Treasury

Pre-budget submission

Allied Health Professions Australia

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

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About AHPA and the allied health sector

Allied Health Professions Australia (AHPA) is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 145,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners. 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 thanks the federal government for the opportunity to contribute to the federal budget planning process for 2022-23.

2021 continued the previous year's significant health and economic challenges for Australia. The COVID-19 pandemic continues to especially impact upon particular sectors of the community such as older people, those with disability, people with chronic disease and First Nations Australians.

The pandemic has highlighted the inequities in our health, care and support systems, and underscored the urgency of establishing multidisciplinary and collaborative models that work across the current silos of primary and preventive health, acute care, aged care, disability, veterans' support, education, social services and justice.

Allied health is well placed to be an integral part of these solutions. We are Australia's second largest health workforce, with over 200,000 allied health professionals. Our practitioners provide services across the spectrum of health care, from prevention and maintenance of wellness to diagnosis and first contact, to supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Many of our clients have chronic and complex physical and mental illnesses or may experience other forms of disadvantage.

Individual allied health practitioners often provide services across multiple sectors, such as health, aged care and disability. Consequently, an allied health professional may be the key formal support in a person's life, communicating with a range of other health and support professionals. Allied health services are also highly cost-effective as both a supplement and alternative to medical interventions, particularly in primary care.

However, the value and benefits of allied health are not yet fully realised in Government policy and practice, and our services are not yet genuinely integrated into all sectors. On several key indicators such as workforce planning, digitalisation and data collection, funded infrastructure support for our services lags behind other health and support providers.

Fundamental building blocks must therefore be put in place to consolidate the existing strengths of allied health, so that it can play its full role in providing care and support for all Australians, now and into the future. The modest recommendations below propose strategies to install these building blocks and to enhance health and support equity for all.

Recommendations

AHPA calls on the federal government to use the 2022/23 federal budget to commit funding to the following, the order of which does not indicate priority:

Recommendation 1: Digital health inclusion

The development and growth of digital health, including My Health Record, has now been underway for many years. As the second largest workforce in health, after nursing, allied health has actively engaged in this development but has seen minimal to nil government commitment to inclusion of this workforce in the rollout. Rhetoric about digital integration to support safe and quality care is belied by the fact that a substantial position of the workforce is prevented from genuine engagement in My Health Record and in the development of compliant software for secure messaging and other applications.

The exclusion of allied health is likely to impact upon the current urgent work to improve digital health systems in aged care in response to the recommendations of the Royal Commission. The state of affairs for allied health belies the current National Digital Health Strategy which states:

> 'Every healthcare provider will have the ability to communicate with other professionals and their patients via secure digital channels by 2022.'

The Strategy notes in passing, as an example of other challenges that need to be addressed, allied health as a sector with low levels of participation. However, there seems to be no plan to address this other than through raising awareness and education. This goal has no chance of being realised anytime soon and the situation will not improve unless the Government invests in making integration for allied health possible, much as it has invested in supporting GPs and pharmacists.

Recommendation 2: Allied health data strategy

Consistent and reliable collection of data is essential to providing best practice health, care and support sector interventions, and for addressing workforce shortages and planning for future needs. But this basic requirement is still not being met for allied health, despite entities such as AHPA, the National Rural Health Commissioner (e.g. *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote* Australia, June 2020) and the Australian Parliament Joint Standing Committee on the National Disability Insurance Scheme (NDIS) regularly raising this issue.

As a priority, via expanding on the recommendations of the Primary Health Reform Steering Group for the Primary Health Care 10 Year Plan, and consistent with the Government's current Regulatory Alignment project, an allied health primary care minimum dataset incorporating all relevant sectors and integrated with other health, care and support data systems, should be developed.

We cannot emphasise enough how important it is that dataset development and collection be across all relevant sectors and be capable of helping to identify what may be quite specific factors, varying even by allied health discipline, that contribute to care outcomes and service provision.

Data mapping and gap analysis is also necessary to pinpoint allied health workforce shortages and devise subsequent tailored support strategies. While we welcomed the allocation of funds in the 2021-22 Budget for a gap analysis of allied health workforce data, this is only designated for the

aged care sector, and is funded at just $700,000. A quantum increase in targeted funding and an expansion to all relevant care and support sectors is urgently needed, to form a meaningful picture of the Australian allied health workforce at national, regional and local levels in primary health, aged care, disability, education and social services.

It is impossible to roll out an effective National Mental Health Workforce Strategy, NDIS Workforce Plan and NDIS Annual Pricing Reviews without access to granular allied health data. Data collection methodology must be informed by a clear understanding of the full range of relevant allied health expertise and skillsets, and their key roles in health, care and support. Drawing on this data and identifying key challenges for specific allied health professions will facilitate effective workforce development and planning strategies.

Long overdue, comprehensive allied health data collection goes to the heart of equity. Data and ensuing analysis of service outcomes and demographics, together with enumerating and mapping the locations of practitioners according to specific allied health disciplines, will enable identification of where, how and why Australians are missing out on the allied health care they need.

Recommendation 3: Aged care allied health assessments

The Royal Commission into Aged Care Quality and Safety found that people receiving aged care at home have limited access to services from allied health professionals. The Commissioners also found that people in residential aged care have seriously inadequate access to allied health.

The Commissioners concluded that allied health care should be an intrinsic part of residential aged care, because it is crucial to maintaining capacity and preventing deterioration of health.[1] There is strong evidence that assessment and early intervention to maintain functionality and well-being can reduce hospitalisation of older people, and support older people to remain safely in their homes for longer.[2] This is an outcome clearly desired by the majority of older Australians as well as being more cost-effective for the system.

It was therefore encouraging to see in the 2021-22 Budget the allocation of $500,000 to examine residential aged care models that incentivise the use of multidisciplinary teams – including allied health professionals – to reduce avoidable emergency presentations and hospital admissions.

However, there is no funding at present to ensure that all older persons entering the aged care system are clinically assessed for potential allied health needs. The Australian National Aged Care Classification (AN-ACC) model, recommended by the Royal Commission and presently being rolled out, does not assess for clinical need, but only for basic care costs. The designers of the AN-ACC model, the Australian Health Services Research Institute at the University of Wollongong, originally recommended that a full individual clinical assessment, preferably by a multidisciplinary team, occur upon admission to aged care.

To give practical effect to the Royal Commission's recommendations, and consistent with the Productivity Commission's *Innovations in care for chronic health conditions* (March 2021), allied health professionals should be funded to collaborate in multidisciplinary teams to conduct assessments and coordinate and assist with care planning.

[1] See also https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/dementia/faq .
[2] https://www.news-medical.net/news/20210909/Study-identifies-predictors-of-hospitalizations-or-emergency-department-encounters-for-older-people.aspx .

Recommendation 4: Consolidate allied health in the NDIS

Allied health professionals are key to the self-determination and reablement of many NDIS participants, providing assessments for access to the NDIS and the development of plan supports, and providing therapy supports. Despite these essential roles, AHPA and the Joint Standing Committee on the NDIS Inquiry into Planning have found that the value and diversity of allied health services is not always fully understood by planners and support coordinators. This leads to participant distress, resource intensive internal reviews and expensive Administrative Appeals Tribunal cases.

Funding for the first part of the project would enable AHPA to facilitate the engagement of its member peak bodies with the National Disability Insurance Agency and to work with the Agency and the NDIS Quality and Safeguards Commission to ensure that knowledge of allied health services is embedded into the recruitment and training of relevant Agency staff.

The second aspect of the project is timely in the aftermath of the proposed NDIS Independent Assessments. This proposal was rejected by the Minister for the National Disability Insurance Scheme following widespread opposition from participants, disability advocates and providers, including AHPA and our member organisations.

Before the proposal was announced, AHPA provided a contracted report to the Agency which considered the development of the credentialing, training and quality assurance aspects of an independent assessor role for allied health practitioners. We provided this report on the assumption that the assessment information obtained would only inform decision making related to access to the NDIS. In contrast, the ambit of the independent assessment proposal was much broader and incorporated assessment tools which we also did not support.

Following the Report of the Joint Standing Committee on the NDIS Inquiry into Independent Assessments, it is clear that an assessment process will still need to be developed for those participants who are not in a position to nominate an available and appropriate provider. Subject to sufficient funding, AHPA is well placed to build on earlier work and develop an assessment model. We propose to do so in collaboration with participants, disability advocates and the Agency.

Recommendation 5: Incentivise rural and remote allied health practice

It is well known that there are profound shortages of health practitioners, including allied health professionals, in rural and remote communities. As documented by the National Rural Health Commissioner, the Australian Institute for Health and Welfare and others, this significantly contributes to poorer health.

The federal Government partly recognised this problem in 2021 by providing an incentive for eligible doctors and nurse practitioners to practice in rural, remote or very remote areas of Australia, through eliminating all or part of their Higher Education Loan Programme (HELP) debt.

Allied health services are key to early intervention in and prevention of health conditions that if left untreated result in costly hospitalisations and increased burden of disease. It makes practical sense to add allied health practitioners, who currently number at least 14,000 professionals in rural and remote areas, to this incentive. This will boost the health workforce and provide more equitable access to health services.

Recommendation 6: Support for interpreter services for allied health

Allied health professionals provide essential services to CALD communities, including refugees. Many of these communities are known to be socially disadvantaged and at higher risk of poor health outcomes.

However, access to allied health services such as psychology and other mental health supports, speech pathology, physical therapies, dietitians, podiatrists and more are not only severely limited – there is also minimal funded access to interpreter services. This makes access even more difficult and results in: inappropriate and potentially dangerous use of family members or other untrained persons; increased out of pocket expenses for those who can afford it least; or the practitioner having to foot the bill.

Allied health professionals working with CALD communities should have the same access to interpreter services as GPs. This is going to be even more important once long COVID is more prevalent, as many of these communities will be disproportionately impacted.

The attached paper was developed in partnership with the Migrant and Refugee Health Council. **Please note that this paper is for the information of Treasury and not for publication.**

Recommendation 7: Dedicated support for long COVID rehabilitation in the community

By mid-2020 it became clear that a percentage of people who contracted COVID-19 would require ongoing treatment and rehabilitation. It was already well known before the pandemic that anyone surviving a long period of hospitalisation in ICU, especially if requiring ventilation, can require significant rehabilitation, including but not limited to physical therapies, speech pathology, nutrition support and psychological therapies.

COVID-19 has substantially increased the numbers of people undergoing such hospitalisation. But even so call 'mild' cases of COVID-19 are producing sequelae now known as 'long COVID', which require similar long-term interventions. It is neither reasonable nor possible for hospital systems to support such activity.

This therefore becomes a primary care responsibility – but it is not the role of GPs. Allied health professionals have the skills to provide the vast majority of such therapeutic support. The issue was flagged with the office of the Commonwealth Chief Medical Officer in mid-2020 by the Australian Allied Health Leaders Alliance, of which AHPA is a member. So far there has been no response, and if there are any plans to address this, allied health has not been consulted.

There is no funding to support this growing health care need. Any suggestion that this could be addressed by using the MBS Chronic Disease Management items is completely inadequate and inappropriate.

AHPA calls on the Government to address this glaring gap as a matter of urgency, noting that those most impacted by the virus are disproportionately to be found in lower socio-economic cohorts and CALD communities.