

**Submission to the
Senate Finance and Public Administration References Committee**

**Inquiry into COAG reforms relating to
Health and Hospitals.**

**Allied Health Professions Australia
26 May 2010**

Members: Audiological Society of Australia, Australasian Podiatry Council, Australian Association of Social Workers, Australian Institute of Radiography, Australian Orthotic and Prosthetic Association, Australian Osteopathic Association, Australian Psychological Society, Australian Sonographers Association, Chiropractors' Association of Australia, Dietitians Association of Australia, Exercise & Sports Science Australia, Occupational Therapy Australia, Orthoptics Australia, Services for Australian Rural and Remote Allied Health Inc, Society of Hospital Pharmacists of Australia, Speech Pathology Australia.

Associates: Australian Diabetes Educators Association.

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About Allied Health Professions Australia

Allied Health Professions Australia (AHPA) welcomes the opportunity to contribute to this Inquiry on the reforms to Australia's health system recently agreed by the Council of Australian Governments (COAG) through the National Health and Hospitals Network Agreement.

AHPA is the national peak body for major health professions and their representative bodies other than medical practitioners, nurses and unions. Members of AHPA are national organizations, who together represent over 50,000 allied health professionals working in the private and public health sectors, including hospitals (public and private), primary health care (community health centres), aged care and in private practice. AHPA works to represent the allied health professions sector, particularly to the Australian Government; and to provide a vehicle for liaison and discussion between the professions themselves. It allows the sector to speak with one voice on issues of common interest and concern.

Members of AHPA include associations of the following professions:

- Audiologists
- Chiropractors
- Diabetes educators
- Dietitians
- Exercise physiologists
- Hospital pharmacists
- Occupational therapists
- Orthoptists
- Orthotists and prosthetists
- Osteopaths
- Podiatrists
- Psychologists
- Radiographers and radiation scientists
- Social workers
- Sonographers
- Speech pathologists
- Allied health in rural and remote Australia

AHPA will now address specific sections of the Inquiry's terms of reference.

(b). what amounts of the \$5.4 billion Commonwealth funding is new spending ... (c). the projected number of additional/new services this additional funding will provide ...

Allied Health Professions Australia is concerned that there seems to be a disproportionate allocation of the \$5.4 billion to acute hospital services to address elective surgical waiting lists, and not enough funding dedicated towards management of chronic diseases in the community through comprehensive primary health care initiatives. It is well recognised that the ageing of the population and the increasing prevalence

of chronic diseases in the community will place the Australian health care system under enormous strain in the coming years – one of the key drivers of the health reform.

Allied health professionals provide a range of primary health care services to consumers, both through State/Territory funded services such as community health centres (to be taken over by the Commonwealth under the proposed reforms), as well as through limited programs funded by the Australian Government (e.g. Medicare rebates for consumer consultations with eligible allied health providers as part of their overall management of chronic and complex conditions).

However, in order to access Medicare rebates for allied health services, consumers are required to first see a GP in order to obtain the relevant referral. This assumes that consumers have access to GPs who are both local and do not have a long waiting list – both of which may not apply for people from disadvantaged backgrounds and those living in rural and remote parts of Australia. Without increasing dedicated and ongoing funding commitments for consumer access to allied health professionals in primary health care, there is a concern that consumers will not be fully supported in the community in the management of their conditions, thus contributing to preventable admissions into acute care (hospitals), particularly for exacerbation of chronic and complex conditions such as diabetes.

A further concern to AHPA is that the proposed reform package makes the underlying assumption that Divisions of General Practice, as Primary Health Care Organisations or “Medicare Locals”, will be fund-holders, and hence critical points of referral and access by consumers to other providers and services. There is no recognition of or details on how consumers will have equitable access to other primary health care providers and organisations such as community health centres (where there is often no GP presence) or private allied health providers.

A revision of the committed funding or dedication of new funding may be required to address this issue.

(d). the \$15.6 billion top-up payments guaranteed to the states ...

As stated above, the overemphasis on acute care is inconsistent with the increased need for greater investment in primary health care. Accordingly, a greater portion of the \$15.6 billion top-up payments will need to be directed to primary health care from 2014-15 through to 2019-20.

(e). the names, roles, structures, operations, resourcing, funding and staffing of any new statutory bodies ...

It is now understood that the new Primary Health Care Organisations, developed from or replacing existing Divisions of General Practice, will be called Medicare Locals. It is also understood that Medicare Locals will provide a range of services, including after-hours access to health services. AHPA wishes to raise four issues regarding the organisation, governance and operations of the proposed Medicare Locals.

1. The new structure ignores existing models of best practice in primary health care. Many jurisdictions, particularly Victoria, have established effective and efficient community health centres, consisting of a range of allied health professions. Unlike the Division of General Practice, clients of community health centres can self refer and directly access allied health providers for a range of chronic and complex conditions. The proposed 100% takeover of Commonwealth funding in relation to primary health care, and the associated roll-out of Medicare Locals, have the potential to abolish current models of best practice, placing those in already marginalised groups at further risk of ill health and inequity of access to a range of primary health care organisations and services.

2. Medicare Local has the potential to mislead consumers and their expectations. Medicare is widely associated by consumers with access to medical services, namely general practice. Apart from the 'No GP – no Medicare' scenario experienced by people living in rural and remote part of Australia and those from socially disadvantaged backgrounds, Medicare Local implies that services provided in these organisations will be funded under Medicare. While most if not all GP services can be accessed under Medicare within these organisations, the same cannot be said for allied health services, many of which have limited number of sessions under Medicare, or are not on the Medicare Benefits Schedule. So while these Medicare Locals can provide a range of services to consumers from GPs and allied health, services from the latter provider group will not be 100% Medicare funded. This will create frustration to some consumers, but to others it represents a real barrier to access appropriate services.
3. Medicare Locals may perpetuate GP-centred care planning and service delivery. The development of Medicare Locals based on the Divisions of General Practice model has the real potential to be inflexible to local needs (especially where there are no GPs available locally, such as in many areas of rural and remote Australia). There is an urgent need for transparency and representative governance in the establishment and operation of Medicare Locals.

It is of concern to AHPA that allied health services are still viewed as peripheral rather than integral to good health outcomes in primary health care, especially for people with chronic and complex conditions such as diabetes. Without representative governance structures, underpinned by robust constitutional frameworks, Medicare Locals may add complexity for consumers without addressing the key issue of equity of access to services and providers other than GP services.

4. Operational boundaries are poorly defined. There is very little detail to date on the operational boundaries between Medicare Locals and the other key plank of health reform – Local Hospital Networks (LHN). This is further complicated by the concession that LHNs will have State management and administration, while the Commonwealth assumes funding and administrative responsibilities for aged care and primary health care. This lack of operational boundaries provides fertile ground for cost and blame shifting between the States and the Commonwealth.

In addition, there needs to be at least shared positions on the boards of LHNs and Medicare Locals.

(h). the number of hospitals which will receive: activity-based funding ...

The use of activity based funding is not always appropriate for allied health activities. For example, two persons with identical fractured hips as a result of falls, both requiring emergency hip replacement surgery, can have different lengths of stay and discharge options based on the social support available to them. Consequently, the range and duration of allied health input will also differ dramatically – from minimal home safety assessment pre-discharge through to organising extensive in-home support for personal care, meals and medication management. Therefore, an appropriate mix of both block funding and activity based funding is needed to ensure that allied health interventions can be adequately funded.

In addition, AHPA urges further consultation with allied health professions about the appropriate costing to fine-tune the allied health involvement in any future funding models for hospitals.

(i). aged care

The chronic underfunding of aged care services means that many residential aged care facilities (RACF) cannot afford allied health services. Many RACFs have the minimum funding for cover for essential medical and pharmaceutical needs of their residents. Any leftover funds are usually used for group-based activities and diversion programs. Unfortunately, this denies residents their rights to access allied health providers for a range of conditions including mental health issues.

In the light of the proposed 100% Commonwealth takeover of aged care, including policy, funding and management, AHPA urges further consultation with the allied health professions to ensure that the health, and not just the medical, needs of all residents of RACFs are met. This will involve a new and ongoing corresponding funding for increased allied health services in line with the introduction of 2500 new aged care beds and the 2000 long-stay beds already announced in the health reform package.

(j). mental health matters

AHPA urges the Australian Government to provide funding for new initiatives in the area of mental health, rather than reallocation of existing funding, as well as continued funding for existing and successful programs. AHPA notes with interest the ongoing discussions between the Australian Government and two AHPA member organisations, the Australian Association of Social Workers and Occupational Therapy Australia, following the Budget, and hopes that all clients with mental illnesses will continue to be supported by a range of allied health professionals as an integral part of the overall health reform package.

Conclusion

Allied Health Professions Australia (AHPA) is pleased to contribute to the health reform initiatives to date by the Australian Government, and to this Senate Inquiry.

While the health reform package marked an important step in making the Australian health system more responsive and resilient to the growing health demands and escalating costs of health care delivery, further consultations, particularly with the allied health professions, are necessary in order to achieve the aim of health reform – equitable access by consumers to health care as a universal right.

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