Consumers Health Forum of Australia

SUBMISSION

Rural Allied Health Quality, Access and Distribution: Options for Commonwealth Government Policy Reform and Investment

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Rural Allied Health Quality, Access and Distribution: Options for Commonwealth Policy Reform and Investment.
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Leanne Wells CEO

P: 02 6273 5444
E: info@chf.org.au

twitter.com/CHFofAustralia
facebook.com/CHFofAustralia

Office Address
7B/17 Napier Close
Deakin ACT 2600

Postal Address
PO Box 73
Deakin West ACT 2600

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Introduction

Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers and those with an interest in health care consumer affairs. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems. CHF appreciates the opportunity to provide a submission to the *Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution.*

CHF believe all Australians, no matter their location, should have access to safe, good quality and timely health care. On almost every measure, the 7 million Australians living in regional, rural and remote areas display health deficits that require attention. According to the latest figures from the Australian Institute of Health and Welfare[1], they are more likely to have shorter lives, poorer access to health services and professionals, and experience higher levels of injury and disease compared to those living in major cities. Yet, unfortunately we find the allied health services and workforce unevenly distributed across Australia. In rural and remote Australia, allied health professionals are under-represented in-person, making accessibility very challenging.

At the heart of CHF's policy agenda is patient-centred care. Previous consultations, submissions, and current literature have informed our response to this consultation. We have also drawn on the expertise of members of our Rural and Remote Health Special Interest Group (SIG), an informal network of consumers who have self-selected to work more intensively on policy issues and solutions to our most pressing rural and remote health challenges from a community standpoint. Our response aligns with the following policy areas identified in the consultation paper:

- Rural Allied Health Policy, Leadership and Quality and Safety
- Opportunities for Rural Origin and Indigenous Students
- Sustainable Jobs and Viable Rural Markets
- Telehealth Allied Health Services

Comments

1. Rural Allied Health Policy, Leadership and Quality and Safety

1.2 Rural Allied Health College

[1] Australian Institute of Health and Welfare 2019. *Rural and Remote Australians*. Canberra: AIHW, available at: https://www.aihw.gov.au/reports-data/population-groups/rural-remote-australians/overview

Question 1.2.b: Which model or approach do you support for adopting a College? Please provide the details of the model and the reasons why.

CHF support the establishment of a Rural Allied Health College and would support 'a controlled entity or affiliated entity established by an existing allied health organisations or consortium of organisations' as the model or approach. There are examples of this approach working well for existing colleges such as the Australian College of Rural and Remote Medicine and the Royal Australasian College of Physicians.

While a member of our Rural and Remote Health SIG supported the same model used for rural university campuses, offering 'traditional courses in addition to being centres of excellence for particular areas of research due to geographic location'. For example, James Cook University and the Australian Institute of Tropical Health and Medicine[2].

Regardless of the model or approach chosen for adopting a College, CHF strongly recommend the model includes a Consumer Advisory Council to ensure the consumer voice is being heard both in the delivery of care and in the way allied health professionals are trained and educated. The Royal Australasian College of Physicians provides a good example of this approach and are 'committed to ensuring all types of healthcare consumers are engaged in the way our next generation of specialists are being educated and learning on the job[3]'. CHF support this approach and strongly believe this should be an essential component of a Rural Allied Health College.

Questions 1.2.c: What performance indicators would determine the effectiveness of a College?

- Consumer Advisory Group
- Academic results
- Enrolment rate
- Graduate rate
- Post-graduate employment rate (growth of rural allied health workforce)
- Graduate and Student Satisfaction
- Research published

1.3 Allied Health Workforce Dataset

1.3.a: What are the benefits and challenges of investing in a unique national rural allied health workforce dataset?

The benefits of investing in such a comprehensive dataset will better inform decisions and enable staff and resources to be more effectively distributed across rural areas.

A major barrier is the lack of any data capturing infrastructure across primary care practices.

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[2] James Cook University 2019, *Australian Institute of Tropical Health and Medicine*, available at: https://www.aithm.jcu.edu.au/

[3] Royal Australasian College of Physicians, *Consumer Advisory Group*, RACP, accessed 2 August 2019, https://www.racp.edu.au/about/consumer-advisory-group

1.3.b: What existing rural allied health workforce datasets/structures could be used already as the basis for this national dataset?

Data from MyHealth Record could be used to capture the activity of allied health professionals such as inter-professional collaboration. However, this would raise some barriers and would require further consultation and consideration before implementing. One obvious barrier is time poor allied health care practices, making it difficult for allied health workers to dedicate time and resources needed to record additional detail. Another barrier is consumer distrust of MyHealth Record, including the appropriate use, management and securing their personal data.

2. Opportunities for Rural Origin and Indigenous Students

2.1 Introduction of Rural Origin Selection Quotas

2.1.a What are appropriate target quotas for universities to select more rural origin students into allied health courses?

Approximately 30% of the Australian population live in rural and remote area[4]. To be representative of the rural and remote population, CHF suggest target quotas of 30%. This is also supported by members of our Rural and Remote Health SIG.

2.1.b: If quotas were to be set at different rates for different courses and university contexts, what should be considered in determining these quotas?

Members of our Rural and Remote Health SIG suggested both vacancies and demand across the rural workforce should be considered. CHF support this, and in addition feel the current and emerging health trends across rural areas of Australia should too be considered.

2.1.c: Please describe other policy options within the Commonwealth's remit, which could achieve the same result in rural and origin student admission rates?

Members of our Rural and Remote Health SIG highlighted the difficulties in obtaining appropriate supervision for students to undertake work experience in rural areas and suggested incentives could be offered to the allied health workforce to increase appropriate opportunities for students.

4. Sustainable Jobs and Viable Rural Markets

4.1 Integrated Allied Health Hubs (IAHHs)

[4] Australian Institute of Health and Welfare 2018. *Australia's health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW.

4.1.b: Please describe any examples of integrated and collaborative service models that could be scaled up and or adapted under the proposed IAHHs principles in this options paper.

CHF is undertaking a trail of Collaborative Pairs supported by the Australian Commission on Safety and Quality in Health Care and four Primary Health Networks in NSW and Victoria[5]. Developed in the UK by the Kings Fund, an independent charity that works to improve health and care, Collaborative Pairs is an initiative designed to coach and mentor clinicians, managers, patients and consumers to develop new ways of working and learning together and – most importantly – ways of relating to each other as peers. Cultural barriers, power imbalance and information asymmetry often exist between those receiving and those delivering health care.

Collaborative Pairs aims to tackle those barriers, moving beyond a 'them and us' relationship to one where power, purpose, ambition, leadership and ownership are shared. Through this program consumers, managers and service providers work as equals. A patient or consumer leader is one half of the pair, the other half a clinician or health service provider looking to find new ways of working with consumers. The initiative is designed to coach pairs from the same local PHN health area to work together on a shared challenge which serves as an anchor around which to develop and embed collaborative practice. The shared challenge could be anything from improving governance, to a service improvement or development of a new program. CHF strongly believe this collaborative model could be scaled up under the proposed IAHHs to increase patient involvement and improving health outcomes within their local area.

5. Telehealth Allied Health Services

Technology is a strong enabler, providing opportunity to improve the delivery of allied health services for people living in rural and remote areas. While CHF supports the use of technology in health care – at the heart of this we must consider how the use of technology will provide improved patient experience of access. Initiatives such as telehealth have brought health services to the comfort of home via video-conference, allowing people to receive treatment promptly and help overcome barriers such as time and expenses that would otherwise be required to travel to regional areas of major cities to receive care[6].

In 2013, CHF conducted a survey to explore consumer views and perceptions of Telehealth in rural and remote areas. The results from the survey were mixed. Almost all survey respondents have heard of Telehealth and Telehealth consultations, and over half of respondents who have used Telehealth believe that it is a step in the right direction and seems to meet their needs. However, results from the survey suggested technology was unable to keep up, with 50% of respondents highlighting technology and availability was a

[5] Consumers Health Forum of Australia 2018, *Collaborative Pairs Australia,* CHF, accessed 2 August 2019, https://www.chf.org.au/collaborative-pairs
[6] Department of Health 2017, 'Telehealth measure to improve access to psychological services for rural and remote patients', Australian Government, accessed 1 August 2019.

major obstacle to their use. Survey respondents suggested it would take education, access and improved technology for them to use Telehealth.

Technology has come along way since this survey was conducted with phones, tablets and computers integrated with webcams now widely available across Australia. However, accessing reliable broadband internet remains one of the most significant technical barriers, particularly for those located in rural areas, preventing consumers and allied health professionals from utilising Telehealth. Training and education for both consumers and allied health professionals is required. CHF believe this should be developed and lead by Government and delivered locally by PHNs and, once established, through IAHHs.

5a: Please describe any existing telehealth models that could be adopted in rural areas to improve the access to and delivery of allied health services

The Allied Health Professions Association (AHPA's) recently released a position statement on *Increasing Access to Telehealth Services*[7] and identified funding as a primary barrier preventing consumers and allied health professionals accessing Telehealth. Members of our Rural and Remote Health SIG echoed this view. CHF welcomed the introduction of Medicare cover for online consultation with psychologist for people in rural Australia and would support the AHPA's call for a 'similar expansion of eligibility criteria for government-funded allied health programs[7]'.

Additional Comments and Feedback

Members of our Rural and Remote SIG agreed the notion of a networked allied health system throughout rural Australia was great however, felt the infrastructure in health facilities and hospitals is severely lacking. One member stated:

> *"There is an assumed equipment and operational capacity that simply does not exist. For example, there is no point in providing a Telehealth facility to a remote or rural hospital if the necessary instrumentation for diagnosis is not available for the city physician to use".*

CHF agree and suggest before any implementation of IAHHs, existing resources should be audited.

General Comments and Feedback

Funding for Allied Health Services

Primary health care services currently available under the MBS go some way to meeting the needs of most Australians, however for those with chronic and complex conditions care can be fragmented and the siloed funding system difficult for consumers and providers to

[7] Allied Health Professions Australia 2019, 'Increasing Access to Allied Health Telehealth Services', AHPA, accessed 2 August 2019, https://ahpa.com.au/wp-content/uploads/2017/09/170531-Telehealth-Position-Statement.pdf

navigate. This is particularly evident in cases where consumers require care from multiple primacy care providers.

A blended funding model would facilitate collaboration and continuity of care between GPs and allied health professionals, as seen where patients are eligible for allied health appointments through Chronic Disease Management (CDM) services as part of their GP Management Plan or Team Care Arrangements.

The current limit of five allied health appointments every twelve months is insufficient for patients suffering from complex and chronic conditions or for cases where such intervention would lead to long-term savings for the health system or specific conditions such as pelvic health, pain and pulmonary rehab.

For example, someone recently diagnosed with diabetes may need to see a dietitian, a diabetes educator, a podiatrist, and a physical trainer. In the early stages of a new condition, consumers require self-management support as they learn to manage and understand their condition, and this involves multiple appointments to build a relationship with the health care provider, monitor progress and adjust treatment. In this instance, there is only one condition and the consumer has already used four out of five appointments eligible for rebate. Additional follow-up appointments would come at an out of pocket cost to the consumer, which may mean they wait twelve months to attend another appointment. This highlights the need for a review of barriers to accessing these services and the need for health care providers to have some input to the number of appointments required in individual cases.

Mental Health Plans are an example where flexibility has been given to healthcare providers. Consumers with a plan are eligible for six sessions each calendar year with psychologists able to request another four sessions if necessary.

CHF recommended a similar arrangement but think it would be more appropriate if the GP was able to request additional appointments where required. There could also be scope for people with multiple chronic diseases to have additional services. For example, each additional condition could attract an additional two services.

Conclusion

Overall, CHF:

- Support the development of a Rural Allied Health College and strongly recommend the model includes a Consumer Advisory Council to ensure the consumer voice is being heard both in the delivery of care and in the way allied health professionals are trained and educated.
- Believe the development of an allied health workforce dataset would better inform decisions and enable staff and resources to be more effectively distributed across rural areas, however requires further consultation if existing datasets such as MyHealth Record are to be utilised.
- strongly believe the Collaborative Pairs model could be scaled up under the proposed IAHHs to increase patient involvement and improving health outcomes within their local area

- Training and education for consumers on how to access and use Telehealth is required, and should be developed and lead by Government and delivered locally through PHNs, and IAHHs.