Australian Podiatry Association

RESPONSE TO DRAFT RECOMMENDATIONS FROM THE PRIMARY HEALTH REFORM STEERING GROUP

Discussion Paper to inform the development of the Primary Health Reform Steering Group recommendations on the Australian Government's Primary Health Care 10 Year Plan

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Executive summary

The Australian Podiatry Association (APodA) welcomes the opportunity to respond to the Draft recommendations developed by the Primary Health Reform Steering Group. The APodA congratulates the Primary Health Reform Steering Committee on progressing this key area of health system reform and we look forward to participating in future consultation toward implementation of these key recommendations.

We are pleased the Steering Committee has recognised the important contribution of allied health providers to primary health reform. There is a clear commitment to sustaining the allied health workforce to enable achievement of these core recommendations.

While we acknowledge that primary health reform has been a focus for several Commonwealth and advisory groups over the past decade, little attention has been paid to the contribution of the allied health workforce to building a stronger, more integrated, sustainable primary health system. Despite several rounds of reform and well-intended recommendations, we have seen no valuable inputs into the allied health system. The sector remains poorly resourced by any measure.

While the APodA welcomes the recommendations, which reflect a more inclusive, contemporary approach to genuine primary health reform, this report is still strongly medically focused. We support the integration of allied health practitioners alongside their medical and nursing colleagues and see this shift as key to achieving the quadruple aim.

While we recognise the recommendations are intentionally high level, we are seeking an implementation plan, and a monitoring and evaluation framework. As with any reform agenda, we appreciate the complexity and resourcing commitment. However, the allied health sector is often the recipient of partial roll-outs, delays and commitments that remain unfulfilled. We are strongly supportive of dedicated milestones broken into short, medium and long-term. The APodA welcomes every opportunity to engage in development work to support implementation.

The APodA strongly supports advancement of the quadruple aim and recognises it as the well-regarded framework for optimising health system performance. We note in particular, the 4th aims to 'improve the work life of health care providers. Very little time, resourcing and leadership has been paid to the work life of allied health providers. As a sector, they lag behind their medical and nursing colleagues in access to and subsidisation of fundamental digital infrastructure, workforce planning models, dedicated research agendas and commitment to funding models that support sustainability of small private practice.

While we whole heartedly support this aim, without genuine commitment to delivering against every recommendation described in Recommendation 11, the attainment of the quadruple aim will remain elusive.

The APodA does not support recommendation 2 in its current form (Single primary health care destination). We are concerned that Voluntary Patient Registration (VPR) undermines the first goal of the quadruple aim and under this scheme consumers may be limited in their choice of allied health provider.

The APodA supports the recommendation to foster cultural change by supporting leadership development in primary care (Recommendation 9). However, we note despite the discussion paper describing the importance of 'strong leadership at all levels so the health system' it appears not a single allied health professional body is captured in the list of professional colleges and associations.

We strongly propose the addition of organisations that reflect the diversity of primary care including all peak profession-specific bodies.

The APodA considers the sub-recommendations described under Recommendation 11 to be comprehensive and addresses many of the key issues raised by the sector over the past decade.

We are calling for this suite of recommendations to be considered as equal to those described in Recommendation 12 (Nursing and midwifery workforce) and Recommendations 14 (Medical primary care workforce).

We are also calling for all sub-recommendations described under Recommendation 11 to sit within the remit of the Chief Allied Health Officer, Anne-Marie Boxall.

The inequity in digital health is a significant and long-standing concern held by the APodA and the whole allied health sector. Without a clear commitment to invest in sector-wide digital infrastructure, goals such as that described in 11.4 will be unachievable.

The APodA supports an enhanced primary health care role in national and local emergency preparedness. We do however note the COVID-19 pandemic has exposed the challenges associated with achieving such an aim.

The APodA strongly supports an Implementation Action Plan with short, medium and long-term horizons and we look forward to further engagement as an implementation and evaluation plan is developed.

Introduction

The Australian Podiatry Association is the largest and oldest peak body representing podiatry and promoting foot health and mobility.

Private practice podiatry is characterised by a low level of concentration and a high degree of fragmentation. Approximately 70% of podiatrists work in private practice. Businesses tend to be small, with a considerable number of podiatry practices operating as sole proprietorships.

Most revenue is derived from occasion-based fee for service, subsidised by third party insurers. There are virtually no episode payment models or outcome informed payments. The environment, as a result, has materially different pressures than other environments in which the podiatrist is paid by salary.

The APodA is an active member of Allied Health Professions Australia (AHPA), the national peak body representing Australia's allied health professions. With over 200,000 allied health professionals, allied health is Australia's second largest health workforce.

Person-centred health and care journey, focusing on one integrated system

RECOMMENDATION 1 – ONE SYSTEM FOCUS:

The APodA supports this recommendation. Our concerns and considerations are noted below.

We support the intention to fund and evaluate vanguard regional initiatives (1.3.4), however we question the extent to which PHNs are connected with allied health. We strongly support the intention to bolster PHN capability and accountability (1.3.5) and support PHNs broadly adopting a leadership role in funding reform. However, we question their readiness to engage with the allied health sector to achieve these recommendations. PHNs remain medically-centric, are not equipped to identify exemplar models of integrated primary healthcare, and do not have a sophisticated view of allied health governance, nor commissioning of allied health services. Without appropriate expertise we are concerned these 'vanguard regional initiatives' will instead turn into funding models that inadvertently disadvantage or threaten the sustainability of small podiatry private practices.

In principle we support dedicated funding investment and redirection into primary care (1.2). We do not support funding being redirected to general practice alone. There is insufficient detail provided in this recommendation for the APodA to make a sensible assessment and would be pleased to see further detail regarding direction of the investment.

The APodA supports the intention of increased performance transparency across the primary health care system (1.4.3) however it is difficult to see how successful examples of quality improvement and multidisciplinary teamwork would be shared. Notably absent in this recommendation is any reference to the current lack of systematic quality improvement activities in allied health, not to mention an inability to collect and evaluate clinical outcome data to identify exemplars worthy of sharing. Achievement of such a goal is surely dependent upon successful implementation of 11.2 (improved digital infrastructure).

RECOMMENDATION 2 – SINGLE PRIMARY HEALTH CARE DESTINATION:

The APodA does not support this recommendation in its current form. We are concerned that Voluntary Patient Registration (VPR) undermines the first goal of the quadruple aim: *'Improve the patient experience of care (including quality of care and satisfaction)'*. Under this scheme consumers may be limited in their choice of allied health provider, and for those with complex conditions, may be exposed to inadequate service availability.

The discussion paper outlines how the VPR contributes to achievement the quadruple aim. We would suggest that the patient experience is only improved when care is consumer-led, not general practitioner-led. It is also difficult to envisage how general practitioners intend on achieving improved, 'more integrated and coordinated care' when the digital infrastructure that connects the various parts of the primary health landscape is entirely absent (see 11.2).

Missing from this discussion paper is recognition of any learnings and evaluation from the Health Care Homes Program. The APodA is disappointed to see a strengthening of the single primary care home when the Health Care Homes Program evaluation has not been made public.

Furthermore, it is difficult to support a reform agenda that so overtly preferences one professional discipline. The VPR scheme reinforces the prevailing medically-focused perspective, and further erodes the sustainability of small private allied health practices.

The APodA believes much has been written by the allied health sector outlining our collective objections to the VPR since this was brought into the public domain in 2019. We are however disappointed that VPR appears to be a 'building block' of this reform agenda.

RECOMMENDATION 3 – FUNDING REFORM:

The APodA supports the principles of this recommendation; value-based team care, flexible funding and redirection of funding from secondary/tertiary care. It is however unclear how this will be achieved by leveraging off the VPR scheme. The VPR scheme seems counter to the intentions of achieving multidisciplinary, intersectoral team care.

This is a complex, multi-year suite of recommendations that requires the engagement of multiple sectors to genuinely trial and evaluate flexible funding models. We strongly support innovations in funding to ensure best value and improved access is achieved however we are concerned these recommendations are medically focused.

Leadership and culture

RECOMMENDATION 9 – LEADERSHIP:

The APodA supports the recommendation to foster cultural change by supporting leadership development in primary care. We note despite the discussion paper describing the importance of 'strong leadership at all levels so the health system' it appears not a single allied health professional body is captured in the list of professional colleges and associations. Almost every organisation noted is connected to delivery of services inside a general practice setting.

We are disappointed to see, in a discussion paper that supports a whole-of-system reorientation to person-centred care, how medically-focused some aspects of this work continue to be.

We note that a strong reform agenda requires intersectoral leadership. We strongly propose the addition of organisations that reflect the diversity of primary care including all peak profession specific bodies: **https://ahpa.com.au/our-members/** and at a minimum, Allied Health Professions Australia: **https://ahpa.com.au/**

Primary care workforce development and innovation

RECOMMENDATION 11 – ALLIED HEALTH WORKFORCE:

The APodA considers the sub-recommendations described under Recommendation 11 to be comprehensive and addresses many of the key issues raised by the sector over the past decade. These recommendations represent the most pressing needs in allied health.

The APodA calls for these recommendations to be implemented as a coordinated package. A piecemeal approach, poorly funded and strung out over decades, will produce no discernible improvement for healthcare consumers.

We are calling for this suite of recommendations to be considered as equal to those described in Recommendation 12 (Nursing and midwifery workforce) and Recommendations 14 (Medical primary care workforce). This includes implementing these recommendations in tandem with those described for general practices and resourcing allied health recommendations sufficiently to avoid a disjointed approach.

We are calling for all sub-recommendations described under Recommendation 11 to sit within the remit of the Commonwealth Chief Allied Health Officer. Implementation of these recommendations will require a level of jurisdictional collaboration that is almost impossible to achieve without committed federal leadership.

We do not support implementation of allied health specific recommendations sitting within the remit of the CNMO or CMO.

We note the Discussion Paper excludes both timelines for implementation and identification of key milestones for each recommendation. We presume this is intentional and allows opportunity for further design refinements and Commonwealth approval of this phase. However, delays in implementation or indeed failure to faithfully implement each recommendation is a key risk and concern for the entire allied health sector.

We welcome future opportunities to engage in the development of an implementation plan underpinned by the identification of program milestones for each sub-recommendation described under Recommendation 11.

We take this opportunity to highlight that allied health professionals are highly qualified, first contact professionals in their own right. We do not support any model whereby access to funded allied health services is contingent upon general practitioner referral. This undermines patient choice, reduces scope of practice to that defined by a general practitioner, threatens regional and rural private allied health practices and undermines the entire philosophy of this reform agenda.

Although not specifically addressed in this discussion paper, the APodA does not support uncapping of the Workforce Incentive Program (WIP). The WIP further reduces the independence of allied health providers, reduces clinical oversight by handing clinical governance to general practitioners, and further impacts workforce sustainability, especially in rural and remote regions where small private business are priced out of the market. This leads to a consolidation of allied health into general practice which erodes patient choice.

11.1. Funding models

11.1.1. Case conferencing: Support and fund allied health professionals to participate in GP and non-GP medical specialist-led case conferences.

The APodA strongly supports the implementation of this recommendation. In particular, we support allied health participation in specialist-led case conferences. In a person-centred model, underpinned by integrated digital infrastructure such as My Health Record there should be no barriers to allied health and specialist-led conferences.

We also strongly support inter-disciplinary referral for allied health providers. This is particularly relevant for consumers with chronic, complex diseases requiring multiple allied health providers.

We fully support an MBS payment for allied health that recognises the time and financial cost implication associated with case conferencing. The APodA expects the MBS payment for this item to be equal to that provided to general practitioners for participation in multidisciplinary case conferencing.

11.1.2. MBS Review Taskforce

The APodA strongly supports the implementation of all recommendations in the MBS Review Taskforce report. However, we note while the Taskforce endorsed 16 recommendations from the Final Report of the Allied Health Reference Group (AHRG), to date there remains no implementation plan and no timeline.

While we recognise MBS funding may not be the most appropriate long-term solution to strengthening access to primary allied health services, enhanced allied MBS items will serve as a bridge until integrated, longer-term solutions are trialled, evaluated and implemented.

The APodA are calling for all allied health recommendations from the MBS Review Taskforce report to be implemented or initiated within 12 months of the commencement of the 10 Year Plan.

11.1.3. Funding reform

The APodA strongly supports the establishment of an allied health funding reform committee. We contend that this committee should be composed of allied health representatives from metropolitan, regional and rural practice, from a diversity of funding settings including private, community, disability, aged and mental health. We recommend this committee is established within 12 months of commencement of the 10 Year Plan.

11.2. Digital infrastructure and 11.4. Improved communication

Recommendation 11.2 and 11.4 are intentionally linked and will be addressed as one.

The inequity in digital health is a significant and long-standing concern held by the APodA and the whole allied health sector. Primary allied health is arguably one of the most complex systems to navigate. Providers are funded through multiple funding streams, work across a diversity of settings and population groups, and are supported by enormous software diversity. Despite these barriers, there is no national remit to improve, integrate and build digital infrastructure for allied health.

Without a clear commitment to invest in sector-wide digital infrastructure, goals such as that described in 11.4 will be unachievable.

There is currently no incentive for allied health providers to innovate their digital platforms. Attempts to engage the Australia Digital Health Agency have gone unheard and the Commonwealth have not mandated PHNs to explore this problem. This inequity continues to hold allied health apart from general practice and reinforces a disparity that threatens the viability of allied health into the future.

11.3. Data and 11.5. Workforce plan

Recommendation 11.5 and 11.3 are intentionally linked and will be addressed as one.

We are pleased see dedicated recommendations designed to strengthen and sustain the allied health workforce, including development of a minimum dataset. There is currently almost no capacity to understand the patient journey through primary care, and there is limited available data linking allied health use across various funding streams. The complexity of allied health funding, when compared to general practice, makes it far more important to capture and link datasets so we can begin to understand and then improve the patient journey.

The first goal of the Quadruple Aim is to: Improve the patient experience of care (including quality of care and satisfaction)'. The APodA proposes that it will be difficult to achieve this aim in the absence of an allied health minimum data set. The absence of linked data means we have no capacity to map the patient journey, understand the drivers of patient choice and importantly no systematic, sector-wide way to measure and assess clinical outcomes. Improved patient experience will only be realised if and when outcome and service participation data is captured in a uniform way.

It will be important from the outset to develop a definition of allied health that is accepted by the sector, jurisdictional governments and insurance schemes, including disability and aged care. There is no single definition of allied health and the importance of getting this right cannot be overstated. The APodA welcomes the opportunity work with the Commonwealth to define allied health and determine which disciplines will be the recipients of any incentive schemes.

There needs to be strong alignment between the allied health disciplines identified in the workforce plan and those identified in the Australian Institute of Health and Welfare primary care data asset project. Our ability to better understand workforce need is underpinned by a minimum data asset that is reflective of the entire allied health sector. We support a minimum data asset that measures both workforce participation (practitioner-facing data) and clinical outcomes.

We note there is no mention nor description of how or if allied health practices will be incentivised to collect patient health data. We strongly support the introduction of a quality improvement payment (similar to the PIP Quality Improvement Payment). It seems both unrealistic and unfair to assume allied health providers will collect health data in the same way their medical colleagues do and not be incentivised to do so. In the absence of an incentive scheme we don't see that PHNs will be successful in supporting allied health practices in their regions.

This recommendation warrants considerable further discussion with the sector before PHNs are mandated to collect allied health data. We welcome every opportunity to progress this discussion further.

11.6. Clinical governance

With the introduction of new models of employment and increasing numbers of allied health employed by general practice settings, we have concerns regarding provision of clinical governance. Specifically, we do not support non-allied health disciplines providing clinical governance to allied health practitioners.

Schemes such as the Workforce Inventive Program, where clinical governance is overseen by the general practitioner, or in some cases, a practice nurse, further exacerbate issues associated with quality, safety and professional development. We note these schemes often perversely encourage the employment of new graduates who require the most intensive supervision of clinical oversight.

We note the Australia Commission on Safety and Quality in Health Care will formally launch the new National Safety and Quality Primary and Community Healthcare Standards in October 2021. While we are extremely supportive of this work, we anticipate considerable implementation issues. We contend that allied health practices will require an incentive, similar to the Practice Incentives Program Quality Improvement Incentive (PIP QI) to encourage participation.

11.7. Research and translation

The APodA is supportive of a formal allied health research agenda to consolidate and strengthen the existing research base. Allied health research is fragmented and poorly resourced. Decades of limited funding avenues have led to research being taken up as a career pathway by only a small fraction of allied health professionals.

We believe administrators of health funding generally have a poor understanding of the value of allied health. There is a critical lack of research into the cost-effectiveness of individual allied health professions exacerbated by the absence of commitment to strengthening the allied health research base.

Formalising an allied health research agenda will allow work in cost-effectiveness and value to be explored across multiple disciplines. We believe this work is critical to advancing the profile of the professions.

We note that knowledge translation is distinct from research and should be considered as a recommendation in its own right. We would like to see opportunities for allied health researchers and those engaged in knowledge translation to have better access to NHMRC and MRFF funding opportunities.

Innovation and technology

RECOMMENDATION 15 – DIGITAL INFRASTRUCTURE:

See Recommendation 11 (11.2, 11.4)

Research, data and continuous improvement of value to people, population, providers and the health system

RECOMMENDATION 17 – DATA:

See Recommendation 11 (11.2, 11.4)

RECOMMENDATION 18 – RESEARCH:

The APodA support the establishment of an Allied Health Program within the Australian National Institute for Primary Health Care Research Translation and Innovation. We propose this as short-term goal.

Emergency preparedness

RECOMMENDATION 19 – PRIMARY HEALTH CARE IN NATIONAL AND LOCAL EMERGENCY PREPAREDNESS:

The APodA supports an enhanced primary health care role in national and local emergency preparedness. We do however note the COVID-19 pandemic has exposed the challenges associated with achieving such an aim. Allied health providers have been the recipients of belated State and Commonwealth messaging, with almost no regard for the thousands of small business operators in allied health. With respect to State Chief Allied Health Officers, their leadership, engagement and willingness to advocate for the sector at the jurisdictional and commonwealth levels has been disappointing.

The current pandemic has also revealed the extent to which PHNs are poorly equipped to work with allied health providers in their catchments. PHNs have been unable to comprehensively support struggling primary care services, provide timely updates on changing restrictions, adequately disseminate PPE supplies, advise on changing PPE and capacity requirements, nor influence policy discussions and advocate on behalf of the allied health professionals in their region. Allied health peak bodies have largely picked up the work of conveying complex health messaging to their members. For most peak bodies this has become a full-time job.

Implementation is integral to effective reform that delivers on the Quadruple Aim

RECOMMENDATION 20 – IMPLEMENTATION:

The APodA strongly supports an Implementation Action Plan with short, medium and long-term horizons. Despite a written commitment in this discussion paper to engaged with national bodies we question the genuine desire to engage with allied health leaders (see Recommendation 9).

We look forward to further engagement as an implementation and evaluation plan is developed.