Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Submission No: 61

Submitted by: Exercise & Sport Science Australia

Publication: Making the submission and your name public

Attachments: See attachment

Submitter Comments:

EXERCISE & SPORTS SCIENCE AUSTRALIA

Submission

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Health and Environment Committee

23 December 2021

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EXERCISE & SPORTS SCIENCE AUSTRALIA (ESSA) SUBMISSION

RE: INQUIRY INTO THE PROVISION OF PRIMARY, ALLIED AND PRIVATE HEALTH CARE, AGED CARE AND NDIS CARE SERVICES AND ITS IMPACT ON THE QUEENSLAND PUBLIC HEALTH SYSTEM

Committee Secretary
Health and Environment Committee
Parliament House
George Street
Brisbane Qld 4000

Thank you for the opportunity to provide feedback in relation to the Health and Environment Committee's Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland health public system.

Exercise & Sport Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing more than 9,000 members comprising university qualified Accredited Exercise Physiologists (AEPs), Accredited Exercise Scientists (AESs), Accredited Sports Scientists and Accredited High-Performance Managers.

In respect to the Terms of Reference, this submission will provide responses to

1. the provision of:
    a. primary and allied health care;
    b. aged and NDIS care;
    c. the private health care system;

and any impacts the availability and accessibility of these services have on the Queensland public health system but will not consider the availability of medical training places at Queensland universities, compared to other jurisdictions.

This submission outlines some current issues seen in the accessibility of AEPs in the aged care system, National Disability Insurance Scheme (NDIS) and Medicare Benefits Scheme (MBS), as well as the underutilisation of AEPs in rural and remote settings, mental health care and private health. Furthermore, this submission provides an overview of how the allied health workforce can assist in minimising public health outpatient and elective surgery waitlists, hospital admission/re-admissions and hospital stays; and outlines issues around Australian Government incentives for health professionals which heavily focus on general practitioners (GPs), with limited engagement of the allied health workforce.

ESSA welcomes the opportunity to appear in front of the Health and Environment Committee (the Committee) to provide further evidence and clarification on the issues outlined in this submission, if required. Please contact ESSA Policy & Advocacy Advisor, Carla Vasoli, on [redacted] or at [redacted] for further information or questions arising from this submission.

Yours sincerely

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1.0 ABOUT ACCREDITED EXERCISE PHYSIOLOGISTS AND ACCREDITED EXERCISE SCIENTISTS

AEPs are four-year university degree qualified allied health professionals. They provide services to people across the full health spectrum, from the healthy population through to those at risk of developing a health condition, and people with health conditions, a disability, and aged related illnesses and conditions, including chronic, complex conditions [1]. Exercise physiology services are recognised by Australian compensable schemes including Medicare, the National Disability Insurance Scheme (NDIS), Department of Veteran Affairs (DVA), workers' compensation schemes and most private health insurers. Australia's exercise physiology profession comprises approximately 6,500 AEPs, with over 1600 of these in Queensland.

AESs are three-year university degree qualified professionals who deliver exercise programs to Australia's well populations to prevent chronic disease, injury and disability, and improve health, fitness and performance. They empower, motivate and coach clients to adopt long-term behavioural changes. AESs work in numerous sectors spanning allied health as Allied Health Assistants (AHAs); the NDIS as Therapy Assistants; personal trainers in the fitness industry; coaches in sporting organisations; and as program coordinators in education and corporate health. There are more than 700 AESs working in Australia today.

2.0 SUMMARY OF RECOMMENDATIONS

Recommendation 1: that Queensland Health employ 8 x Accredited Exercise Physiologists in existing diabetes clinics in metropolitan and larger regional hospital and health services, including in Cairns and Hinterland, Queensland Children's Hospital, Gold Coast, Metro South, Sunshine Cost, Townsville, West Moreton and Wide Bay to deliver diabetes care in line with best practice models of care.

Recommendation 2: that the Queensland Treasurer support the removal of Goods and Services Tax (GST) on exercise physiology services at a Council on Federal Financial Relations meeting in 2022.

Recommendation 3: that the Queensland Government via the Health Council requests the Australian Government expand the eligibility for the HECS-HELP incentive to allied health professions, including Accredited Exercise Physiologists.

Recommendation 4: that the Queensland Government via the Health Council requests the Australian Government expand the eligibility of the Workforce Incentive Program subsidies to allow allied health business owners to employ allied health staff in rural areas.

Recommendation 5: that the Queensland Government supports the seven Queensland Primary Health Networks to incorporate more clinical guidance on exercise treatment and build stronger pathways to Accredited Exercise Physiologists and Accredited Practising Dietitians in HealthPathways.

Recommendation 6: that the Queensland Government via its Hospital and Health Services promotes the availability of Exercise is Medicine ® to medical, nursing and allied health professionals in the public system.

Recommendation 7: that Queensland Health increases access to prehabilitation exercise therapy services in outpatient services to patients currently on semi-urgent (Category 2) and non-urgent (Category 3) wait lists to help reduce specialist outpatient wait lists.

Recommendation 8: that the Queensland Government via the Health Council advocate to the Australian Government to implement new Medicare Benefits Schedule (MBS) group services items for respiratory and coronary conditions, that are equivalent to the current group services items for type 2 diabetes, 81110 and 81115.

Recommendation 9: that Queensland Health employ one allied health professional in each Health and Hospital Service whose role specifically focuses on supporting public clients to transition to community-based services.

Recommendation 10: that Queensland Health increase visibility and accessibility of Accredited Exercise Physiologists in Community Health Services by:

- Encouraging block funded Community Health Services to employ Accredited Exercise Physiologists

- Increasing allocation of activity-based funding to exercise physiology in activity-based funded Community Health Services
- Ensuring AEPs are considered where vacancies exist for allied health professionals in all Community Health Services.

Recommendation 11: that each Hospital and Health Services within Queensland Health employ a minimum of one Accredited Exercise Physiologist in each community mental health site to provide specialist physical health care (including individual and group-based clinical exercise treatment) to help reduce the incidence of physical comorbidities in people with mental health conditions.

Recommendation 12: that each Hospital and Health Service within Queensland Health broadens the professions included as allied health case management positions to include Accredited Exercise Physiologists, to expand the physical health skillset of the mental health workforce.

Recommendation 13: that the Queensland Government support planning and investment for 'precision prevention' of chronic disease as means of delivering value-based models to ensure future healthcare sustainability.

Recommendation 14: that the Queensland Government via the Health Council advocate to the Australian Government that it needs to provide dedicated access to a range of allied health services, including exercise physiology, in each Residential Aged Care facility.

Recommendation 15: that the Queensland Government via the Health Council recommends to the Australian Government that it develop and implement strong policies to embed allied health care into Residential Aged Care.

Recommendation 16: that the Queensland Government via the Health Council recommends to the Australian Government that it increases the overall number of home care packages, particularly the number of level 3 and 4 packages.

Recommendation 17: that Queensland Health implements a health literacy program targeting older people and those with chronic conditions to support better consumer decision making about access to exercise and lifestyle change programs, in consultation with ESSA and other relevant allied health peak bodies such as Dietitians Australia.

Recommendation 18: that the Queensland Government via the Health Council advocates to the Australian Government that the NDIA provide adequate budgets for NDIS clients to allow them the appropriate access to qualified allied health professionals, including Accredited Exercise Physiologists.

Recommendation 19: that the Queensland Government via the Health Council requests that the Minister for the NDIS

- mandates:
  - a minimum level of knowledge of each NDIS therapeutic support and allied health profession for internal NDIA decision-making staff, including planners and Local Area Coordinators
  - ongoing planner training to ensure planners' knowledge of therapeutic supports and allied health professions is regularly updated, in accordance with new and emerging evidence and
  - the employment of planners who have qualifications and/or experience in health or human services and
- provides support to planners to develop a strong understanding of the complex needs associated with participants' disabilities.

Recommendation 20: that the Queensland Government via the Health Council requests the NDIA engage ESSA to implement the Exercise is Medicine© program for NDIS planners and support workers to augment workforce knowledge and health literacy to better support NDIS participants.

Recommendation 21: that the Queensland Government via the Health Council requests the Minister for the NDIS develop a legislative instrument to support NDIA staff accountability in enabling participant decision making, and which will be administered by the NDIS Quality and Safety Commission.

Recommendation 22: that the Queensland Government via the Health Council advocates to the Australian Government that Australian Prudential Regulation Authority to include exercise physiology as a standalone category when reporting general treatment (ancillary) services.

Recommendation 23: that the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase and allow equitable access to exercise physiology services as other mainstream allied health services in all levels of each of the 37 policies, including listing in polices separate from other disciplines.

Recommendation 24: that the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase access to the HEAL™ program, by encouraging all private health insurers to offer the program within their policies.

Recommendation 25: that the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase access to Accredited Exercise Scientist delivered programs, such as personal training, by encouraging all private health insurers to:

- offer Accredited Exercise Scientist delivered personal training within their policies and
- work with ESSA to develop an appropriate model for the provision of Accredited Exercise Scientist delivered personal training.

Recommendation 26: that Queensland Health works with the Queensland Primary Health Networks to better communicate the availability of these temporary items to General Practitioners, to increase their uptake before 30 June 2022.

Recommendation 27: that the Queensland Government via the Health Council advocates to the Australian Government to permanently retain the additional physical therapy Residential Aged Care Facilities Medicare Chromic Disease Management items.

Recommendation 28: that the Queensland Government via the Health Council advocates to the Australian Government that it fast track additional Medicare Benefits Schedule allied health sessions and/or provide funding for additional allied health services to be commissioned via Primary Health Networks.

Recommendation 29: that the Queensland Government via the Health Council requests the Australian Government

- backdates indexing for allied health MBS item to ensure consistency of indexing with GP items or increases MBS rates to align better with current market conditions
- ensures that any future indexing payments for clinical items within the MBS be made equitably across all health professions and
- ensures that any new non-clinical MBS items applying to both medical and allied health professions are the same.

Recommendation 30: that the Queensland Government via the Health Council requests the Australian Government take action on providing better incentives for allied health MBS services delivered in rural and remote areas.

Recommendation 31: that the Queensland Government via the Health Council requests the Australian Government consult with stakeholders about the possibility of establishing a Health Workforce Distribution Priority Areas (DPAs) scheme for allied health to support the recruitment and retention of allied health professionals in MMM 4-7 areas.

Recommendation 32: that the Queensland Government considers establishing an incentive package program for allied health new or recent graduates to relocate to areas of critical need in rural and remote Queensland similar to the NSW program.

Recommendation 33: that Queensland Health works with education providers to ensure that appropriate rural allied health student practicum placements are available.

Recommendation 34: that Queensland Health works with peak allied health professional bodies (including ESSA) to develop mechanisms for adequate clinical supervision of new and early career allied health professionals, especially those from newer and smaller allied health professions like exercise physiology.

3.0 PRIMARY AND ALLIED HEALTH CARE

Effective coordination and integration of health care services is a key predictor to the hospitalisation of patients with chronic disease. A significant proportion of potentially preventable hospitalisations (PPHs) and preventable hospital re-admissions can be avoided through patient education, behaviour change, lifestyle intervention, pharmaceuticals and/ or access to appropriate primary healthcare [2]. Strategies that increase the engagement of the allied health workforce will ensure individuals with chronic health conditions remain stable and can self-manage without reliance on hospital-based care or frequent medical intervention.

Increased engagement of allied health in the community and primary health care setting facilitates superior continuity of care for discharged hospital patients and individuals at risk of hospital admission. Allied health (including access to exercise physiology services) can effectively improve patient symptom management, detection of risk factors, appropriate intervention, and patient self-management [3].

Specifically, AEPs take a person-centred approach to manage chronic health conditions, including cardiovascular disease, mental health conditions and type 2 diabetes [4], which contribute to PPHs. This approach involves a combination of elements and strategies designed to improve health status and produce behaviour change, including clinical exercise treatment, education, advice, and support to achieve a particular outcome.

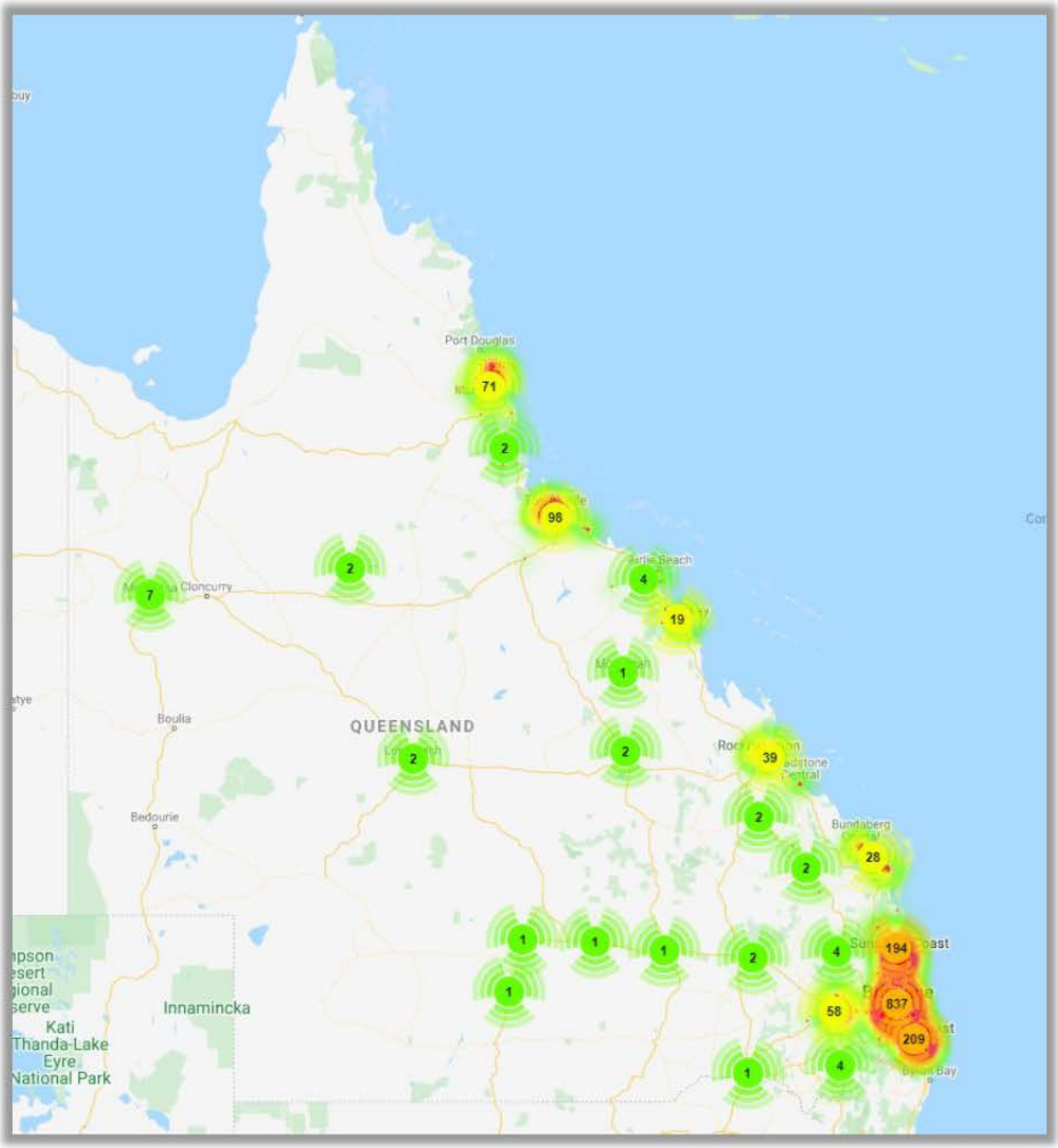
3.1 ACCREDITED EXERCISE PHYSIOLOGY WORKFORCE

The current geographical distribution of the AEP workforce in Queensland is shown in Table 1 and Figure 1 below:

Table 1: Distribution of AEPs in Queensland on 31 December 2020
:

Majors Cities of Queensland	1216	76%
Inner Regional Queensland	174	11%
Outer Regional Queensland	195	12%
Remote Queensland	11	>1%
Very Remote Queensland	5	>1%
Total	1601	100%

Figure 1: Queensland AEP numbers by geographic distribution on 31 December 2020



ESSA has seen constant growth in the number of AEPs across Australia, as demonstrated in Table 2 with an average of 11.67% increase per year since 2016, demonstrating that exercise physiology is a growing profession.

Table 2: Total number of AEPs in Australia per year, including change in AEPs

Year	Total AEPs	Change in AEPs from previous year (Number)	Change in AEPs from previous year (%)
2020	6315	609	+10.67%
2019	5706	605	+11.86%
2018	5101	475	+10.27%
2017	4626	461	+11.07%
2016	4165	528	+14.5%
2015	3637		

Given the benefits of AEP interventions on preventing and managing chronic disease that can result in savings to the public health system, the broad distribution of AEPs across Queensland, and the consistent growth of the AEP workforce, it should be a priority for Queensland Health to consider harnessing the AEP workforce to help improve the health of Queenslanders and reduce the burden on the public health system.

3.2 UNDERUTILISATION OF ALLIED HEALTH PROFESSIONALS

Allied health professionals, including AEPs, have the ability to assist in reducing PPHs, by using their knowledge and skills to prevent, manage and mitigate chronic and acute conditions highlighted by the Australian Institute of Health and Welfare (AIHW). One study found that the largest contributing factor to PPHs relating to chronic conditions in both New South Wales rural and metropolitan districts was the lack of access to allied health services [5].

Further, a report [6] developed for Services for Australian Rural and Remote Allied Health on allied health interventions (including exercise physiology interventions) targeting type II diabetes, osteoarthritis and post-stroke populations highlighted a considerable number of adverse health outcomes were avoided when patients are treated by allied health professionals. The report highlighted significant potential annual savings for the implementation of individual interventions ranging from $5.1 million to $77.9 million per intervention [6].

As exercise professionals, AEPs can play a pivotable role in achieving the delivery of the *Queensland Health Prevention Strategic Framework: 2017 to 2026* [7]. There are currently over 1600 AEPs across Queensland with the capacity to support Queenslanders to live healthier lives, specifically in preventing the onset of diabetes, with diabetes complications being one of the most significant causes of PPHs, and prescribing exercise interventions as an evidence-based mode of treatment. Thirty-five AEPs currently work in the Queensland hospital sector and only one is employed to work specifically in a diabetes service in North Metro Hospital and Health Service.

Case Study A outlines the model of diabetes care being delivered by AEPs / Credentialled Diabetes Educators in the Community & Oral Health Diabetes Service – Metro North Hospital & Health Service. This model of care is delivered as part of a multi-disciplinary service where the AEP collaborates with other health professionals to provide holistic care for people with diabetes.

Case Study A: Community & Oral Health Diabetes Service – Metro North Hospital & Health Service

For people diagnosed with type 1 diabetes the following treatment is provided by an AEP:

- **Education** for children, adolescents and adults on exercise physiology and adaptions required for managing type 1 diabetes while being active. This may include overcoming the fear of hypoglycaemia. Family members and carers are also included in this education.
- **Development of an individualised glucose management plan** is very important, with specific advice on exercise within the plan covering instructions on insulin management, carbohydrate intake and exercise timing. Plans are updated as required considering the type and amount of carbohydrate required for specific exercise; insulin management pre and post exercise and when best to exercise safely.
- For children and adolescents **written advice is provided to schools** to advise on exercise and sport and is updated annually. The school management plan includes care at school camps, sports carnivals and other venues providing guidance for carers and teachers.
- For adults an additional **plan may be required for work purposes** if employment is of a physical nature.
- **Exercise assessment and prescription** of an exercise program may be required and will depend on the individual. At times, supervision of high-risk clients in group exercise sessions is undertaken, particularly for children and adolescents.

People with type 2 diabetes are referred to the AEP after a nursing assessment. Clients receive an exercise assessment and are prescribed a home exercise program or a supervised exercise program if they are considered high-risk. Like people with type 1 diabetes, an individualised glucose management plan is developed including instructions on insulin management, carbohydrate intake and exercise timing. This plan considers the type and amount of carbohydrate required for specific exercise and the percentage reductions in insulin prior to exercise.

As demonstrated in Case Study A, people of all ages including children, adolescents and adults with either type 1 or type 2 diabetes are catered for within the Community & Oral Health Diabetes Service. Everyone attending the clinic is screened for sedentary lifestyle behaviours and provided with practical strategies to improve engagement in an active lifestyle. Areas that have been identified that would benefit from the inclusion of an AEP in the diabetes service are Metro South, Gold Coast, Sunshine Coast, Darling Downs, West Moreton, Cairns and Hinterland, Townsville and the Queensland Children's Hospital.

Despite the benefits allied health services have on improving health outcomes and reducing healthcare costs, including AEPs in diabetes management, allied health professionals are still underutilised across the health sector, with most working in the private sector and only accessible to consumers who can afford to pay privately for these services, or who are covered through a compensable scheme, such as workers compensation, or have private health insurance.

Expanding access to exercise physiology services in public hospitals and in community health will reduce existing barriers to better health outcomes and long-term behaviour change and lifestyle improvements for Queenslanders.

Recommendation 1: that Queensland Health employ 8 x Accredited Exercise Physiologists in existing diabetes clinics in metropolitan and larger regional hospital and health services, including in Cairns and Hinterland, Queensland Children's Hospital, Gold Coast, Metro South, Sunshine Cost, Townsville, West Moreton and Wide Bay to deliver diabetes care in line with best practice models of care.

3.3 GST PAYABLE ON AEP SERVICES

ESSA has long been campaigning to remove the Goods and Services Tax (GST) from exercise physiology, as exercise physiology services are not "Eligible Health Services" under the *GST Act*.

Importantly, there are existing policy inconsistencies between taxation and private health insurance laws. From 1 April 2019, 2 x natural therapies (naturopathy & western herbal medicine) were excluded from the definition of private health insurance general treatment and no longer receive the private health insurance rebate as part of a general treatment policy under the *Private Health Insurance (Complying Product) Rules*. Both natural therapies continue to be GST exempt.

At present, AEPs are the only stand-alone allied health professionals delivering Medicare chronic diseases management (CDM) services that attract GST for most services outside Medicare. The requirement to charge patients GST for a health service is confusing to the public when they are not required to pay GST for their other health services. The additional 10% fee for AEP services, once five Medicare subsidised sessions have been exhausted, often results in patients ceasing treatment with their AEPs, compromising their treatment outcomes at a time when they are only starting to see improvements.

Patients who are not treated properly often go on to become a burden on the health system, often needing expensive drugs or surgery, which could have avoided if they had continued to follow their recommended courses of treatment.

A recent letter to ESSA from the Queensland Treasurer indicated that the Council on Federal Financial Relations (CFFR) is planning to consider the findings from a GST Policy and Administrative Committee (GPAS) review and ESSA's proposal to remove GST from EP services at a CFFR meeting in early 2022 (end of Feb/early March).

Recommendation 2: that the Queensland Treasurer support the removal of Goods and Services Tax (GST) on exercise physiology services at a Council on Federal Financial Relations meeting in 2022.

3.4 RURAL AND REMOTE INCENTIVES

ESSA notes that the Australian Government has recently announced that it will wipe the HECS-HELP debt of doctors and nurse practitioners who work at least 24 hours per week in a remote location for a period equivalent to half the length of their degrees, or in a rural location for a period equivalent to their entire degrees [8].

ESSA is concerned that these incentives exclude allied health professionals, when the *2020 Health Workforce Needs Assessment, Summary of the Primary Care Workforce Needs in Remote and Rural Queensland Report* highlighted that there are 10 health workforce disciplines, other than nursing and general practitioner, that have

a mean workforce gap rating of 50 or more in rural and remote Queensland, including exercise physiology [9]. Further, this report identifies four allied health workforces with a higher workforce gap rating than the general practitioner workforce and seven allied health workforces with a higher workforce gap rating than nurse practitioners [9]. This means that there is a higher need for four allied health workforces (psychology, social work, speech pathology and occupational therapy) in rural and remote Queensland than there is for the nursing and general practitioner workforces, yet these professions have not been included in the new incentive.

Inadequate access to allied health professionals in rural and remote locations is largely due to the perilous viability of private practice within thin markets in rural settings [10]. The Worley *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* [11] highlighted both an undersupply and a maldistribution of allied health services in rural and remote towns of less than 30,000 people. Viability issues severely impact on the inability to recruit and retain allied health professionals in these locations [12, 13].

Given that access to allied health professionals is one of the largest drivers of PPHs relating to chronic conditions [5], efforts should be made to expand both Australian and Queensland Government rural and remote health workforce incentives to include allied health professions, to attract and retain a sufficient workforce to rural and remote locations in Queensland.

Recommendation 3: that the Queensland Government via the Health Council requests the Australian Government expand the eligibility for the HECS-HELP incentive to allied health professions, including Accredited Exercise Physiologists.

The existing Australian Government Workforce Incentive Program (WIP) – Practice Stream funding model currently excludes AEPs from employing AEPs (and other allied health professionals employing other allied health professionals) in rural areas. It also has a cap on the subsidies available per business.

ESSA supports the Australian Medical Association (AMA)'s position of lifting the caps on subsidies available through the Practice Stream WIP to better support the employment of nurses, pharmacists, and other allied health professionals to support enhanced access to GP-led team-based patient care in rural areas so larger practices can employ the same ratio of nursing and allied health staff as smaller practices [14].

ESSA does not support the AMA's position for the direct employment and co-location of allied health professionals only within general practices.

Recommendation 4: that the Queensland Government via the Health Council requests the Australian Government expand the eligibility of the Workforce Incentive Program subsidies to allow allied health business owners to employ allied health staff in rural areas.

3.5 GENERAL PRACTITIONERS AND AEPS

According to The Royal Australian College of General Practitioners (RACGP), GPs consider it their roles to give physical activity and nutritional advice to their patients, however time constraints prevent physical activity counselling beyond broad advice. GPs and registrars would like to develop skills in providing effective brief advice and motivation to patients where time is limited [15]. Despite RACGP members feeling confident in providing physical activity and nutrition counselling in their practices, the reality is far different.

A 2016 Australian study found less than one in five inactive Australian adults, especially those who have existing medical conditions or who are overweight received a physical activity recommendation from their GPs in the past 12 months [16]. Furthermore, a recent 2019 study indicated that GPs are only referring 1.4 patients in every 1,000 to an AEP [17].

Upskilling via the ESSA supported evidenced based professional development program, Exercise is Medicine ® would assist GPs, primary health care nurses and other health professionals understand the importance of exercise in preventing and managing chronic diseases and the value of working with AEPs in the public system.

Effective early intervention through health services and GPs requires clearer referral pathways and appropriate options to direct patients. HealthPathways, a web-based portal with evidence-based information on the assessment and management of common clinical conditions including referral guidance, is an existing tool to incorporate clinical guidance on exercise treatment and referral pathways to AEPs.

Recommendation 5: that the Queensland Government supports the seven Queensland Primary Health Networks to incorporate more clinical guidance on exercise treatment and build stronger pathways to Accredited Exercise Physiologists and Accredited Practising Dietitians in HealthPathways.

Recommendation 6: that the Queensland Government via its Hospital and Health Services promotes the availability of Exercise is Medicine ® to medical, nursing and allied health professionals in the public system.

3.6 SPECIALIST WAIT LISTS AND AEPS

ESSA is aware that the Queensland Government has attempted to reduce wait lists for specialists in the public health system. However, the recent report from the Queensland Audit Office has stated that demand for services is exceeding supply, resulting in the number of long waits for non-urgent cases steadily increasing since 2017 [18]. The report made four recommendations, including:

1. Work with hospital and health services to embed proven, innovative models of care and more integrated health solutions across the state to help increase capacity and optimise benefits more broadly.
2. Implement initiatives to stream non-urgent referrals, where clinically appropriate, to alternate pathways to address priority pressure areas and early intervention.

Referral to AEP services can alleviate some of the pressures on Queensland's public health system regarding long wait lists for non-urgent specialist outpatient referrals, by addressing Recommendations 1 and 2 of the Audit Office's report based on the following evidence.

Various clinical guidelines including the 2017 Association of Anaesthetists of Great Britain and Ireland (AAGBI)'s *Clinical guideline and recommendations on pre-operative exercise training in patients awaiting major non-cardiac surgery* support access to supervised clinical exercise treatment delivered by individuals with relevant expertise. Specifically, the AAGBI guideline states

> "pre-operative exercise training should be offered to all patients undergoing elective major or complex surgery, with the aim of improving physiological and functional reserve to both reduce the risk of peri-operative morbidity and mortality, and facilitate postoperative recovery of functional capacity," and
>
> "Sessions should be individualised, supervised by appropriately trained members of staff." [19]

In Australia, AEPs are well qualified to provide individualised and supervised pre-operative clinical exercise treatment which could also be done in small groups.

A 2019 review of the evidence underpinning the broader prehabilitation concept and the targeted behavioural and lifestyle risk factors shows prehabilitated patients are better placed to cope with surgery [20].

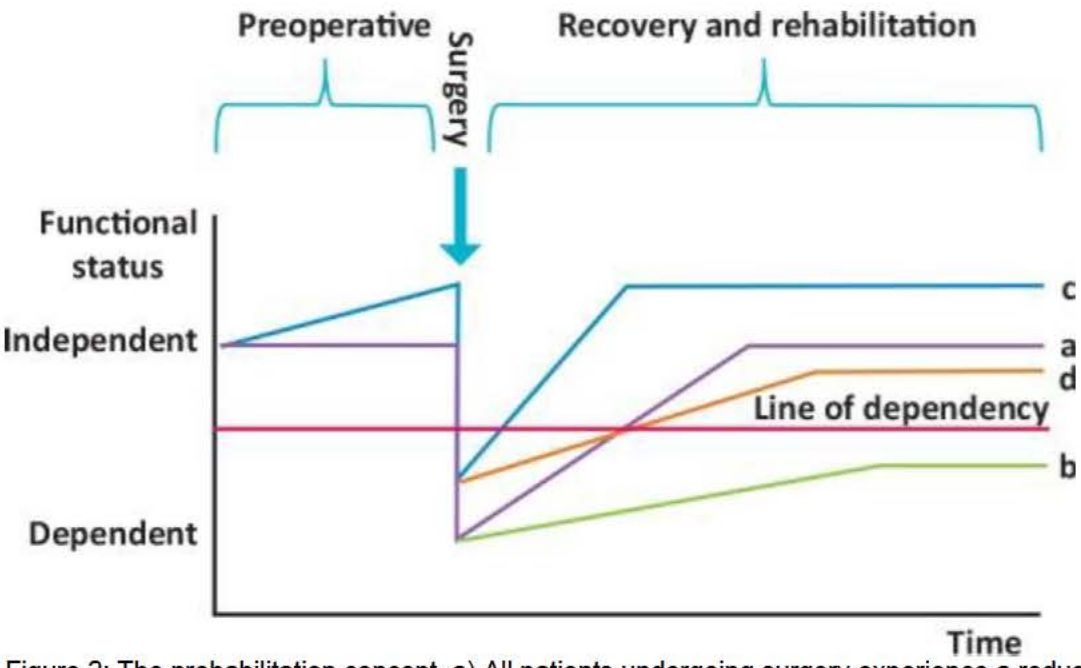


Figure 2: The prehabilitation concept. a) All patients undergoing surgery experience a reduction in functional status postoperatively followed by a recovery period. b) Patients suffering a complication may experience a slower and incomplete recovery threatening longer-term independence. c) Prehabilitated patients are better placed to cope. d) Should a complication occur, prehabilitation might be crucial to safeguarding longer-term functional status and independence [20].

Access to supervised clinical exercise treatment would help address the Audit Office's Recommendation 2, based on the following evidence. A 2019 systematic review found physical prehabilitation (exercise training) with a high therapeutic validity had beneficial effects on postoperative outcomes for patients undergoing major intra-abdominal cancer surgery. Prehabilitation (including supervised aerobics, strength and flexibility training) reduces the number of post-surgical complications for patients undergoing non-urgent cardiovascular surgical intervention [21]. Another systematic review [22] found that preoperative exercise treatment can reduce the length of stay after cardiac or abdominal surgery.

Recommendation 7: that Queensland Health increases access to prehabilitation exercise therapy services in outpatient services to patients currently on semi-urgent (Category 2) and non-urgent (Category 3) wait lists to help reduce specialist outpatient wait lists.

3.7 TRANSITION FROM PUBLIC TO PRIVATE OR COMMUNITY SERVICES

AEPs in the public health system have trouble facilitating the transition of their clients from public to community-based care. Successful transition is important for continuity of care to avoid future hospital presentations. Community-based exercise physiology services are either private services or Community (government funded) Health Services. Both types of community-based care present accessibility challenges.

3.7.1 PRIVATE SERVICE CHALLENGES

A large portion of public exercise physiology clients cannot afford to see an AEP privately, unless accessing services through compensable scheme funding, such as through MBS chronic disease management (CDM) plans. However, the MBS CDM plans only allow access to five allied health services across all professions, which is not enough to support ongoing and effective transition into private options.

An increase in sessions through Medicare for allied health should be considered to support this transition – particularly for chronic diseases such as Diabetes, Cardiac, Pulmonary, all of which possess high portions of preventable hospitalisations and burden on the health system. For further information regarding MBS CDM plans, please see section *7.1.2 Number of Allied Health Services* of this submission.

An option currently exists for exercise groups for the management of type 2 diabetes through Medicare Benefits item 81115, but dismisses the top 5 PPH Chronic Conditions made up of Coronary and Respiratory issues,

which could see this extended to include Pulmonary Rehabilitation and Cardiac Rehabilitation. A previous submission by Lung Foundation Australia for a new MBS item number for group exercise and education services for Pulmonary Rehabilitation can be found here: MSAC - 1405.1 - MBS Item for Pulmonary Rehabilitation (Re-submission). Including a new MBS item number like what was proposed by Lung Foundation Australia would be beneficial for reducing PPHs.

Further, AEPs in the public health system are unable to directly refer clients to a private clinician, as this shows bias. The client must choose and engage their preferred AEP on their own accord, which presents a barrier for some clients.

3.7.2 COMMUNITY HEALTH SERVICE CHALLENGES

At 31 December 2020, ESSA's workforce data suggests that there were only 16 AEPs working in public Community Health Services in Queensland. This is insufficient to meet the need for publicly funded community AEP services. Insufficient access to public AEP services in the community increases the likelihood that clients who cannot afford to pay privately to see an AEP will decondition after leaving the public hospital AEP service while on wait lists to see an AEP at a public Community Health Service.

Recommendation 8: that the Queensland Government via the Health Council advocate to the Australian Government to implement new Medicare Benefits Schedule (MBS) group services items for respiratory and coronary conditions, that are equivalent to the current group services items for type 2 diabetes, 81110 and 81115.

Recommendation 9: that Queensland Health employ one allied health professional in each Health and Hospital Service whose role specifically focuses on supporting public clients to transition to community-based services.

Recommendation 10: that Queensland Health increase visibility and accessibility of Accredited Exercise Physiologists in Community Health Services by:

- **Encouraging block funded Community Health Services to employ Accredited Exercise Physiologists**
- **Increasing allocation of activity-based funding to exercise physiology in activity-based funded Community Health Services**
- **Ensuring AEPs are considered where vacancies exist for allied health professionals in all Community Health Services.**

3.8 MENTAL HEALTH AND AEPS

Despite the strong link between mental and physical health, an Australian study has found only 1.6% of GP referrals were made to AEPs for mental health conditions [17]. The importance of including exercise as a cornerstone of effective mental health care has been well-established in clinical research [23-30].

Strong evidence supports integrated physical health care and mental health care being offered to those living with mental health conditions from the time of first diagnosis or appearance of signs of subclinical mental health issues.

The seminal Lancet Psychiatry Commission [31] provides a practical blueprint towards protecting physical health and includes an update on evidence on the link between physical and mental health, with findings from over 100 systematic reviews and meta-analyses. Critically, the blueprint recommends that all people living with mental illness have access to exercise and dietary interventions as part of routine mental healthcare.

The Lancet Psychiatry Commission proposes that future lifestyle interventions in mental health care must adopt core principles, exemplified in a gold standard program, the Diabetes Prevention Program (DPP), by ensuring that exercise interventions are delivered at an 'early intervention' stage by qualified exercise professionals (with a university qualification in exercise prescription, such as an AEP), and by providing sufficient access to supervised exercise services.

Further to this, recent evidence guides published by the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Commission of NSW recommend referral to, or engagement with, dedicated

allied-health professionals with expertise in exercise prescription, specifically AEPs, to promote improved health outcomes of people living with a mental illness [32]. To assist with appropriate referral to exercise physiology for mental health, ESSA has developed a *Consensus Statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: A Guide for mental health professionals* [33].

Working towards a system that removes barriers to collaboration across client care can ensure that those with mental ill-health are not only treated for their mental health condition/s but that they also receive care for any physical health comorbidities and that this care is holistic, client centred, and recovery focused.

The evidence and practice review undertaken for the recent *The Royal Commission into Victoria's Mental Health System* identified where evidence of community-led initiatives involving social connection was strongest and distilled the common elements of successful initiatives. The review found that group-based exercise, support groups and intergenerational programs (that is, activities that facilitate interaction between members of younger and older age groups) demonstrated the most positive impacts on mental health and wellbeing [34].

The Commission also encouraged area mental health services to employ physical health clinicians as part of their multidisciplinary teams, such as speech pathologists and exercise physiologists [34].

ESSA recommends that the employment of physical health clinicians (which includes AEPs) as part of standard multidisciplinary allied health teams within Mental Health services and group exercise classes be considered as essential standard best practice care within mental health programs, especially within any prevention and early intervention programs. By addressing comorbidities associated with mental health conditions, as well as providing mental benefits from exercise, AEPs can play a large role in reducing both long- and short-term reliance on Queensland's public health system for this cohort.

Currently, mental health case management positions within Hospital and Health Services are restricted to nurses, social workers, psychologists, occupational therapists and in certain settings, to speech pathologists. It is important that AEPs are included in the case management workforce as AEPs offer significant value in delivering specialist exercise services and physical health care to manage the symptoms of mental illness and protect the physical health of people with mental health conditions. AEPs are also highly skilled in behavioural lifestyle counselling and holistic care across the spectrum of health care.

Recommendation 11: that each Hospital and Health Services within Queensland Health employ a minimum of one Accredited Exercise Physiologist in each community mental health site to provide specialist physical health care (including individual and group-based clinical exercise treatment) to help reduce the incidence of physical comorbidities in people with mental health conditions.

Recommendation 12: that each Hospital and Health Service within Queensland Health broadens the professions included as allied health case management positions to include Accredited Exercise Physiologists, to expand the physical health skillset of the mental health workforce.

3.9 NEW MODELS OF PREVENTION CARE

Given the launch of the *National Preventive Health Strategy* on 13 December 2021, and the importance prevention will play in reducing future health budgets, it is important that the health systems support new models of prevention care and a move to 'precision prevention' interventions.

A recent CSIRO article [35] by Queensland academics and Queensland Health leaders highlights how digital health and digital citizens can initiate a 'precision prevention era, where consumer-centred, real-time data enables a new ability to count and fund population health, making disease prevention matter'. These 'precision prevention' interventions target precise, at-risk groups or communities by tailoring interventions to unique characteristics, modifying care delivery systems or implementing targeted policy or macroenvironmental changes that are customised to each group based on risk and need.

Three key areas (digital health foundations, using data and analytics to transform care and a learning system) to support the digital health transformation are needed for precision prevention of chronic disease and support new efficient person-centred predict–prevent digital models of care as opposed to the current inefficient break–fix models of healthcare.

Recommendation 13: that the Queensland Government support planning and investment for 'precision prevention' of chronic disease as means of delivering value-based models to ensure future healthcare sustainability.

4.0 AGED CARE

People aged 65 and older account for 47% of Queensland's PPHs [36], which is likely due to the higher rates of chronic disease in this cohort. Allied health professionals deliver interventions to older people in the aged care system that allow older people to maintain their health and wellbeing, resulting in a reduced need to access Queensland's public health system. Specifically, AEPs help older people to prevent and manage existing chronic disease, maintain mobility and prevent falls, optimise cognition and brain function and improve mental health through individually tailored exercise therapy [37].

However, access to allied health services, including exercise physiology, under the current aged care system is limited. The Royal Commission into Aged Care Quality and Safety reported that just 2% of home care funding was spent on allied health care and that those in residential aged care (RAC) had insufficient access to allied health care [38].

4.1 ALLIED HEALTH IN RESIDENTIAL AGED CARE

The Royal Commission into Aged Care Quality and Safety revealed that allied healthcare offered in residential aged care (RAC) is insufficient to meet the needs of older Australians, and recommended that allied health become an intrinsic part of RAC [38]. The *Resource Utilisation and Classification Study (RUCS)* confirms that access to wellness and reablement in the current residential aged care system is limited in supporting older Australians to achieve greater independence and quality of life. According to *The AN-ACC assessment model: The RUCS Report 2*, only six out of the 775 (0.8%) residents that participated in the study had accessed a structured reablement or restorative care program in the previous 6 months [39].

A Royal Commission *Research Paper 18: Hospitalisations in Australian Aged Care: 2014/15 – 2018/19* [40] lists the reasons for hospitalisation of residents in aged care facilities, many of which could have been avoided with sufficient access to allied health services. For example, 18.4% of all hospitalisations of residents were a result of falls and injury, and 11.9% were due to circulatory issues [40]. Many of these hospitalisations may have been prevented if residents had adequate access to an AEP.

The Royal Commission recognised that RAC was lacking adequate allied health access, with Commissioner Briggs recommending in Recommendation 38 (b) that all approved aged care providers be required to employ or engage at least one professional from each of the allied health professions, including an AEP [41]. Unfortunately, the Australian Government has not adequately demonstrated a commitment to implementing the Royal Commission's allied health recommendations in RAC.

In its response to Recommendation 38, the Government has stated that it "accepts-in-principle" the need for increased allied health and that implementing the new Australian National Aged Care Classification (AN-ACC) funding model will address the issues around allied health in RAC [42]. However, the AN-ACC was not designed to determine the care needs of residents [39], and was only intended to determine the optimal funding allocation per resident. *The AN-ACC Assessment Model: The RUCS Report 2* states that a separate assessment will need to be undertaken to determine each resident's care needs.

ESSA maintains that the Australian Government has not developed a meaningful strategy to support residential aged care providers to engage and retain adequate allied health services, including exercise physiology, for older Australians residing in care facilities.

Recommendation 14: that the Queensland Government via the Health Council advocate to the Australian Government that it needs to provide dedicated access to a range of allied health services, including exercise physiology, in each Residential Aged Care facility.

4.1.1 RESIDENTIAL AGED CARE FUNDING MODEL

The Royal Commission also found that the low accessibility of allied health in RAC is influenced by the current funding model, which does not address the care needs of the resident [38]. The current funding model

disincentivises the provision of reablement interventions delivered by allied health professionals, particularly those delivered by AEPs.

The current Aged Care Funding Instrument (ACFI) requires residents to be reassessed every 12 months or when there is a significant change in their care needs [43]. If residents' care needs reduce, the RAC facility receives less funding. This offers a disincentive for providers to invest in allied health care that can improve residents' function and wellbeing and reduce their care needs.

Following the Royal Commission's report, the Australian Government announced that the ACFI would be replaced with the AN-ACC on 1 October 2022 [42]. The AN-ACC funding model provides funding in two components, fixed and variable. The fixed amount is to cover the shared care costs of all residents in a facility, while the variable amount is to cover the individual care needs of the resident [39].

The new funding model eliminates the disincentive to offer reablement care by not requiring providers to have residents reassessed if their care needs reduce. However, there is no certainty that this approach will be adequate to cover the real costs of reablement and restorative services. There is also no evidence to conclude that not requiring a reassessment is enough of a lever to ensure that access to reablement and restorative services will be improved.

The broader issue is how the current lack of access to these reablement and restorative services (which include allied health services, and specifically exercise physiology services) can be improved in residential aged care given these services are general health services and are more accessible to older Australians living in the community.

Clinical exercise treatment prescribed and delivered by AEPs is a key part of best practice reablement and restorative services, however both the health and residential aged care systems do not support consumers with adequate access to clinical exercise treatment. This is even though successful reablement is possible with exercise interventions as evidenced by various government reviews and research which supports the value of therapeutic exercise in aged care [44-49].

Possible stronger policy levers to ensure allied health is appropriately embedded in RAC made by ESSA and other stakeholders in the aged care sector include:

- Mandating allied health care minutes in RAC facilities
- Providing the variable funding component of the AN-ACC directly to consumers so that they can control the allied health care services they receive, like what happens in home care.

Recommendation 15: that the Queensland Government via the Health Council recommends to the Australian Government that it develop and implement strong policies to embed allied health care into Residential Aged Care.

4.2 HOME CARE PACKAGE DELAYS

The Royal Commission reported that wait times for Home Care Packages have been unacceptably long for several years [38] and recommended (Recommendation 39) that the Australian Government clear the Home Care Package wait list by 31 December 2021 [41]. This recommendation was to ensure that all older people who required a Home Care Package had access to one at the appropriate funding level for their needs. However, the Government's response to this recommendation was that it would only be releasing 80,000 new Home Care Packages (40,000 in 2021/22 and 40,000 in 2022/23) [42], which is insufficient to meet consumer needs and does not align with the Royal Commission's recommendation.

It is now December 2021 and current wait times for Home Care Packages are still at least three months for the lowest level package and at least six months for all other package levels [50]. Further, those that require level 2, 3 or 4 packages must wait at least three months, and up to nine months, for an interim package that does not contain sufficient funding to meet their needs [50].

Delayed or complete inability to access allied health services by older people, including exercise physiology, significantly impacts their ability to maintain independence and avoid frailty. Research demonstrates that increased frailty in older people directly correlates with increased hospitalisations [51].

To reduce the incidence of PPHs in older people, it would be in the interests of the Queensland Government to ensure older people have immediate access to adequately funded allied health services through their Home Care Packages.

Recommendation 16: that the Queensland Government via the Health Council recommends to the Australian Government that it increases the overall number of home care packages, particularly the number of level 3 and 4 packages.

4.3 HEALTH LITERACY OF OLDER PEOPLE AND THOSE WITH CHRONIC CONDITIONS

The Australian Commission on Safety and Quality in Health Care (ACSQHC) identified that almost 60% of adult Australians have low individual health literacy levels and this can affect their capacity to make decisions and manage their health [52]. The impact of low health literacy levels has been observed in the Commonwealth Home Support Program, where people often prioritise domestic assistance and personal care over allied health interventions that have the potential to prevent functional decline and increase capacity to complete tasks independently.

This suggests that there is a need to improve the health literacy of older Australians, so that they may be better informed in relation to utilising their Commonwealth Home Support Program funding for allied health services. Increased access to allied health services in the Commonwealth Home Support Program will reduce reliance on domestic assistance, enabling older people to maintain their independence for longer and avoid frailty.

One example of a program that can increase the health literacy of older people is the Exercise Right for Active Ageing program. This is a national program designed for Australians aged 65 years and older, and Indigenous Australians 55 years and older. Funding from the Australian Government's *Move it AUS – Better Ageing Grants* Program subsidises 12 group exercise classes delivered by an AEP or an AES. The program began providing exercise classes in August 2019 and is scheduled to finish on 30 June 2022.

Participants are assessed prior to the commencement of their 12 sessions and again after completion of all exercise sessions. Preliminary results suggest that the program is successful in improving the physical mobility, functioning, physical activity lifestyle factors and perceived quality of life of participants. Upon completion of the program, participants are provided their individual assessment results (both initial assessment and final assessment) so they can see their improvement over the course of the program. The provision of this information offers evidence of the benefits of regular exercise to program participants, resulting in improved health literacy. This is evident in reports which indicate most people choose to continue attending exercise classes after completing the program.

Another example is ESSA's Exercise Right, a free evidenced based information channel and an information partner providing quality, trusted content for publication on Healthdirect Australia. Exercise Right supports health literacy for consumers with:

- Exercise Right at Home: https://exerciseright.com.au/exercise-home/
- Exercise Right Fact Sheets on various chronic conditions: https://exerciseright.com.au/chronic-conditions/
- ESSA's six e-Books:
  - Exercise & Mental Health
  - Exercise for Older Adults
  - Exercise & Cancer
  - Exercise & Men's Health
  - Exercise & Women's Health
  - Exercise & Disabilities.

Recommendation 17: that Queensland Health implements a health literacy program targeting older people and those with chronic conditions to support better consumer decision making about access to exercise and lifestyle change programs, in consultation with ESSA and other relevant allied health peak bodies such as Dietitians Australia.

5.0 NATIONAL DISABILITY INSURANCE SCHEME (NDIS)

5.1 INAPPROPRIATE DELEGATION TO SUPPORT WORKERS

ESSA has expressed concerns to the National Disability Insurance Agency that participant outcomes are being diminished by cost cutting at both the NDIS planning and review stages. ESSA has evidenced a growing trend in NDIA planners cutting, or significantly reducing, participant funding for exercise physiology and requesting that AEPs train unqualified support workers in the delivery of clinical exercise physiology interventions.

ESSA advocates for an active Australian population and understands the importance of support workers and carers in encouraging physical activity. However, ESSA has repeatedly expressed to the NDIA that there is a significant distinction between:

1. understanding the benefits of physical activity and encouraging incidental exercise day-to-day, and
2. the assessment, prescription and delivery of clinical physical activity interventions, and the monitoring and evaluation of those prescribed interventions for particular outcomes.

These concerns are underpinned by the physical and health risks to NDIS participants where unqualified workers are expected to deliver prescribed, clinical exercise treatments. It is inappropriate and dangerous to expect carers or support workers, who do not have the expertise, experience, qualifications, knowledge, or skill of AEPs, to conduct ongoing risk stratification, monitor symptomology, and adjust the prescription of exercise based upon complex interactions of diagnosis, exercise tolerances and changing medication regimes.

In other circumstances where AEPs have complied with NDIS demands and provided training to support workers, the following has been observed:

- Some participants receive supports from more than one allied health professional, which increases the amount of therapy support expected to be delivered by support workers (refer to Case Study B).
- Participants do not always receive the same support worker day to day or week to week, making it difficult to train a consistent team of support workers to deliver therapy support (refer to Case Study B).
- Support workers who are trained by AEPs often do not follow through on actively supporting participants to engage in prescribed activities and lack the behavioural counselling skills of AEPs to motivate clients to complete exercise sessions.
- Group home staff have been known to sign off on records confirming that home exercise services have been provided, but these records often conflict with the advice of participants.

Case Study B

A 17-year-old female had been receiving a range of therapies, including exercise physiology, occupational therapy, physiotherapy, and speech pathology. As part of the review process, funding was reduced across all therapies and the therapists were asked to train the participant's support workers in the delivery of therapy supports. The AEP noted that the participant received support from over 20 different care workers a week, and concerns had been raised about the risks associated with training such a large number of care workers in such a diverse range of therapy supports. The participant's mother was appealing the decision and expressed fear that her daughter may need to consider residential aged care if her body deteriorated any further.

Such delegation practices for short-term cost cutting by NDIS planners are likely to increase hospital presentations, as a result of increased risk of acute harm and injury to NDIS participants.

Further, participants that are forced to receive allied health therapy from support workers are less likely to receive therapeutic benefit from treatment, limiting their ability to experience improved functional capacity and optimal health outcomes. If sufficient allied health intervention delivered by an appropriately trained and qualified professional is supported by adequate NDIS plan funding, and NDIS planners cease inappropriately delegating allied health interventions to support workers, PPHs relating to chronic conditions of NDIS participants are more likely to reduce.

Recommendation 18: that the Queensland Government via the Health Council advocates to the Australian Government that the NDIA provide adequate budgets for NDIS clients to allow them the appropriate access to qualified allied health professionals, including Accredited Exercise Physiologists.

5.2 NDIS PLANNERS' LACK OF UNDERSTANDING OF ALLIED HEALTH AND ACCOUNTABILITY

ESSA has observed that NDIS planners do not understand the role or value of allied health. They have insufficient knowledge and lack qualifications and experience to determine the allied health needs of a participant. They also lack understanding of the scopes of practice and value of various allied health professions and often look to identify lower value alternatives which can be to the detriment of the participant's functional capacity outcomes. NDIS planners also do not receive ongoing training or professional development, despite new evidence and research emerging in relation to the impact of therapeutic supports on functional outcomes for people living with disability.

ESSA members have noted that planners are refusing to allocate funds in NDIS participant plans for therapy supports that are recommended by treating allied health professionals, including AEPs. Currently, AEPs must spend time educating individual NDIS planners on the role of an AEP and benefits of exercise physiology to support their NDIS participants to access exercise physiology funding in their plans, often without success.

Refusal to allocate funds to therapeutic supports is consistently occurring in the sector, despite participants and allied health professionals providing all the evidence requested by the NDIA to support the need for recommended allied health supports. Evidence provided has included peer reviewed research, case studies and allied health progress reports demonstrating therapeutic benefit for individual NDIS participants. Insufficient funds for recommended therapeutic supports have resulted in the functional decline and negative impacts on the health of many participants that are treated by AEPs, as seen in Case Study C.

Case Study C
A 9-year-old male with Autism Spectrum Disorder (ASD) presented with communication shut-down, emotional regulation issues, lack of motivation and below average fine and gross motor skills. Goals included developing communication and social skills so he can build and maintain friendships and relationships with others, and to recognise and understand emotions, learn strategies to self-regulate his emotions. During the 12-month plan period, as a result of weekly AEP interventions, the client had improved confidence; increased engagement and communication with little to no signs of communication shut down; increased exercise tolerance; increased time engaging within a community environment; improved gross motor skills; and required little to no parental support and supervision during therapy compared to last plan period. The participant's AEP recommended in the client's progress report that he continue to receive exercise physiology to further improve functional capacity, health and wellbeing outcomes and recommended that a future goal be to increase his exercise tolerance from 45 minutes to 1 hour per week.

At plan review, all AEP funding was removed and only funding for occupational therapy and psychology was provided, despite the family's preference for him to continue seeing his AEP. The planner indicated that funding for AEP was removed, as the child would now be able to get the physical activity he needed from school. After a few months of engaging with the new plan, the child's parents contacted his AEP to provide feedback that he was disengaging from school due to reduced confidence to participate in social and sporting activities, as he did not have the coordination or social skills to participate. The participant was not responding to new allied health therapies, resulting in them being ineffective.

Case Study C highlights that the planner was not aware of the value that exercise physiology provides over general physical activity, or the impacts that AEP interventions provide relating to the development of fine and gross motor skill development, coordination and increased confidence for social engagement in people with ASD. As indicated in Case Study C, if the participant's fine and gross motor skills, coordination, and confidence are not addressed, the participant will not engage in physical activity within a community environment. Therefore, by allowing this participant to access an AEP with his NDIS plan funding, the participant will ultimately reduce his risk of developing many of the chronic conditions that contribute to PPHs, such as diabetes, hypertension, angina, or congestive cardiac failure.

ESSA members have previously reported claims from planners that AEP supports are only relevant for people with a physical disability. However, research evidence highlights that exercise therapy is beneficial for many cognitive and psychosocial disabilities as well. For example, various forms of exercise therapy have been proven to provide behavioural, emotional and social benefits for people with ASD [53-57].

Exercise is also shown to improve the lives of people with psychosocial disability by improving both their mental and physical states [58]. AEPs are qualified to understand and treat the symptoms and presentations of mental illness to prescribe the appropriate level and type of physical activity at each presentation, as people with severe psychosocial disability are not recommended the same level of physical activity as the general population [59].

The lack of planners' understanding about the role or value of allied health is currently one of the most significant issues that AEPs report in relation to their ability to successfully provide services to NDIS participants and has been highlighted by many other allied health peak bodies. The NDIA needs to ensure these workers are appropriately trained and educated on each allied health scope of practice, so that funding allocations will ensure the best possible outcomes for NDIS participants.

NDIS planners who chose to reduce participant plan funding or limit funds to services against allied health professionals' evidence-based recommendations see no repercussions for the harm they cause to participants who are forced to engage support workers to deliver allied health therapy, or to those that see funding for much needed allied health therapy removed from their budgets. As seen above, both scenarios have negative consequences on NDIS participants' functional capacity and health outcomes.

ESSA believes a large reason for these occurrences is that there is no enforced requirement for planners to undergo training, including ongoing training, on the value that allied health therapy has for people with disability, longer-term scheme sustainability and PPHs. Nor are there repercussions for poor decision making by an NDIS planner, which results in negative functional and health outcomes for a participant.

Recommendation 19: that the Queensland Government via the Health Council requests that the Minister for the NDIS

- **mandates:**
  - **a minimum level of knowledge of each NDIS therapeutic support and allied health profession for internal NDIA decision-making staff, including planners and Local Area Coordinators**
  - **ongoing planner training to ensure planners' knowledge of therapeutic supports and allied health professions is regularly updated, in accordance with new and emerging evidence and**
  - **the employment of planners who have qualifications and/or experience in health or human services and**
- **provides support to planners to develop a strong understanding of the complex needs associated with participants' disabilities.**

ESSA has offered the NDIA the opportunity to inform planners by providing education and resources on the evidence-based health and functional benefits of exercise treatments for NDIS participants as well as the role and value of exercise physiology services on numerous occasions, through tailoring the content of Exercise is Medicine© (EIM©) Australia, to suit the needs of NDIS planners.

EIM® is a bespoke education program facilitated by local AEPs and can be delivered in face-to-face workshops and on online. EIM sessions are currently designed to increase literacy of primary healthcare providers on the role that physical activity plays in health, wellbeing, inclusion, self-efficacy and the prevention and treatment of chronic disease. However, ESSA yet to receive a response from the NDIA relating to its desire to utilise these resources.

Recommendation 20: that the Queensland Government via the Health Council requests the NDIA engage ESSA to implement the Exercise is Medicine© program for NDIS planners and support workers to augment workforce knowledge and health literacy to better support NDIS participants.

ESSA advocates for the development of a legislative instrument such as a Code, Standard or Rule to align the NDIA's operations with the required accountability under the *National Disability Insurance Scheme Act 2013*. This instrument would support NDIA employees and provide clear requirements for accountability in NDIS participant decision making.

Recommendation 21: that the Queensland Government via the Health Council requests the Minister for the NDIS develop a legislative instrument to support NDIA staff accountability in enabling participant decision making, and which will be administered by the NDIS Quality and Safety Commission.

6.0 PRIVATE HEALTH CARE SYSTEM

There is a lack of data visibility on exercise physiology service utilisation in the private health insurance sector. The Australian Prudential Regulation Authority (APRA)'s *Private Health Insurers Operations of Private Health Insurers Annual Report* (*Annual Report*) currently does not include data on exercise physiology service provision [60]. Instead, data on exercise physiology services provided by private health insurers is included under "other" in the *Annual Report*. As noted, earlier exercise physiology is a growing profession and is increasingly being included in private health insurance policies. The lack of data through APRA means that it is not possible to determine the current state of exercise physiology service provision through private health insurance in Queensland. Changes need to be made to future reporting by APRA.

Recommendation 22: that the Queensland Government via the Health Council advocates to the Australian Government that Australian Prudential Regulation Authority to include exercise physiology as a standalone category when reporting general treatment (ancillary) services.

Despite the inability to determine exercise physiology expenditure in its own regard, by understanding that exercise physiology is a service within "other," the *Annual Report* demonstrates that exercise physiology services are severely underutilised in the private health system. Only 136 "other" ancillary services were provided in the private health insurance sector in financial year 2020-21 in Queensland, with exercise physiology being a subset of this service provision [60]. This is an extremely low utilisation rate, when compared to other ancillary services, such as dental, which was accessed 9,376 times by insured Queenslanders last financial year.

Given the potential for exercise physiology to reduce PPHs relating to a broad range of chronic conditions, including mental health conditions, it is in the best interests of the Queensland Government, as well as private health insurers, to increase access to AEPs within the private health care system. ESSA notes however that although exercise physiology is available in 35 of the 37 available APRA listed private health insurance policies, each policy has various levels of cover, and exercise physiology is not accessible at all levels of these 'extras' policies creating an accessibility issue within private health. Additionally exercise physiology is often combined in policies with physiotherapy and whilst physiotherapy prescribes exercise, the scope of practice for exercise physiology is focused entirely on clinical exercise treatment including psychosocial elements [1] and is therefore a different treatment to physiotherapy and should be listed separately.

Recommendation 23: that the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase and allow equitable access to exercise physiology services as other mainstream allied health services in all levels of each of the 37 policies, including listing in polices separate from other disciplines.

6.1 HEALTHY EATING ACTIVITY AND LIFESTYLE (HEAL™) PROGRAM

The Healthy Eating Activity and Lifestyle (HEAL™) program is a lifestyle modification program that enables participants to develop lifelong healthy eating and physical activity behaviours. HEAL™ consists of 8 weekly group education and group exercise sessions as well as individual consultations pre- and post-program, plus 5 and 12-month follow-up health consultations, where health-related behaviours and outcomes, such as minutes spent executing planned physical activity, fruit and vegetable consumption, weight and body mass index are measured and recorded. HEAL™ is specifically designed to assist people who are obese, are at high risk of chronic disease or who have one or more chronic diseases such as heart disease and diabetes.

The *2020 HEAL™ Evaluation Report* [61] shows that the program is successful in improving and maintaining most health-related behaviours and outcomes at 8 weeks, 5-month follow-up and 12-month-follow up. This program is now available for eligible customers of Bupa, Medibank, HCF, Teachers Health Fund and the Nurses Health Fund. By providing access to healthy behaviour promoting programs such as HEAL™ more broadly, private health insurers and public health systems may reduce their healthcare expenditure [62-64].

Recommendation 24: that the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase access to the HEAL™ program, by encouraging all private health insurers to offer the program within their policies.

6.2 ACCESS TO ACCREDITED EXERCISE SCIENTISTS

While AEPs deliver clinical exercise treatment to high-risk populations, including people with chronic disease or disabilities, Accredited Exercise Scientists (AESs), who are not recognised allied health professionals, deliver exercise programs to healthy and low-risk populations to help prevent or delay the onset of chronic conditions [65]. AESs often provide personal training services and group exercise classes, as part of their preventative care approach. AESs present as an appropriately trained and qualified workforce to deliver many preventative health programs to reduce the impact of chronic disease.

For this reason, some private health insurers, including Bupa, Medibank and HCF, have begun including personal training services delivered by an AES or a personal trainer, for their members who have specified policies with these insurers to help them manage an existing health condition, as approved by a referring health professional. Personal training offers a lower-cost service that may help prevent severe chronic disease, reducing longer-term costs to the insurer and the public health system.

Recommendation 25: that the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase access to Accredited Exercise Scientist delivered programs, such as personal training, by encouraging all private health insurers to:

- **offer Accredited Exercise Scientist delivered personal training within their policies and**
- **work with ESSA to develop an appropriate model for the provision of Accredited Exercise Scientist delivered personal training.**

7.0 MEDICARE AND BULK BILLING POLICIES

7.1 CHONIC DISEASE MANAGEMENT PLANS

7.1.1 TEMPORARY PHYSICAL THERAPY ITEMS FOR RESIDENTIAL AGED CARE

Until 30 June 2022, new Medicare items are available for people in RAC facilities impacted by the COVID-19 pandemic. The Australian Government has recognised that lockdowns may have resulted in the decline of residents' overall mental and physical health. People residing in RAC facilities that have a CDM plan (new or existing) are currently eligible to access:

- 5 individual and 8 group allied health services
- 5 additional services for individual exercise physiology, occupational therapy and physiotherapy,
- 2 additional services for group exercise physiology.

These temporary items have been available to residents since December 2020, and uptake has so far been poor. ESSA members have reported that many GPs are not utilising these additional items in their patient's CDM plans, as they are either not aware of the items, or have received inaccurate information on these items or are scared of being audited for over-referring.

ESSA also believes clinical directors and care managers within RAC facilities are also not facilitating GP referrals to these items for residents.

Recommendation 26: that Queensland Health works with the Queensland Primary Health Networks to better communicate the availability of these temporary items to General Practitioners, to increase their uptake before 30 June 2022.

Recommendation 27: that the Queensland Government via the Health Council advocates to the Australian Government to permanently retain the additional physical therapy Residential Aged Care Facilities Medicare Chromic Disease Management items.

7.1.2 NUMBER OF ALLIED HEALTH SERVICES

Under a Medicare CDM plan, patients have access to a maximum of five allied health services per calendar year [66]. Five allied health sessions per calendar year is far less than standard clinical practice suggests is necessary to effectively manage chronic health conditions [67], making current Medicare arrangements

insufficient to meet the needs of patients with a chronic disease, particularly when considering that the five sessions are shared among all allied health services.

If patients with chronic disease have sufficient access to allied health services, they are less likely to present at emergency departments, be admitted into hospital, and, if admitted, have a reduced length of stay [68].

Within the MBS Review, the Allied Health Reference Group recommended the number of allied health appointments under team care arrangements be increased by stratifying patients to identify those with more complex care requirements [69]. Despite solid evidence from many peak allied health professional bodies, and many other recommendations being accepted from other Reference Groups and Clinical Committees with more limited evidence, the MBS Review Taskforce, whilst supportive of the rationale behind this recommendation, recommended more research be undertaken [70].

Allied Health Professions Australia responded to this underwhelming news by writing to the Australian Health and Rural Health Ministers on behalf of its allied health member associations in mid-December 2020 and met with Minister Hunt in early March 2021 to discuss the *MBS Review Taskforce Report*.

As a result of this advocacy, the Australian Government responded in the 2021-22 Budget with a funding announcement to create new MBS items to reimburse allied health professionals for participating in multidisciplinary case conferences for chronic disease management and for children with autism and other pervasive developmental disabilities for 1 November 2021 implementation. The additional conferencing items have gone some way to providing incentives for allied health professionals to participate more fully in multidisciplinary team care.

The issue of additional sessions and additional allied health access is still unresolved with the *Consultation Draft of the Primary Health Care 10 Year Plan* [71] proposing a short-term action (within 1-3 years) to reward allied health participation in MBS team care arrangements and a future state action (7-10 years): Finding models incentivise and support a multi-disciplinary approach.

Recommendation 28: that the Queensland Government via the Health Council advocates to the Australian Government that it fast track additional Medicare Benefits Schedule allied health sessions and/or provide funding for additional allied health services to be commissioned via Primary Health Networks.

7.2 REMUNERATION AND INDEXATION

Allied health indexing payments within the Medicare Benefits Schedule (MBS) were frozen in the 2013–14 Budget to 1 July 2019, some two years after indexing for bulk billing incentives for general practitioners resumed in 2017 [72]. Comparatively, fee schedules in workers' compensation schemes consistently receive a Consumer Price Index (CPI) increase on an annual basis. There was no reasonable explanation provided as to why allied health payments were frozen for a longer period than other groups of health professions, other than as a short-term cost saving measure for the Australian Government.

The current rates do not provide an incentive to deliver services and encourage providers to prioritise other schemes over Medicare, thus reducing access and choice for patients.

AEPs can set their own prices for service provision within the aged care sector. The community based aged care sector is designed to be a competitive market. Aged care consumers can choose not to engage a service if they are able to find a similar service at a more competitive price. An analysis of recent Home Care Package data indicates that on average, AEPs charge $186.85/ per hour [73]. Workcover Queensland provides $189/hour plus GST [74] to all allied health professionals delivering services under Workcover Queensland, including exercise physiologists, and Workcover WA provides $207.05 per hour plus GST for exercise physiology [75].

In comparison, AEPs working under MBS attract a fee of just $53.80 (GST exclusive) for a 20-minute service [76], which is equivalent to a $161.40 per hour of service and less than the aforementioned equivalent compensable schemes' remunerations.

ESSA is aware that some integrated multidisciplinary primary health care providers (mostly not-for-profit entities) aggregate and pool funding from a variety of sources (e.g. Medicare Benefits Scheme, National Disability Insurance Scheme) including program and/or recurrent funding from the Australian and Queensland

Governments for contracted service provision. These providers generally operate for specific target groups (Culturally and Linguistically Diverse People, indigenous, low income, regional etc). Some struggle to offer competitive salaries for new allied health graduates because of the higher starting salaries for graduates in private practices which do not rely heavily on Medicare.

There are broader inequities in the MBS where 'like for like' non-clinical services are not rewarded equitably. As one example of a blatant disparity between professions, the current flag fall fees for COVID-19 Temporary MBS Allied Health Services for Residents of Aged Care Facilities are $57.25 for GPs and $48.95 for allied health providers [77]. This flag fall is not dependent on clinical skills and there is absolutely no reasonable case for the difference in these benefits.

Recommendation 29: that the Queensland Government via the Health Council requests the Australian Government

- **backdates indexing for allied health MBS item to ensure consistency of indexing with GP items or increases MBS rates to align better with current market conditions**
- **ensures that any future indexing payments for clinical items within the MBS be made equitably across all health professions and**
- **ensures that any new non-clinical MBS items applying to both medical and allied health professions are the same.**

7.2.1 REMUNERATION IN RURAL AND REMOTE

As mentioned at the Public Briefing for this inquiry, MBS items attract the same rate in urban areas as they do in rural and remote locations. This discussion focused on the inability to attract and retain GPs, based on the lack of financial incentives under the MBS. However, the Committee should be mindful that this is also the experience of allied health professionals and that allied health MBS services should also attract increased remuneration when delivered in rural and remote locations.

In comparison, the NDIS offers increased remuneration for service provision in remote (MMM6) and very remote (MMM7) areas [78]. Services provided in remote locations attract 40% more funding than services delivered in metropolitan and regional areas, while services provided in very remote locations attract 50% more funding than services delivered in metropolitan and regional areas [78].

Recommendation 30: that the Queensland Government via the Health Council requests the Australian Government take action on providing better incentives for allied health MBS services delivered in rural and remote areas.

8.0 COMMONWEALTH GOVERNMENT'S DEFINITION OF THE COMMONWEALTH DISTRIBUTION PRIORITY AREAS

ESSA notes that the Australian Government has recently announced the expansion of Distribution Priority Area (DPA) classification to make it easier for rural and regional areas to recruit from the pool of GPs under location moratoriums [79]. Previously, only Modified Monash Model (MMM) 5-7 regions and the Northern Territory were automatically assigned DPA classification to GP catchments. Now MMM 3-4 regions will receive this automatic inclusion [79].

While it is now even easier to recruit GPs to rural and remote locations, there remains no DPA classification and incentive scheme for allied health professionals to be eligible for Medicare.

There is some recruitment of international allied health professions who can obtain visas if they are qualified to work or train in an eligible skilled occupation. Current allied health occupations on the Australian Government's Medium and Long-term Strategic Skills List [80] include:

- orthotist or prosthetist
- chiropractor
- osteopath
- occupational therapist
- physiotherapist
- podiatrist
- sonographer

- audiologist
- speech pathologist
- exercise physiologist under the 'Other Natural and Physical Science Professionals nec'.

Physiotherapy, is the only allied health profession with a National Board under Australian Health Practitioner Regulation Agency (AHPRA) to have an Overseas Practitioner Registration category. Many physiotherapists with this registration work on providing pain management services in residential aged care providing therapeutic massage, despite this not being consistent with contemporary practices [44].

Other allied health professions regulated by AHPRA including occupational therapy, osteopathy, podiatry and psychology have pathways for internationally-qualified occupational therapists wanting to practise in Australia as do internationally qualified self-regulated allied health professions like exercise physiology which has an International Exercise Physiology accreditation pathway [11].

As previously noted, Emeritus Professor Worley in his *Report* [11] noted the greatest need for the allied health workforce occurs in MMM4-7 regions.

There are many options to support allied health professionals to relocate to rural and remote areas. One option is to establish Distribution Priority Areas for allied health and support the recruitment of more international allied health professions. Another option is to establish a Bonded Allied Health Places program similar to the one for general practitioners (GPs). Both programs support the recruitment of GPs in MM 5 – 7 locations.

Alternatively, programs like the NSW Health's Allied Health Rural HECS-HELP Incentive Package support new or recent graduates (with a HECS-HELP loan) with a four-year comprehensive incentive package to relocate to areas of critical need in rural and remote NSW.

ESSA also notes that Health Workforce Queensland in partnership with Northern Queensland PHN has developed a targeted allied health campaign to recruit and retain a sustainable allied health workforce in that region; and administers scholarships and bursaries for allied health providing primary health care services in rural and remote Queensland.

A reference has been made earlier to the very recent announcement by the Australian Government of a scheme to write off the HECS debts for GPs and nurse practitioners seeking work in remote, rural and regional areas.

Recommendation 31: that the Queensland Government via the Health Council requests the Australian Government consult with stakeholders about the possibility of establishing a Health Workforce Distribution Priority Areas (DPAs) scheme for allied health to support the recruitment and retention of allied health professionals in MMM 4-7 areas.

Recommendation 32: that the Queensland Government considers establishing an incentive package program for allied health new or recent graduates to relocate to areas of critical need in rural and remote Queensland similar to the NSW program.

9.0 AVAILABILITY OF TRAINING PLACES AT QUEENSLAND UNIVERSITIES, COMPARED TO OTHER JURISDICTIONS

ESSA is not in a position to respond to the use of availability of medical training places at Queensland Universities. However, ESSA requests the Committee consider the availability of training places at universities for allied health professionals, particularly in rural and remote Queensland, as these locations have the greatest need for allied health professionals.

9.1 RURAL AND REMOTE TRAINING PLACEMENTS

The following Queensland based universities deliver ESSA accredited courses for exercise physiology [81]:

- Australian Catholic University, Banyo
- Griffith University, Gold Coast
- James Cook University, Townsville
- Queensland University of Technology, Kelvin Grove
- Southern Cross University, Gold Coast
- University of Queensland, Brisbane

- University of Southern Queensland, Ipswich
- University of the Sunshine Coast, Sippy Downs

There are specific training issues relating to the recruitment and retention of health practitioners in rural areas. Emeritus Professor Worley's *Report* [11] notes:

> "Extensive research over two decades has demonstrated the connection between rural origin and the retention of rural practitioners. Research has also shown us that extended rural exposure during training has a positive influence on early-career decision making and higher rates of retention. However rural students face numerous barriers to accessing tertiary allied health courses and limited options to undertake their training in rural settings. Most of the rural allied health training consists of short-term placements in MMM2-3 locations, while the greatest need for workforce occurs in MMM4-7 regions. An added complexity is the lack of capacity for practitioners (who are often solo or part-time) in these areas to supervise students."

An example of an initiative connecting students with rural communities in Queensland is GROW Rural. This immersion program goes over three years and provides students in medical, nursing, midwifery and allied health an opportunity each year to experience clinical practice in a rural setting. Over the period of the program students get to know the residents in these communities and to understand the attractions of working in regional and rural areas.

Recommendation 33: that Queensland Health works with education providers to ensure that appropriate rural allied health student practicum placements are available.

9.2 SUPERVISION TO SUPPORT RURAL AND REMOTE PLACEMENTS

The availability of rural and remote allied health university training placement is dependent on the communities' ability to attract, retain and train already qualified allied health professionals to act as student supervisors [82].

Emeritus Professor Worley confirms many of these issues surrounding the lack of supervision [11]:

> "Increasing the number and capacity of allied health professionals providing supervision will not only support students but also new graduates and early career allied health professionals who currently make up a large proportion of the rural allied health workforce and where it is not uncommon for them to be the sole provider for their profession in the town. These new or recent graduates can experience isolation, burnout and often only have access to minimal and remote supervision. Understandably, the attraction to, and retention of, allied health professionals in these positions is an ongoing challenge. What has come through strongly in the literature and consultations is that these unsupported positions are a risk to individual professionals and communities alike. Safety and quality can be compromised for the worker who is practising in an unsupported environment and for the client who is receiving treatment from an inexperienced or burnt-out allied health professional without ready access to appropriate clinical expertise and support."

Recommendation 34: that Queensland Health works with peak allied health professional bodies (including ESSA) to develop mechanisms for adequate clinical supervision of new and early career allied health professionals, especially those from newer and smaller allied health professions like exercise physiology.

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