Medicare Benefits Schedule Review Allied Health Reference Group Submission

Introduction

The Australian Podiatry Association (APodA) welcomes the opportunity to support the work of the Medicare Benefits Scheme (MBS) Review Taskforce and in particular, the work of the General Practice Primary Care Clinical Committee and the associated Allied Health Reference Group.

The APodA's recommendations focus primarily with the priority one, in-scope MBS items and an associated issue currently being addressed by the Vascular Clinical Committee.

Summary of Recommendations:

Subgroup M3 Allied Health Services (Item Number 10962)

Recommend immediate adjustment to the duration and dose of service condition in order to address issues of accessibility and limited capacity to achieve the consumer health outcomes for which they are intended. We further recommend the MBS Review Taskforce focuses on the following areas:

- **Schedule fee: review the schedule fee for podiatry services to ensure that these are sufficient to support universal access to podiatry services and keep out of pocket costs to consumers at a reasonable level**
- **Care setting/location of service: changes should be made to the care setting/location of service limitations currently imposed on item number 10962 to enable consultations to be delivered via telehealth**
- **Provider/referral restrictions: allow podiatrists to make direct referrals for imaging and pathology services and to other health professionals where appropriate and within their scope of practice.**
- **Service conditions: urgent adjustments are required to increase both the maximum number of annual services and the duration of services to bring them in line with standard practice. APodA recommends an initial longer duration assessment is made available annually for each profession included in the management plan, and further recommends that the five annual session cap is increased to a maximum of 12 sessions available to newly diagnosed patients or those displaying higher risk.**

Group D1 Miscellaneous Diagnostic Procedures and Investigations Subgroup 5 Vascular (Item Number 11610)

- **Recommend to the Vascular Clinical Committee that current MBS rebates under item number 11610 be made available to patients referred to a podiatrist for these tests**

Diabetes: foot treatment and complications

The statistics around chronic disease are well known. In Australia, diabetes affects nearly 2 million people, with approximately 1 in 5 of those people experiencing peripheral neuropathy (loss of sensation) or peripheral arterial disease as a result. Annually, there are around 10,000 hospital admissions due to diabetes related foot ulcerations and recent evidence suggests that each year, in excess of 4,300 amputations are due to diabetes. Each of these amputations costs the Australian healthcare system $26,700 plus aftercare costs.

Best practice research indicates that improved access to podiatry services for patients with foot complications from diabetes would prevent future hospitalisations and amputations, recouping the costs of these services in turn. Cost savings from the implementation of best practice research was estimated in 2012 as being up to $397 million annually.[1]

Chronic disease management involves a complex array of primary care professionals who test, diagnose, prescribe medicines, treat symptoms and consequences of disease and support patients to understand their disease, identify the signs, symptoms and risk factors, and to develop resources and skills to seek help to manage this lifelong condition,

Access to allied health is not affordable and universally accessible. Current arrangements are inequitable and exacerbate the disparity in health outcomes between those from higher and lower socioeconomic strata. Evidence clearly demonstrates poorer outcomes for minority or marginalised groups, those experiencing disadvantage, and those in rural and remote regions. Changes will be required to ensure schedule fees and service durations are aligned to consumer requirements and to minimise out of pocket expenses.

The current MBS funds a range of services that have been demonstrated to be 'low-value' interventions and fails to fund other services that are recognised as representing best practice. Annual service limits must be adjusted, and referral pathways improved to increase the accessibility and use of best practice interventions. The current limit of five services per annum in total for allied health chronic disease service is too little to achieve adequate health outcomes.

Limitations of Medicare Benefits Schedule Item Number 10962

MBS item number 10962 describes a podiatry health service provided to a person by an eligible podiatrist if (amongst other conditions) the service is provided to a person who has a chronic condition; and complex care needs being managed by a medical practitioner. Further, this service is to be provided to the person individually and in person, that service is of at least 20 minutes duration with up to a maximum of five services in a calendar year.

It is the position of APodA that the current model of treatment and funding accessible to patients with diabetes related foot complications is insufficient to handle the scale of the problem in Australia. A number of limitations to this item number, specific to podiatry, are identified below:

[1] Australian Podiatry Association Submission to the Inquiry into Chronic Disease Prevention and Management in primary health care, August 2015

Schedule fee

One of the reasons our system is not currently realising opportunities to prevent the development of chronic conditions and associated deterioration is that these systemic and structural funding issues mean that Australian health consumers are left with only limited access to allied health services.

Private health insurance is not a viable alternative for many given rebates are not based on clinical outcomes but rather, the sale of policy products that may only cover limited professions and treatments. Instead, allied health access is heavily dependent on the ability of consumers to fund out of pocket costs, further compounding the fact that people experiencing disadvantage have worse health outcomes.

The consequences of high out of pocket are increasingly being recognised. High out of pocket costs are known to be a barrier to accessing health services, particularly for people with a chronic condition, who are more likely to skip treatment due to cost than other cohorts.

Location of service

Telehealth is increasingly being recognised as an effective way to improve access to health services for people living in regions where access to certain services may be limited. A wide body of research has demonstrated that telehealth consultations can be equivalently effective for patients and improve continuity of care and overall patient outcomes.

In podiatry, a pilot study conducted in 2010 concluded that telehealth systems should be made available for diabetic foot ulcer management. The study examined the integration of a store and forward telehealth system into a diabetic foot service. It was reported to be a useful method for improving diabetic foot management and, in particular, access to specialty services[2].

The pilot study also suggested larger studies and/or Medicare rebates would be justified to investigate the advantages of telehealth in all geographical populations for diabetic foot management due to the existing limitations of diabetic foot specialist clinicians in Australia.

Provider/referral restrictions

Podiatrists are currently unable to access MBS item number 11610 *Measurement of ankle: brachial indices and arterial waveform analysis.* This item number is currently being reviewed by the Vascular Clinical Committee.

Patients experiencing diabetes mellitus and those at risk of peripheral vascular disease are being increasingly referred to podiatrists by General Practitioners (GPs) for peripheral vascular assessment including brachial index and/or toe brachial index investigations.

[2] Lazzarini PA, Clark D, Mann RD, Perry VL, Thomas CJ and Kuys SS Does the use if store-and-forward telehealth systems improve outcomes for clinicians managing diabetic foot ulcers? A pilot study. Wound Practice and Research November 2010; Volume 18 Number 4: 164-172.

Podiatrists routinely perform Doppler ultrasound analysis of posterial tibial and dorsalis pedis, and the calculation of ankle and/or toe brachial systolic pressure indices and arterial waveform assessment, in the evaluation of lower extremity arterial disease.

Given this, it is currently inadequate that this item number is restricted to GP access only. It is critical that access to this item number be expanded to podiatrists, considering that many GPs are requesting podiatrists actually perform these assessments.

It is also relevant to note that podiatrists are currently able to separately access the exact equivalent of this item number when treating Department of Veteran's Affairs (DVA) patients under the DVA schedule of fees and podiatrists routinely utilise this separate vascular assessment item number to investigate DVA patients at risk of peripheral vascular disease.

To limit the test being used for inappropriate screening, clinical application could be restricted to those patients at high risk of PVD with these limits to apply to the item number, regardless of the practitioner performing the test.

Services conditions

Under Chronic Disease Management (CDM) plans, patients with diabetes have access to only five subsidised services with allied health practitioners, including podiatrists, per year.

CDM funding is currently capped at 20 minutes regardless of the type of consultation or the profession of the treating practitioner. This is out of touch with standard practice for podiatry, in particular, which typically would involve an initial assessment that would normally take 45 to 60 minutes. This initial consultation is important in laying the foundation for further treatment and establishing the needs of the particular patient. Many podiatry consultations delivered as part of chronic disease care exceed two 20-minute session currently rebated, resulting either in significant out of pocket costs for the consumer or services that are unable to sufficiently deal with the patient's health needs. The 20-minute duration also fails to account for the complexity of the health needs of many consumers.

Artificial limitations on the annual number of items that can be claimed as well as short service durations are out of line with other similar items and suggest rationing rather than a focus on ensuring universal access to care. Other schemes supporting clients with similar health issues such as DVA funding as well as other MBS item groups are based on need or episodes of care rather than individual services and allow a far greater and more appropriate number of services. Many chronic conditions are likely to require at least two, possibly even three or four different health professions to provide care. An annual limit of five sessions means that Medicare support is barely adequate for an annual check up and has no provision for more intensive intervention where greater complexity or risk is demonstrated.

The current model leaves a funding gap between initial diagnosis and the most serious complications that arise from chronic diseases. This situation often leaves patients with a single option of hospitalisation and expensive and traumatic treatment. Incentives should be in place to ensure care is provided to patients at the earliest time possible rather than leaving it too late.

Conclusion

APodA acknowledges and supports the role that multidisciplinary care plays in treating patients with diabetes and diabetes related foot complications, as supported by current research.

Implementing a new funding system that responds to patient need rather than utilising a prescriptive approach across the board has the potential to lower the amputation rate in Australia into line with other industrialised nations and save on healthcare costs relating to hospitalisation and amputation.

This system will also address the current situation, whereby patients who are at high risk to lower limb amputation are forced to fund podiatric consultations themselves after exhausting their inadequate allocated of allied health consultations under the current CDM plan.

Best practice in CDM requires a funding model that supports proactive management of the disease rather than over spending on reactive treatment for complications that should have been preventable when it is already too late.

Further Information

Mr Nello Marino
Chief Executive Officer
Australian Podiatry Association
89 Nicholson Street
Brunswick, Victoria, 3057

Email: nello.marino@podiatry.org.au
Phone: 03 9416 3111