disease. Currently, ~>1 million Australians have pre-diabetes, with 5-10% annual incidence of developing diabetes compared to ~1% in the general population[9].

In these patients who are not yet dependent on pharmaceutical intervention, lifestyle interventions are effective in preventing progression to type 2 diabetes, simultaneously reducing associated comorbidities and risk factors [8,]10, 11].

KEY POINT: ESSA requests expansion of the eligibility criteria for 'Allied Health Group Services under Medicare for patients with Type 2 Diabetes' to allow access for people diagnosed with pre-diabetes. This will ensure the progression of pre-diabetes to diabetes is dramatically reduced, and the subsequent unsustainable and alarming rate of healthcare expenditure associated with Diabetes is reduced.

4. The interaction between elements of the health system, including between aged care and health care

Effective coordination and integration of health care services is a key predictor to hospitalisation of patients with chronic disease[12]. For example, during hospitalisation older people experience significant functional decline, loss of independence, decreased quality of life, and an increased rate of readmission [13-15]. Further, up to 46% of people experience one or more falls during their hospitalisation, increasing length of stay and associated costs[2].

KEY POINT: Hospitals need to adopt innovative transitional care strategies for patients into the community setting to reduce adverse health outcomes.

Specifically, an AEP community exercise intervention positively influences primary outcomes such as emergency health service use and functional ability and secondary outcomes such as health related quality of life, patient satisfaction and cost effectiveness [10, 16, 17].

KEY POINT: Engaging allied health professionals, such as AEPs, in the hospital and community health setting facilitates superior integration and continuity of care for people with chronic disease during their transition from hospital inpatient back into the community.

The current and projected state of online technology means that health consultations which largely involve the exchange of information can be satisfactorily carried out over the internet. This was validated by the *2010 Telehealth for Aged Care Report* demonstrating that older Australians

participating in Telehealth may be able to stay in their homes for longer, rather than entering residential aged care facilities.

KEY POINT: ESSA requests that existing provisions under Telehealth should be expanded to include all allied health professionals to optimise timely access and continuity of health care.

5. Improvements in the provision of health services, including Indigenous & rural health

One third of Australia's population live outside major cities, with many rural and remote communities facing a significant health disadvantage, poorer health outcomes and reduced access to health services than their metropolitan counterparts[5]. This is demonstrated by the fact that these populations have a ~10% higher rate of mortality and increased prevalence of certain chronic diseases such as mental illness and coronary artery disease[17].

KEY POINT: ESSA supports the continuation of work done by Health Workforce Australia (HWA) in identifying and implementing reforms to improve equitable allocations of the health workforce to rural and remote regions. Whilst we support this fundamental goal to improve health care system access, ESSA contents that the skill sets of each of AHPs need to be optimised, rather than just looking at AHPs as one amorphous group.

HWA's Aged Care Workforce Reform Program and Expanded Scopes of Practice Program have been instrumental in redesigning jobs, increasing flexibility of job roles and facilitating innovative team approaches to care.

KEY POINT: Whilst ESSA supports AHPs working with an expanded scope of practice, we do not support AHPs developing a below average ability on a large number of clinical skills (as generalists), as this will negatively affect health care service quality.

Telehealth video consultations have been an effective strategy in addressing this inequality in health care access and subsequent adverse health outcomes in rural and regional populations. However, unfortunately Telehealth consultations are currently limited to specialists and selected health care professionals.

KEY POINT: ESSA requests that existing provisions under Telehealth should be expanded to include all AHPs, such as AEPs.

Enabling AEPs to provide MBS Items 10953 and 81315 to eligible remote/ regional patients will improve timely access to health care. This will improve health outcomes in these populations through addressing high rates of physical inactivity and the associated burden of lifestyle related chronic diseases[4].

The geographical distribution of Indigenous people residing in rural and remote areas (69%) is another barrier contributing to poorer health outcomes in this population through reducing timely access to healthcare. Evidence demonstrates an appropriate exercise intervention leads to positive clinical outcomes and reduced risk factors associated with Type 2 Diabetes development in clinically obese Indigenous Australian men[20].

KEY POINT: Expanding the Telehealth eligibility criteria to allow access to all AHPs will enhance the "prevention, early detection and treatment of chronic diseases in Aboriginal and Torres Strait Islander people" *(Commonwealth Indigenous Chronic Disease Package).*

6. The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

There is a significant administrative burden associated with the Chronic Disease Management (CDM) program that could be better directed toward increased access to care. Currently, the 5 sessions do not meet best practice service delivery requirements, particularly for the many patients with multiple comorbidities.

KEY POINT: ESSA supports the provision of at least 5 services within the MBS CDM program. However, we request review of the CDM item numbers as they currently do not reflect best practice, could be better optimised to improve patient health outcomes, and ensure better use of government resources.

The MBS requires general practitioners (GPs) to facilitate referral between specialists and some AHPs. This process is inefficient, costly, delays patient treatment and is not currently practiced in the private health sector. For example, a patient with Type 2 Diabetes may be referred by their GP to an Endocrinologist for management advice. This specialist can subsequently refer the patient to a podiatrist and AEP directly, providing a letter to the GP stating what they have initiated. This will reduce time and costs associated with a specialist having to request GP referrals and the process being actioned.

KEY POINT: ESSA advocates for direct referral between medical specialists and all AHPs, within their scope of practice. This would achieve significant cost savings for Medicare and consumers, reduce GP administrative burden and ensure early access to appropriate health care.

7. Health workforce planning

HWA has been instrumental in national planning for a sustainable health workforce through monitoring workforce trends, collating data and building the evidence base on Australia's health workforce. This information has instigated

and informed clinical redesign and innovation improving efficiencies within the health system. For example, the HWA report[15], Australia's Future Health Workforce (HW2025), predicted a significant shortage of nurses (109,000) and doctors (2,700) by 2025 unless staffing models change, further supported by Health Workforce Planning documents.

KEY POINT: ESSA supports continued inclusion of the Allied Health disciplines within workforce modelling and profiling, previously undertaken by HWA. Furthermore, we advocate increased consultation with peak bodies throughout this workforce profiling process.

HWA have identified and supported the implementation of productive workforce models that have been successfully adopted on a national scale.

KEY POINT: ESSA endorses ongoing consultation with peak bodies to provide leadership and innovation. This will reduce inefficiencies in the system and enhance support of the allied health workforce.

8. Any related matters

To ensure best patient outcomes during the transition from Medicare Locals to Primary Health Networks (PHNs), ESSA strongly supports ongoing and full consultation with allied health service providers and peak professional bodies.

KEY POINT: PHNs must adopt a system based approach to primary care, rather than a discrete service-delivery focus. This will require a multidisciplinary approach in healthcare governance, planning and delivery, engaging GPs, nurses and allied health professionals.

Thank you for the opportunity to provide comment on the *Senate Select Committee on Health Terms of Reference.* Please contact if you would like any further information.

Kind Regards,

Katie Williams
Industry Development Officer
Exercise & Sports Science Australia

Anita Hobson-Powell
Executive Officer
Exercise & Sports Science Australia

EXERCISE & SPORTS SCIENCE AUSTRALIA

REFERENCES

1. deBoer, A., W. Wijker, and H. de Haes, *Predictors of healthcare utilisation in the chronically ill:a review of the literature.* Health Policy,1997. 42:p.101-115.
2. Taylor, C., D. Ahn, and M. Winkleby, *Neighborhood and individual socioeconomic determinants of hospitalization.* American Journal of Preventive Medicine, 2006. 31(2): p. 127-134.
3. George, T., et al., *Introduction of an accelerated diagnostic protocol in the assessment of emergency department patients with possible acute coronary syndrome: The Nambour Short Low-Intermediate Chest pain project.* Emergency Medicine Australasia, 2013. 25(4): p. 340-344.
4. Australian Institue of Health and Welfare. *Australia's health 2012*. 2012 21/06/2012 [cited 2014 5 May]; Available from: http://www.aihw.gov.au/publication-detail/?id=10737422172.
5. Blair, S., *Physical inactivity: the biggest public health problem of the 21st century.* British Journal of Sports Medicine, 2009. 43: p. 1-2.
6. Shaw, J. and S. Tanamas. *Diabetes: the silent pandemic and its impact on Australia*. 2012 [cited 2014 15 January]; Available from: http://www.diabetesaustralia.com.au/Documents/DA/What%27s%20New/12.03.14%20Diabetes%20management%20booklet%20FINAL.pdf
7. National Health Priority Action Council, *National chronic disease stratergy*, D.o.h.a. Ageing, Editor 2006: Canberra.
8. Diabetes Prevention Program Research Group, *Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin.* New England Journal of Medicine, 2002. 346(6): p. 393-403.
9. Gerstein H, S.P., Raina P et al., *Annual incidence and relative risk of diabetes in people with various categories of dysglycemia: a systematic overview and meta-analysis of prospective studies. .* Diabetes Res Clin Pract, 2007. **78**(3): p. 305–312.
10. Colberg, S., et al., *Exercise and type 2 diabetes. The American College of Sports Medicine and the American Diabetes Association: Joint position statement.* Diabetes Care, 2010. 33: p. e147-e167.
11. Lindstrom, J., et al., *Sustained reduction in the incidence of type 2 diabetes by lifestyle intervention: Follow-up of the Finnish Diabetes Prevention Study.* Lancet, 2006. 368(9548): p. 1673-1679.
12. Muenchberger, H.K., E., *Determinants of avoidable hospitalization in chronic disease: Development of a predictor matrix.* Centre for National Research on Disability and Rehabilitation, Griffith Institute of Health and Medical Research, Griffith University., 2013.
13. Basu, J., Friedman, B., & Burstin, H., *Primary Care, HMO Enrollment, and Hospitilisation for Ambulatory Care Senstive Conditions: A New Approach.* Medical Care, 2002. 40(12): p. 1260-1269.

14. Stewart, S., S. Pearson, and J. Horowitz, *Effects of a home-based intervention among patients with congestive heart failure discharged from acute hospital care.* Archives of Internal Medicine, 1998. 158: p. 1067-1072.
15. Health Workforce Australia, *Health worrkforce 2025 - Doctors, nurses and midwives - Volume 1*, 2012, HWA: Canberra.
16. Australian Institue of Health and Welfare, *Australian hospital statistics 2012-2013: Emergency department care*, 2013, AIHW: Canberra.
17. Davies, E., et al., *Exercise based rehabilitation for heart failure.* Cochrane Database of Systematic Reviews, 2010(4).
18. Goble, A. and M. Worcester, *Best practice guidelines for cardiac rehabilitation and secondary prevention*, 1999, Department of Human Services Victoria: Melbourne.
19. World Health Organisation, *Global health risks: Mortality and burden of dosease attributable to selected major risk*, 2009, WHO
20. Mendham, A.E., Duffield, R., Marino, F., Coutts, A. *A 12-week sports-based exercise programme for inactive Indigenous Australian men improved clinical risk factors associated with type 2 diabetes mellitus,* 2004, Journal of Science and Medicine in Sport