



An Australian Government Initiative

Models of Care and Funding for Integrated Primary Care Allied Health Services Policy Paper

National PHN Allied Health in Primary Care Engagement
Framework

Contact

[Redacted contact information]

Date: 13 November 2024

Primary Health Network (PHN) Cooperative

Contents

Executive Summary.....	2
Introduction	5
The Policy Context – why is this important now?.....	5
The imperative for change.....	5
The Case for Change	6
Understanding the problem with current models of care.....	6
New and emerging models of integrated allied health care and funding	7
Current allied health service funding models in primary care.....	8
Future models of integrated primary allied health care.....	9
Principles underpinning integrated models of allied health primary care	9
Potential models of integrated primary allied health care.....	10
Funding primary allied health care into the future	14
Approach to funding future models of care	14
Essential elements of funding models	15
Actions required to support new models of care and funding.....	16
Actions required at a system level.....	16
Role of PHNs in taking forward new models of care	16

While the Australian Government helped fund this document, it has not reviewed the content and is not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Executive Summary

This policy paper has been prepared to support implementation of the Primary Health Network (PHN) Cooperative's National PHN Allied Health Engagement Framework. It offers advice on practical, sustainable and adaptable models of care and funding to facilitate an expanded and integrated role for the allied health workforce in primary care. It explores barriers to an increased and integrated role for allied health professionals in multidisciplinary team care and considers merits of current and emerging placed based models of care, and funding.

An expanded role for allied health professionals in primary care through integrated multidisciplinary team care has been identified as fundamental to delivering key national reform proposed through the Strengthening Medicare Taskforce and other key reports and to support prevention, early intervention and treatment to reduce the impact of chronic disease. To achieve this reform, models of care are required that make optimal use of available workforce, and funding arrangements are required to support integration into team care arrangements.

There are a number of financial and practical barriers which will need to be overcome to optimally integrate allied health care in new models of care:

- Allied health professionals working in private practice are not currently resourced or supported to work collaboratively or to participate in unpaid meetings or case conferences;
- Allied health professionals often have limited capacity for digital implementation or training;
- Practical barriers, including lack of space in GP practices inhibit integration;
- Current models of care and funding are not sufficient to sustain integrated services in areas of limited allied health workforce;
- There is limited funding for integrated primary allied health care services for people unable to afford out of pocket expenses or private services;
- Federal and State/Territory governments are not optimally working together to make best use of the allied health workforce.

Through PHNs, promising models of commissioning allied health service engagement in the delivery of primary health care services have emerged. These models have included centre based care, outreach services, virtual services and services tailored to deliver models of care to reduce impact of particular chronic conditions. To date many of these models have been developed to meet primary mental health care needs, given significant funding available to PHNs for these services. Several PHNs have developed Allied Health Engagement strategies or frameworks which have enabled communication, capacity building, referral pathways and information on the allied health workforce, and have facilitated integration into team care.

At present funding arrangements for allied health care beyond commissioning rely largely on MBS funding, incentive payments to GPs, private insurance, National Disability Insurance Scheme (NDIS) funding and workers compensation. Funding for the Multidisciplinary Team Care Pilot through PHNs will provide an opportunity to explore how expanded funding for integrating allied health services through PHNs could improve outcomes in relation to chronic health conditions and help to develop specific models of care.

A number of principles should underpin further development of integrated models of allied health primary care, based on PHN experience to date:

- The allied health sector must be involved in co-design and implementation of new models of care, both at a national program level and at a regional level;
- Place based models of care should be designed and implemented, which meet the needs of local consumers and are informed by local knowledge of the area, and its service networks;

- These models should offer genuine integration of allied health services with general practice and other primary care services, within a structure and system that promotes communication, data sharing, and planning;
- Evidence based models of integrating allied health professionals into multidisciplinary team care should be developed to address disease specific needs for people with chronic illness;
- Models of care should promote local care neighbourhoods and pathways;
- Models of care should support all health professionals to work to their full scope of practice;
- Equity of access to allied health primary care should be supported for under-served groups;
- Models of care which promote cultural safety and participation of Aboriginal and Torres Strait Islander allied health workers within primary care should be available.

Using these principles, the following potential models of integrated primary allied health care services could be explored through future commissioning of multidisciplinary team care:

- Promoting evidence based models of allied health involvement in team care that target needs of patients with specific chronic disease or mental health needs;
- Building flexible models including outreach services to meet needs of people in rural and remote locations or other areas of thin markets. This could include use of assistant allied health workers on the ground to support all team members to work to full scope of practice;
- Utilising group service delivery to optimally utilise allied health workers in areas of short supply;
- Establishing regional hubs or centres for allied health service delivery integrated with local general practice;
- Virtual models of allied health service delivery.

In funding models of integrated primary health care, consideration should be given to resourcing planning, capacity building, coordination, team meetings, travel time, workforce recruitment and development and evaluation as well as direct service delivery.

To optimise the role of allied health professionals in primary care, significant shifts at a system level are needed. This includes joint planning and investment from state and federal governments, digitalisation of the allied health workforce, and expanded funding which recognises the costs of integration. PHNs can play a significant role in taking forward new models of prevention, early intervention and care, if resourced to do so, through:

- Joint regional planning with LHDs and other stakeholders;
- Co-designing new place-based multidisciplinary team solutions with allied health professionals, GPs and other stakeholders;
- Engaging with the regional allied health sector to promote networks and pathways to care;
- Helping to build digital capacity and skills to support integration;
- Commissioning place-based face to face and digitally assisted models of multidisciplinary team care, and;
- Providing feedback through needs analyses and evaluations of emerging challenges and opportunities for the allied health workforce.

Table 1 Summary of recommended elements of effective models of primary allied health care

Recommended elements of effective models of primary allied health care					
Integration	Place based	Co-designed	Evidence-informed	Working to full scope of practice	Equity
Recommended potential models					
Commissioning multi-disciplinary team care through PHNs	Evidence based models to target particular patient needs	Flexible outreach models for rural and remote areas linked to local teams	Utilise group service delivery for common primary allied health care needs	Hub or centre based allied health care linked to GPs	Utilising e-allied health services as part of integrated team care
Recommended key elements of future funding					
Regional planning and coordination	Digital capacity and skill building	Service delivery	Non service delivery costs of team	Recruitment relocation and workforce development	Evaluation and continuous improvement
Recommended enablers at service delivery level					
Digitally capable, skilled workforce	Service coordination and planning	Central role of GP	Remunerating participation	Peer support and collaboration	Continuous quality improvement
Recommended system level enablers					
Shared investment and pooled funding with states and territories	Bilateral agreements with states/territories	Authorising environment for PHNs	Digitilisation of workforce and engagement in Your Health Record rollout	Workforce development and support	Increased funding to support role of allied health workers

Introduction

This policy paper has been prepared by the Primary Health Network Collaborative to offer advice on practical, sustainable and adaptable models of care and funding to facilitate an expanded role for the allied health workforce in primary care. The focus is on drawing from the experience of PHNs in implementing place-based solutions engaging allied health workers in chronic disease management to identify key elements of successful models, flexible models which can meet the health needs of particular population groups, and approaches to funding which address barriers to workforce participation.

PHNs have a significant role in supporting the engagement of the regional allied health sector to be part of an integrated primary health care system through collaborative planning, commissioning and building capacity and pathways in the local community. They play a vital role in bringing the community and primary health care providers together, building on strong relationships across local health services and a deep understanding of community needs, regional constraints and the local workforce.

This paper explores the importance of promoting models of care and funding which can support an increased and integrated role for allied health professional in multidisciplinary team care and also the barriers to this that need to be addressed. The paper continues to recognise the important role of general practice, while exploring place-based models which PHNs have demonstrated to be effective at a regional level and the way in which funding has enabled integrated engagement of allied health workers. It draws out the key elements and the important flexibilities that contribute to effectiveness.

This paper has been prepared to support implementation of the PHN Cooperative's National PHN Allied Health Engagement Framework. Specifically it expands upon Priority Area 6 of the Framework – *“Integration, Models of Care and Funding: supporting models of care, HealthPathways and systems that better connect and integrate Allied Health with other parts of the health sector, utilising commissioning levers to support integration and focus on outcomes-based funding.”*¹

The paper complements another policy paper which has been prepared under the Framework, entitled *Allied Health Workforce Data Needs in the Primary Care Sector*, which explores need and opportunities to build a better foundation of data on allied health workforce supply, activity and impact in primary care. Both policy papers are intended to help inform the development of the First National Allied Health Workforce Strategy.

The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs. It is a joint initiative of the PHNs and a commitment to collaboration and delivering on the national agenda in primary health priority areas.

The Policy Context – why is this important now?

The imperative for change

An expansion of the role of allied health professionals in primary care through integrated multi-disciplinary team care has been identified as fundamental to delivering key national health reform.

¹ <https://hneccphn.imgix.net/assets/src/uploads/resources/The-National-PHN-Allied-Health-in-Primary-Care-Engagement-Framework.pdf>

To achieve this reform, more systematic and evidence based approaches to engaging and integrating the allied health workforce with general practice and other primary care services through sustainable, outcome focused models of care and funding are needed.

The Strengthening Medicare Taskforce Report offered a vision for primary care within which “coordinated multidisciplinary teams of health care professionals work to their full scope of practice to provide quality person-centred continuity of care, including prevention and early intervention”.

²The Report noted the importance of integrating allied health into primary care in order to help reduce the burden of chronic illness and support integrated physical and mental health care. It also noted this required:

- Strategic planning and strong partnerships between PHNs, the allied health sector, GPs, LHN/Ds and other sectors; and
- Funding arrangements that enable integrated care and promote evidence-based multidisciplinary team care approaches.

The **Primary Health Care 10 year Plan 2022-2032** also recognised the need for a greater focus on Allied Health as a key foundation for reform and highlighted potential for partnerships between PHNs and the allied health sector particularly with a focus on wellbeing, prevention and early intervention.

The First National Allied Health Workforce Strategy is under development by the Australian Government Department of Health. The Australian Government is working with state and territory governments to develop the Strategy.

All these initiatives require models of care that make optimal use of the available workforce and funding arrangements that support integration.

The Case for Change

Understanding the problem with current models of care

The Australian primary care system is not currently making optimal use of the available allied health workforce under current models of care and funding, nor facilitating opportunities for integration of allied health services into multidisciplinary team care. If integration and expansion of the role of allied health providers is to be achieved, these barriers need to be addressed.

- Allied health workers are not sufficiently supported to work with other health care providers - there is limited incentive, time, digital tools or opportunity for working collaboratively;
- The most common models of care and funding (eg MBS items) are inadequate to support localised, place-based solutions to sustain integrated services in areas of limited allied health workforce including rural remote areas or thin or failing markets or to meet the specific needs of vulnerable populations;
- The salary discrepancy between primary care settings and private practice for most allied health professionals often means it is not financially attractive to work outside of private allied health services. Nursing staff and pharmacists are commonly the exception in this regard.
- Private allied health professionals working in sole practices have limited business capacity to apply for or participate in roles which require unpaid meetings or case conferences;

² https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf

- Allied health professionals have limited digital capacity or training, which limits their ability to use particular software, to safely store and share patient information;
- Practical barriers are impeding integration - for instance the lack of space in GP practices to accommodate visiting allied health professionals’;
- There is very limited funding overall through Government programs for primary allied health care for individuals unable to afford MBS or private services, which commonly carry out of pocket expenses;
- Appropriately resourced and coordinated multidisciplinary team care, supporting integration of allied health providers into primary care to support evidence based chronic disease management, is currently only available for pilot initiatives or through limited innovative commissioning. These models of care are not supported or funded in a systemic or coordinated way.
- Finally, Federal and State/Territory governments are not optimally working together to make best use of the allied health workforce. Cross-government collaboration to share allied health resources or co-commission services to achieve better patient outcomes, particularly in areas of thin or failing markets, is seen as innovative and courageous rather than necessary.

New and emerging models of integrated allied health care and funding

Despite the above barriers, there is much to be gleaned from new and emerging care models, including innovative service delivery targeting particular consumer needs through PHNs.

Models of team care provided through PHNs involving allied health professionals have commonly targeted one of the following primary care needs:

- Support across the continuum of care for people with chronic disease;
- Mental health services;
- Services for individuals in rural and remote areas or places of workforce shortage including services and supports provided through Rural Workforce Agencies
- Allied health services targeting the needs of particular population groups, including people impacted by disaster, residents of aged care facilities, refugees or survivors of domestic abuse.
- Services for First Nation people, particularly through the community controlled sector or for other underserved groups.

Case Study: First Nations Speech Pathology - Central and Eastern Sydney PHN

The First Nations Early Intervention Speech Pathology program, established in 2018 by CESP HN and Sydney Children's Hospital Network (SCHN), and in collaboration with South Eastern Sydney LHD (SESLHD) since 2024, provides culturally appropriate services to Aboriginal and Torres Strait Islander children and their families. The program focuses on early intervention for developmental and communication challenges for First Nations children. It provides targeted speech pathology assessments and interventions for children identified at medium to high risk, and developmental support for low-risk children. The program was developed in partnership with the local First Nations community and is supported by an Aboriginal Health Worker. The approach involves close collaboration among speech pathologists, early childhood staff, caregivers, First Nations community and other health professionals. Services are delivered at early childhood education centres, community health centres, events, and playgroups.

PHNs have longstanding experience in engaging allied health workers in the delivery of primary mental health care services, dating back to the Access to Allied Psychological Services program which preceded the inclusion of mental health psychological services items on the MBS. In general PHN commissioning has been intended to address service gaps associated with MBS service delivery associated with affordability, rurality, or for particular vulnerable groups. Models of commissioning allied mental health services through PHNs have included centre based services through headspace and Medicare Mental Health Centres (formerly Head to Health services), commissioning NGOs to deliver allied health services to particular groups or in particular locations, and virtual service delivery. More recently a focus has been on funding very specific evidence based interventions associated with models of care such as Early Psychosis.

A number of PHNs have developed Allied Health Engagement strategies or frameworks which have enabled communication, capacity building, referral pathways and information on supply and location of Allied Health Professionals. This in turn has supported the integration of allied health professionals into team care environments, and enabled input into co-design of new services

Case Study: Allied Health Engagement Strategy, Primary Health Tasmania PHN.

Primary Health Tasmania developed the Allied Health Engagement Strategy to better engage and support allied health professionals across the state. This strategy, aligned with the National PHN Allied Health in Primary Care Engagement Framework, was developed in consultation with representatives from 25 allied health peak bodies, ensuring a diverse range of perspectives and needs were considered. The strategy outlines four key priority areas for engagement and support:

- Embedding allied health in decision making
- Enhancing connectivity
- Supporting workforce initiatives; and
- Fostering awareness of allied health's role within the healthcare system.

Primary Health Tasmania are developing a road map to classify these priorities and identify appropriate stakeholders and timelines.

Current Allied Health service funding models in primary health care

Allied health services in primary care are most commonly funded privately through the MBS, and private health insurance, through Department of Veterans Affairs, Rural Workforce Agencies and through PHN commissioning. Some services are also funded through NDIs and Workers Compensation.

MBS funding provides an efficient, system based fee for service approach to making services broadly available. MBS services are subject to workforce availability, and despite GP referral arrangements, do not guarantee integrated care arrangements. The payments available to allied health workers are reported by the sector as offering little incentive for participation. Allied health MBS funding is most significant in relation to mental health allied services through the Better Access initiative, which provides significant access for people with mental illness to primary mental health care. Over 10

million people (39% of Australians) received an MBS funded allied health service in 2022-23.³ The access by Australians to MBS funded allied health services was similar in rural areas to urban areas overall, though there was of course some significant variation between rural areas.

Incentive payments to GPs – including Workforce Incentive Program incentives provided to GPs. Incentives such as these may help to support integration. However there may be a tendency in uptake of these incentives by GPs for engagement of practice nurses rather than allied health professionals, and incentives do not allow for both. General practices often have greater familiarity with practice nurses allied health professionals within the practice. A Review of GP Incentives has proposed a stronger focus on promoting integration through incentives.⁴

Sessional payments through Rural Workforce agencies and other organisations – some funding models are purchasing services of private providers on a sessional rather than a fee for service basis, particularly when there is an expectation of travel, outreach, or time spent on team meetings. These payments may more fairly remunerate the time of allied health providers.

Community controlled sector block funding – In the community-controlled sector, Federal block funding supports a wraparound care model. The ACCHO model targeting First Nations people has proven successful in providing a range of allied health and other services and encourages flexible use of funds to deliver culturally appropriate team based care

Funding centre based care – Some allied health services are provided through government funding for centres to deliver specific models of care on referral from GPs or on self-referral. Community health centres, Medicare Mental Health Centres, and mental health hubs associated with responding to COVID involved this sort of funding. Commonly these services are provided virtually as well as face to face and clear arrangements are in place for assessment.

PHN Commissioning including Multidisciplinary team care funding pilot– The Australian Government Department of Health is funding PHNs up to \$77.35m over 4 years to commission allied health services to support solo or small GP practices to improve access to underserved groups, targeting those unable to afford services. The pilot focuses on chronic health conditions amenable to multidisciplinary team support. The initiative provides an average of \$600,000 per PHN per year and is generally being implemented in only two or three sites in each PHN.

Prior to and in parallel to this, PHNs have implemented innovative projects which have demonstrated the value of funding allied health services in primary care. However the stop/start nature of these projects has been problematic.

Future models of integrated primary allied health care

Principles underpinning integrated models of allied health primary care

A number of key principles have emerged from PHN experience with allied health service delivery to date which should guide the development of appropriate integrated models of care supported by sustainable funding arrangements. These include the following:

- The allied health sector must be involved in co-design and implementation of new models of care, both at a national program level and at a regional level;

³ <https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/contents/allied-health-services>

⁴ <https://www.health.gov.au/our-work/review-of-general-practice-incentives>

- Place based models of care should be designed and implemented, which meet the needs of local consumers and are informed by local knowledge of the area and its service networks;
- These models should offer genuine integration of allied health services with general practices and other primary care services, within a structure and system that promotes communication, data sharing, and shared planning;
- Evidence based models of integrating allied health professionals into multidisciplinary team care should be developed and promoted, particularly to enable them to help address needs across the continuum of care for people with chronic illness;
- Models of care should be designed in a way that promotes local care neighbourhoods and pathways;
- Models of care should support allied health professionals and other providers to work to their full scope of practice;
- Equity of access to allied health primary care should be supported for under-served groups;
- Models of care should be available which promote cultural safety and participation of Aboriginal and Torres Strait Islander allied health workers within primary care.

Potential models of integrated primary allied health care

If the role of allied health professionals is to be expanded and better integrated into primary care as foreshadowed in the Strengthening Medicare agenda, there are a range of models which could be further developed and commissioned through PHNs, each meeting different types of consumer needs. These models could be funded through expansion of funding for Multidisciplinary Care Team funding model for chronic disease management through PHNs, subject to early analysis of the pilot projects currently underway. A significant expansion of this program could build capacity and flexibility to meet the needs of particular vulnerable groups and place based needs, drawing on PHN knowledge. Potential models of care which could be delivered are as follows:

Promote evidence based models of allied health involvement in team care that target specific chronic diseases, with guidance on the skills and services needed within the team and evidence based interventions. For example specific dietary and lifestyle interventions by allied health workers for diabetes to complement medical members of the diabetes team and evidence based psychological services or low intensity supports for mental health conditions to complement role of GP, mental health nurse and/or psychiatrist.

Build flexible models including outreach services to meet needs of people in rural remote locations or other areas which have a severe workforce shortage – many PHNs have demonstrated ways in which teams of allied health workers can form part of a team in rural or remote areas through outreach programs to contribute to a plan of care, working closely with on the ground team members. This enables all members of the team to work to scope of practice.

Case Studies

Targeted Allied Health Services to Address Thin Markets in Rural and Remote Areas – Western Queensland PHN.

Allied Health Assistants (AHAs) are vital for ensuring access to allied health services in rural and remote areas, especially when supervised by Allied Health Professionals (AHPs). Many AHPs start their careers in these settings and require location-specific guidance from seasoned AHPs to effectively delegate tasks to AHAs. However, there are notable skill gaps among AHAs in rural communities, exacerbated by shortages of AHPs.

To bridge these service delivery gaps, it is crucial to evaluate client needs across rural areas and assess current professional development opportunities for AHAs. Enabling AHAs to attend targeted professional development courses could help them deliver innovative services that address unmet community needs. Two initiatives have been undertaken by one of WQPHN's commissioned Allied Health providers. These initiatives have been launched to improve AHP training in delegation and to create service delivery models aligned with both AHA capabilities and community needs: Project 1: Develop an internal professional development course. Project 2: Facilitate AHA participation in targeted professional development courses to enhance their ability to deliver innovative services.

Your Care Path (YCP), Regional Care Partnerships Chronic Conditions – Western Victoria PHN

Throughout 2022-2023, WVPHN undertook a process to recommission core flexible funding to better support the delivery of services for people with chronic conditions that supports thin markets to overcome allied health workforce shortages to increase service access for people in rural regions. A comprehensive service redesign process involving codesign and market sounding with service providers, community members and people with lived experience led to the development of an enhanced chronic condition service model, known as Your Care Path (YCP), that is delivered through regional partnerships across the four WVPHN subregions. Each partnership includes one lead agency that represent formal partnerships with relevant organisations (12 rural health services and one general practice collectively) required to deliver YCP across all rural areas within the subregion. YCP includes a broad range of treatment interventions delivered by qualified allied health clinicians to support the needs and preferences of consumers with chronic conditions.

Utilise group service delivery to efficiently make the most of allied health workers in areas of limited workforce. For example psychologists offering group therapy for postnatal depression, or group exercise instruction by physiotherapists for people on the same recovery path. These models may work best in areas of higher population, where there is a higher volume of patients. At present group based allied health care is often limited to diabetes.

Establish regional hubs or centres for allied health service delivery to service local integrated referral networks and to support the volume of service delivery needed to ensure viability of private practice or to efficiently utilise salaried or sessional allied health professionals. These centres can provide a conduit between GPs and their patients to support ease of access to allied health care as part of comprehensive care. Funding Centre based care based around a disease set in the chronic disease space may be an option that would support regional and metro communities but may only suit rural area via hub and spoke models.

Case Study: Healthy Ageing Hub – Central and Eastern Sydney PHN

GPs often lack the time to support social prescribing and service navigation which links older people to non-medical supports addressing the social determinants of health and activity in the community to improve mental and physical health and well being. The Healthy ageing hubs initiative aims to provide an important conduit between general practice and the additional health and social care needs often required by older people in order to manage their health, independence and wellbeing.

Staffed by social workers, healthy ageing hubs assist older people to know what programs, services and groups are available in the community to help them maintain their health and wellbeing, and how to access them. They provide practical navigation support and help older people resolve practical issues associated with ageing. The hubs offer in person or phone based support tailored to meet individual needs. This includes assistance connecting with;

- Local programs, services, groups and activities of interest
- My Aged Care services
- Healthy eating, strength and movement programs
- Mental health and wellbeing programs
- End of life planning support, and
- Legal, housing and financial assistance services

The healthy ageing hubs;

- Form a backdrop to social prescribing for our GPs and other primary health care workers lacking the time to assist older people to access the non-medical care and social support services they need
- Empower consumers to take the lead in the provision of their own health by seeking out information on health and social services available to them close to where they live

Making greater use of e-allied health services to deliver virtual services where it is appropriate to do so. Sometimes an initial face to face assessment by an allied health professional can be followed by e-allied health services, particularly in areas of limited workforce. Allied health assistants on site in the remote area have been shown to capably form part of the team on the ground, undertaking initial assessments, monitoring care and helping patients to implement care plans.

Case Study: Virtual Psychologist for Postnatal Wellness Pilot – Hunter New England PHN

The Virtual Psychologist Pilot introduced a digital mental health service providing on-demand access to qualified psychologists through text, chat, and other digital means. Unlike traditional services that often require a GP referral, this program is self-referred, allowing individuals to access support directly when needed. This model improves accessibility and reaches a broader pool of individuals, especially new mothers, who can refer themselves or be referred by others within their community, effectively targeting those most in need. The service has been praised for its convenience, cultural safety, and the ability to provide immediate support to those who might not seek traditional avenues.

Case Study: Indigenous Wellness Connect - Darling Downs and West Morton PHN

The Indigenous Wellness Connect model will improve equity of access for Aboriginal and Torres Strait Islander people based in rural and remote Australia. The model will introduce a Telehealth Hub co-located at the local Medical Centre. A Health professional will be recruited as a Telehealth Hub Care Coordinator and Aboriginal Health Worker and will be embedded within the local General Practice in Goondiwindi. The Hub Care Coordinator will work closely with eligible patients and the Multidisciplinary Team to facilitate access to care. The role includes triaging patients/assessments; receiving and monitoring device outputs (via a Telehealth cart); booking and coordinating appointments; coordinating transport; patient communication and advocacy; and support with health literacy. Care will be delivered through a connected network of primary care services to the closest primary care hub and beyond to support underserved rural communities with Indigenous populations. The care model will include the use of a sophisticated telehealth cart system with diagnostic peripheral tools, enhanced digital satellite connectivity, and remote support from a multidisciplinary team of General Practitioners, Allied Health and Specialists.

Whilst these models vary in their focus and mode of delivery, they share a number of core enablers required to ensure allied health workers have capacity, support and connections to play an integrated role in multidisciplinary team care. These elements are as follows:

- A digitally capable allied health workforce, with capacity for secure and safe communication of patient information
- Service coordination and planning
- An active role for GPs, recognising their central role in primary care delivery
- Remuneration to enable participation in shared care and team meetings
- Support for travel if required
- Peer support, training, continuing educational pathways, sustainable remuneration and sustainable workloads
- Continuous improvement activity supported by analysis of patient experience and patient outcomes through use of common software.

Funding primary allied health care into the future

Approach to funding future models of care

Ultimately more resources are required for coordinating, supporting, and delivering allied health these resources are allocated in a judicious and targeted way. Future funding arrangements for allied health services in primary care should deliver:

- Administrative simplicity – noting many allied health workers are sole traders or in private business,
- Equity – blended payments funding in particular should target individuals with limited capacity to access services because of cost, location or other factors;
- Collaboration – promoting and funding team activity, not simply individual service delivery;
- Flexibility – place-based solutions and different services need different funding approaches;
- Quality – funding should focus on delivering the best outcomes for consumers and continuous improvement should be supported and encouraged;
- Efficiency – a value-based approach to funding.

It is assumed that the future will continue to see a mix of fee-for-service and blended payments approaches to funding allied health services in primary care. In line with broader trends in primary care, allied health services should also benefit from advances in paying for services provided digitally as well as face to face, from pooled funding arrangements in places of short workforce supply and from bundled payments to address additional costs in rural and remote areas or for particular groups. If the models suggested above are to be implemented, the following considerations apply against these different funding approaches.

Table 2 Considerations in relation to funding models for primary care allied health services

MBS fee for service funding for allied health services	The level and nature of MBS payments for allied health services associated with chronic disease management and mental health service delivery will need to be subject to continuing review to ensure sustainability and targeting.
Commissioned services through PHNs and other community organisations	This funding model is capped, but also scalable to meet emerging needs. An expansion of multidisciplinary team arrangements involving integrated allied health services will require additional funding and workforce measures to support implementation.
Pooled funding, particularly in rural and remote areas	In locations with unmet but low level demand, pooling funds across state/federal services or even sectors could efficiently secure allied health professionals to meet service needs.
Bundled funding to meet local needs or to support outreach services	To secure integrated allied health services, bundled payment arrangements should help to resource nonservice delivery costs such as building digital capacity, team participation, quality assurance, and workforce costs such as recruitment, travel and housing in rural and remote areas.
Funding virtual or e-services	Capacity to fund e-service delivery by allied health professionals where it is appropriate to do so should be considered.

Essential elements of funding models

Regardless of the mode of direct service delivery, the following elements of providing integrated allied primary health care will require resourcing to achieve the best outcomes.

Table 3 Elements of funding for integrated primary allied health care

Planning – jointly planning services with the allied health sector, LHDs and broader primary care
Capacity building – investing in the digital capacity of allied health workers to support safe, secure and consistent data sharing and use of software for measuring outcomes of care
Coordination, case management and clinical governance – funding overall service coordination but also the costs of working as part of a team supported by clinical supervision and with clear accountabilities.
Service delivery – direct costs of providing the service
Recruitment and relocation costs – the costs of securing allied health workers, particularly in areas of low workforce
Supplementary costs for services in rural and remote areas – travel costs to address lost income associated with time spent travelling, and also potentially support for housing affordability as well as securing remote supervision arrangements.
Building the workforce of the future – Resourcing student placements and study pathways in primary care to attract the allied health workforce to primary care positions.
Evaluation and continuous improvement – costs associated with ensuring consistent data is collected to monitor outcomes of care.

Actions required to support new models of care and funding

Actions required at a system level

To achieve reform to optimise the role of allied health professionals in primary care through new outcome driven, integrated models of care, several significant shifts at a system level are needed.

- Joint planning and shared investment from state and federal governments in community based allied health care is needed, supported by bilateral agreements similar to those in mental health. Pooled funding arrangements for areas of thin workforce supply should be authorised to make optimal use of available workforce.
- A systemic approach to supporting the digitisation of the allied health workforce, to support engagement, communication, and safe data sharing in a team environment. This includes roll out of My Health Record.
- The level and nature of MBS payments for allied health services associated with chronic disease management and mental health service delivery will need to be subject to continuing review to ensure sustainability and targeting.
- Funding must recognise all the above cost elements associated with actively integrating allied health workers into primary care teams and allow for bundled payments which reflect the non-service delivery elements of participating in team care; and
- A continuous improvement framework through building capacity of the allied health workforce to collect patient experience and outcomes data.

Role of PHNs in taking forward new models of care

PHNs have demonstrated their capacity to engage allied health workers in areas such as mental health, chronic disease, and rural remote service delivery and are embracing the opportunity to pilot multidisciplinary team care. If empowered and resourced to do so as a priority, PHNs could expand their role to plan for and build capacity of the allied health professional workforce at a regional level if authorised and resourced to do so. A Briefing Paper prepared by the PHN Cooperative on Enabling New Models of Care and Workforce Solutions recommended that “PHNs should be explicitly resourced and authorised to lead collaboration with local stakeholders to develop workforce place-based solutions to improve access to primary health care, development and delivery of early intervention and chronic disease management”.⁵

This could include:

- Joint regional planning with LHDs and other stakeholders. Co-designing new place-based multidisciplinary team solutions with allied health professionals, GPs and other stakeholders;
- Engaging with the regional allied health sector to help coordinate service development, promote networks, and develop pathways to care;
- Helping to build digital capacity and skills to support integration;
- Commissioning multidisciplinary team services to support chronic disease management;
- Promoting and trialling new models of care including virtual service delivery and hub based models of allied health care;
- Providing feedback through needs analyses and evaluations of emerging challenges and opportunities for the local allied health workforce.

⁵ Enabling New Models of Care and Workforce Solutions, Briefing Paper, PHN Cooperative, May 2022.