

Strategic Plan for the Allied Health Sector

- better utilisation, better health outcomes

During 2015, allied health stakeholder groups considered how allied health could strengthen its contribution to the health system in order to deliver better health outcomes for Australians.

In March and April 2015, four ‘brainstorming’ workshops titled: ‘Strategic Thinking of Allied Health Services in Primary Care’ were conducted. The workshops canvassed ideas from allied health professionals, general practitioners and public health organisations. In August and September 2015, two follow-up workshop sessions were held to further examine and prioritise the ideas that were generated in the initial series of workshops and to formulate actions for all key players in the sector. The Australian Government Department of Health assisted in the logistics of organising the workshops, and supporting development of this outcomes paper. The document does not represent the views of the Department of Health.

The Strategic Plan for the Allied Health Sector document provides a record of the ideas and proposed actions that were developed during the workshops. It represents a collection of views of organisations involved in the development of this document.

The ‘issues to be addressed’ segment is based on feedback from all workshops and meetings, as well as current literature. The key activities outline some possible actions to take forward with timeframes. It needs to be noted that the ideas, issues and key activities are not a consensus view, and that the actions for those organisations specified are not commitments.

PURPOSE

To identify:

- the value Allied Health Professionals (AHPs) are contributing to the health system;
- options for greater and more efficient use of AHPs. This can address some of the demand on the increasingly overburdened health system; and
- some actions to strategically better place AHPs for the future of health service provision, with particular attention to the primary care context.

ALLIED HEALTH – CORE CONTRIBUTORS TO CONSUMERS’ HEALTH

It is estimated that Allied Health (AH) comprises 20% of the health workforce and delivers 200 million services per year¹. These services include those with: people of all ages to maintain their health and help prevent illness; patients in acute care and in rehabilitation to contribute to their recovery; and consumers in community health care settings to manage their health condition and to continue to participate in their life choices.

There is no universally accepted definition of allied health. However, AH has been defined by a number of key AH organisations in Australia. The Australian Allied Health Forum (AAHF), a collaborative of representatives from allied health organisations who work together on issues of national importance to the allied health professions and the Australian public, has defined the Allied Health Professional as follows:

AHPs are qualified to apply their skills to retain, restore or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations. Allied Health Professionals hold nationally accredited tertiary qualifications (of at least AQF Level 7 or equivalent), enabling eligibility for membership of their national self-regulating professional association or registration with their national Board. The identity of allied health has emerged from these allied health professions’ client focused, inter-professional and collaborative approach that aligns them to their clients, the community, each other and their health professional colleagues².

CURRENT AUSTRALIAN CONTEXT

- There has been a shift in the burden of disease in Australia away from short episodes of ill health to a growing prevalence of chronic disease which is placing significant strain across the Australian healthcare system.
 - An estimated 80% of the burden of disease and injury suffered by Australians is attributable to chronic conditions³.
- The number of chronic diseases a person has increases with age:
 - One in two Australians aged 65 years and over report having 5 or more long-term (or chronic) conditions⁴.
- Patients with poorly managed complex multiple chronic conditions are likely to consume a disproportionate share of health system resources, in particular through experiencing emergency department presentations and unplanned hospital admissions.^{5,6}
 - The Australian Institute of Health and Welfare (AIHW) reports that at least 10% of hospital stays for patients with chronic conditions are potentially preventable had timely and adequate non-hospital health care been provided⁷.
- Increasing prevalence of multiple chronic conditions in older Australians combined with high expectations for access to new health technologies and quality services will, over time, increase and compound the independent effect of population ageing on health system usage

1 Allied Health Professions Australia March 2013 <http://www.ahpa.com.au>

2 Australian Allied Health Forum. Overview for 2014-15.

3 Australian Government Department of Health and Ageing (2010), *Building a 21st Century Primary Health Care System: Australia’s First National Primary Health Care Strategy*.

4 2007-08 National Health Survey

5 DoHA (2008), *Towards a National Primary Health Care Strategy: A discussion Paper from the Australian Government*.

6 For example, in the US in 2002, 5 per cent of the population accounted for 49 per cent of health care expenditure. Agency for Healthcare Research and Quality, ‘The High Concentration of U.S. Health Care Expenditures’. <http://www.ahrq.gov/research/findings/factsheets/costs/expriach/index.html>

7 Australian Institute of Health and Welfare, 2014. *Australia’s health 2014*. Australia’s health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

and costs⁸.

- Australia's ageing population base means that from 2009–10 to 2049–50, real health spending on those aged over 65 years is expected to increase around seven-fold and twelve-fold for those aged over 85 years⁹.

THE CURRENT AUSTRALIAN HEALTH SYSTEM

The Australian health care system is fragmented, and is driven by a mix of government funding, including federal, state, territory and local government, non-government organisations, private insurers as well as a significant out of pocket contribution by the consumer. The out-of-pocket cost to the consumer has been identified as a barrier to receiving appropriate treatment, and is relatively high compared to most other OECD countries. A report published in 2013 states that in NSW 15% of adults reported skipping doctor's appointments, medications or tests due to cost and 23% said their family spends more than \$1000 a year on medical expenses¹⁰. The same report notes that from 11 countries in a Commonwealth Fund survey, Australia was second only to the US in terms of out-of-pocket costs.

A key aspect of federal funding is Medicare. Medicare was designed to manage episodic, acute or one-off illnesses¹¹. With this fee-for-service model, the data collected is on system inputs, it is more difficult to monitor the impact of service provision. Payment is not outcome based.

Currently, the health system has a siloed (single disease) approach to chronic disease management. It is not effectively managing long-term, multiple conditions. In addition, there is an over-reliance on the acute care sector to manage poorly managed chronic diseases and disease exacerbations.

HOW ALLIED HEALTH IS CURRENTLY PLACED IN THE HEALTH SYSTEM

- *The profile of Allied Health is poor.*

Allied health (AH) is the third pillar of the health workforce. Yet, it does not have the same public profile as nursing and medicine. At a systems level, AH is largely overlooked¹².

One of the barriers is that the term Allied Health is not universally defined. Its definition varies by country, which makes international comparisons of the AH workforce difficult. Even within Australia, there is generally a poor understanding of what AH means, which leads to inconsistent use of the term between state, territory and federal governments. As AHPs are employed in a number of sectors, including health, education and social services, there is also inconsistency in definition between sectors.

Allied health professions can be registered with Australian Health Practitioner Regulation Agency (AHPRA) or self-regulated by their own professional associations. Those professions registered with AHPRA are those that may present a serious risk to public health and safety. Registered professions include physiotherapists, occupational therapists, optometrists, podiatrists, and pharmacists. The self-regulated professionals include: audiologists, social workers, dieticians, exercise physiologists and speech pathologists.

Allied health is made up of a number of professions, some of which are small in size. The range of tasks performed between professions is also quite broad. This makes workforce planning difficult,

8 Australian Institute of Health and Welfare, 2014. *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

9 Intergenerational Report 2010 - Australia to 2050: future challenges, Commonwealth of Australia. January 2010.

¹⁰ Bureau of Health Information. Healthcare in Focus, 2013, *How does NSW measure up?*
http://www.bhi.nsw.gov.au/__data/assets/pdf_file/0008/216971/Main-report_HealthcareInFocus-2013.pdf

11 Australian Government Department of Health 2015 *Better Outcomes for people with chronic and complex health conditions*. Primary Health Care Advisory Group consultation paper.

12 Philip, K 2015 Aust Health Review. Perspective: *Allied Health: the untapped potential in the Aust health system*.

as it is usually based on large volume workforce groups to ensure the efficacy of the modelling¹³.

- *The role of Allied Health in primary care could be expanded*

The role of AH in the acute care setting is well established. This includes diagnostic technologies, assessing function and risk from disease, mitigating length of stay and facilitating effective discharge¹⁴. For example, a physiotherapist assesses stroke patient mobility, a speech pathologist may assess the patient's swallowing function and an occupational therapist assess and advise on the home environment – all facilitating early safe discharge. Allied health interventions in subacute settings have been shown to result in cost savings due to shorter hospital admissions or better management of medications. Screening assessments by AHPs significantly reduce the waiting lists of specialists, for example an Orthoptist can test patients thought to have a vision problem and refer on those with actual defects.

AH has the potential to play a greater role in chronic disease management delivered in the primary care setting. New primary health care service delivery models and locally developed care pathways have potential to better support people to manage their chronic diseases close to home. This would enable a more sustainable health system into the future. To manage chronic illness people need to extensively modify their lifestyle (diet, exercise, smoking etc), adhere to a demanding treatment plan, and cope with psychological and social issues associated with having a chronic illness. There is very limited capacity in the existing health system to provide people with evidence-based interventions to tackle these behavioural and psychological issues. They need to be holistic, well integrated, coordinated and supported by enhanced communications to improve health outcomes for people with chronic diseases.

Allied health professionals are well placed to make a significant contribution to these primary health care service models by providing care to optimise patient's function, reduce the likelihood of disease complications, improving the patient's ability to live independently in their own homes, and assisting patients to self manage their care. Evidence shows that self-management is more likely to be effective when there is AHP intervention¹⁵. In addition to patient education for self-managed care, a psychologist can assist for psychological and behavioural strategies to support adjustment and social support. Other examples include: regular dietitian interventions can lead to improved diet which can in turn lead to better blood sugar control in diabetes; and an occupational therapy assessment can lead to more appropriate living arrangements such as home modifications to decrease the likelihood of falls for stroke patients in their homes.

- *Allied Health evidence is mounting but there are challenges*

Currently, it is difficult to quantify the number of services provided in Australia by all AHPs and there is currently no demand data for AH. Data on the full range of services is not centrally collected or analysed. It is also difficult to know the geographic distribution of AH services for population planning. This is in contrast to medical services that are well captured and studied by the use of Medicare data. AH services provided through Medicare represent a small proportion of AH services provided by private practitioners. Private AH services may also be subsidised by private health insurance, Department of Veterans Affairs, third party compensation or paid for fully by consumers who can afford to pay. Public AH services are provided by State and Territory governments. This data is also not centrally collected or analysed. This represents a significant challenge for policy makers.

Published studies on AH interventions have shown that AHPs have improved outcomes for patients

13 Buchan, J & Law, D 2015. *A review of allied health workforce models and structures*. A report to the Victorian Ministerial Advisory Committee for Allied Health

14 Philip, K, 2015 [op.cit](#)

15 Taylor, S.J et al. 2014. *A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions: Practical systematic Review of Self-Management Support for long-term conditions*. Health Services and Delivery Research. 2(53).

with chronic diseases including diabetes, stroke, cardiac and respiratory conditions. In addition, a number of studies have shown AH intervention to have cost benefits, resulting in savings to the health system. This includes:

- A 2015 Deloitte Access Economics study has shown that Accredited Exercise Physiologist (AEP) interventions provide a high return on investment in treating people with chronic conditions, including diabetes, mental illness and cardiovascular disease. For cardiovascular disease, the total lifetime burden of disease savings resulting from intervention with an AEP is estimated to be \$11,847 per person annually. In comparison, the cost associated with delivering the intervention was \$1,903 per person¹⁶.
- A 2015 report developed for Services for Australian Rural and Remote Allied Health (SARRAH) by Novartis Pharmaceuticals Australia showed potential annual savings to the Australian healthcare budget from the implementation of allied health interventions ranges from \$5.1 million to \$77.9 million across the range of outcomes targeting type II diabetes, osteoarthritis and post-stroke populations¹⁷.
- A diabetic foot care program focusing on podiatry care in NSW showed cost savings in emergency department presentations, hospitalisations, and length of stay¹⁸.

Most of the data showing AH effectiveness is specific to a profession, and focused on a specific intervention and outcome measure¹⁹. For example, limb range of movement post physiotherapy intervention. It can be challenging to show the cost effectiveness of a AH intervention when most professions work as part of a multi-disciplinary team. In addition, to undertake economic modelling, significant data sets are required, given the size of some AH professions, this can be difficult to achieve.

- *There is a need for greater, targeted AH capacity in the health system, especially in rural and remote regions, and for those on low incomes with multi chronic conditions.*

Despite evidence demonstrating the impact of allied health intervention, the best care is not always offered or available. Every 2-3 hours in Australia there is an amputation that could have been prevented with better management of diabetes²⁰. This is more evident in rural and remote areas, with residents in rural and remote areas having mortality rates 1.4 times as high as residents in major cities. They are also 1.44 times more likely to die from a stroke than urban Australians²¹. Data has shown that the regional and remote areas of Australia have fewer AHPs per 100,000 population than the major cities²². Doctors may be less likely to refer in those areas of low AHP availability and patients may be less likely to attend if they are referred due to travel time.

AH services are currently inadequate and are not meeting community needs, especially those with chronic disease on low incomes. In the public sector, AH services are usually provided by state and territory governments in community health centres or in public hospitals. These are often overwhelmed by demand, have strict access criteria and/or have significant waiting lists. The AH services provided in the private sector can be government subsidised by Medicare, but the referral

¹⁶ Deloitte Access Economics, 2015. *Value of Accredited Exercise Physiologists in Australia*. Exercise & Sports Science Australia. <https://www.essa.org.au/for-media/position-statements/>

¹⁷ Novartis Pharmaceuticals Australia, 2015. *The impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke*. <http://sarrah.org.au/resources/publications>

¹⁸ DeCourcy, V 2014. *Investigating the Efficacy of Allied Health: Reducing Costs and Improving Outcomes in the Treatment of Diabetes, Osteoarthritis and Stroke*. A report drafted for SARRAH. <http://sarrah.org.au/resources/publications>

¹⁹ Buchan, J & Law, D 2015. op cit

²⁰ Australian Government Department of Health 2015 op cit

²¹ DeCourcy, V 2014. op cit

²² Australian Institute of Health and Welfare, 2012. *Allied health workforce 2012*. National health workforce series no.5. Cat no.HWL51.Canberra. AIHW.

process is complex, there is often a consumer out-of-pocket expense and the services are limited to a total of five AH visits (across all AH professions) in a calendar year. To access the Medicare subsidy, a patient must have a General Practitioner initiated Chronic Disease Management plan and a Team Care Arrangement (TCA) plan. In addition, the AHP is paid the same fee by Medicare for all visits regardless of time spent, even though initial consultations usually require more time and assessment.

Some people use their private health insurance extras cover, but again there is an out of pocket expense and limits on the number of visits by profession. From professional association surveys it appears that there are a significant number of AH services that are fully paid for by consumers who can afford to pay for these services.

- *There is a need for a culture shift for more Allied Health innovation to be realised. Other health professionals would need to accept scope of practice changes for Allied Health as established practice.*

More recently, advanced practice AH roles have been piloted. The issue of how to transform these developments from pilot to established practice requires careful consideration, as it is as much about cultural change, especially the role change acceptance by the medical profession, as it is about actual evidence provision²³. There have been a number of AH advanced role pilot projects both in Australia and other countries, including the United Kingdom and Canada in a range of settings including triaging in emergency, and outpatient clinics so that the less complex cases can be conservatively managed²⁴. These have shown to be cost-effective models often reducing waiting times, and improving patient flow. The United Kingdom in particular has been quick to transition the changes into established practice. It is worth exploring the cultural change in the Australian context, as the fundamental shift needs to start with our doctors.

- *There is a need to do future AH professional workforce planning based on community need.*

It is worth noting, that there is a lack of capacity for some AH professions to provide more services, due to low numbers of graduates, whilst for other professions, graduate numbers have increased to such an extent that recruitment for public sector new graduate positions is highly competitive but there are still shortages in rural areas and a lack of senior practitioners. Universities set up courses, and manage course student numbers. Some professions are more popular with students and are less expensive for universities to run. Professions including dietetics, physiotherapy and speech therapy have new graduates who are finding it difficult to find professional experience. Student clinical placements whilst training are also becoming difficult for larger numbers of students. Traditionally, new graduate positions in the public system enabled less experienced professionals to be mentored and guided by the more experience professionals. Some new graduates may choose to set up private practice without the oversight of an experienced professional. This is presenting a challenge, as the opportunity to develop and learn new skills from more experienced professionals in a private practice may be limited.

As there is a public investment in university courses for AH professions, it is worth also considering strategies to address high turnover within professions. In Victoria, within 7 to 8 years of graduation, approximately 30% of the AH workforce leave their profession²⁵. If practitioners stay in the professions for limited time periods, due to a lack of career opportunities or are unable to enter the profession, this is not a good return on investment. Turnover can also mean that the expertise to fill more senior positions may be limited. The profile of a profession with a large younger cohort may result in a lack of more experienced professionals available to be mentors.

23 Buchan, J & Law, D 2015. [op cit](#)

24 Allied Health Professions' Office of Queensland. 2014. *Ministerial Taskforce on health practitioner expanded scope of practice: final report.*

25 Philip, K, 2015 [op.cit](#)

SYSTEM ENABLERS

Given the current situation of AH services in Australia, what are the enablers that would provide better quality of care, and a more efficient and cost effective health system? What are the key elements needed to better utilise AH?

We need to:

- recognise, respect and promote allied health's role in health care. For health care to be holistic, well integrated, and coordinated, allied health needs to be part of the multidisciplinary team and promoted as such in policies and programs;
- consider access, both in terms of availability and affordability, for the most vulnerable in the population, especially those with multiple co-morbidities, as well as those living in rural and remote communities;
- better target AH services and support to those who will benefit most, recognising that the health sector funding is finite.
- greater focus on early intervention by AHP to reduce the risk of costly, complex interventions later;
- utilise more digital technology (including tele health) to enable better access to services, including consideration given to its use in patient education;
- develop a payment system based on outcomes not inputs to incentivise health professionals to provide appropriate services that lead to better health outcomes;
- improve information collection mechanisms, access to existing health data sets and data linkage (with patient confidentiality needs addressed) to improve the ability to use data analysis to inform policy. This needs to occur in the public and private sector;
- do more high quality research on allied health models and cost effectiveness of interventions;
- enhance communications in primary care between all health care providers to ensure a truly intergrated approach for people with chronic diseases;
- promote consumer engagement in designing, delivering and evaluating AH services for their community including enhancing the cultural responsiveness of all health practitioners providing services to First Australians, as well as with people with CALD background.
- scope best practice pathways for chronic conditions in the primary care setting, identify gaps, and develop them recognising the value of a flexible pathways with key decision points/promoters with support for care options when patient condition changes;
- develop mechanisms to embed all best practice pathways into routine practice to ensure consistency of treatment;
- transition AH innovative pilots to established practice, focusing on culture change;
- conduct workforce planning according to community needs to ensure an appropriate skills mix for a community;

- further explore workforce supply for allied health. Some professions have an oversupply of new graduates, and for others there is a chronic undersupply and unmet demand; and
- collaboration between the tertiary training sector, Australian Government Department of Education and Training, and Department of Health to guide the development of new training programs and support training programs where there is a proven workforce shortage.

ACTION AREAS

The action areas were developed following the workshop process of exploring, identifying, and understanding a full range of key enablers. The sector then formulated some tangible actions to take it forward. During this process, full stakeholder participation was encouraged so that the sector could offer some solutions that professional groups could own, and look to progress.

The first part of the process was four ‘brainstorming’ workshops focusing on strategic innovation of allied health services in primary care. There were four workshops held in March and April 2015. The workshops consisted of AH stakeholders, GPs and public health organisations.

The second part of the process was a further exploration of the ideas generated at a meeting of the National Allied Health Advisory Committee (NAHAC), and a subsequent meeting with interested AH stakeholders. NAHAC membership comprises State/Territory Chief Allied Health Advisors or Officers.

The ‘issues to be addressed’ segment below is based on feedback from all workshops and meetings, as well as the current literature. The key activities outline some possible actions to take forward with timeframes. It needs to be noted that the ideas, issues and key activities are not a consensus view, and that the actions for those organisations specified are not commitments.

It is important to note that there is a *Medical Benefits Schedule (MBS) Review Taskforce* work program currently underway at the Federal level which will explore some issues identified in the allied health workshops. The Taskforce’s work program is clinician led and is looking at opportunities for reform of the MBS over the short, medium and longer term.

In addition, the Australian Government announced on 31 March 2016, a significant change in the way that services for people with multiple chronic conditions will be delivered and funded. This involves the development of a Health Care Home model to keep people out of hospital and allow them to remain well in their own homes. This initiative is based in large part on the work of the *Primary Health Care Advisory Group* (PHCAG). This model also explores some issues identified in the allied health workshops.

This report identifies all key issues raised during the AH consultations, noting where some of these are best addressed by other initiatives. The AH perspective is also identified for the issues to be addressed.

ACTION AREA 1: EFFECTIVE AND APPROPRIATE CARE

1.1 COLLABORATIVE CARE

IDEAS SUMMARISED

- Integrated care - better communications between all health care practitioners;

- Quality and outcome based health system;
- Natural consumer driven pathways (concierge driven) consumer choice;
- Team based care (virtual or face to face);
- Wheel of care model- a patient nominates a provider who knows everything about the person (not necessarily a GP); trusted advisor model, person who knows the health system to navigate the patient;
- Educate GPs and other AH professionals regarding the roles of AH;
- Educate patients using technology. This may include the role of AH, or more broadly the health system (including AH and GP services); and
- Increase the visibility of AH.

ISSUES TO BE ADDRESSED

- Poor health practitioner communication. This often means less effective care, which can lead to worse patient outcomes and more hospital visits;
- We need to improve care timeliness and appropriateness, which can result in savings for the consumers and the health system;
- Circular referrals could be reduced to increase efficiency in the system;
- GP awareness of the full scope of practice and role of some AHPs is lacking. This means consumers are sometimes not getting the most appropriate care, which may be due to AH professional not being fully utilised. Increased AH visibility could address this;
- Patients experience different pathways for the same diagnosis, depending on GP knowledge and understanding of AH;
- We need national consistency of health pathways;
- There is a need to focus more on the patient and their outcomes, patient centred care;
- Patients need to understand the system better to set expectations; and
- We need to understand patient awareness and perceptions of AH services.

KEY ACTIVITIES FOR CONSIDERATION

Short term:

1. Consider a pilot looking to engage multi-disciplinary teams by region to initially engage in shared professional development (via webinars), as a networking opportunity (based on the Mental Health Professionals Network).

ACTION:

- Allied Health Professions Australia (AHPA) in collaboration with AAHF to set up a subgroup by partnering with other key bodies (such as National Heart Foundation, Diabetes Australia, relevant PHNs) to implement pilots.
2. A pilot with a care coordinator for patients with multiple chronic conditions or highly complex needs to provide a navigation and care co-ordinating role through the health system. From an AH perspective:
 - The roles require advanced problem solving skills and relationships, with a broad knowledge of the conditions and factors that are common to all chronic and complex care, and belief and skills in person centred care, person-centred goal setting and self-efficacy;
 - train care coordinators to ensure their understanding of the role of AH professionals, the ideal point of intervention in the treatment pathway and access to AH professionals within their area;
 - care coordinators trained according to Case Management Society of Australia and New Zealand standards (www.cmsa.org.au);

- ensure the scope of the qualifications of health practitioners to fill the care coordinator role is not discipline specific, nor a registered discipline. Allied health professionals would be well placed to fill these roles particularly in complex multi-morbidity.
- AH skills and expertise, in particular, could be used to optimise outcomes for people that:
 - frequently move between primary and specialist care settings;
 - that have a diagnosed long term condition but are a targeted population experiencing greater health inequity;
 - with a specific chronic condition, but have risk factor for multiple long term conditions; and
 - may have difficulty navigating the health system due to social and/or cultural determinants, thereby limiting access.
- A care coordinator may be located either regionally or within a primary healthcare home, or work across multiple GPs, depending on population health profile of communities/regions and the available health workforce; and
- coordination is everyone's business, but enacted at different levels of competence and expertise. The community front line workers (care worker or allied health assistants) could be up-skilled to be equally cognisant of risk factors and needs of coordination to make timely detection and referrals, but would not function at the expertise of a health professional and/ or care coordinator in delivering care.

ACTION:

- The Department of Health to consider this issue internally.

Short / Medium term

3. Do a scoping exercise to establish which medical conditions already have best practice pathways. This would consider work already undertaken by:
 - a. the International Centre for Allied Health Evidence;
 - b. the Western Australian New Primary Health Networks Health Pathway Project Work; and
 - c. Primary Health Tasmania.

Identify which conditions need a best practice pathway developed or reviewed. Pathways to be developed with key organisations to ensure the pathways include AH professionals.

ACTION:

- AHPA to meet with Royal Australian College of General Practitioners, Australian Medical Association and PHNs to discuss best practice pathways development.

1.2 WORKFORCE ISSUES

IDEAS SUMMARISED

- Multiskilling: produce practitioners who can work across professions;
- Workforce planning based on needs of community;
- Match mix of generalist versus specialist AH with needs of community;
- Better use of scope of practice and competencies;
- Expanded scope of practice: AH doing some things doctors, nurses or other AH currently do to free those other professions up to do their higher scope activities;; and

- Mobile workforce either physically or electronically.

ISSUES TO BE ADDRESSED

- Rural and remote lack of AH services. There are capability and service gaps. We need to address the market failure;
- Community needs vary, if the community needs are assessed, and recruitment of AH services matches needs, it can be more efficient to meet demand;
- Treatment pathway can be improved; efficiency gains are needed to address unmet demand on the system. This can also cost less for the consumer and government;
- Reduce staff attrition rates; skill diversity leads to greater job satisfaction; and
- Technology (e.g. tele health) exists, but is not supported under Medicare for AH services and is under-utilised.
- Division between registered and self-regulating professions.

KEY ACTIVITIES FOR CONSIDERATION

Short / Medium term

4. A communication and information sharing strategy to engage Primary Health Networks (PHNs) to raise the profile of AH professionals to ensure PHNs are aware of the full range and scope of AH services. This would contribute to PHN community needs assessments being inclusive of a broad range of AH services. This would include awareness of both registered and self-regulated AHPs.

ACTION:

- Department of Health to discuss options for a communication strategy internally.
5. Investigate opportunities for more medication reviews to be conducted by pharmacists in primary care. The 6th Community Pharmacy Agreement between the Commonwealth and the Pharmacy Guild of Australia has some pharmacist lead home medication reviews as part of this Agreement. The number of reviews is capped, and is expected to be oversubscribed. The Agreement has recently been negotiated.

ACTION:

- Department of Health (Pharmaceutical Benefits Division, PBD) would need to consider this issue when it next negotiates a Community Pharmacy Agreement;
6. Test case for Medical Services Advisory Committee (MSAC), direct referral between AH and specialist doctors.

ACTION:

- AHPA to take the lead in collaboration with AAHF. AHPA board to discuss which case would have the most evidence to take forward. AHPA to collaborate with college of physicians.
7. MSAC process needs to be reviewed to take into consideration the administrative burden on small professions to submit and support an application. There needs to be consideration for the potential cost of the MBS item and the earning potential of the applicants. Low cost items for professions with less earning potential (i.e. non-medical) should have a streamlined process.

ACTION:

- Department of Health to discuss this issue internally.

ACTION AREA 2: INCREASED USE OF TECHNOLOGY

IDEAS SUMMARISED

- Simple shared patient records between all professionals;
- AH access and input to My Health records;
- AH access to tele-health;
- Offer different investment models by integrating and providing virtual options for providers;
- Use technology to educate and support patients on role of AH and/or the broader health system. This may include an official health web portal, smart phones or social media; and
- Patient driven use of technology (an Algorithm) to triage provider.

ISSUES TO BE ADDRESSED

- The current General Practice disease management care plans are too long and complex, there needs to be short updates, and quick care provided. This would save time and provide better care. This would be particularly valuable for chronic disease cases;
- AH currently has limited input into the My Health record whilst GP have had government incentives to facilitate utilisation of the My Health record;
- Tele-health for AH would provide better services to rural locations. A lot of AH professionals spend too much time travelling in rural and remote areas. Tele-health would add efficiency to the system. Local generic AHPs could be supported by specialist AHPs. More patients could be seen for the same time period. This could be supported by locally based AH assistants and support workers;
- Providers need enabling technology which has GP and all AH services incorporated. This would lead to better communication between professional groups;
- Patients need to be assisted to be better informed regarding health prevention and management;
- We need to support self-management programs for patients to assist them in their understandings and behavioural change. This would empower patients to make more active decisions regarding their care; and
- Patient triage using software would make system more efficient. It puts a semi-gatekeeper in place. It avoids making a GP visit to do the triage step. It means appropriate GP bookings.

KEY ACTIVITIES FOR CONSIDERATION

Short /medium term

8. AH professionals to have full access to MyHealth record and supported to become compliant and compatible with MyHealth software.

ACTION:

- AHPA seeks AH representation on any committees with stakeholder representation for MyHealth record pilots;
- AHPA to lead AH professions to collaborate for a sustainable software market. AHPA to consider significant non-member AH professions in this process; and
- AHPA in collaboration with AAHF to coordinate development of a strategy for cost-effective roll out of MyHealth software compliance in AHP practices. This includes:
 - investigate methodologies used in other health organisations to get eHealth uptake. E.g. radiation oncology/cancer care; and
 - investigate linkages between private, community and acute sector to ensure seamless patient journey when care setting changes).

9. Communication strategy aimed at consumers on the role of AH in primary care. This may be a smart phone application.

ACTION:

- Smart phone application developed by AAHF, disseminated through professions.

Long term

10. Tele-health in primary care for the AH professional needs to be more fully considered by all stakeholders and all governments.

ACTION:

- Department of Health (or AHMAC?) to form a working party with key stakeholders to consider the current consolidated evidence and develop a tele-health strategy. There have been some tele-health pilots funded by the Commonwealth. A lot of tele-health experiences to date have been done in state and territory hospitals. The experiences could to be evaluated, built on and expanded at a national level. Funding of AH Tele health services would be considered as part of this process.

ACTION AREA 3: HOW DO WE KNOW WE ARE ACHIEVING OUTCOMES?

IDEAS SUMMARISED

- Collect quality data, at a community level to provide targeted solutions; and
- Consolidate the evidence for effectiveness of interventions, focusing on the entire system not just individual AH profession to increase credibility for AH.
- AH to translate research outcomes into clinical practice and evaluate the implementation process.

ISSUES TO BE ADDRESSED

- There is currently a lack of data for private and public AH services and no data to establish demand for AH services within communities or local government areas;
- Evidence needs to underpin all policy. Community level data is often not available; data is mostly published at broad levels;
- We need a central collection point for the AH data to be pooled and analysed, with system support and agreement on what is collected;
- There are a lot of projects currently underway in Australia, but there is no mechanism to share this information more broadly with interested stakeholders. There is a need for a 'clearing house', where researchers with similar interests can explore possible collaborative opportunities;
- We need data to demonstrate effectiveness of AH interventions, as AH contribution is currently not always recognised. AH interventions can lead to better outcomes for clients, reduced costs and increased efficiency. We need more data to support this;
- We need to gather relevant information which will support appropriate funding and investment decisions. Evidence is skewed to some services therefore funding is skewed;
- Evidence for AH is often profession and outcome specific;
- National Health and Medical Research Council (NHMRC) grants are narrowly defined. AH research often does not meet the criteria;
- We need to collect feedback from consumers on our successes or failures. This should be simple, and could take the form of a smart phone application; and
- Consider the burden on small business for data collection. The quantity of data

collected needs careful consideration, otherwise incentive payments may be needed, or another compliance mechanism.

- Poor knowledge translation as part of all AH clinical practice.

KEY ACTIVITIES FOR CONSIDERATION

Short term

11. We need to capture patient reported outcomes for as many AH services as possible, both privately and publicly delivered.

ACTION:

- AAHF to meet with Consumer Health Forum to explore options to capture patient reported outcomes. This may be a customer feedback smart phone application for private services.
- Consider Patient Reported Outcome Measures (PROM) for all AH services. This should leverage existing work outside of allied health. There are PROM measures for AH that have been developed and are validated.

Medium term

12. We need to collect and analyse standardised data regarding services.

ACTION:

- Department of Health to approach State and Territory governments to seek data on AH public services for analysis;
- Department of Health to seek data from private health insurance companies; and
- AHPA to canvass with professional associations whether they can survey their members regarding private services to capture private AH services fully paid out of pocket by consumers.

13. Support more allied health research and program evaluation. Establish links between research bodies with expertise in AH research and/or program evaluation. This may include providing more targeted funded opportunities for AH research.

ACTION:

- Form an Allied Health Research Consortium through AAHF in partnership with the International Centre for Allied Health Evidence (iCAHE), University of South Australia and Primary Health Care Research and Information Service.
- Department of Health to consider increasing the component of AH research as part of future primary care research.
- Government funding (AHMAC cost shared?) for a research collaborative to facilitate evaluation of allied health models and workforce initiatives.

Long term

14. Sharing of data on AH services by PHN to enable better planning and analysis for AH services. This would occur once central data collection on AH services is established and first year of collection is completed.

ACTION:

- Department of Health to share with individual PHN the de-identified data on AH services for its own region.

15. A clearing house for AH researchers to share information and 'grey' literature should be

considered to foster collaborations. Education and training resources could also be stored in the clearing house.

ACTION:

- Department of Health to consider hosting or outsourcing a clearing house for researchers to share information.

ACTION AREA 4: HOW DO WE ESTABLISH SUITABLE PAYMENT MECHANISMS TO SUPPORT A BETTER PRIMARY HEALTH CARE SYSTEM?

IDEAS SUMMARISED

- Financial incentives based on location of practice;
- Bundle or blend funding based on population needs or by patient;
- Funding model that is focused on patient outcomes;
- Medical Benefits Schedule (MBS) changes, including:
 - Cashing in chronic disease plan for more complex care needs;
 - Increase number of AH services within chronic disease items for complex needs;
 - AH direct referral to specialists with MBS rebate;
 - AH direct referral to other AH with MBS rebate;
 - Patient self-referral to AH with MBS rebate;
 - Increase MBS imaging and pathology items for AH; and
 - Tele-health items on MBS for GPs and AH in primary care.
- Eliminate dual government funding in the health system; and
- Blend funding/ allow bulk billing of AH MBS items.

ISSUES TO BE ADDRESSED

- The current overall funding structure:
 - is segmented;
 - is not cost effective;
 - is not outcomes based;
 - is not patient centred;
 - it doesn't encourage an efficient treatment pathway;
 - does not adequately address population needs; and
 - does not encourage early intervention.
- We need to:
 - provide more services with greater flexibility to provide better patient centred care;
 - incentivise health professionals to keep people out of acute care;
 - enable access to funding that is consistent with agreed health treatment pathways; and
 - even out pay structure to enable AHPs to be paid as equals compared to other professions with the same amount of education and training. A blended funding model may be able to achieve this.
- Patient journey has unnecessary steps as it is driven by funding not patient focused. There are currently GP referrals to gain access to state or territory government funded services. This may mean sending patients through the hospital system, due to the lack of available affordable AH services in the private sector for those on low incomes.

- The MBS AHP Chronic Disease items are not working well due to the referral process; significant out of pocket expenses for consumers; flat fee payment structure; and a limited number of consultations per patient, regardless of their presenting medical conditions.
 - The referral process for the AH items is unnecessarily complex and expensive. Currently, the GP is expected to complete a Chronic Disease management plan as well as a Team Care Arrangement (TCA) plan. Both plans enable GPs to claim MBS items three times the value of a general consultation.
 - A major issue is that there is still a significant out of pocket expense for most patients. People on low incomes are often not bulk billed (if the rebate is significantly less than the cost of the service), they are channelled through the public system or they simply miss out on treatment.
 - The out of pocket cost is partly because of the flat MBS fee for all consultations, regardless of whether it is a new or review visit. This does not keep pace with what is current practice in the private sector. Usually, new visits are longer, and payment indicates the additional time for assessment.
 - The number MBS items available for AH visits do not take into account the complexity of medical conditions. Some patients with chronic disease are keeping well, and do not need as much intervention as those who are newly diagnosed or have multi chronic conditions.
- There are some unnecessary restrictions in Private Health Insurance legislation which impede services that can complement current medical interventions in primary health care. For example, interventions for pre diabetes.

KEY ACTIVITIES FOR CONSIDERATION

Long term

15. Review the MBS AH Chronic Disease items so that:

- TCA plans are no longer a requirement for accessing AHP visits;
- the number of AH items available to a patient is based on complexity of their condition;
- a tiered fee structure, a higher fee for the initial visit and extended interventions and a lower fee for reviews and short interventions to be more consistent with what is currently the case for payment in the private sector; and
- structuring GP incentive payments for the Chronic Disease Management Plan (CDMP) so that part of the incentive is paid following a GP plan review visit, once some AH visits have occurred (not full payment upfront as is currently the case).
- A CDMP plan can be initiated by an AHP for referral to another AH profession.

ACTION:

- Department of Health to consider this internally, or as part of the MBS Taskforce review.

16. Consider MBS AH group therapy for more patients with similar conditions. E.g cardiovascular disease, or asthma. It can be a more efficient way to educate patients than individual sessions. There are allied health group MBS item numbers for diabetes, mental health and autism.

ACTION:

- Department of Health to consider this internally.

17. Once best practice pathways are developed, investigate options for remunerating professionals for following the pathways. This may be best considered as part of a broader review of funding models. The PHCAG consultation paper outlines a number of ways to approach this.

ACTION:

- Department of Health to consider this once best practice pathways are developed. From an AH perspective, the GP incentives would be outcome based, or provided in instalments according to pathway milestones to ensure a degree of consistency of treatment including referral patterns to AHPs.