



Australian Association of Developmental Disability Medicine

SUBMISSION TO THE PRODUCTIVITY COMMISSION ON THE HEALTH WORKFORCE

July 2005

Australian Association of Developmental Disability Medicine (AADDM)

The Australian Association of Developmental Disability Medicines is a newly formed association of 40 medical practitioners from across Australia who aim to:

- (1) Improve health across the life span of people with developmental disability
- (2) Establish national standards for health of people with developmental disability
- (3) Work towards a national approach to delivery of health care in Australia for people with developmental disability.

This submission is made on behalf of the Association on the health issues of people with developmental disability.

The committee of the Australian Association for Developmental Disability Medicine has read the submission by the New South Wales Council for Intellectual Disability and would like to add our whole hearted support to this document. We would like to comment on a number of issues raised and comment from the perspective of a group of medical practitioners who have first hand experience of dealing with the consequences of the failure of governments to recognise and act upon the poor health outcomes of a group that makes up around 2% of our population. This group has health outcomes at least as bad as those in our indigenous communities (Bittles & others 2002, Beange & others 2002, Scott & others 1998 Stewart & others 1994, Community Services Commission 2001, Einfeld & Tonge 1996).

We have tried to make our own submission to align with the principles in the national health work force strategic framework, in particular:

- Principle 2 – Distribution of the workforce should optimise equitable access to health care for all Australians, and recognize the specific requirements of people and communities with greatest need.
- 5 – A realignment of existing workforce roles or the creation of new roles may be required to address health needs and provide sustainable quality health care.
- 6 – Health workforce planning should be population and consumer focused.

The specific areas that we feel are important for improved productivity in the health care of this group are:

- having a better systems in place monitoring health outcomes
- an improved knowledge base within the medical and health professionals
- adaptation of public health measures for people with intellectual disability
- access to generic health services
- development of specialised health support
- improved interdisciplinary capacity

Better Accountability

There is a growing awareness within the community and within the professional groups that this population is relatively disadvantaged. There has been a movement of health services for this group away from state based institution models to commonwealth funded community based generic models. A concern has been that the reporting on health outcomes for the bulk of this population has been subsumed within that for the general population. This is a vulnerable population that has a limited capacity to voice its own concerns so systems of accountability are even more important to ensure our governments' duty of care to this group. It is therefore critically important that the commonwealth has in place a national system of monitoring that can achieve a true indication of the current state of health and identify where action needs to be taken to improve the health for this population. Competitive research grants rely on established track records and as there is a limited history of research in this area a proactive role with special research grants needs to be made to develop capacity.

Improved Knowledge Base

While inroads have been made in the education of medical students in some medical schools with the establishment of centres (Centre for Developmental Disability Health Victoria, Queensland Centre for Intellectual and Developmental Disability, the Centre for Developmental Disability Studies in NSW and more recently the Centre for Intellectual Disability Health in South Australia) there is a need to have more input into the undergraduate programs in the other states and territories and there remain real gaps in post graduate training. Two important groups in the delivery of health services to adults with intellectual disability; General Practitioners (Lennox et al 2000, Phillips et al 2004) and Psychiatrists (Lennox and Chaplin 1996) while indicating that they would like to better service the needs of this group have acknowledged gaps in their own training. Using the state based and funded resources on a national scale we could provide economies of scale and potentially benefit all states, however, state based services are reluctant to fund national initiatives.

Adaptation of Public Health Measures

Public health activities and preventive health initiatives have important potential benefits for people with intellectual disability. Yet there are barriers to these benefits being realised. The information and distribution system it is often geared for the non disabled population and inaccessible to the person with an intellectual disability. Issues like the importance of a pap smear for women, eating habits and the link to heart disease and the opportunities for healthy exercise rely on either modified versions of that information or the information being passed on through carers and parents. Carers with responsibility for the lives of people with intellectual disability have limited training on health problems and their management. Preventive health campaigns therefore need to include strategies that make these initiatives more accessible to people with intellectual disability.

Access to Generic Health Services

Research shows that this population does have access to medical practitioners with an average of 5 visits per year (Sutherland & Iacono 2005), yet access does not ensure an awareness of the current health problems and their appropriate management (Beange et al 1995). Even with appropriate training, medical practitioners are concerned if they demonstrate an interest they will be overwhelmed by a group with complex health needs and support structures that demand more time and would therefore be severely financially disadvantaged in a system that rewards more frequent and shorter consultations. Incentives introduced with the Enhanced Primary Health Scheme for the aged and indigenous population have relevance to people with intellectual disability. An annual health assessment that specifically targets the health issues associated with people with intellectual disability identified by the health working party of (IASSID 2002) would go a long way to bringing the health issues to the attention of GPs and setting up an appropriate system of health monitoring. The Royal Australian College of General Practitioners (RACGP) has already met with the Human Rights and Equal Opportunity Commission on the issue of developing better strategies to encourage GPs to spend the required time with this group. This initiative needs to be further encouraged.

Development of Specialised Health Support

The complex and lifelong nature of the health problems of the population and some of the specific physical and psychiatric health problems often require a special knowledge, a familiarity with the population and links with the system that supports them to be dealt with effectively. Within paediatrics there is a well developed special interest group in this field that should be further supported. In the Netherlands a specialist training system has been developed for the speciality of intellectual disability medicine. In the United Kingdom there is a chapter of Learning Disability psychiatry within the college of psychiatrists. Both these professional bodies have been created in response to the needs of this population, similar initiatives should be supported in Australia. Developing recognised centres of excellence with medical practitioners with a special interest in this field not only supports other medical practitioners but gets the health issues of this population on the agenda in professional training. It is important that these have both primary and specialist health care settings. For a whole range of potential benefits including clinical services, teaching, research and advocacy it makes sense to support and promote the development of special interest group in intellectual disability nationally.

Improved Interdisciplinary Capacity

Specialist training should not be confined to the medical profession and specialised health support should not be seen only through medical specialisation. Other allied health workers and nursing staff need to have special skills developed in this area. The training programs for these groups should also include education on the needs of people with intellectual disability. It is important to recognise that better health outcomes will rely on collaboration and working relationships being developed by these groups. This may be informal or formalised health resource teams in each health area. These would be a multidisciplinary model that included a doctor who specialises in intellectual disability and professionals in other disciplines such as nursing, dietetics, speech pathology, neurology and psychiatry. The make up of these teams could vary depending on the needs and available resources in its local area. In more isolated areas there should be enhanced supports for existing services ie RDNS, Regional Health Services, Divisions of General Practice.

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