Submission to the

Australian Government
National Rural Health Commissioner

Rural Allied Health
Quality, Access and Distribution

7 August 2019

Introduction

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide this submission to the Australian Government National Rural Health Commissioner discussion paper for consultation: *Rural Allied Health Quality, Access and Distribution: Options for Commonwealth Government Policy Reform and Investment*.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

AHHA has developed a plan to transition the Australian healthcare system to a patient centred, outcomes focused and value-based healthcare system. *Health people, healthy* systems[1] identifies four domains of reform that are critical to achieving this goal. These include reforms to governance structures, performance information and reporting that is fit for purpose, health workforce and funding arrangements. The plan is underpinned by key concepts that include universal health care, quality health outcomes, a holistic view of health and wellbeing, coordinated and integrated care, long-term sustainable funding, innovation in response to need, and equity in health.

Reforming rural allied health quality, access and distribution requires action across all of these domains, as is reflected in our responses to selected questions posed in the discussion paper.

[1] Australian Healthcare and Hospitals Association. 2017. Healthy people, healthy systems. Available at https://ahha.asn.au/sites/default/files/docs/policy-issue/ahha_blueprint_2017_0.pdf.

Policy Area 1: Rural Allied Health Policy, Leadership and Quality and Safety

1.1 Appointment of a Commonwealth Chief Allied Health Officer

1.1a If the Commonwealth were to appoint a Chief Allied Health Officer/Advisor, what would be their top priorities for improving rural allied health distribution, access and quality in the next five years?

According to the Australian Government Department of Health website[2], Caroline Edwards is the Chief Allied Health Officer, in addition to her role as Deputy Secretary of Health Systems Policy and Primary Care Group. While the responsibilities of these roles should align, there appears broad lack of awareness and accountability for this role. Further, her background is as a lawyer, not an allied health clinician. While she has managed relevant programs, it would be helpful to have this portfolio led by a clinician if it is to be more than a management role.

This role should be instrumental in driving the development of a national workforce strategy that goes beyond the adequacy, quality and distribution of the workforce as it currently exists. It must:

- Involve a cross-jurisdictional and cross-sector planning approach;
- Enable outcomes-focused and value-based changes in scopes of practice and models of care, for both regulated and unregulated practitioners and across health service environments;
- Coordinate education, regulation and funding at the Commonwealth, state, territory and regional service levels; and
- Embed long-term sustainability.

Priorities for improving rural allied health distribution, access and quality in the next five years should include:

- Improved data and reporting on the allied health workforce that can be used to monitor equity in access and evaluate outcomes-focused and value-based changes in scopes of practice and models of care;
- Enabling and supporting service delivery strategies at regional levels. Primary Health Networks (PHN) and Local Hospital Networks (LHN; or equivalent) are increasingly establishing governance arrangements for joint activity, including regional needs assessments, priority setting and pooling funds for service delivery. These activities should be supported nationally for consistent and evidence-based approaches;
- Enabling and supporting employment and supervisory structures, through PHN and LHN activity (as above); and
- Facilitating connected policy development across the health, aged and disability sectors in rural communities.

1.1b How could a Chief Allied Health Officer/Advisory position be structured to improve inter-sectoral collaboration?

AHHA proposes the role sit within the portfolio of the Chief Medical Officer, given this portfolio encompasses workforce, training and access. Reporting lines could be similar to those of the Chief

[2] Australian Government Department of Health Leadership. Available at: https://www.health.gov.au/about-us/who-we-are/leadership

Medical Officer. Consideration may also be given to the role's relationship with the Health Systems Policy and Primary Care portfolio, given the portfolio encompasses Indigenous Health, Portfolio strategies (including Commonwealth State relations), Primary care and Mental health.

1.2 Rural Allied Health College

1.2a What would be the advantages and disadvantages of the abovementioned models for establishing a College?

AHHA agrees there is need for the Commonwealth to support an entity (or entities) to facilitate access to allied health services to meet the needs of rural communities. Allied health services are not solely a responsibility of the states and territories. The Commonwealth, for example, has responsibilities associated with the funding and delivery of services in the primary health, disability, veterans and aged care environments, as well as in relation to private health insurance and in the education of the workforce. The Commonwealth and the states and territories must work in partnership to implement a nationally unified, but regionally responsive health system.

Functions

The discussion paper identifies a number of functions for a proposed College, including leadership and advocacy, standard setting, professional guidance, a repository for workforce data, and an accrediting body for education programs.

For each of these functions, AHHA recommends separately defining the required governance to enable them to be carried out most effectively, as well as mapping existing entities who have roles and responsibilities that may align/overlap/duplicate. Functions vary in the extent to which:

- there should be expectation of Commonwealth support;
- existing entities hold the expertise and experience required;
- efficiencies can be gained through existing entities and structures;
- the influence of vested interests needs to be managed;
- community need must be addressed as the primary purpose through governance structures.

Governance

It is critical that the defined purpose and governance structures for any model ensure a primary focus on community need. These should recognise the roles of existing entities in identifying and addressing community needs, and integrate with and build on, not replicate or conflict with, these responsibilities and accountabilities. Examples of existing entities include (but are not limited to):

- PHNs, with responsibilities including analysing relevant health data; prioritising local health needs, including joint planning with Local Hospital Networks (or equivalent); working with providers, clinicians and communities to co-design services to meet those needs; working closely with providers to agree referral pathways; commissioning services

to meet local needs; and monitoring and evaluating service delivery to inform future needs. Workforce is a priority area for targeted work.[3]

- State and territory governments and LHNs (or equivalent), with responsibilities including the management of public hospital and health services.
- The Australian Institute of Health and Welfare (AIHW), with responsibilities including developing a National Primary Health Care Data Asset.
- The Australian Commission on Safety and Quality in Health Care, with responsibilities including developing national safety and quality standards; developing clinical care standards; and supporting health professionals to deliver safe and high-quality care through the way it is informed, supported and organised.
- Professions and their respective regulating bodies (or the equivalent self-regulating entities), with responsibilities including setting the standards members of the profession must meet and ensuring standards of practice are upheld to protect the health and safety of the public.[4]
- Education providers and accreditation authorities who have responsibility for programs of study that provide graduates with eligibility for registration with a profession.[5]

AHHA therefore recommends the following:

- Any entity supported by the Commonwealth for this purpose must be driven by service providers, commissioners or recipients of health services in rural and remote areas. This must be reflected, for example, in the Constitution in the purpose/objects, membership and Board nomination requirements. Vested professional and financial interests will be an impediment to effective reforms in rural health service delivery and this should be minimised through governance structures. As the term 'College' typically refers to a profession-led entity, AHHA does not support the use of this term (or such a model) in pursuing improvements in rural allied health distribution, access and quality.
- The policies and procedures for any entity supported by the Commonwealth must ensure the expertise and experience of all stakeholders involved with the provision of health services in rural areas are included in the co-design of activities. This includes consumers, health practitioners or entities representing these, education providers, those involved in the supply of goods and services in rural and remote areas, and those involved in the improvement of healthcare.
- An evaluation framework is established at the outset with transparent monitoring and public reporting.

The feasibility of funding models and sustainability of an entity should also be an express consideration of the Commonwealth supporting any entity, whether that be evolution of an existing entity or a new entity.

The work undertaken by AHHA in 2018, on behalf of Queensland Health, relating to an accreditation system for rural generalist education programs for the allied health professions included stakeholder mapping and business model development that should inform further

[3] PHN Program Performance and Quality Framework. Available at: https://www.health.gov.au/internet/main/publishing.nsf/Content/55B22FCB1BB6A94ECA257F14008364CC/$File/V1.1%20-%20PHN%20Program%20Performance%20and%20Quality%20Framework.pdf
[4] AHPRA FAQ. Available at: https://www.ahpra.gov.au/About-AHPRA/What-We-Do/FAQ.aspx
[5] Education. Available at: https://www.ahpra.gov.au/Education.aspx

development. It is recommended that the accreditation system now be supported through to implementation.

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

For the reasons expressed in response to question 1.2a, AHHA believes there is further work that needs to be undertaken to inform the most appropriate models for the different functions that need to be pursued. AHHA would be pleased to participate in work to explore the functions proposed and a mapping of stakeholders to inform the development of a model or approach.

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

Building on the work described in response to question 1.2b, AHHA believes there is opportunity to embed performance indicators in the performance frameworks for existing entities already holding responsibility and accountability in these areas, e.g., in agreements between the Commonwealth and PHNs, and between states/territories and LHNs, in rural areas. Indicators should reflect the unique needs of different rural communities that will require joint activity in conducting regional needs assessments, priority setting and pooling funds to meet allied health service delivery needs.

1.3 Allied Health Workforce Dataset

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

A dataset on the allied health workforce must go beyond the numbers and distribution of the workforce as it currently exists, and support the pursuit and evaluation of outcomes-focused and value-based changes in scopes of practice and models of care.

It must facilitate, for example, action in rural areas that are expected to have no practising GP, as expressed in the case study of Western NSW[6]. Current funding models, workforce recruitment and retention strategies and approaches to the problem are not working. New models for primary care are needed, delivered based around team care, extending scopes of practice and using telehealth. A dataset to understand the rural allied health workforce would need to capture data to evaluate models of care and expand those that are successful.

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

AIHW would be best placed to lead work on the development of a data set to understand the rural allied health workforce. This should align and build on the work already done (e.g. the Allied health National best practice data sets relating to public hospital services[7], and the National

[6] Blueprint case study: Securing the future of Primary Health Care in small towns in Western NSW. Available at: https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_case_study_-_securing_the_future_of_phc_in_small_towns_in_western_nsw.pdf

[7] Health sector data set specifications. Available at: https://meteor.aihw.gov.au/content/index.phtml/itemId/345165

Health Workforce Data Set: allied health practitioners[8]) and work being undertaken to develop a National Primary Health Care Data Asset[9].

Policy Area 3. Structured rural training and career pathways

3.2 Career pathways in rural allied health

3.2a What are the factors that would need to be considered to ensure the successful expansion and promotion of the Health Workforce Scholarship Program?

Scholarship recipients should be linked with regional needs, as identified through cross-sector joint planning efforts, with regional cross-sector commitment to providing the supervisory and mentoring support and career development opportunities. Funding must be sufficiently flexible for individuals who work in multiple roles, across multiple sectors and in both public and private sector positions.

3.2b Please describe other policy options, within the Commonwealth's remit, which could achieve the same result in clearly articulating and promoting structured career opportunities.

AHHA recommends that the Allied Health Rural Generalist Pathway[10], which has been developed, trialled and evaluated by Queensland Health in partnership with five other Australian states and territories, provide the basis by which national efforts continue to progress the establishment and maturing of career pathways in rural allied health.

Career pathways must reflect the responsibilities of Commonwealth and states and territories governments, working in partnership to be nationally unified yet regionally responsive.

Objectives could be defined and funded through agreements with the rural PHNs for coordinating joint primary care positions across a region. Agreements should enable pooled funding, joint placements and coordinated supervision and mentoring with LHNs, as well as with the primary health, veterans, aged and disability sectors, to ensure a response that addresses regional needs.

Policy Area 4. Sustainable jobs and viable rural markets

4.1 Integrated allied health hubs

4.1a What are the factors that would need to be considered to support the development of IAHHs which service regional catchments of Australia?

Integrated Allied Health Hubs is one potential and interesting option for addressing allied health rural needs. However, it does not reflect the importance of regionally developed responses to address specific regional needs.

[8] National Health Workforce Data Set. Available at: https://meteor.aihw.gov.au/content/index.phtml/itemId/626540
[9] Primary health care data development. Available at: https://www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/primary-health-care-data-development
[10] Rural and remote allied health professionals. Available at: https://www.health.qld.gov.au/ahwac/html/rural-remote

AHHA cautions against proposing a single prescriptive solution to address allied health rural needs, when it is known that the strengths and needs of each rural community is unique and changing. Actions taken will be determined not only by evidence and the needs of a particular population, but also by the pattern of services and infrastructure that has evolved during decades of growth. AHHA recommends, rather, establishing governance arrangements at a higher level, as noted in the response to question 4.1c.

4.1b 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.

AHHA has published a number of case studies which align with its blueprint on health reform. These can be found on the AHHA website[11]. The following cases reinforce the importance of governance in achieving success in implementing integrated and collaborative service models, and accountability in addressing regional needs. Weblinks are provided to full cases.

- The Lower Gulf strategy[12]: A tripartite agreement was signed between the Boards of North West HHS, Gidgee Healing (a local Aboriginal Community Controlled Health Organisation) and Western Queensland PHN to deliver comprehensive primary care services in areas where previously none have been available, shifting the focus of services from acute care.
- Primary health care in Western NSW[13]: Eleven small towns are expected to have no practising GP within 2-3 years, and 41 towns in the next 10 years in Western NSW. The Western Health Alliance has been building a coalition of support to focus on high priority communities at risk. It requires a commitment to a more flexible approach to funding with new models for primary care delivered based around team care, extended scopes and use of telehealth.
- Aged Care workforce in South Australia[14]: University-service provider collaboration has been used to better link education and training to workforce need in underserved areas such as aged care.
- The Collaborative[15]: In Melbourne, through a collaborative arrangement between Melbourne Health, North Western Primary Health Network, Merri Health and cohealth, timely access to community based allied health services has been achieved through a focus on referral processes.

4.1c How could Government structure funding arrangements to allow the flexibility necessary for regions to manage funding in the way that suits the specific needs of their communities

As noted in response to question 1.2a, PHNs have existing responsibilities which include analysing relevant health data; prioritising local health needs, including joint planning with LHNs (or

[11] Blueprint Case Studies. Available at: https://ahha.asn.au/Blueprint
[12] Blueprint case study: The Lower Gulf Strategy: Integrating care, improving health outcomes. Available at: https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_case_study_-_lower_gulf_strategy_0.pdf
[13] Blueprint case study: Securing the future of Primary Health Care in small towns in Western NSW. Available at: https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_case_study_-_securing_the_future_of_phc_in_small_towns_in_western_nsw.pdf
[14] Blueprint case study: Increasing workforce capacity in aged care through student placements and stronger links with universities. Available at: https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_case_study_-_ua_aged_care_helping_hand.pdf
[15] Blueprint case study: The Collaborative: improving access to community based allied health services. Available at: https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_case_study_-_access_to_community_based_allied_health_0.pdf

equivalent); working with providers, clinicians and communities to co-design services to meet those needs; working closely with providers to agree referral pathways; commissioning services to meet local needs; and monitoring and evaluating service delivery to inform future needs. Workforce is a priority area for targeted work.[16]

Aligned agreements are needed between the Commonwealth and PHNs, and the states and territories with LHNs, to establish governance arrangements for regional needs assessments, priority setting and funding, aimed at a coordinated and integrated approach to meeting rural allied health distribution, access and quality.

Policy Area 5. Telehealth allied health services

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.

AHHA has published a number of case studies which align with its blueprint on health reform. These can be found on the AHHA website[17]. One case from West Moreton Health[18] reflects use of a telehealth and virtual care model, monitored by a multidisciplinary clinical team, in supporting patients with chronic disease.

[16] PHN Program Performance and Quality Framework. At: https://www.health.gov.au/internet/main/publishing.nsf/Content/55B22FCB1BB6A94ECA257F14008364CC/$File/V1.1%20-%20PHN%20Program%20Performance%20and%20Quality%20Framework.pdf

[17] Blueprint Case Studies. Available at: https://ahha.asn.au/Blueprint

[18] Blueprint case study: MeCare (Mobile Enhanced Care) through the power of partnerships. Available at: https://ahha.asn.au/sites/default/files/docs/policy-issue/blueprint_case_studies_-_3._mobile_enabled_care_through_the_power_of_partnerships.pdf

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