14 August 2019

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Professor Paul Worley
National Rural Health Commissioner

By Email: NRHC@health.gov.au

AMA response to the Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution

The AMA appreciates the opportunity to respond to the options for the Commonwealth Government to address the shortage of allied health professionals in rural Australia. The AMA welcomes efforts to improve access to allied health care for rural and remote Australians and provides in principle support for the discussion paper.

The AMA agrees with the three pillars of sustainable high quality rural allied health service noted in the concluding remarks, which are:

- Increased rural origin participation in the allied health workforce.
- Increased high quality training in rural communities.
- Increased sustainability and viability of allied health jobs in rural Australia.

It is important that the National Rural Health Commissioner to maintain the centrality of GP care when making recommendations to Government. This aligns with the pillars listed above and will ensure that continuity and coordination of patient care is enhanced and well supported.

Increasing the rural allied health workforce and improving the standard of training and career development opportunities available will greatly improve the health outcomes of Australians living in rural and remote communities. It will also reduce the burden on medical practitioners providing care in these communities.

The AMA agrees that many of the policy options outlined in the discussion paper will improve patient access to appropriate care to improve their health, functionality, well-being and quality of life. However, the AMA believes that many of the issues raised stem from the underfunding of state/territory-based programs. To counter this, new sources of funding are required – programs cannot just be funded through redistributing existing funds.

In particular, the AMA does not believe that new or additional items under the Medicare Benefits Schedule (MBS) are appropriate to address these issues. It is also vital that the programs and initiatives suggested are pursued with the goal of providing coordinated care. If a patient is receiving government funded services, the coordination should be led by a general practitioner in a collaborative arrangement.

The AMA has chosen to respond to specific policy area suggestions. Where there is no specific answer it is because this should be determined by organisations representing allied health professionals.

Response to Policy Area suggestions:

Rural allied health policy, leadership and quality and safety

The AMA agrees that leadership is fundamental to the success of any efforts to improve and reform the health workforce. However, the AMA is not clear what benefit a Commonwealth Chief Allied Health Officer position would add. It is important that if this position is established, that the primary objective of the Officer is the improvement of health outcomes for all Australians. The Officer must work within clearly defined parameters and collaboratively with existing structures, in particular the Chief Medical Officer, and aim to increase the rural allied health workforce.

The AMA is unclear how a rural allied health college would benefit rural communities. The cost of establishing such an entity, the added bureaucratic burden it could add to allied health professionals seeking to work rurally, and the potential to cause divisions within the workforce are significant risks. The AMA recommends that the cost of establishing a college be directed to incentives and supports for rural allied health professionals.

The AMA agrees that data driven improvement is important and would like to see an allied health workforce dataset. As an allied health dataset is intended to be a significant part of the National Primary Health Care Data Asset, the AMA advises that the National Rural Health Commissioner discuss this with the Australian Institute of Health and Welfare who are developing the plan. This would ensure that any investment does not overlap with work already underway.

Opportunities for rural origin and Indigenous students

The AMA supports the objective to train and recruit more rural origin and Indigenous students to the rural allied health workforce. This strategy has been demonstrated as successful in medicine.

While there are challenges, in particular the lack of programs at regional universities, it is important that the standard of education and training received is not lowered to facilitate more rural origin or Indigenous students being educated and trained outside of metropolitan areas. The AMA has no objection to quotas for rural origin or Indigenous students provided they are not exorbitant and are evaluated to ensure they are delivering the desired outcomes.

The AMA supports any efforts to increase the Indigenous allied health workforce. The AMA strongly believes that Aboriginal and Torres Strait Islander people have a leading role in identifying and responding to the nature and challenges of Aboriginal and Torres Strait

Islander health, and that Indigenous health services should be increasingly provided by Aboriginal and Torres Strait Islander people.[1]

It is important that if a scholarship scheme is pursued that it does not include any bonding or mandated return of service as in the Bonded Medical Places (BMP) scheme. The BMP has not been demonstrated to have any positive impact and there is significant anecdotal evidence to suggest that it has had the opposite impact on medical graduates in terms of developing the rural medical workforce.

Structured rural training and career pathways (MMM2-7)

Provided that all training posts are accredited, the AMA supports the development of rural training opportunities and the development of post graduate training to ensure that rural communities have access to health providers with the skills and experience required.

However, the AMA is not clear on what an "Allied Health Rural Generalist" is. There is reference to "additional skills required" without detailing exactly what they are. The Collingrove Agreement details the scope and purpose for medical practitioners to be recognised as Rural Generalists. The AMA would like to see a similar agreement or set of principles to define the scope and purpose for allied health rural generalists.

The AMA notes that James Cook University offers an allied health rural generalist program and that Queensland Health has an Allied Health Rural Generalist Pathway. The AMA suggests that the James Cook University program should be evaluated and could form the basis for further curricula development. The development of any program to promote allied health rural generalists must demonstrate that the additional skills are relevant and contributing positively to rural communities, and that it is encouraging more allied health professionals to practice rurally. The Queensland Health Pathway could form the basis for this if it is determined to be delivering its goals.

In terms of recognising additional skills, the AMA is very clear that only medical practitioners have the training and expertise to perform certain tasks. Where an allied health rural generalist provides services within their scope of practice and with appropriate credentialing to provide the additional skills, the AMA has no objection. However, we would like to see this proposal more thoroughly detailed before additional comments can be submitted and a governance model is considered.

The AMA supports end-to-end immersion training opportunities and further rural immersion programs for allied health students. The expansion of existing programs and introduction of new programs must be achieved while ensuring that students have positive experiences. Students who have negative exposure during rural placements will not return to work rurally. Their programs must be adequately funded and resourced.

[1] AMA Position Statement Aboriginal and Torres Strait Islander Health - revised 2015. https://ama.com.au/position-statement/aboriginal-and-torres-strait-islander-health-revised-2015

Sustainable jobs and viable rural markets

The AMA agrees that professional sustainability is crucial to encouraging more allied health professionals to pursue rural careers and remain in their communities. The establishment of Integrated Allied Health Hubs is a positive idea provided that it does not create siloes of health care, and does not disrupt functional working arrangements in communities. The AMA recommends that the Hubs incorporate the principles of the patient-centred medical home.[2]

The medical home model refers to a model of primary care that is patient-centred, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It enables well-coordinated multi-disciplinary care, particularly for patients with chronic and complex diseases. As rural and remote communities have higher incidence of most major chronic conditions, this model would be of great benefit.

As the Hubs are described in the discussion paper, the most logical place for the Hub will often be in the local general practice where allied health professionals may already provide private services and have strong existing relationships with the GPs. Even when a Hub is not co-located, it is important to ensure that virtual integration occurs – that is formal links are established between Hubs and general practice. The Hubs should build on existing infrastructure and networks within regions, adapting to local needs and circumstances. Hubs must be built in consultation with existing healthcare providers to ensure they best serve the community.

As noted in the discussion paper, around fifty per cent of the income of occupational therapists working in outer regional and remote communities is earned through Medicare Chronic Disease Management items. Establishing Hubs with formalised links to general practice will strengthen this and could be used as part of the recruitment process.

It is also important that the Hubs are funded on an ongoing basis so as to provide certainty for allied health workers, the community, and the medical practitioners who refer patients to or coordinate the care of patients receiving services there. This funding must not be redistributed from existing services unless they are to be combined into a Hub.

The AMA cautiously supports the removal of the cap on the number of allied health services any one patient in MMM4-7 can receive under any of the relevant programs. While this proposal could benefit both patients and allied health providers, the patient's GP must be the care provider who decides whether further appointments are appropriate based on discussions with the allied health professional, and in consultation with the patient.

The AMA supports rural loading fees or incentive payments for rural allied health professionals as this will act as an incentive to relocate to rural areas. However, the funding for these payments must come from new funding to support this workforce. As such, the AMA does not believe that Medicare is the most appropriate source of funding for these services.

[2] AMA Position Statement on the Medical Home – 2015. https://ama.com.au/position-statement/ama-position-statement-medical-home

Telehealth allied health services

The AMA supports allied health providers, subject to the proposed restrictions, being able to access telehealth items to enhance the delivery of patient care. Rural and remote communities already have very limited or no reasonable access to allied health professionals and enabling service provision via telehealth supports greater equity for access to care.

The AMA supports subsidising the procurement of necessary infrastructure and devices to be able to provide telehealth services. The AMA would also advise the National Rural Health Commissioner to use this opportunity to advocate for improved access to high-speed internet service in the regions which currently do not have the same level of internet speed or access as larger population centres.[3]

The AMA supports virtual training using this infrastructure where appropriate and safe. However, this must not be used as a tool to prevent students in rural areas from having the same level of access or exposure to important training as metropolitan students.

The AMA does not support policy option 5.5. MBS funding for case conferencing must be initiated by a medical practitioner and involve relevant clinicians and health care providers with an existing relationship with the patient. The proposal outlined in 5.5 does not specify that the "sub-specialist" is even required to have any knowledge of or role in the care of the patient. The AMA suggests that clinical support can be provided to allied health professionals in MMM4-7 through the Integrated Allied Health Hubs, which should have as part of their remit the forming of support networks. Medicare is not intended to provide payment for conferring with colleagues.

General comment

The AMA recognises the complimentary role of allied health across the health system. This has been demonstrated in our support and advocacy for funding mechanisms to support multi-disciplinary health care teams and for practices to engage non-dispensing pharmacists and allied health workers within the practice team.

Preventative care is a fundamental part of the care that GPs provide on a daily basis, both personally and via referral. The AMA would agree that supporting patients with identifiable risks for chronic conditions to take action to reduce their risk and improve their health is vitally important. Better health outcomes for patients is a key tenet of the Quadruple Aim[4] which underpins the AMA's support for quality improvement measures, multi-disciplinary health care teams and the central role of general practice as patient's medical home.

The AMA is seeking to engage with Government to develop a long-term funding plan to better enable general practices to transform into patient-centred medical homes. Enabling the

[3] AMA Position Statement Better Access to High Speed Broadband for Rural and Remote Health Care – 2016. https://ama.com.au/position-statement/better-access-high-speed-broadband-rural-and-remote-health-care-2016

[4] Bodenheimer, T. and Sinsky, C. (2014) From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Annals of Family Medicine, 12, 573-576.

provision of a comprehensive range of services, including preventative measures, will reduce patients' need for more complex, high-cost health care, particularly for patients with or at risk of chronic disease.

Enhanced access to allied health services must be well coordinated by the usual GP to ensure it aligns with patients' health care objectives and is cost effective. The AMA wants to see a more robust funding model, that builds on existing fee-for-service arrangements, to enable patients to access improved care in the community. This might include, for example, enabling enhanced access to allied health services on a referral basis for those patients who formally nominated their usual GP and general practice.

For further information, please see the AMA's Response to the Report from the Allied Health Reference Group.

Should you require any further information or clarification on the AMA's response to the Recommendations, please contact Nicholas Elmitt at nelmitt@ama.com.au.

Yours sincerely

Dr Sandra Hirowatari,
Chair, AMA Council of Rural Doctors