Allied Health Professions Australia

# Submission in response to the Primary Care Reform Steering Group - Discussion Paper consultation

July 2021

**This submission has been developed in consultation with AHPA's allied health association members.**

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**Advocating on behalf of Australia's allied health professions to create fairer and more equitable health, aged care and disability systems**

## About AHPA

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents 130,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce of around 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

## Introduction

AHPA welcomes the opportunity to respond to the Discussion Paper, and thanks the Department of Health for the extension of time granted to enable consultation with our members.

AHPA strongly supports the aim of the Australian Government's Primary Health Care 10 Year Plan 'to maintain and strengthen our world-class primary health care system in order to deliver the best possible health outcomes for all Australians' (Discussion Paper [DP], 1). We agree with the conclusions of the Primary Health Reform Steering Group that our current health system is not fit for purpose, and that significant reforms are urgently required for Australia to be able to provide a truly equitable primary health care system that is capable of enabling the wellbeing of all people in the context of increasing local, national and global challenges. AHPA therefore also broadly supports the eight themes around which the 20 recommendations for reform are grouped.

However, the content and structure of the draft recommendations are not always consistent with the rationale underpinning the Discussion Paper. The reforms proposed, despite Recommendation 11, continue the tendency in Australian primary health care to relegate allied health to the periphery while general practitioners remain at the centre of the system.

AHPA therefore proposes changes to the recommendations to strengthen the role of allied health services in primary health care. We do so not out of any narrow or sectarian professional interests, but rather because in multiple ways, allied health typifies the desired approaches identified by the Steering Group.

## The value of allied health in system reform

We contend that full recognition of the value and breadth of allied health is key to successfully achieving a genuinely integrated system with the vision of a person-centred health care journey at its core. This is demonstrated by assessing current and potential contributions of allied health using the Quadruple Aim, and against the draft recommendations.

### *Applying the Quadruple Aim*

AHPA first adds two qualifications to interpretation of the Quadruple Aim. Achieving health equity is clearly central to the proposed reforms (eg DP, 7-8; Recommendation 8), and therefore the second

element, 'Improve the health of populations', must be explicitly interpreted as including addressing equity in health outcomes.[1]

The third element, 'Improve the cost-efficiency of the health system', should be understood as not simply concerned with cost efficiency in any narrow sense, but also with best value for public health system resources. The concept of 'best value' can encompass three types of efficiency: technical efficiency (usually the dominant and narrowest interpretation, concerned with reducing resource waste); productive efficiency (putting health care resources to their best possible use); and allocative efficiency (determining the best value of inputs).[2] Recommendations and actions should be viewed through this 'triple coating' element of the lens of the Quadruple Aim.

### *Allied health in practice*

Using the slightly refined lens, it is evident that fully resourcing and integrating the provision of allied health services to achieve consistent availability throughout Australia will drive improvements in patients' experience of care and improve the health of populations. With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, including providing diagnostic and first-contact services, making preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations.

In these ways, allied health professionals already work alongside medical practitioners and nurses as formal or informal members of primary health teams. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where allied health service provision can represent the key formal health supports in a person's life journey. However, the full value of this 'allied' meaning in 'allied health' can only be practically realised through system restructuring and resourcing.

Allied health practice also spans a broad range of professional practices that, both singly and together, challenge any simple body-mind binary notion of health and are predisposed to prioritise holistic, preventive and lifelong care. This emphasis enables allied health service provision – once appropriately funded – to tick all the boxes of cost efficiency.

For example, physiotherapists, exercise physiologists, diabetes educators, occupational therapists, speech pathologists, podiatrists, osteopaths, social workers, music therapists and more can treat ageing clients within frameworks of wellness and recovery, and reablement and wellbeing, leading to improvements in quality of life and reducing hospital admissions. However, allied health is poorly integrated into the aged care sector and only a few allied health treatments are funded under the Medicare Benefits Schedule (see our responses to Recommendations 3, 8 and 11 below).

Technical and productive efficiencies would be further enhanced if allied health practitioners were enabled to perform at the top of their scope of practice or expand their scope. For example,

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[1] Cf *Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care*, New Zealand Institute of Economic Research report to Allied Health Aotearoa New Zealand (23 June 2021), 19.
[2] Cf *Hidden in plain sight*, 26-27.

paramedics form an important part of the allied health workforce, practising not only in State-based ambulance services but also in primary care settings, including GP clinics, hospitals, schools, rural and remote communities, disability, aged care, and community settings. However, as our member the Australasian College of Paramedic Practitioners has submitted to the Discussion Paper consultation, the role, education and clinical practice of paramedics is poorly understood by policy makers. This has resulted in underutilisation of paramedic knowledge and skills, particularly in remote, rural and disadvantaged communities where paramedic practitioners could help to address GP shortages.

Allied health's model of strength in professional diversity is also ideally suited for a future primary health system that is organised around multidisciplinary care teams and values interprofessional practice collaboration.[3] Allied health professionals already provide highly valued contributions to positive client outcomes for those with chronic diseases and conditions, early developmental needs, progressive health conditions, and mental illness. Our practitioners' flexibility and adaptability prepare them for a future system that will rely on seamless transitions to and from quality secondary care and tertiary care sectors and within primary care, so that people receive a continuum of health services according to their needs and throughout the life course.

When properly resourced and embedded in the broader primary health matrix, allied health is also well placed to deliver care in a manner that is innovative and focused on consumers and the community.

### *Fast-tracking allied health's place in reform*

We note the Discussion Paper's emphasis on a commitment to implementation across short, medium and long-term horizons as a distinctive feature of the 10 Year Plan (DP, 3). This is particularly important for allied health, because as submitted below, on several key indicators such as workforce planning, digitalisation and data collection, funded infrastructure support for our services has lagged behind other health providers. As a result, AHPA calls not only for time-defined, including fast-tracked, allied health goals in the 10 Year Plan, but for the inclusion of associated benchmarks for recommended actions and outcomes, which should be monitored as part of implementation.

## Person-centred health and care journey, focusing on one integrated system

### *Recommendation 1*

AHPA strongly supports this recommendation in principle, but proposes amendments as follows.

It is essential that the understanding in both policy and practice of 'enable flexibility for local solutions and partnerships, tailoring services, workforce and funding options to meet community needs' (1.3) fully includes allied health in its vision of a reformed system.

[3] 'Interprofessional practice' is defined here as 'the spectrum of care models from multi-disciplinary to transdisciplinary within a system that has mechanisms in place to activate the appropriate team to meet patient needs and preferences, from traditional GP-nurse teams and variations of this such as GP-physiotherapist teams to chronic disease models and other team-based care involving combinations of health and other professionals [including various allied health]' (*Hidden in plain sight*, 1-2).

For example, while AHPA supports the concept of an integrated and coordinated care system, including in aged care, community care, disability and mental health services, as well as other social support services linked to the determinants of health (1.3.3), we propose the incorporation of a medium-term benchmark – a gap analysis of allied health service provision in primary health, aged care and disability sectors. Allied health cannot seamlessly join up with other forms of primary health care when there is unmet need for diverse allied health services that is well known anecdotally but has not been systematically charted, let alone redressed via resourcing.

Similarly, we agree that it is important to fund and evaluate vanguard regionalised initiatives (1.3.4), but allied health is notably absent from the list of PHNs, ACCHSs and LHNs. We further note that it is the experience of many allied health providers that PHNs are medical-centric, and therefore it is not generally appropriate for allied health to integrate into PHNs as the desired model in the reformed system, for many of the same reasons that we detail in relation to GP-led clinics in our response to Recommendation 2 below.

The ACCHS model is clearly seen as attractive, but it is important to note that allied health is mostly poorly represented in these structures due to the current funding models mitigating against employment of allied health professionals.

AHPA therefore recommends as a 12-month benchmark, mapping existing allied health service relationships with PHNs, ACCHSs and LHNs and identifying relationship gaps. As a medium-term benchmark, at least 10 allied health professions should be included across the initiatives**.**

it is also not clear from Recommendation 1 whether allied health is envisaged to integrate into the primary health system via some other mechanism not expressly noted, or if the multidisciplinary healthcare teams in 1.4 will also include models that incorporate allied health services, alongside the PHN and ACCHO models in 1.3.5. See also our comments on Recommendation 2.

### *Recommendation 2*

AHPA does not support this recommendation in its current form.

#### Problems with a GP-centric model

The current model of primary care based on uni-disciplinary GP practices does not support Recommendation 1's concept of person-centred care. The fact that GP consultations are typically short makes them especially unsuitable for people with multiple or complex conditions. Current funding models mean that GPs can often be unwilling to refer their patients to allied health or are unaware of the services that exist and their value.[4] Lack of shared patient records and the cost of allied health care being prohibitive for low-income patients (see our response to Recommendation 11) further contribute to GP reluctance to refer.

[4] See eg Dennis, Sarah, Ian Watts, Ying Pan, and Helena Britt (2018), 'The likelihood of general practitioners referring patients to physiotherapists is low for some health problems: Secondary analysis of the Bettering the Evaluation and Care of Health (BEACH) Observational Study,' *Journal of Physiotherapy* 64 (3): 178, https://doi.org/10.1016/j.jphys.2018.05.006 ; Supper, I., O. Catala, M. Lustman, C. Chemla, Y. Bourgueil, and L. Letrilliart (2015), 'Interprofessional collaboration in primary health care: A review of facilitators and barriers perceived by involved actors,' *Journal of Public Health* 37 (4): 716, https://doi.org/10.1093/pubmed/fdu102 .

Any successfully reformed health system should recognise the expertise and professional credentials of allied health practitioners and accord them their own place and status in the integrated framework, rather than subsuming their practice under GP-centric structures. A profoundly inefficient example of this tendency is the current structure of many Medicare Benefit Schedule (MBS) items, which requires general practices to play an intermediary gatekeeper role.

This primarily administrative support role for GPs adds costs and time delays rather than necessarily enhancing the quality of care. Current referral requirements fail to recognise the primary contact role of allied health providers, or the expertise of allied health and specialist providers. Simple changes to the service conditions for a range of MBS items would provide significant improvements to the efficiency of our health system and reduce costs.

Key examples include musculoskeletal interventions where chiropractors, osteopaths and physiotherapists are likely to provide the primary point of contact for patient care. Those allied health professionals have the skill, expertise and scope of practice to diagnose the issue and to determine whether additional diagnostic imaging services may be required. Similarly, those health professionals may determine that immediate referral to an orthopaedic surgeon is required. However, current MBS service conditions slow down the referral process and add time and financial costs by requiring the consumer to first see a GP for the required referral.

Another example concerns audiologists, where under current requirements a patient must be referred to an audiologist by a medical practitioner or specialist. For instance, an adult who has their hearing assessed by an audiologist working in a hospital, and who is identified as requiring hearing aids, will need to obtain a referral from a medical practitioner to access the Office of Hearing Services Voucher scheme, and will then require a second hearing assessment prior to being fitted with the aids. Patients identified by an audiologist as having a disorder that is most appropriately treated by surgery must similarly return to their general practitioner to obtain the required referral to an ENT surgeon. This is <u>not</u> patient centred care.

These requirements not only prolong the treatment pathway and add unnecessary costs for both providers and patients. – they may also compromise health care, including prevention. An example is a child in a remote community, diagnosed by an audiologist with otitis media with accompanying hearing loss and requiring hearing aids. The local nurse must then organise for the child to be seen by the next visiting medical officer so that a referral can be made to the ENT to obtain clearance to fit the hearing aids. It is not inconceivable that there will be a six to twelve-month delay before the hearing aids are actually fitted. This is <u>not</u> patient centred care.

It is difficult to see how a VPR model that largely retains the GP-centric focus will not add another form of administrative burden for already overworked GPs. Even if funding arrangements were radically restructured in a 'future focused' general practice, it is not clear from the Discussion Paper how – or even whether – allied health professions and practices would be formally linked into it. There are certainly no needs based, coordinated or effective funding mechanisms to facilitate co-location of allied health in GP-led clinics, nor to enable team-based, coordinated care as routine practice. The latter absence is particularly relevant for small private allied health practices who would be faced with trying to sustain their own business while also attempting to integrate into a GP-led model.

The Discussion Paper acknowledges that a model where the GP is the central point of coordination will not always be appropriate (DP, 28). Most allied health practices are likely to be such examples. However, although Recommendation 2 acknowledges that the VPR model will not suffice for the whole of Australia's population, the associated proposed actions only address this model. The proposed alternatives to the GP-centred model of VPR also do not explicitly accommodate allied health services.

Irrespective of whether a co-location or networked model focused on GPs can ever truly support collaboration with allied health professionals to provide optimal care, or whether allied health practices are engaged via some other structure, a profound shift in the culture of health provider organisations is needed. A recent New Zealand report on the role of allied health professions in sustainable integrated health care observes that a visit to a GP can represent a form of unmet need that is better addressed by allied health practitioners.[5] The report indicates some support from GPs for this approach, and concludes that it would be not only more efficient but also better aligned with increasing patient expectations of more person centred care.[6]

Regardless of the specific model, potential single primary health care destinations such as community-based health centres require funding commitments to ensure adequate coverage of the diversity of allied health patient needs. Funding must also be allocated for governance and interdisciplinary collaboration and partnerships. To achieve this change in interprofessional practice, health provider organisations must work with professional groups to agree on a national competency framework for collaborative practice. They must identify changes to education programmes to support the development of interprofessional collaboration competencies in the workforce, including embedding collaboration and teamwork capabilities in student curricula.[7]

Under a more efficient and equitable Australian health system, all allied health practitioners with demonstrated clinical expertise would also make direct referrals for imaging and pathology services, and to other health professionals where appropriate and within their scope of practice, while maintaining communication with the whole team supporting the patient.

### *Recommendation 3*

Overall, we strongly support this recommendation, but we comment and propose some amendments as follows.

It is not clear how this recommendation for funding reform, which includes allied health, will 'leverage off VPR' to ensure adequate allied health funding.

AHPA strongly supports the focus of the actions outlined at 3.1: value-based care, flexibility and consistency with community needs. We particularly welcome the recommendations to develop mechanisms and governance arrangements to support appropriate accountability for patient outcomes when integrated care is delivered across health systems, and to support efficient use of funding available across health, mental health, aged care and the National Disability Insurance Scheme to deliver integrated outcomes for people. As the peak body for health professionals who

[5] *Hidden in plain sight,* 15-18.
[6] *Hidden in plain sight*, 15-18.
[7] Cf *Hidden in plain sight*, 42-45.

frequently engage across health-related sectors, we regard these actions as essential to an effective 'one system' approach. Based on our members' practice experience, we recommend explicitly adding the early childhood, education and justice sectors to the list in 3.1.4.

The commitments to develop innovative equitably funded models, including block, blended and bundled approaches, and to provide greater support for providers and practices, including innovative models for multidisciplinary and intersectoral team care, are necessary to enable consistent and high quality of allied health services, regardless of postcode.

We comment more specifically on the proposed actions in our response to Recommendation 11.

### *Recommendation 4*

AHPA supports the broad themes of this recommendation in principle, but we defer to our First Nations allied health colleagues for detailed analysis.

### *Recommendation 5*

We support this recommendation, while noting that the problems of delivering coordinated care to rural and remote regions have been known for at least 50 years. It is time to abandon the 'solution' of limited pilots and instead identify and roll out a range of bold approaches with commitments to ongoing evaluation, tailoring and funding.

Effectively addressing health needs in rural and remote settings as part of the 10 Year Plan also offers an opportunity to turn on its head the usual approach where 'the country follows the city' in health modelling, and consequently, urban solutions do not always translate well. Given that thin markets also exist in regional and metropolitan pockets, innovative rural and remote health delivery models could offer benefits in other locations and should be monitored on this additional basis.

## Adding building blocks for future primary health care – better outcomes and care experience for all

### *Recommendation 6*

We support this recommendation, noting that financial investment will be necessary to achieve the proposed actions.

### *Recommendation 7*

AHPA supports this recommendation and makes the following comments and proposals.

One of the most significant failings of our current system is that it is not taking advantage of opportunities to prevent the development of chronic conditions or to support secondary prevention activities that are likely to reduce the incidence of avoidable negative health outcomes. A significant portion of Australia's chronic disease burden could be prevented by screening and early intervention that addresses modifiable risk factors such as lifestyle or behavioural aspects. In our response to Recommendation 11 we detail some of the barriers that currently exist for effective allied health treatment of people with chronic disease.

As a more specific example, nutrition interventions can make a highly efficient contribution to reducing the growing disease burden linked to over/poor nutrition.[8] Once a GP or other health practitioner has identified high levels of risk for the development of a condition such as Type 2 diabetes, effective integration of allied health interventions, including diabetes education and exercise physiology, could prevent the development of the illness.

Similarly, if the person has already developed the illness, the right interventions are likely to reduce further consequences. For instance, exercise and strength training for knee osteoarthritis are highly cost-effective interventions, compared to treatments such as arthroscopy which have been shown to be ineffective.[9] People with Type 2 diabetes – totalling 1,191,919 as registered with the National Diabetes Services Scheme (NDSS) at June 2020[10] – are entitled to one Medicare funded assessment service per year by a diabetes educator (Item 81100), exercise physiologist (81110) or dietitian (81120). However, the total number of MBS assessment services across the three items in the year ending June 2020 was 12,214,[11] indicating that only 1.02% of eligible patients were referred for and received this service in 2019-2020.

Preventive health programs and early intervention programs provided through allied health can maintain and improve patients' strength and functionality and increase their levels of wellness and wellbeing. This also reduces aged care costs, as older Australians can be supported to live independently in the community or at least remain living in their own homes for longer.

Allied health interventions aimed at both primary prevention and amelioration of symptoms thereby produces multiple efficiencies for the health system, including saving the costs of providing medical and hospital services.[12]

Allied health practitioners play a direct service provision role in prevention of disease, and indirectly contribute through education of patients and, where appropriate, their carers. An integrated system that prioritises holistic care and prevention would fund these types of allied health service provision from cradle to grave. As detailed in our response to Recommendation 11.1, the current approach is at best piecemeal and episodic.

### 7.4 Allied health funding

We propose that as a short-term benchmark, appropriate funding models should developed, and selected targeted interventions initiated, within 12 months of commencement of the 10 Year Plan. Targeted interventions should focus on a few selected conditions such as impaired glucose tolerance, and preventive services evaluated via measures like delay of onset of full-blown diabetes.

In the medium term, the selected targeted interventions should have been evaluated.

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[8] Dalziel, K., and L. Segal (2007), 'Time to give nutrition interventions a higher profile: Cost-effectiveness of 10 nutrition interventions,' *Health Promotion International* 22 (4).
[9] National Institute for Health Care Management, *The concentration of health care spending* (2012).
[10] https://www.ndss.com.au/about-the-ndss/diabetes-facts-and-figures/diabetes-data-snapshots/.
[11] Department of Human Services, Medicare Benefits Schedule statistics, Report generated 2 August 2021.
[12] See eg *The value of accredited exercise physiologists to consumers in Australia*, Deloitte Access Economics for Exercise & Sports Science Australia (30 November 2016); Homeming, Lyndon J et al (2012), 'Orthopaedic podiatry triage: process outcomes of a skill mix initiative,' *Australian Health Review* 36(4) 457.

In the long term (within five years), there should be universal access to early intervention at minimal cost to patients.

### *Recommendation 8*

We broadly support this recommendation. Allied health practitioners, even without full integration into the current primary health system, frequently 'fill the gap' by providing treatment to people with limited access to health care or at risk of poorer health outcomes. An illustration is the role of allied health in chronic disease management, outlined in our response to Recommendation 11.

There are many other examples of allied health practice which, with reasonable investment, can be tailored and embedded to deliver equitable and approachable services for people living with disadvantage. However, this also requires addressing the disconnects and disparities in the current health system. One example concerns people with dementia.

#### Dementia and allied health in a reformed health system

Following the recommendations of the Royal Commission into Aged Care Quality and Safety, the Aged Care Quality and Safety Commission, the Australian Commission on Safety and Quality in Health Care, and the NDIS Quality and Safeguards Commission are collaborating to align and strengthen regulatory approaches to the use of chemical and physical restraints.

There is currently a high dependence on restraints to manage patients with challenging behaviours, including people with dementia.

Better access to services provided by allied health professionals trained in behaviour support helps to avoid this dependence. Via increased funding for high quality care and through developing and implementing a best practice needs assessment and care planning tool, significant improvements can be made to the health and wellbeing of people with dementia.

Cognitive rehabilitation, such as treatment provided through occupational therapy, psychology, social work, speech pathology, and music and creative arts therapy, can be valuable in the early stages of dementia where new strategies can still be learnt. Allied health support for physical reablement is also important for greater mobility and pain management, which can also help reduce verbal and physical aggression. However, people with dementia do not routinely have access to allied health services for the purpose of reablement and rehabilitation, particularly if they are in residential aged care homes (RACHs). There is currently no way for people in RACHs to access funded allied health cognitive rehabilitation.

## Leadership and culture

### *Recommendation 9*

AHPA broadly supports this recommendation, but proposes the addition of the following allied health peak bodies to the list of relevant health sector entities:

- Allied Health Professions Australia
- Indigenous Allied Health Australia
- allied health profession-specific peak bodies (see https://ahpa.com.au/our-members/ )

## Primary care workforce development and innovation

### *Recommendation 10*

We broadly support this recommendation, but it should also signpost Recommendation 11 as specifically addressing allied health workforce issues.

### *Recommendation 11*

AHPA strongly supports this recommendation, but proposes some amendments as follows.

#### 11.1 Funding models

We strongly support the recommendation to establish an allied health funding reform committee. Given that many other allied health-related actions are contingent on funding changes, AHPA recommends a benchmark requiring that within 12 months of the commencement of the 10 Year Plan:

- the committee is established;
- local solutions are identified via mapping and gap analysis; and
- funding models are developed.

AHPA strongly contends that the recommendations from the MBS Review Allied Health Reference Group related to allied health services, and the MBS Review Taskforce in relation to mental health, should be fully implemented.[13] We propose that full implementation be a short-term benchmark for the 10 Year Plan to improve access to allied health. We do note that MBS funding may not in the long term be the most appropriate funding model, but it needs to be supported until more appropriate options are developed.

A more seamless and integrated system requires investment that goes beyond episodic direct service provision and also funds multidisciplinary care planning, shared care plans, and care coordination activities such as case conferencing. A classic illustration of the present barriers and inequities concerns people with chronic disease and/or mental illness.

The chronic disease MBS rebate is typically lower, and can be significantly lower, than the costs of providing the service. This leads to large out-of-pocket costs. For example, out-of-pocket expenses for chronic health conditions such as arthritis, diabetes, cardiovascular disease and mental illness are all likely to be at least double the average costs for people with no health condition. Adults with asthma, emphysema and chronic obstructive pulmonary disease have 109% higher household out-of-pocket healthcare expenditure than do those with no health condition, and adults with depression, anxiety and other mental health conditions have 95% higher household out-of-pocket expenditure.[14]

[13] MBS Review Taskforce, *Post-consultation report from the Allied Health Reference Group* (2019); MBS Review Taskforce, *Taskforce findings on primary care*, 23-24.
[14] https://www.ncbi.nlm.nih.gov/pubmed/27451858 .

Given that people on lower incomes are much more likely to experience chronic disease than those better off,[15] combined with the reality that access to private health insurance also disproportionately favours those with higher incomes and in metropolitan regions, people with a chronic condition are more likely to forego care, including allied health treatment, because of cost.[16] State-funded community health services may provide some allied health, but the range of services vary from region to region, as do waiting times (often extensive) for access.

The current MBS approach to chronic disease is not simply inefficient in terms of missed opportunities for prevention. Those patients who do manage the out-of-pocket costs are restricted by present MBS funding limits to five consultations per year for chronic disease items and ten per year for Better Access mental health items. MBS CDM funding is also currently capped at 20 minutes, regardless of the type of consultation or the profession of the treating practitioner. This is out of touch with standard practice for allied health services, which typically involve an initial assessment that would normally take between 45 and 60 minutes. That initial consultation is important in laying the foundation for further treatment and establishing the needs of the particular patient.

Many of the allied health services likely to be delivered as part of chronic disease care are also likely to significantly exceed the 20-minute session currently rebated, again resulting either in significant out-of-pocket costs for the consumer or services that are unable to sufficiently deal with the patient's health needs. The 20-minute duration also fails to account for the complexity of the health needs of many consumers. Co-morbidity is common among people with chronic illnesses, with 90% of people with chronic obstructive pulmonary disease, 85% of people with diabetes, and 82% of people with cancer having two or more chronic diseases.[17]

Nevertheless, we again emphasise that MBS item reform, like the commitment in Recommendation 3 to reform private health insurance funding to allow delivery of contemporary and evidence based primary care by allied health professionals, is only one part of what is necessarily a suite of funding approaches. To meet the varying needs of patients and support broad access to allied health services, it is also imperative that Australia moves far beyond any simple reliance on fee-for-service models and instead introduce a range of innovative models of care and funding (including block, blended and bundled).

In the medium term, the suite of overarching and funded local solutions should therefore be developed.

### 11.2 Digital infrastructure

The lack of a level playing field in digital health is currently one of the biggest obstacles to bringing allied health into primary health care as a full and equal partner. Despite being the largest workforce in primary care, the largest professional workforce in disability, and a core component of home

[15] For example, people in the lowest 20 per cent of incomes are about five times more likely to have cardiovascular disease or diabetes than those in the highest 20 per cent (https://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf).
[16] https://www.ncbi.nlm.nih.gov/pubmed/27451858 ; see also Consumers Health Forum of Australia, *Out-of-pocket pain research report* (April 2018).
[17] http://www.aihw.gov.au/chronic-diseases/comorbidity .

based aged care – all of which need to be interconnected for coordinated, multidisciplinary care – allied health professions have not been given any priority to support digital health integration. Although an integrated approach has been the rhetoric for more than a decade, there has been no concrete commitment to address the issue.

The PHNs have no overall remit to integrate allied health into any digital readiness programs, and software providers have limited interest and no incentive to innovate for allied health inclusion. The Australian Digital Health Agency does not have allied health on its priority list for the foreseeable future.

AHPA therefore recommends as a short-term benchmark, funded provision of digital infrastructure in existing allied health practices.

In the medium term, a funding pool should be established for emerging/new allied health practices and for take-up of new technologies as they are developed, so that within three years, all allied health practices are digitally enabled.

### 11.3 Data

Again, this recommendation is critical to reform success. We propose as a short-term action benchmark, identification of the allied health primary care minimum dataset and data collection methodology and requirements. This should be a discretely funded project to facilitate Australian Institute of Health and Welfare (AIHW) and allied health peak body collaboration.

By the medium-term, allied health practices should be contributing through PHNs, or, where appropriate, other local solutions, to the AIHW primary care data asset project.

The long-term benchmark should be the full contribution of allied health data to the AIHW primary care data asset project.

### 11.4 Improved communication

This is another essential and long overdue component. Allied health practices must be able to communicate securely and efficiently not only with general practice, but with one another. All key nodes in the wider care communication system, including My Health Record and secure messaging, must be fully accessible to allied health. This is far from the case at present.

AHPA recommends benchmarks of 50% of allied health practices networked within 12 months, and 100% within three years.

### 11.5 Workforce plan

We strongly support this. Workforce planning should include the development of national minimum data sets which support allied health workforce analysis and can be used to formulate strategies to ensure adequate supply to meet current and projected future demand. Investment is needed to support recruitment and training of students in primary care settings, including health, disability and aged care.

AHPA proposes a medium-term benchmark of plan completion with 50% of identified measures implemented. Within five years, implementation should be completed with evaluation being regular and ongoing.

### 11.6 Strong clinical governance for allied health in primary care

Strong clinical governance is important and must be achieved and maintained in tandem with workforce planning. For example, the obstacles to professional pathways and supervision posed by thin markets, particularly in rural and remote areas, need to be addressed. Appropriate delegation frameworks must be put in place to enable appropriate work to be undertaken by allied health assistants and support workers, and to provide career satisfaction for these roles.

We recommend as a short-term benchmark, completion of a gap analysis and identification of best practice models and standards, including for allied health in rural and remote locations and areas of disadvantage.

50% of allied health should demonstrate compliance with best practice within three years, and 100% within five years.

### 11.7 Research and translation

It is vital that the existing research evidence for allied health interventions is built upon, and that data on client outcomes is collected and analysed to demonstrate the efficacy and efficiency of allied health. Similar to the research underpinning medical interventions, this cannot be effectively undertaken without dedicated funding.

See our response to Recommendation 18.

## *Recommendation 13*

AHPA broadly supports this recommendation, with the following comments.

### 13.1 Role and scope of all health professionals

The National Alliance of Self Regulating Health Professions (NASRHP) standards should be formally recognised, and the nationally endorsed list of primary health professions developed, within the first 12 months of the Ten Year Plan.

### 13.3 Regulatory frameworks

With regard to allied health assistants, note our response to 11.6.

## Innovation and Technology

## *Recommendation 15*

We support this recommendation and refer to our proposal, in response to 11.2, that allied health be prioritised for funding and support so that it may achieve digital equity with other health providers.

## *Recommendation 16*

We support this recommendation in broad principle, but it should also signpost Recommendation 11 as specifically addressing allied health digital issues, after incorporating AHPA's suggested additions.

In relation to telehealth, the current approach treats it as an equivalent direct substitute for face-to-face consultation, which does not take into account the complexities of providing video conferencing which can often be more costly and time consuming for both practitioner and client. Allied health

practitioners in particular, due to the nature of their work, need a different approach to that taken with GPs. Allied health practice has already demonstrated great aptitude for developing telehealth systems and is more advanced than general practice, and yet the focus continues to be on a GP-centered model.

AHPA is also concerned that the dominant stance on telehealth only considers a very limited notion of cost efficiency, to the ultimate detriment of productive and allocative efficiencies (see 'The value of allied health in system reform', above). The current costing structures will not support a sustainable or, in many cases, an effective, clinical approach. Unless this is considered and addressed promptly, telehealth will continue to be seen as a last resort rather than an opportunity.

## Research, data and continuous improvement of value to people, population, providers and the health system

### *Recommendation 17*

We broadly support this recommendation, but it should also signpost Recommendation 11 as specifically addressing allied health research and data issues.

### *Recommendation 18*

AHPA supports this recommendation with the following suggested additions.

#### 18.1 Research translation and innovation body

AHPA proposes, as a short-term benchmark, establishment of an Allied Health Program within the Australian National Institute for Primary Health Care Research Translation and Innovation.

#### 18.3 Primary health care research capacity

We propose, as short-term benchmarks, representation of allied health in the reinstated national governance framework, and establishment of an allied health practice-based research network.

In the medium term, we recommend that each PHN or equivalent local solution has at least five allied health clinician academic positions across a range of treatment intervention types; and that there should be five academic research partnerships involving allied health.

## Emergency preparedness

### *Recommendation 19*

AHPA supports this recommendation, noting that the biggest current barrier – as starkly shown in the COVID-19 pandemic – is the inability of the States and Territories to collaborate to provide a consistent approach.

It also remains essential for a unified system response to formally acknowledge and implement the now agreed definition of 'allied health', together with a clear understanding of which forms of allied health treatment need to continue in an emergency or disaster and which aspects can be safely delayed or delivered by telehealth.

With all respect to Chief Health Officers, their role as doctors and the focus on immediate concerns only is likely to compromise their understanding of the value of diverse allied health practice and the associated consequences for patients, and the health system in both the short and long term, if they

cannot be treated. Allied health experience during the COVID-19 pandemic has generally been simply to be told of decisions about restrictions and treatments that are deemed essential. Even here it is often a matter of having to continually ask for information and clarification in different jurisdictions, and then being forced, often under considerable pressure, to try to catch up. Allied health peak bodies and practices are usually not consulted until after it is too late, with announcements being made about providing measures such as more mental health services without an understanding of the capacity and distribution of the workforce. Effective data collection and analysis for the allied health sector would assist in decision making.

There should be a high-level representative of allied health on the AHPPC and any future disaster planning activities. If the Commonwealth Chief Allied Health Officer, as the lead of around 1/3 of the health workforce, were at similar seniority to the Chief Nurse and Deputy Chief Medical Officers and engaged as they are this would be very beneficial. Development of allied health emergency policy and practice must be led by Chief Allied Health Officers in partnership with allied health peak bodies and registration boards.

The continuing lack of access to health care interpreters particularly for private for allied health professionals also compromises equitable health outcomes at any time. Addressing this issue is a matter of urgency, particularly in order to support those during a pandemic or disaster for whom English is at most a second language.

### Implementation is integral to effective reform that delivers on the Quadruple Aim

*Recommendation 20*

AHPA strongly supports this recommendation, and as the allied health professions' national peak body, looks forward to future engagement and collaboration in the implementation and evaluation stages of the reforms.