2nd Allied Health Roundtable – 18 September

Attending: Jen Coulls, Russ Hoye

The purpose of the second Allied Health roundtable was to:

- discuss reform options relevant to the allied health sector that have the potential to improve patient-centred care, the quality of care, the efficiency and effectiveness of the health system.
- develop a set of recommendations to take to the Primary Care Steering Group that inform the development of the Primary Health Care 10 Year Plan.

At the first Roundtable, participants identified a range of issues that affect access to allied health services in primary health care. Some of the issues raised were:

- The need for strategic leadership on workforce planning, training, retention and data collection;
- The need to build capacity of the Aboriginal and Torres Strait Islander workforce;
- The need to address the maldistribution of practitioners, with widespread shortages in rural and remote communities;
- The current primary health system not supporting team-based and integrated care – including equitable access to allied health services – which has a negative impact on so the patient journey and health outcomes;
- The misalignment between existing payment and reporting schemes for allied health (e.g. Medicare, the National Disability Insurance Scheme, aged care funding), which places an unnecessary burden on the clinician and the patient;
- The links between access to services in the health sector and demand in other sectors, including disability and ageing; and
- Digital health improvements that could better support team-based care and care coordination.

For this Roundtable, participants undertook a deeper exploration of the following key issues:

1) Building the data and evidence base for allied health;
2) Funding models that support patient centred primary health care; and
3) Maximising potential of digital health.

The Department noted that many in the allied health sector are keen to progress an **allied health workforce plan. This will be explored separately as part of the role of the Chief Allied Health Officer.**

3 Key issues discussed

Building allied health data and evidence

Workforce data is one area where there are substantial gaps. Allied health professionals registered with the Australian Health Practitioner Regulation Agency (AHPRA) are required to fill in a survey each year outlining details of work hours and main areas of work, but this data is collected on residential address, not places of work. Some data on the self-regulated allied health professions is collected in the Australian Bureau of Statistics census every five years, but it lacks granularity. Individual professional associations also capture some data on their members, but the elements are not consistently collected by all professions, and the proportion of professionals who are members of their professional associations varies greatly.

There are also gaps in data on patient demand for allied health services. An Australian Bureau of Statistics survey published in 2017, for example, found that although there was a 38 per cent average increase in services for 10 allied health professions between 2011-12 and 2014-15, there was no data available to explain why people were increasingly accessing these services

The lack of robust evidence on the effectiveness of some allied health interventions is also a challenge. Where there is evidence, it is not always translated into easy-to-use guidelines for health care professionals, including GPs.

The Commonwealth are keen to gather and use data and evidence to answer questions such as:

- What constitutes best practice in allied health service delivery for a range of common chronic health conditions, and for people with multiple chronic conditions?
- Do we currently have enough allied health professionals to meet demand for services? Are they distributed equitably across the country?
- Do we have enough allied health professionals in training to meet anticipated future demand for allied health services?
- Are these allied health professionals accessible to people in all part of thecountry, including rural and remote areas?

There was a general consensus that there is a lot of evidence about best practice but there is no mechanism/framework by which to collate that evidence. It was suggested by many that a clearing house be established as a matter of priority. (It will be interesting to see if this gains traction …)

From an ACDHS perspective we have an opportunity to showcase and demonstrate the evidence. (An action on the ACDHS Comms workplan is to develop a capability statement by the end of the year). In terms of workforce, is it time to pitch for the graduate destinations database? This would also serve to inform issues around maldistribution of the workforce in regional and remote areas.

Funding models that support patient centred primary health care

Many in the allied health sector have advocated for expanding access to allied health services under the existing Medical Benefits Scheme (MBS). Proposals include: expanding the range of allied health services eligible for rebate under the MBS; increasing the number of allied health services eligible for rebate under the MBS; and increasing rebate levels. Because these proposals are already in the public domain, this paper seeks the allied health sector's views on alternative funding models that have the potential to better support patient centred primary health care.

The Roundtable considered some of the main alternative funding mechanisms with a view to identifying which of them have the most potential to improve access to allied health services in Australia and promote value-based health care.

Blended payments

Blended payment methods use a combination of different funding mechanisms in an attempt to overcome the limitations of fee-for-service payments. Blended payments aim to give providers incentives to promote better access to care, improve quality, and delivery services more efficiently while still retaining some control over total health expenditure.

Blended payments are used in general practice where GPs receive for-service payments for the majority of care provided, but may also receive Practice Incentives Programme (PIP) payments and/or capitation payments under the Health Care Home trial. These blended payments support general practice to enhance capacity, continually improve the quality of care, support team-based care and adopt more innovative service delivery models.

Some of the key advantages of blended payment models in the Australian context might be that they:

- allow greater flexibility in service delivery but retain episodic payments for acute illnesses;
- can include stronger incentives for quality improvement;
- enable more innovative use of expanded roles for health professionals; Some of the challenges might be that:
- the complexity of payment arrangements may lead to a greater administrative burden on providers;
- establishing the right mix of payment methods needs to be given careful consideration to ensure there are financial incentives for quality improvement and innovation.

Bundled payments

Bundled payments (also referred to as episode payments) are payments made to hospitals or health professionals based on the expected cost of an entire episode of care. Using bundled payments, various providers can be linked through a single funding amount that spans the continuum of care, including pre-acute, acute, and post-acute care. Some of the key advantages of bundled payment models in the Australian context might be:

- stronger financial incentive for preventive care, keeping the population well and out of hospital;
- reduced incentives for cost-shifting as one party has sole responsibility for the entire episode of care;
- providers are held accountable to their peers for the total cost of care they provide during an episode of care, which creates incentives to avoid waste, duplication and ensure efficient service delivery;
- stronger incentives for improved coordination and integration of providers across different settings.

Some of the challenges might be:

- designing bundled payments can be complex given the current mix of private and public providers in Australia;
- requires substantial cultural and practice shift for providers as they need to accept responsibility for the entire episode of care.

Funds pooling

Pooled funding combines one or more separate health funding streams and brings them together into a single, flexible resource pool. Funds are generally distributed by a regional authority that has responsibility for purchasing and/or providing specified health services for the population in that area. The regional authority may be responsible for purchasing a discrete set of services – for example, mental health or inpatient hospital services – or the full spectrum of health and social services. In Australia, Primary Health Networks (PHNs) currently hold Australian Government funds to administer mental health services for people in their regions. While the Government outlines some requirements for this funding, PHNs generally have a level of independence in determining the most appropriate use of funds for their respective regions.

In the Australian context, some of the key advantages of pooling funds from different governments or portfolios, as well as private funders (such as insurers, employers, NGOs) might be:

- more opportunities to improve the integration of services;
- the ability to better match resource allocation to local level need;
- greater flexibility for local service providers to determine the type and mix health services provided;
- stronger accountability for outcomes at the regional level;
- less service duplication, waste and cost shifting; and
- efficiency gains through lower administrative costs.

Some of the key challenges with funds pooling may include:

- less choice for patients;
- difficulties allocating resources based on accurate measures of population health need;
- opposition to establishing and funding new bureaucratic organisations;
- concern about capability and performance of regional level funding authorities, and growing inequities in population health outcomes.

There was a general consensus from the participants that there is a role for all of the above payment types.

From an ACDHS point of view while recognising the primary aim of MBS is to improve access to services, we advocated for consideration of workforce development within the MBS. As significant proportions of each of the professions of allied health now work and provide services within the private sector, educating the future allied health workforce in practice settings across services and sectors will best equip clinicians of the future. Consideration of the role of students contributing in part to services billed to Medicare would be welcome.

Maximising the potential of digital health for allied health professionals

Issues explored: My Health Record, secure messaging and telehealth.

As of 30 July 2020, the number of Australians enrolled in the My Health Record has increased to 22.8 million people. There is currently great variation in the use of the My Health Record amongst allied health professions, but overall the uptake is fairly low. From 7 July 2019 to 26 July 2020, allied health professionals viewed 9,879 documents that were uploaded by others. Most documents viewed were medicines, pathology reports diagnostic imaging or Medicare overview. During the same time period, only 38 records uploaded by allied health professionals were viewed by other professionals.

The COVID-19 pandemic has resulted in a significant uptake of telehealth by some health professionals since March 2020. Between 1 April and 30 June 2020, 43.4% of mental health services provided by allied health professionals were conducted using telehealth. Of this, 62.8% were provided using videoconferencing compared to telephone consultations. For the same time period, the uptake of telehealth for the allied health chronic disease management items was 3.6% of services provided.

From an ACDHS perspective a key question is what are the short, medium and long term goals to work towards improving digital health usage by allied health professionals (and by implication, goals for future curriculum)? Some thoughts:

- *Jobs most likely to be automated will be those that involve dealing with digital information, radiology and pathology for example, rather than those with direct patient contact, ie the 'hands on' disciplines.*
- *The complexity and rise of data in healthcare means that AI will increasingly be applied in a decision support capacity, rather than replacing human to human interactions. Improved digital literacy and continuous learning about AI, mathematical modelling, decision theory will be the required skills of the future.*
- *Healthcare professionals will also have a role in supporting service users in uptake of digital technologies.*
- *The speed at which digital technologies evolve will challenge education providers' capacity to support cutting edge curriculum.*