Australian Physiotherapy Association
Submission

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Feedback on ACCC Senate Report on Private Health Insurance

Presented to Australian Competition and Consumer Commission (ACCC)

September 2012

Authorised by:

Melissa Locke
President
Australian Physiotherapy Association
Level 1, 1175 Toorak Rd
Camberwell VIC 3124
Phone: (03) 9092 0888
Fax: (03) 9092 0899
www.physiotherapy.asn.au

Feedback on ACCC Senate Report on Private Health Insurance

Background

In 2010-2011, more than 10 million persons in Australia were covered by private health insurance[1]. Data from June 2011 reports that 45.3% of Australians were covered by hospital treatment insurance and 52.5% held general treatment insurance[2].

Private health industry statistics from June 2011 showed that the five largest insurers accounted for approximately 83.7% of market share, with the remaining 27 insurers sharing in 16.3% of market share. Medibank (MPL)/AHM held the largest market share of 30.6%, followed by BUPA[i] with a market share of 26.9%, HCF[ii] with a market share of 10.5% and then HBF/H'guard with 8.2%, followed by NIB with 7.5% of market share[3].

The larger private health insurers hold such a significant portion of the overall market share, and anti-competitive practices by such health funds may reduce the extent of health cover for Australian consumers and overall increase out-of-pocket expenses.

The APA does not have at its disposal data pertaining to what services are or are not rebated for amongst other health professions, such as chiropractors or podiatrists. As a general principle, the APA does not endorse rebating for any and every potential course of treatment and the APA supports decreased funding for non-evidence based alternative therapies. However, where there is clinical evidence of the efficacy and cost-effectiveness of a particular treatment intervention, the APA advocates that health funds should offer higher rebates for such treatment services. Evidence-based practice supports an argument for higher rebates for physiotherapists treating arthritis in the knee, lower back pain, female stress urinary incontinence, cerebral palsy, children with visual and hearing impairment, Down's syndrome and fragile x syndrome.

At present, private health insurers recognise physiotherapy as a generic service and apply standard rebates for physiotherapy treatments, irrespective of whether the treatment was provided by a specialist or titled physiotherapist. Specialist and titled physiotherapists generally charge higher rates for the treatment services they provide, commensurate with their specialised training and higher level of expertise in their chosen field. However, private health funds do not implement any mechanisms or systems for recognising such expertise and rebating accordingly. It is the APA's position that specialist and titled physiotherapists should receive higher rebates, as these highly trained practitioners can treat patients in a fewer number of treatments and offer high quality treatments that facilitate early recovery.

Another central concern for the APA is that rebates to consumers who visit preferred providers are significantly higher than rebates to consumers who visit other providers and this can disadvantage consumers who require specialist or expert treatment.

The APA is further concerned that contractual arrangements between Australian physiotherapy clinics and health funds create a balance of power, especially in negotiating fees for service. Physiotherapists who join as preferred providers have to accept restrictions on fees for service in return for higher benefits paid to the client by the health fund. Physiotherapists also elect to abide by the treatment descriptors stipulated by the health funds but since the health funds often allow for a limited scope of treatments, patient quality of care could well be compromised by participating in such arrangements.

---

[i] The health benefits funds conducted by the three BUPA Australia group insurers were merged on 1 July 2010.

[ii] The health benefit funds conducted by HCF and MU were merged on 30 June 2011.

The APA is also concerned that consumers are not in a position to provide informed financial consent because allied health providers find it difficult to make an accurate assessment of future treatment expenses. An accurate assessment is complicated by the health funds' policy of step-downs, which imposes economic constraints on treatment that might go against best evidence practice health outcomes.

There is also a concern with some larger health funds refusing to rebate for physiotherapists prescribing orthotic devices and splints, mandating that rebates will only be offered to podiatrist fitting orthotics. Similarly, there is no recognition amongst private health insurers of clinical pilates, despite it being a specialised treatment (often individually tailored) involving specialised equipment. Further, Chronic Disease Management Programs (CDMPs) have been proven effective at reducing complications associated with diagnosed chronic disease and preventing the onset of chronic disease but few private health funds participate in such programs.

The APA is strongly concerned at the development of NIB's trip-advisor style ratings website publishing consumer reviews of allied health treatments. The APA believes that this website is neither fair nor unbiased for providers or physiotherapy clients.

1. Examples where allied health care providers offer the same or similar services as other providers and are not recognised by health funds.

1.1 Orthotic rebates

BUPA has recently revised its policy on orthotic rebates and, under the revised policy, rebates will only be offered for upper limb orthosis/splints if the orthotic is obtained and fabricated by an orthotist. The APA contends that BUPA's policy is in contrast to rebate policies of other private health insurers and goes against current best practice.

Physiotherapy intervention in upper limb orthosis/splints

Fabricated upper limb splints and orthotics are an essential intervention to support diseased or injured tissue to undergo healing. Upper limb orthoses are especially useful for people with neurological disorders, including acquired brain injury and stroke patients, children with neurological disorders such as cerebral palsy or obstetric brachial plexus injuries and have been shown to significantly improve hand function, especially pinch strength.

Physiotherapy intervention in lower limb orthotics

It has been brought to the attention of the APA that patients have been denied a private health rebate for casted prescription orthotics and prescription heat-moulding orthotics.

The APA is aware that BUPA does not pay benefits for 'off-the-shelf', stock or customised orthotics. BUPA is currently the only private health insurer that does not offer the rebate to customers for orthotics supplied by physiotherapists.

The APA upholds that physiotherapists are qualified to assess dysfunction and injury and have a sophisticated understanding of lower extremity biomechanics, sufficient to prescribe and dispense orthotics. Orthotic devices are an important treatment modality and, along with other modes of treatment such as tape, measurement tools, corrective exercises and manual therapy, orthotic devices are widely used within a physiotherapist's ordinary scope of practice.

The APA contends that physiotherapists are qualified to contour prefabricated and customised orthotics to the upper and lower extremities.

1.2 Clinical pilates

The APA contends that, at present, there is no recognition amongst private health insurers of clinical pilates as a recognisable service. Clinical pilates, as distinct from generic pilates classes (such as those provided in a gym), identifies applying carefully selected exercises designed by physiotherapists to patients with specific injuries. Clinical pilates administered by a physiotherapist ensures optimal gains and minimises the likelihood of injury aggravation.

In a clinical pilates setting, patients are closely supervised when utilising specialised equipment. Quite often there are limits on the equipment available, as well as limited space which is needed for the use of these pieces of equipment. Given this supervision requirement, only a small number of patients are able to attend clinical pilates classes and the treatment received is therefore more individually tailored to the patient's specific condition.

A 2011 New Zealand pilot study of low back pain found that clinical pilates was effective for promoting increased function and decreased pain levels, and these improvements were maintained for up to 26 weeks after supervised treatment was completed. The pilot study also found that clinical pilates improved overall general health and had a positive influence on mental health and vitality[4].

The APA contends that clinical pilates should be recognised as a specific and distinct treatment from generic pilates and should therefore attract higher rebates.

1.3 Pre/Postnatal exercise classes

Pre and post-natal exercise classes are limited in number, ordinarily to about three or four patients per class. This allows for greater one-on-one attention and treatments tailored to the individual patient's condition. Physical therapy has been correlated with a significant reduction in the intensity of lower back pain after exercise in prenatal women[5]. In postpartum women, instruction in pelvic floor muscle training by physiotherapists was found to be more effective than routine antenatal and postnatal care for both prevention and treatment of incontinence[6].

The APA contends that prenatal classes are effective in treating lower back pain and that postnatal classes are effective at preventing and treating postpartum incontinence.

1.4 Pervasive developmental disorders

Research demonstrates a positive impact of physical activity on the attention span of a child with Attention Deficit Hyperactivity Disorder (ADHD) and research supports that physical therapy exercises actually led to a short-term reduction in stereotypical autistic behavior in children with autism spectrum disorder (ASD).

Lang et al (2009) studied accelerometer measurements, which indicated that children with ASD were significantly less active than children without disabilities. It's predicted that since children with ASD often suffer impairments in motor skills, they are therefore likely to engage in lesser exercise. Children with ASD suffered greater health problems related to a sedentary lifestyle including cardiovascular disease, insulin resistance syndrome and obesity at greater rates than individuals without a developmental disability.

Exercise-based physical therapy has been found to be highly beneficial for children with autism. This study concluded that a variety of physical therapy exercises actually led to a short-term reduction in stereotypical autistic behavior in children with autism spectrum disorder. An example of a behaviour typical of autistic children is stereotypy. Stereotypy involves behaviours such as body rocking, arm flapping and spinning in circles, which are hypothesised itself to produce pleasant internal consequences for the individual patient. Since physical exercise involves similar body mechanics to that of stereotypy, physical exercise may produce similar internal states, so that the participants' need for this automatic reinforcement is obtained sufficiently, giving them greater energy for completion of academic or work related tasks[7].

Children diagnosed with ADHD similarly experience academic difficulties and often have trouble completing assigned tasks. The presence of ADHD is associated with behavioural problems, as well as staying focused. Though children with ADHD may well engage in behaviour such as shouting out answers in class, it was found that engaging in physical activity acted as a reinforcer for calmness and improved classroom conduct[8].

Evidence-based practice supports that physiotherapy interventions are effective at assisting patients with autism spectrum disorder (ASD) by reducing the effects of disruptive behaviour typical of autistic children. Physical therapy reinforces calmness and improves classroom conduct in children with Attention Deficit Hyperactivity Disorder (ADHD).

1.5 Hydrotherapy

Hydrotherapy is an effective physical treatment and can be especially useful in treating joint pain and stiffness associated with rheumatoid arthritis (RA). The painful swelling in the joints that occurs with rheumatoid arthritis has been shown to decrease with hydrotherapy. The warmth of the water is effective on the joints and soft tissues because it decreases swelling and improves joint mobility. In addition, hydrotherapy patients show significant improvement in joint tenderness and in knee range of movement[9].

In relation to ankylosing spondylitis (inflammatory rheumatic condition, causing inflammation of the spine and joint stiffness), clinical studies support that more physical therapy given on a regular basis will lead to better treatment outcomes. Performing home-based exercises leads to a short-term direct improvement in pain, stiffness and cervical rotation, with most significant improvement found in the two intervention groups. The positive effects of physiotherapy, in particular spa therapy has been proven effective in the management of ankylosing spondylitis[10].

Hydrotherapy improves joint mobility and decreases soft tissue swelling and patients treated by physiotherapists through water-based physical therapy show improvement in joint tenderness, range of movement and reduction in stiffness in cases of rheumatoid arthritis and ankylosing spondylitis.

1.6 Pulmonary rehabilitation

Chronic Obstructive Pulmonary Disease (COPD) is a significant health problem in Australia, ranked as the third leading cause of death. COPD is responsible for significantly more morbidity and mortality than other airway disease in adults aged over 60 years. For older adults requiring hospitalisation, the mortality rate is 11%, with a six month mortality rate of 33% and one year mortality rate of 43%. In Australia COPD caused over 5000 deaths in 2003[11].

Clinical studies indicate that patients with COPD perceive peer and professional exercise-focused support to be important for maintaining an active lifestyle after pulmonary rehabilitation. The importance of routine and social reinforcement within the exercise setting is also supported. Pulmonary rehabilitation has been shown to be instrumental in enhancing physical activity participation by improving patients' confidence to manage breathlessness and reducing fear of physical activity[12].

Clinical studies support that Chronic Obstructive Pulmonary Disease (COPD) patients can benefit significantly from pulmonary rehabilitation and that routine and social reinforcement within the exercise physiotherapy setting supports patients to manage their breathlessness and to improve their confidence.

1.7 Chronic disease management programs

Chronic Disease Management Programs (CDMPs) are important for reducing complications associated with diagnosed chronic disease and preventing the onset of chronic disease. The number of insurers offering cover for CDMPs increased from 14 insurers in 2009-10 to 30 insurers for 2010-11.

Benefit outlays were small, by comparison to acute treatment cover payments and totalled $39.6 million in 2010-11, up from $24.7 million in 2009-10. PHIAC predicts that, as the benefits of such individual programs become more widely marketed and accepted, participation in CDMPs will most likely continue to grow[13].

The APA advocates that more private health insurers should participate in chronic disease management programs.

2. In each instance referred to, whether this lack of recognition is warranted. In particular, are there any regulatory, medical or other reasons for this lack of recognition?

There is no regulatory, medical or other reason to explain the lack of recognition of physiotherapists who fit orthotics. Physiotherapists understand anatomy, including biomechanics and exercise physiology and are well equipped to assess the impact of orthotics on function and to evaluate various treatment outcomes.

Similarly, there are no regulatory or other restrictions that prevent recognition of clinical pilates as a specialised and distinct treatment modality. Public perception of pilates as a 'generic' service that could just as easily be provided by gym instructors may well play a part in how private health funds perceive this service.

The APA advocates that private health funds should rebate for custom upper and lower limb orthotics and clinical pilates, as there are no regulatory, medical, legislative or other restrictions that prevent such recognition of services.

Participation of private health funds in the CDMP seems burdened not so much by regulatory restrictions but by private health funds being unaware of such programs. Greater benefit outlays need to be dedicated to such programs, to increase the recognition of CDMP amongst consumers.

3. Whether this lack of recognition places allied health care providers at a competitive disadvantage. If so, how are allied health care providers disadvantaged by the practices of health funds?

3.1 Contractual agreements and preferred provider schemes

Restricted fees and length of treatment

The APA is concerned that preferred provider schemes require practices to place restrictions on fees for service, in return for a higher benefit paid to the client by the health fund than if the client were to visit a non-network physiotherapist. Practitioners agree to bring their fees in line with the billing practices of the particular health fund, in return for potentially greater marketing opportunities to fund members through the health fund's website. 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 APA contends that it is important to treat patients early and to guard against unnecessary lapses in treatment. Early intervention for injured people improves health, social, financial, interpersonal and intrapersonal outcomes by promoting recovery and preventing long-term disability and work loss[14,15].

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. The above scenario would apply in the case of an honest practitioner who has no choice but to charge two standard consultations, as the health fund does not permit extended consultations. It must be acknowledged however that some practitioners may, in the alternative, over-service clients in an attempt to remain financially viable, despite the restrictive billing practices of private health funds.

A third alternative is that practitioners wary of over-servicing clients may well rush through a course of treatment to ensure that treatment provided fits within the time constraints of a standard consultation, rather than risk being pin-pointed as outliers. As a result, there is a risk that quality of patient care is compromised.

Preferred provider schemes may well compromise quality of patient care by restricting the length and types of treatment services that attract rebates, even if such treatments may be best suited for recovery and full return to health and function. Preferred provider schemes also open the door to potential over-servicing or under-servicing, as allied health professionals attempt to circumnavigate the preferred provider scheme without compromising the financial viability of their business.

The problem of 'choice' in joining a preferred provider scheme

An argument is often put forth that practitioners have a choice to partake in a preferred provider scheme, on the proviso that they accept any drawbacks that come with scheme participation. However, there are often competitive and restrictive market forces that operate which make it very difficult to decline scheme membership. For example in rural or remote areas, where possibly two or three practices service an entire community, a decision not to join any of the health funds would make it very difficult for a business to remain financially viable. The situation in metropolitan and central suburban areas is not so different. As more patients elect to join private health funds and private insurers push their preferred provider schemes, practitioners are often left with little or no option but to partake in the scheme or risk losing clients to competitors.

When a small business enters into a contractual relationship with a health fund, there is a significant power imbalance inherent in all transactions. Many health funds do not take advantage of this imbalance, as they prefer to support high quality services for their fund members, but some funds do take advantage of small providers who want to access marketing opportunities through health fund provider networks.

The ACCC considers a consumer contract to be unfair if:

- it would cause a significant imbalance in the parties' rights and obligations arising under the contract;
- it is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term; and
- it would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

An example the APA was presented with where terms of a contract were unfair, was a continence and women's health physiotherapist with further qualifications who wanted to ensure that her

patients received the highest possible benefit. Women's health physiotherapists provide specialised treatment for stress incontinence, which requires longer consultations with senior practitioners. Women's health physiotherapists cannot and generally will not provide this treatment at the maximum price required under many health insurance contracts. As these physiotherapists are unable to provide effective treatment within the constraints of the contract, they are locked out of preferred provider arrangements – patients are often not aware of this until they seek treatment.

When the physiotherapist in question contacted the health fund to join their network provider scheme so her patients could access higher rebates, the health fund offered the physiotherapist a standard contract, but refused to negotiate on the maximum fee allowable under this contract. The APA believes that this is unfair, and in terms of the criteria listed above:

- the small business would have been required to reduce fees payable by a significant proportion of the business' clients – severely affecting business productivity, while the health fund would not be subject to any increased financial burden. Therefore, the APA believes that there is a significant imbalance in the obligations of the term agreeing to cap prices;
- some health funds claim that caps on maximum fees are necessary to inform fund members about the out-of-pocket costs. The APA believes that this is not a substantive benefit to clients, when compared to the relative value of increased rebates to access more highly trained and experienced physiotherapists. Essentially, the benefit to the client, and thus to the fund, would be far outweighed by the ability to negotiate on this contractual term, and facilitate client access to the most appropriate physiotherapist for their condition; and
- the APA believes that health funds should be protecting the health of their members by ensuring that they do not have increased gaps for specialised practices, such as women's health physiotherapy, or complex cases of lymphedema management, development delay in children and chronic regional pain management, where longer appointment times and more advanced qualifications mean that higher charges are needed to ensure the viability of a small business. The client is disadvantaged by this refusal to negotiate on fee caps with highly specialised physiotherapists because they receive reduced health fund rebates for consulting a physiotherapist who elects not to participate in a network provider arrangement.

The APA understands that fair contracting law applies only to contracts between consumers and businesses and thus is not currently applicable to this scenario. There is also an evidentiary onus of proof on the party who believes that the term of the contract is unfair.

To facilitate proper investigation of these terms, the APA believes that the fair contracting laws should be applicable to all contracts where there is a significant imbalance in the size and market penetration of the parties to the contract and that the Australian Consumer Law (Schedule 2 of the *Competition and Consumer Act 2010)* should be amended to include businesses.

South Australia offers an interesting example of market penetration by health funds. In 2008, 80% of South Australian APA members were participating in network provider schemes. The BUPA group has control of a significant proportion of the market in South Australia. PHIAC's most recent statistics indicate that 427,461 of 916,449 people are covered by BUPA policies – constituting 47% of the private health insurance market in that state during the financial year 2009-10[16]. The APA believes that such network provider contracts may well constitute third line forcing and that an 'overall effect test' should be applied where market penetration by an industry detrimentally affects the viability of physiotherapy businesses, such as in South Australia.

The APA is also concerned that some health insurers are starting to restrict the number of physiotherapists on their preferred provider schemes in South Australia. APA members attempting to join a preferred provider scheme have been put on an indefinite waiting list or told that they must be 'invited' to join a scheme. These restrictions may limit the entry of physiotherapists into the South Australian market and inhibit consumer choice of provider.

The contractual terms of a preferred provider arrangement create an imbalance of power between preferred providers and network physiotherapists. The APA believes that the maximum cap on fees

(presumed to provide greater certainty around expenses) is not a substantive benefit to clients, when compared to the relative value of increased rebates to access more highly trained and experienced physiotherapists. The APA contends that consumers are disadvantaged by health funds' refusal to negotiate on fee caps with highly specialised physiotherapists because consumers receive reduced rebates for consulting a physiotherapist who elects not to participate in a network provider arrangement. The APA considers that where market penetration by health funds is particularly significant, participation in preferred provider schemes is almost unavoidable and such monopolistic business practices constitute third line forcing.

Rebate discrepancy between preferred providers and non-contracted practitioners

A trend that has continued in the 2010-2011 year is the widening discrepancy between rebates paid when a fund member visits a network provider, and when a fund member visits a non-network physiotherapist. Physiotherapists have reported to the APA that there has been little or no indexing of the non-network provider rates for physiotherapy for an extended period. The APA feels that it is unlikely that health fund members are aware that rebates have not increased with the cost of living over the years, nor are consumers aware that there is such a significant gap between the network and non-network rate prior to purchasing a particular health fund policy.

Physiotherapists are extremely concerned about increasing out-of-pocket fees for their clients. One member said:

> *The real issue with private health insurance physiotherapy rebates is that the funds have not substantially increased their rebates outside of these preferred provider schemes for the last decade or more. Hence, we have patients turning up and receiving $20-$30 rebates for $70 consultations*.

Another APA physiotherapist provided examples of out-of-pocket expenses for patients who have been treated at his clinic over a period of years:

	Previous Rebate	Previous Fee	Previous Gap	Rebate 2011	Fee 2011	Gap 2011
Client 1	$26 (2006)	$47 (2006)	$21	$26	$70	$44
Client 2	$22 (2000)	$32 (2000)	$10	$22	$63(pensioner)	$41
Client 3	$21 (1999)	$35 (1999)	$14	$25.60	$70	$44.40

These figures were taken from a random selection of long term clients at a single physiotherapy practice, and clearly demonstrate the extent of the rising out-of-pocket costs faced by consumers who wish to see their chosen physiotherapist. The health insurers who have provider networks usually point to increases in the network provider rebates to justify the lack of movement in the non-network rates.

It is important to note that the physiotherapy fees included in these tables are in line with the average rates charged by APA physiotherapists in this state.

The APA recommends that a minimum rebate be applied to general health insurance, where differential rates are applied between network and non-network providers. This will provide a fall back for consumers seeking higher level and specialist services and certainty for small providers unable to negotiate with health insurers around the fees necessary to run their business.

Misleading consumer perceptions of preferred providers

There is no clinically justifiable reason for assigning a higher benefit to preferred providers, as they are not necessarily better trained, more qualified or better value than non-preferred providers. The APA is concerned however that some health funds misleadingly represent that preferred network providers are in some way screened by the fund. This is simply not the case, as preferred provider schemes operate as 'opt-in, opt-out' schemes and any allied health practitioner can elect to join the scheme, subject to acceptance of the fund policies and billing practices.

Further, to increase a rebate available to one consumer who chooses to use a health fund preferred provider discriminates financially against the member who chooses to maintain their relationship with a non-preferred allied health professional. In many instances, a patient may have had a long-standing relationship with their physiotherapist for several years prior to joining the fund. The APA considers that health insurers who provide higher rebates to members who visit preferred providers disadvantage consumers who have an established therapeutic relationship with a non-contracted provider, as well as those who require specialist or expert treatment or who do not have a local preferred provider.

Since all health fund members pay identical premiums, the APA contends that eligibility for rebates should also be identical. The APA contends that it is quite unfair for health funds to provide financial incentives to bait consumers to break down an existing relationship of trust with a non-contracted provider. Such conduct goes against consumer interest and may well compromise the quality of care received by the member, as presumably a physiotherapist who has treated such a patient for quite some time has a better grasp of the patient's condition, progress to date and any biopsychosocial factors that may impact on patient recovery.

3.2 Step-downs

Many health funds subject consumers to 'step-downs', which come into force when a client comes close to using up their annual limit for physiotherapy services. In order to extend the number of services that clients can access, health funds reduce the benefit they will pay for the service, often resulting in an unpleasant surprise when a client pays using HICAPS facilities at the end of their consultation.

To avoid unpleasant surprises, the APA contends that consumers have a right to be properly informed of the expenses they are likely to incur when undertaking a course of treatment. The right to informed financial consent (IFC) is protected under the *Private Health Insurance Bill* (2006):

> *'… the consent to treatment obtained by a medical practitioner from a patient, prior to that treatment whenever possible, where the practitioner has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about costs. Medical specialists who participate in health funds' gap cover arrangements are required to provide informed financial consent prior to treatment where possible.'*

The APA believes that these step-downs serve no benefit to clients, and they make it difficult for physiotherapists to give accurate advice about out-of-pocket costs. The APA believes that properly informed consumers should have the ultimate choice to decide whether to continue treatment.

Another point worth noting is that some health fund rules relating to rebates payable can result in patients declining a course of treatment that may be best suited for them. Further, the 'step-down' system constrains the way in which treatment is provided and is largely based on economic parameters and not clinical evidence pertaining to best practice treatment outcomes.

In some instances the very act of attending a preferred provider – and thus receiving a higher rebate – may mean that annual limits on benefits for a particular kind of treatment are actually reached more quickly than would be the case if the member attended a non-preferred provider and received

a lower rebate. The APA submits that in such a circumstance, it may be misleading for a fund to promote preferred providers to consumers as being the more cost-effective option in the long run, when in reality attending a non-contracted provider may well give the consumer greater leeway in treatment options before reaching their annual limit for physiotherapy services.

The APA believes that step-downs serve no benefit to clients and they make it difficult for physiotherapists to provide advice to clients around an accurate and realistic estimate of costs.

3.3 NIB Whitecoat

The APA continues to be strongly opposed to NIB's Whitecoat website, which is a ratings website publishing consumer reviews of the treatment they receive at a general provider. The APA's first concern is that the provider's individual details were published on the website, with no opportunity to opt out of participation. The APA felt that this was unreasonable given that the website rates individual physiotherapists, but there was no intention to give providers any say in their participation. Enquiries received by the APA around the source of the information to be published revealed that Medicare Australia's data would be published online. Given that physiotherapists apply for Medicare provider numbers upon registration, this is doubly concerning, as a physiotherapists' home address could be routinely published, with the onus on the physiotherapist to check the website and raise an issue with the insurer if their private address is published.

Such data was intended to be published without the consent of Medicare Australia or of physiotherapists. NIB has since acknowledged that it did not have authority to use the Medicare data and delayed their launch.

The APA was also concerned with the conduct of NIB around the intention to publish patient comments on the website. The APA sought the opinion of the Physiotherapy Board of Australia (PBA) on the issue of whether or not the publishing of comments could constitute a breach of legislation which prohibits the publication of testimonials. In response, PBA notified NIB that they are likely to consider published customer comments as testimonials. This puts physiotherapists at risk of fines of up to $10,000 for breaching the PBA's Physiotherapy Guidelines for Advertising of Regulated Health Services.

In response to this concern, NIB amended their website to build in functionality to allow physiotherapists who register on the website to hide comments from public view. NIB then met with the APA to discuss the change, and asked the APA to not take a publicly hostile position regarding the website, in exchange for NIB granting physiotherapists the right to opt out of the publication of comments on the site. The APA found these tactics to be heavy handed and inappropriate given the risk of breaching PBA Guidelines implicit in the publication of these comments.

The APA is strongly opposed to NIB's Whitecoat website and believes that this website is neither fair nor unbiased for providers or physiotherapy clients. The APA expresses particular concern around the publication of patient comments on the website, as such comments could well constitute testimonials according to the Physiotherapy Board of Australia (PBA) and such a practice could put physiotherapists at a risk of being fined $10,000 for breaching the PBA's Physiotherapy Guidelines for Advertising of Regulated Health Services.

3.4 Better rebates for evidence-based practice

Knee osteoarthritis

The APA supports the delivery of physiotherapy management within an evidence based framework. The APA believes that private health insurers should offer better rebates for evidence-based treatment practices. Physiotherapists are highly qualified in the assessment and diagnosis of musculoskeletal disorders, including arthritis and back pain. All physiotherapy interventions are

provided on the basis of scientific knowledge, evidence and clinical expert opinion, thorough assessment, diagnosis and ongoing evaluation.

Physiotherapy has been recommended in a number of international guidelines, including the guidelines of the American College of Rheumatology (2000), for the management of knee osteoarthritis[17].

There is significant clinical evidence for the efficacy of physiotherapy in the management of knee osteoarthritis (OA). Two randomly controlled trials showed that a combined physiotherapy program comprising strengthening exercises and manual therapy leads to reductions in pain and improvements in function. The APA supports that physiotherapists are highly skilled in exercise prescription and as such, play a key role in the design, delivery and implementation of exercise programs for the management of these disorders. Physiotherapists can design appropriate modifications so that the benefit of increased physical activity is achieved without aggravating the coexisting musculoskeletal problems of arthritis[18].

Clinical guidelines also recommend the use of a transcutaneous electrical nerve stimulator (TENS) machine, which emits low voltage electrical currents to a specific area of the body and has beneficial effects on relieving pain. Evidence also supports that knee taping appears to be beneficial when applied by a trained physiotherapist, and has been proven effective in immediate and short-term reduction of knee pain in OA patients[19].

Lower back pain

Exercise therapy has also shown to be effective for patients with sub-acute (6–12 weeks) and chronic (> 12 weeks) low back pain[20]. Intensive rehabilitation programs led by physiotherapists have shown to be as effective as spinal surgery in improving outcomes for patients with chronic low back pain (LBP) and are associated with lower costs.

The APA supports the use of water-based exercise therapies, such as hydrotherapy. Hydrotherapy is effective because the warmth of the water can alleviate pain and stiffness and the effects of buoyancy can relieve stress on joints. Water-based exercise therapy has been shown to be effective in treatment of rheumatic conditions and chronic low back pain, as it improves function, self-efficacy, joint mobility, strength and balance[21].

A combination of physiotherapy interventions, including manual therapy, specific exercise training, and education focusing on the neurophysiology of pain has shown to be effective in producing functional and symptomatic improvement in patients with chronic low back pain[22].

Female stress urinary incontinence

There are significant evidence-based studies that support physiotherapy intervention in urinary incontinence, in particular female stress urinary incontinence (FSUI)[23]. Physiotherapy treatments for FSUI can include instructing patients in pelvic floor exercises to strengthen muscles, electrical stimulation, real time ultrasound and biofeedback (teaching patients to control involuntary body processes to improve health).

A 2005 study published in the Australia and New Zealand Journal of Obstetrics and Gynaecology, found that 82 per cent of women were cured of FSUI after one episode of physiotherapy care[24]. A further outcome of the study, which has been published in the Australia and New Zealand Journal of Public Health[25], found that physiotherapy management of FSUI on average $302.40 while surgical management costs between $4668 and $6124. Not to mention that surgical management would require greater workforce contribution by specialist surgeons, anaesthetists and additional nursing and health support staff.

The APA contends that treatment of specific conditions by the allied health professional most qualified to treat the condition facilitates early recovery and best health outcomes for the patient. The APA believes that a long-term strategy of private health funds should focus on providing better care to patients, which in turn saves costs to the health funds. Where there is evidence of the

efficacy and cost-effectiveness of a particular treatment intervention, the APA advocates that health funds should offer higher rebates for such treatment services. The APA contends that evidence-based practice supports that physiotherapists should receive higher rebates for treatment of specific arthritic, urinary and musculoskeletal conditions.

3.5 Higher rebates for specialist and titled physiotherapists

The APA contends that lack of recognition of particular treatment services places individual, highly-trained allied health providers at a competitive disadvantage.

Physiotherapists who provide specific treatment services, such as fitting custom orthotics or clinical pilates, but who are not acknowledged for these services feel that their training and expertise are devalued. Lack of recognition is of special concern to titled and specialist physiotherapists who are highly educated and have a higher level of professional expertise.

The APA National Physiotherapy Service Descriptors for 2012 identify a Level 1 physiotherapist as an APA member, a Level 2 physiotherapist as an APA-titled member (clinical Masters degree or equivalent), and a specialist physiotherapist as a practitioner who is a Fellow of the Australian College of Physiotherapy. These service descriptors clearly identify the increasing level of expertise within the physiotherapy profession.

Indeed, evidence has clearly demonstrated that experienced physiotherapists have higher levels of knowledge in managing musculoskeletal conditions than medical students, physician interns and residents, and all physician specialists except for orthopaedists[26]. When magnetic resonance imaging (MRI) was used as the gold standard, the diagnostic accuracy of physiotherapists for clients with musculoskeletal injuries was found to be as good as that of orthopaedic surgeons and significantly better than that of non-orthopaedic providers[27].

If health funds were to offer higher rebates to specialist and titled physiotherapists, the APA contends that higher rebates would not necessarily be at the financial expense of the health funds long-term. This is because highly trained specialist and titled physiotherapists are able to treat patients in a shorter amount of time and can return the patient to full function more quickly. The APA submits that chronic and complex private patients could benefit from treatment by titled and specialist physiotherapists and enjoy the benefit of improved treatment outcomes such as increased capacity, early recovery and reduced health costs. The APA would submit that fees for specialists be increased where there has been a referral from a medical practitioner or physiotherapist.

If health funds fail to recognise treatment services provided by specialist or titled physiotherapists and fail to rebate accordingly, there is a significant disincentive for specialist and titled physiotherapists to join as preferred providers. This is because specialists operating under preferred provider schemes are precluded from charging above the standard rate for other physiotherapists who operate under the billing structure of that particular health fund. This in turn has an impact on consumers of private health funds, as they have less access to quality or specialist treatment services through their health fund. The only option for such customers is then to access such specialist services and accept that they will incur higher out-of-pocket expenses as a result. Clearly, this is to the financial disadvantage of consumers.

The APA contends that specialist and titled physiotherapists have better training and higher expertise and are able to achieve better treatment outcomes for patients in a shorter timeframe. The APA submits that specialist and titled physiotherapists should receive higher rebates for the specialised treatment services that they provide. The APA believes that higher rebates for specialist and titled physiotherapists are unlikely to lead to increased costs for the health funds, as patients treated by a specialist or titled physiotherapist require lesser treatments overall to achieve recovery.

4. Whether this lack of recognition results in a reduction in the extent of health cover or an increase in the out-of-pocket medical expenses?

4.1 Increasing consumer out-of-pocket expenses through limited recognition of health services and recognition of experts

If a particular health fund refuses to rebate for a treatment modality, such as custom orthotics fitted by a physiotherapist, consumers are clearly disadvantaged, as they cannot claim a rebate for such services. Following on from this example, if a consumer visited a physiotherapist before the policy change, the consumer naturally has to elect to see another health practitioner who can fit orthotics. It should also be noted that clients usually have an established therapeutic relationship with their treating provider and it is not always clinically appropriate for them to change treatment providers. The APA is concerned that restrictive insurance policies which refuse to cover certain conditions encroach an uncomfortable boundary in limiting an allied health provider's scope of practice and accordingly restrict consumer access to quality health care.

The APA is certainly not endorsing non-evidence based treatment services. However, the APA believes that allied health practitioners who provide treatments that are within their scope of practice and training should not be precluded from having such treatment services recognised by private health funds.

The APA supports a wider scope of practice and believes that private health funds should not limit a physiotherapists' scope of practice through formally recognising only select services. Further, refusing to cover certain treatment modalities, without an acceptable clinical justification for such refusal, limits consumer access to quality health care.

4.2 Preferred provider scheme limiting access to quality treatment

Rebates to consumers who visit preferred providers are significantly higher than rebates to consumers who visit other providers and this can disadvantage consumers who require specialist or expert treatment. If there are insufficient specialists or expert preferred providers in a customer's local area, the customer may miss out on valuable treatment or be forced to travel long distances (if living in rural or remote locations) to visit a specialist preferred provider in another area. This will in turn likely impede the customer's recovery. This could be an issue especially for customers living in rural areas, where there are high rates of hospitalisation and a high incidence of chronic disease[28].

One of the central advantages of joining a preferred provider scheme is the potential for greater patient referrals. Physiotherapists accept that they must align their billing practices with that of their chosen health insurer as a condition of becoming a preferred provider. However, private health funds are not bound to provide across the board minimum rebates or to align their standard fees with market rates for physiotherapy services. The fees mandated under many preferred provider arrangements often fall below standard market rates for physiotherapy services. This gives rise to a potential problem, being that physiotherapists may elect to reduce the length of a consultation, to account for the reduced fee for service under preferred provider arrangements. For a consumer, such time-cutting measures might compromise the quality of patient care provided to the consumer as a result.

The APA contends that appropriate indexation should be equally applied to the rebates provided to both network and non-network providers.

References

1. Private Health Insurance Administration Council (PHIAC). 2011. The Operations of Private Health Insurers – Annual Report 2010-2011. Available at http://www.phiac.gov.au/resources/file/Annual%20Report%20on%20Operations%202010-11%20web%20version.pdf, p vii
2. Private Health Insurance Administration Council (PHIAC). 2011. The Operations of Private Health Insurers – Annual Report 2010-2011. Available at http://www.phiac.gov.au/resources/file/Annual%20Report%20on%20Operations%202010-11%20web%20version.pdf, p 4
3. Private Health Insurance Administration Council (PHIAC). 2011. The Operations of Private Health Insurers – Annual Report 2010-2011. Available at http://www.phiac.gov.au/resources/file/Annual%20Report%20on%20Operations%202010-11%20web%20version.pdf, p 10
4. Taylor L, Hay-Smith EJC, Dean S (2011): Can clinical pilates decrease pain and improve function in people complaining of non-specific low back pain? A pilot study. New Zealand Journal of Physiotherapy 39(1) 30-38
5. Bhargava, A., Gelb, D., Ludwig, S. and Michael J. DePalma. (2005). Physical Therapy for Low Back Pain. *Curr Opin Orthop* 17:199–207
6. Lapitan, M. Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women: RHL commentary (last revised: 1 April 2009). *The WHO Reproductive Health Library*; Geneva: World Health Organization
7. Lang, R., Kern Koegel, L., Ashbaugh, K., Regester, A., Ence, W., Smith, W. (2009). Physical exercise and individuals with autism spectrum disorders: A systematic review. Broad Asperger Research Center, University of California, Santa Barbara, USA
8. Tantillo, M., Kesick, CM., Hynd, GW., Dishman, RK. (2009). The effects of exercise on children with attention-deficit hyperactivity disorder. Department of Exercise Science, The University of Georgia, Athens, GA, USA
9. Hall, J., Skevington, SM., Maddison, PJ., Chapman, K. (1996). A randomized and controlled trial of hydrotherapy in rheumatoid arthritis. *Arthritis Care Res.* 1996 Jun;9(3):206-15
10. Van der Linden, S., Van Tubergen, A., Hidding, A. (2002). Physiotherapy in ankylosing spondylitis: What is the evidence? *Clin Exp Rheumatol* 2002; 20 (Suppl. 28): S60-S64.
11. North West Melbourne Division of General Practice. (2006). Chronic Obstructive Pulmonary Disease. Available at: http://www.impetus.org.au/after_hours/GPRAC-CIS-COPD.html
12. Hogg, L., Grant, A., Garrod, R., and Fiddler, H. (2012). People with COPD perceive ongoing, structured and socially supportive exercise opportunities to be important for maintaining an active lifestyle following pulmonary rehabilitation: a qualitative study. *Journal of Physiotherapy* Vol. 58
13. Private Health Insurance Administration Council (PHIAC). 2011. The Operations of Private Health Insurers – Annual Report 2010-2011. Available at http://www.phiac.gov.au/resources/file/Annual%20Report%20on%20Operations%202010-11%20web%20version.pdf, p 21
14. Ellis, N. (2001). Work and Health Management in Australia and New Zealand. Oxford University Press, p3

15. WorkCover NSW. (2008). Improving outcomes: Integrated, active management of workers with soft tissue injury. Available at http://www.workcover.nsw.gov.au/formspublications/publications/Documents/overview_improving_outcomes_5364.pdf

16. Private Health Insurance Administration Council (PHIAC). 2010. The Operations of Private Health Insurers – Annual Report 2009-2010. Available at http://www.phiac.gov.au/resources/file/110201%20264-15%20Annual%20Report%20Tables.xls

17. Australian Physiotherapy Association (2005). APA Position Statement - Physiotherapy in the management of arthritis and musculoskeletal conditions. Available at www.physiotherapy.asn.au

18. Australian Physiotherapy Association (2005). APA Position Statement - Physiotherapy in the management of arthritis and musculoskeletal conditions. Available at www.physiotherapy.asn.au

19. Australian Physiotherapy Association (2005). Evidence-based Clinical Statement - Knee joint osteoarthritis. Available at www.physiotherapy.asn.au

20. Smidt N, de Vet H, Bouter L and Dekker J (2005): Effectiveness of exercise therapy: A best-evidence summary of systematic reviews. *Australian Journal of Physiotherapy* 51:71–85.

21. Geytenbeek J (2002): Evidence for effective hydrotherapy. *Physiotherapy* 88: 514–529.

22. Moseley, L (2002): Combined physiotherapy and education is efficacious for chronic low back pain. *Australian Journal of Physiotherapy* 48: 297–302.

23. Australian Physiotherapy Association (2009). APA Submission to the Department of Health and Ageing – Response to the Terms of Reference for the HTA Review Discussion Paper. Available at www.physiotherapy.asn.au

24. Neumann PB, Grimmer KA, Grant RE and Gill VA (2005): Physiotherapy for female stress urinary incontinence: a multicentre observational study. Australian and New Zealand Journal of Obstetrics and Gynaecology 45(3): 226–232.

25. Patricia B. Neumann, Karen A. Grimmer, Ruth E. Grant, Virginia A. Gill (2005) The costs and benefits of physiotherapy as first-line treatment for female stress urinary incontinence. *Australian and New Zealand Journal of Public Health* 29 (5), 416–421.

26. Weale, A.E. and G.C. Bannister, Who should see orthopaedic outpatients-physiotherapists or surgeons? Ann R Coll Surg Engl, 1995. 77: p. 71 - 73

27. Daker-White, G., et al., A randomised controlled trial. Shifting boundaries of doctors and physiotherapists in orthopaedic outpatient departments. J Epidemiol Community Health, 1999. 53: p. 643 – 650

28. Australian Institute of Health and Welfare. (2010). Australia's Health 2010. *Australia's Health Series* no.12.Cat.no. AUS 122. Canberra: AIHW