ACDHS AUSTRALIAN COUNCIL OF DEANS OF HEALTH SCIENCES

Australian Council of Deans of Health Sciences response to the Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution.

The Australian Council of Deans of Health Sciences (ACDHS) welcomes the opportunity to provide comment on the Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution. Options for Commonwealth Government Policy Reform and Investment.

ACDHS is the peak representative body of the Australian universities that provide pre-professional education in the allied health sciences. ACDHS members are allied health heavy universities, many of whom are involved in the Rural Health Multidisciplinary Training Program (RHMT) funded by the Commonwealth. This has been an important support mechanism for rural allied health (as well as medical, nursing and midwifery) placements and infrastructure. The Council adopts a whole of health system perspective and considers the development of an innovative and sustainable health workforce will best position Australia to address present and emerging health care demands.

ACDHS member universities include:

Central Queensland University
Charles Sturt University
Curtin University
Deakin University
Edith Cowan University
Flinders University
Griffith University
James Cook University
La Trobe University
Monash University
Queensland University of Technology
University of Canberra
University of Melbourne
University of Newcastle
University of Queensland
University of South Australia
University of Sydney
Western Sydney University

While it is noted that many of our members teach a broader range of health programs, the following professions fall within the remit of our Council:

Audiology
Clinical exercise physiology/sport and exercise science
Medical laboratory science
Nutrition and dietetics
Occupational therapy
Optometry
Orthoptics
Paramedicine
Pharmacy
Physiotherapy
Podiatry
Prosthetics and orthotics
Psychology
Medical radiation science
Social Work
Speech pathology

The opportunity provided by the request to the National Rural Health Commissioner to develop advice about the current priorities for improving the access, distribution and quality of rural and remote health services across Australia is both welcome and timely. ACDHS welcomes impactful system level changes to reduce longstanding barriers to equitable access to allied health services for remote, rural and regional community members.

To this end, members welcome and encourage implementation of the following recommendations:

- The appointment of a Chief Allied Health Officer within the Commonwealth Department of Health
- Developing a national allied health workforce dataset that includes data points for rural allied health

- Qualified expansion of the Health Workforce Scholarship Program for allied health professions
- Developing viable markets through Improved access to Commonwealth funding for allied health professionals and patients in MMM 4-7 areas as listed in policy area 4, ie:
    1. The Commonwealth could work with states and territories to determine efficient, transparent and fair mechanisms to overcome the unintended consequences of section 19(2) of the HIA in rural areas, thereby allowing the aggregation of state and federally funded work into single-employer rural jobs.
    2. Commonwealth to fund supervisors of allied health students in private practice in MMM4-7 areas for the time they spend teaching and demonstrating in practice settings (e.g. through a Commonwealth incentive program). Such funding would not prevent the supervisor from accessing other eligible service-related income (e.g. Medicare payments for services personally rendered).
    3. To acknowledge and compensate for the complexity that increases with rurality of practice, provide incentives for rural practice allied health services, for example, in MMM4-7, the Commonwealth could offer:
        a. rural loading on fees for allied health services (e.g. on Medicare payments)
        b. a bulk billing incentive
        c. a GPRIP-like incentive
    4. Remove caps on the number of allied health services any one patient within MMM4- 7 can receive for items under Better Access, Chronic Disease Management, and Medicare Follow-up Allied Health Services for People of Aboriginal and Torres Strait Islander Descent.
    5. Fund HECS-HELP loan repayments for early career professionals working in a permanent or fixed duration contract in a rural location. These payments could be structured to include a loading to encourage professionals to work in areas of higher need.
- Implementation of six telehealth recommendations for Allied Health Services as listed in policy area 5 (listed below), *noting that telehealth services should not evolve to a replace local service options.*
    1. Fund eHealth software and systems
    2. Fund training in telehealth and promote awareness
    3. Fund virtual training
    4. Fund allied health services delivered by telehealth
    5. Fund allied health intra-disciplinary case conferences
    6. Invest in point-of-care equipment

Members recommend further exploration and clarification of the conceptual Integrated Allied Health Hubs, the notion of a College as an assumed entity, the impact of Rural Origin Selection Quotas, the feasibility of offering full year of full program in rural areas

Responses to the specific questions.

Policy Area 1: Rural Allied Health Policy, Leadership and Quality and Safety

Question 1.1.a: *If the Commonwealth were to appoint a Chief Allied Health Officer/Advisor, what would be their top priorities for improving rural allied health distribution, access and quality in the next five years?*

ACDHS members encourage the establishment of a National Chief Allied Health Officer.

Following the appointment of a Chief Allied Health Officer, the top priorities for improving rural allied health distribution, access and quality in the next five years would include the following

1. Developing an intersectoral workforce plan for the professions of allied health.
    a. Plan to include detail on rural allied health workforce availability in health, aged care and disability
2. Commission/facilitate the development of viable workforce data collection options for the

self-regulating professions of allied health
3. Progress agreed initiatives emerging from the work of the NRHC
4. Establish rural allied health advisory group
5. Establish collaborative service planning fora for health, aged care, mental health and disability sectors with a focus on remote, rural and regional (RRR) communities
6. Identify and promulgate successful service delivery models in RRR communities
7. In collaboration with IAHA, explore opportunities to expand the Aboriginal and Torres Strait Islander allied health professionals, allied health assistants and Aboriginal Health Workers
8. Advise on allied health research priorities and outcomes to help inform evidence based policy

Question 1.1.b: How could a Chief Allied Health Officer/Advisor position be structured to improve inter-sectoral collaboration?

The separation of workforce, aged care, health systems policy and primary care within the Department of Health (DoH) presents a challenge as to how best to structure and position the Chief Allied Health Officer (CAHO) to address both rural allied health service *and* workforce recommendations and more broadly, to improve inter sectoral collaboration to improve access to allied health services.

The role should be closely aligned with the Chief Medical Officer (CMO) and Chief Nursing and Midwifery Officer (CNMO) to help provide a more integrated policy advisory and implementation process in portfolio areas such as workforce.

Qualifications and experience in one of the professions of allied health would be an essential criteria for the CAHO role. The appointment of a senior allied health professional will provide the role with authority, credibility, and content expertise required to achieve priority outcomes and drive reforms that benefits the community.

Primary location within health systems policy branch could best position the CAHO to influence at a system level, *but only if also tasked with directly informing policy* internally with regards to allied health services and workforce in aged care and workforce branches, and to liaise externally with the Department of Social Services, state and territory chief allied health officers and other key organisations/sectors.

Thinking beyond the current DoH structure, the CAHO role could be positioned in a restructured workforce division that includes a tri-professional leadership team of the CMO, CAHO and CNMO, each with a matrix of service and workforce responsibilities.

Question 1.2.a: What would be the advantages and disadvantages of the abovementioned models for establishing a College?

This and subsequent questions within 1.2 are written with the presumption that a College is both necessary and the preferred option.

Before discussing advantages and disadvantages, it is important to consider the notion of a College within the context of the allied health professions generally, and then more specifically in regard to rural allied health and the Allied Health Rural Generalist Program/Pathway.

Colleges have been established by a number of individual allied health (AH) professional associations that recognize qualifications for specialization and titling. Unlike the medical profession, in general, there is no requirement for additional registration/credentialing beyond entry level qualification for the professions of allied health to practice. There is currently no 'specialist' registration category for allied health professions under the National Law for "rural generalists" or any other form of narrow and restricted practice scope. Professional associations can establish pathways and titled memberships in key areas identified by the profession. Rural allied health practice has typically not been recognized in such structures to date,

however, it is understood that SARRAH (Services for Rural and Remote Allied Health) is in the process of doing so.

Undertake training

While recognizing support is required for rural allied health professionals to undertake training to gain rural allied health generalist qualifications, it is not clear that establishment of a College is a necessary requirement. Additional supports are welcome. Supports may include financial supports such as scholarships to undertake the education components and organizational/service supports to establish training positions that meet the specifications of the Allied Health Rural Generalist (AHRG) program. Existing entities could provide or advocate for specific supports.

As such, ACDHS members do not believe that establishment of another entity/organisation is required to support rural allied health professionals to undertake training to gain allied health rural generalist qualifications from accredited programs.

Accreditation

Development of a College would not be required to credential an individual graduate of a formal program of study delivered through a university, such is currently the case for the AHRG program. The program of study itself can be accredited by an independent entity such as a College or other identified body. The program of study would be assessed against the accreditation requirements and competency framework for rural allied health generalist education. An accreditation system has already been developed for the Allied Health Rural Generalist Program in 2018 by the Australian Healthcare and Hospitals Association.[1]

The Allied Health Rural Generalist Pathway training model includes a post-graduate qualification (AQF Level 8), with the assessment of whether an individual has met the requirements outlined in the standards (competency framework, education framework) being undertaken by the university, *not by an independent professional body separate from the education delivery.*

ACDHS would be supportive of an independent entity to maintain the responsibility for the AHRG competency and education frameworks and other related documents required for program accreditation and for the accreditation of programs once there are sufficient numbers enrolled in the AHRG programs. As with the development of the AHRG accreditation system, accreditation of new programs could be fulfilled by an existing rather than new entity.

Individual recognition

A form of recognition could be established within existing organisations. This could include conferring a title as occurs in many of the professional associations or is understood to be in development by SARRAH.

Advisory body or central repository

A number of existing bodies could provide leadership and advice on matters such as safety and quality standards and related performance indicators. The networks and sector wide representation of the Australian Allied Health Leadership Forum (AAHLF), already recognized by AHMAC as the body to provide allied health workforce advice, would be one such body subject to appropriate resourcing. SARRAH, as the peak rural allied health body within AAHLF, could be charged with a leadership role in collaboration with other AHHLF organisational members.

Promotion of rural career pathways

SARRAH has long been promoting opportunities to work in RRR communities and more recently has been active in the promotion of the Allied Health Rural Generalist program. Many of the profession specific associations and organisations such as the National Rural Health Alliance also provide support for rural

[1] https://www.health.qld.gov.au/ahwac/html/rural-remote

practice. This function is unlikely therefore to require the establishment of a new or separate entity such as a College.

Viability

The size of the rural allied health workforce and the subset that will seek membership of a rural allied College *in addition to membership of their professions specific association* are relatively small. Combined, the small numbers and dual association/college membership, make the viability of a College without substantial, ongoing government funding, unlikely.

In summary, ACDHS

- supports the recommendation for an independent body to accredit the Allied Health Rural Generalist Education programs as demand requires
- is supportive of initiatives to support health services to establish AHRG training positions,
- is supportive of funding to develop an allied health central data and information repository
- encourages associations to develop prestige indicators for rural allied health by professional associations such as SARRAH or profession specific entities

ACDHS members support initiatives to enable the functions listed above, but are ambivalent as to whether such a body would be a College. ACDHS members believe that the investment could be better allocated to one or more existing entities relevant to each of the above functions.

ACDHS members are broadly supportive of the policy intent described on page 16/79 of the discussion paper with a qualifying statement regarding use of an existing entity rather than the assumed formation of a new College. To *task an existing entity or entities* to

- facilitate the implementation of national rural allied health programs
- provide accreditation of post graduate rural training courses to meet quality and safety standards
- promote high quality rural context training and career pathways to the current and future rural allied health workforce
- provide a central repository to collect, manage and share rural allied health data, research and innovation

Question 1.2.b: *Which model or approach do you support for adopting a College? Please provide the details of the model and the reasons why.*

Noting the ACDHS comments in 1.2.a regarding ambivalence towards establishing another entity that if a College were to be the considered recommendation, then ACDHS members would recommend option B: the evolution of an existing organisation or association (logically a rural allied health entity).

Question 1.2.c: What performance indicators would determine the effectiveness of a College?

If a College were to be recommended, clearly articulated functions and accountabilities would be required before description of performance indicators.

Question 1.3.a: *What are the benefits and challenges of investing in a unique national rural allied health workforce dataset?*

ACDHS members encourage the development of a national allied health workforce dataset that could be interrogated for the subsets of remote, rural and regional allied health professions. Consideration of how best to include the self-regulating professions is important to inform a comprehensive data set, but should not be considered a barrier to commencement with the regulated professions.

Benefits

- Whole of sector workforce planning- that would include a focus on rural allied health rather than a unique national rural allied health workforce dataset
- Understanding availability and distribution of allied health workforce

Challenges

- To establish a mechanism to obtain reliable workforce data from the self-regulating professions of allied health
- To accurately capture, describe and distinguish between locally based and visiting allied health professionals
- To accurately capture and describe the service sector and setting of the allied health professionals in RRR Australian communities
- To recognize the limitations of service availability that is implied, and perhaps assumed by workforce availability
- To understand the limitations and difference between the scope of the individual practitioner and the scope of their profession when inferring service availability from workforce data

Question 1.3.b: *What existing rural allied health workforce datasets/structures could be used already as the basis for this national dataset?*

There are gaps in national allied health workforce data sets without further specifying rural allied health datasets

Existing data sets include

- ABS
- AHPRA,
- AIHW
- DET student entry and completion data
- DVA
- HWA workforce needs assessments (2014)
- MBS
- NDIS data
- NGO data bases
- PHN needs assessments and commissioning data
- Professional associations

Policy Area 2: Opportunities for Rural Origin and Indigenous Students

Question 2.1.a: *What are appropriate target quotas for universities to select more rural origin students into allied health courses?*

This question is framed presuming the introduction of targets.

In general, our members do not support the introduction of targets.

The addition of rural origin student quotas into allied health programs may have a range of unintended consequences, including:

- Potential diversion of rural students to metropolitan universities
- Negation of rural background and/or rural exposure if there are no appropriate positions for new or early career allied health professionals.

As such, ACDHS does not support the introduction of rural quotas.

While differences exist, there is some support for consideration for directing initiatives to rurally based programs in regional universities or offered at the rural campus of metropolitan universities. ACDHS would encourage any such initiative to occur concurrently with initiatives to improve employment options in remote, rural and regional (RRR) communities for the professions of allied health. It should be noted that there are many universities or university campuses based in rural and regional settings and these should be supported to continue to develop allied health education options.

Introducing targets may impact on the viability of the current valuable rurally based university offerings. This model of rurally based university offering feeds into the more important concept of educating locally to build a rural health workforce.

Question 2.1.b: If quotas were to be set at different rates for different courses and university contexts, what should be considered in determining these quotas?

There is no clear support at this time for introducing rural origin quotas. Quotas without specific funding support may lead to perverse behaviour by bigger and well off universities thus attracting high quality students away from local rural universities.

Question 2.1.c: *Please describe other policy options within the Commonwealth's remit, which could achieve the same result in rural origin student admission rates.*

Shift focus to new and early career graduate support

There are rural origin students currently graduating from both metropolitan and rural/regional universities who are not able to obtain positions in RRR communities. It is time that the focus shifted from a priority on pre-entry initiatives to prioritizing the employment end of the rural allied health pipeline.

Relevant initiatives described in the discussion paper include developing viable markets, including exploring IAHHs, progressing the allied health rural generalist pathway with scholarships to access the formal post entry education program.

Incentivizing and supporting health service providers to establish rural allied health training positions would be a welcome step in addressing the rural allied health workforce maldistribution and to improving local access to allied health services informed by community need.

Regarding support for rural students, where there are no rurally/regionally based allied health programs there could be consideration for support to assist rural students accessing allied health programs as has occurred previously.

Question 2.2.a: *Please describe alternate policy options within the Commonwealth's remit, which could achieve the same results in providing opportunities for rural and Aboriginal and Torres Strait Islander students to train as rural allied health professionals.*

In addition to the priority ACDHS members place on providing opportunities for rural and Aboriginal and Torres Strait Islander students to train as allied health professionals, ACDHS defers to our IAHA (Indigenous Allied Health Australia) colleagues.

Question 2.2.b: *Please describe any regional, culturally safe and appropriate training and employment models, that could be scaled up and/or adapted to increase the Aboriginal and Torres Strait Islander allied health workforce.*

ACDHS defers to our IAHA (Indigenous Allied Health Australia) colleagues.

Suggestions are included elsewhere about the potential for expanding the role of the Aboriginal Health Worker to provide assistance with the provision of Allied Health Services

Policy Area 3: Structured Rural Training and Career Pathways (MMM2 – 7)

Prefacing comments.

Pipeline/pathway beyond graduation

Initiatives focusing on increasing supply and/or rural experience will have limited success **unless concurrent work is undertaken to increase the availability of appropriate new/early career positions** for the professions of allied health in remote, rural and regional (RRR) communities and the senior AHP positons to provide clinical leadership, mentoring and support.

Allied health rural generalist pathway

While noting the discussion paper indicated that recognition of Allied Health Rural Generalism was outside the stewardship of the Commonwealth Department of Health, ACDHS would welcome statements from the Commonwealth affirming and acknowledging the existence of the Allied Health Rural Generalist Pathway. The AHRG pathway has been developed and trialled over the past 6 years with training positions currently established in Queensland, Northern Territory, South Australia New South Wales and Tasmania.

Redressing the rural workforce maldistribution has long been a priority area for ACDHS members. Initiatives to redress this maldistribution, such as strategies that embed a National Allied Health Rural Generalist Pathway, are supported and encouraged by the Council members.

Question 3.1.a: *What are the key strategies, considerations and feasible timeframes for provision of comprehensive allied health training in rural areas for:*

- *full course training?*
- *full year training?*

Full course training already occurs in a number of states with fully rurally based Universities.

Allied Health programs are offered in rurally based universities including: Central Queensland University, Charles Sturt University, James Cook University and many would also include Charles Darwin University. There are also rural campuses of metropolitan universities that offer allied health programs, for example the Whyalla and Mt Gambier campuses of the University of South Australia and the Bendigo campus of La Trobe University.

Small populations and student numbers make full program provision in smaller rural communities not viable undercurrent university funding models. The resource implications provide significant barriers and any such program would require a special funding mechanism beyond the existing universities funding mechanisms. The sustainability of such funding would be questionable.

Full year training or long look programs are less common in the professions of allied health compared to a many medical programs that include these options. Moves to introduce such options will require collaboration between universities and RRR placement providers (including but not restricted to UDRHs). It is important to consider the local RRR capacity to provide appropriate clinical experience and supervision, the additional resources required for supervision, clinical service provision and accommodation and the impact (including unintended consequences) on placement availability typically used by local/regional universities. Building teaching capacity that enables curriculum to be delivered locally by rural and remote practitioners would require medium to long term funding and development strategies.

While recognising that the UDRHs are designed to be a key enabler of rural education and training capacity, geographic coverage of the UDRHs is limited. UDRHs are not the sole or primary mechanism for impacting clinical placement availability for allied health programs.

Resourcing is a critical issue for placement availability. Clinical placement funding to universities for the allied health professions does not include a loading for clinical placements (in contrast to medicine and other professions). The 2020 Commonwealth contribution amounts for supported places for health profession clusters will range from $13,308 for allied health, to $14,858 for nursing and $24,014 for dentistry and medicine.[2]

It is also important to recognise the contribution of the existing fully rurally based programs (listed above) to the overall rural training capacity. Potentially funding these programs and universities to a higher level when providing courses in rural locations would help to subsidise the expense of providing training to students outside metropolitan areas.

Question 3.1.b: *What are the factors that would need to be considered to ensure the successful expansion of the John Flynn Program to include placement scholarships for rural allied health students?*

- Quality of learning experience and available supervision are important factors to consider.
- Authentic integration of existing practice education roles and opportunities.

Question 3.1.c: *Please describe other strategies within the remit of the Commonwealth that could be implemented to:*

i) increase the number of allied health courses and training available in rural locations?

ii) increase the number of allied health student rural placement opportunities?

Beyond the Rural Health Multidisciplinary Training Program, an important Commonwealth program that supports rural health placements and professional development and research, ACDHS provides the following comments for consideration.

The initiatives to support students to access rural placements through the provision of scholarships or accommodation and travel subsidies are important and welcome. ACDHS members would now encourage the introduction of initiatives at the employment end of the rural allied health pipeline.

Before increasing the number of allied health courses in either metropolitan or rural areas, **a first step** would be to prioritize the employment end of the rural allied health pipeline. Creating viable markets in rural communities, consideration of the IAHHS and other strategies listed in the discussion paper that, if

[2] https://docs.education.gov.au/system/files/doc/other/2020_allocation_of_units_of_study.pdf (accessed 31 July 2019)

well planned and structured, could lead to appropriate employment opportunities in RRR communities for new and early career graduates and the senior allied health clinicians who provide their clinical leadership, mentoring and supervision.

The increasing supply of graduates over the past decade or so, while welcome, has not significantly shifted the proportion of each of the allied health workforces that work beyond metropolitan areas (data tables below)

Geographic Distribution

Data from the National Workforce Health Datasets (NWHDS) for the registered professions reveals a continuing geographic maldistribution in all of the registered AH professions compared to the 29 % of the population living in rural and remote areas (in 2013)[3] with the exception of Aboriginal and Torres Strait Islander Health Practitioners.

% of the professions working in major cities[4]

	2015	*2016*
Aboriginal and Torres Strait Islander Health Practitioners	64%	*13.3%*
Occupational Therapy	*76%*	*77.1%*
Pharmacy	*76%*	*77.1%*
Chiropractic	*76%*	*75.7*
Podiatry	*77%*	*75.4%*
Optometry	*78 %*	*79.0*
Medical Radiation Practice	*79%*	*78.8*
Physiotherapy	*80 %*	*80.8%*
Osteopathy	*80%*	*80.3*
Psychology	*82 %*	*82.9*
*Chinese Medicine Practitioners**	*87%*	*86.7*

Workforce growth[5]

	% growth 2014-15	% growth, number and Av Growth %pa 2013-2016
Aboriginal and Torres Strait Islander Health Practitioners	10.4	77.1 % (239) Av 21.0% pa
Occupational Therapy	7.0	20.5 % (3,232) Av 6.4% pa
Pharmacy	2.3	7.2% (2,023) Av 2.4%pa
Chiropractic	3.2	9.0% (426) Av 2.9%pa
Podiatry	5.4	17.8 (719) Av 5.6%pa
Optometry	4.7	11.3% (536) Av 3.6%pa
Medical Radiation Practice	3.2	10.2% (1,435) Av 3.3%pa
Physiotherapy	5	15.8% (4,046) Av 5%pa
Osteopathy	4.7	18.2% (335) Av 5.7 %pa
Psychology	3.5	10.1 % (3,090) Av 3.3%pa
Chinese Medicine Practitioners	6.0	11.3% (480) Av 3.6% pa

Despite this increase in supply there remain reports of regional shortages for existing positions. 2016 Department of Employment data list there were 3 occupations experiencing skill shortages. All three are

[3] Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW. Section 5.11 Rural and remote health http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129556798 (accessed 23 February 2017)

[4] NHWDS - Allied Health Fact Sheets 2016 https://hwd.health.gov.au/publications.html (accessed 31 July 2019)

[5] NHWDS - Allied Health Fact Sheets 2016 https://hwd.health.gov.au/publications.html (accessed 31 July 2019)

professions of allied health: Audiologist, Optometrist and Sonographer[6]. The 2018 labour market surveys, reported by the Commonwealth Department of Jobs and Small Business, indicate that recruitment of a number of allied health professions remains a challenge, with many allied health professions listed on the national and state specific skills shortage lists.[7] While podiatry and speech pathology reported no shortage, professions reported as 'in shortage' noted specific requirements for a number of the unfilled vacancies. For example

- Relevant and practical work experience, for instance two or more years of experience working in the private sector (June 2018 Physiotherapy NSW report)
- Almost all employers stated that location was a factor in not filling vacancies, with some applicants applying from interstate or overseas (June 2018 Occupational Therapy NT Report)[8]

So while initiatives to increase rural training capacity will be welcomed, the pipeline beyond graduation requires attention. The approach adopted by Queensland Health in the funding and implementation of the allied health rural generalist pathway **is designed to build capacity of local health services**. The intent is to integrate the pathway into normal business to enable workforce and service sustainability. It is strategies such as the AHRG pathway that can redress existing workforce maldistribution and address the well described recruitment and retention challenges.

Question 3.2.a: *What are the factors that would need to be considered to ensure the successful expansion and promotion of the Health Workforce Scholarship Program?*

Recognise the public private mix of work in RRR areas and open eligibility to allied health professionals working in both sectors

Specifically mention funding for the Allied Health Rural Generalist formal programs- while noting the importance of integrating the training into the work role.

Offer some flexibility in the use of funding to address local issues.

Question 3.2.b: *Please describe other policy options, within the Commonwealth's remit, which could achieve the same result in clearly articulating and promoting structured career opportunities.*

Stronger recognition by the Commonwealth of the multi-jurisdictional work and investment over the past six years to develop the Allied Health Rural Generalist Pathway that has a formal post-graduate education as the foundation of training, would be welcome.

Question 3.2.c: *What is an appropriate governance model for rural generalist training which also supports skills extension for existing qualified rural allied health workers?*

The AHRG training was developed to **maintain academic rigour** through delivery by established education providers (universities) with programs structured within the Australian Qualifications Framework (AQF). The award conferred following completion of the AHRG university based program provides a recognised qualification across Australia states and territories. This option was selected as it was recognised that a medical College-style entity to develop and oversight training and assessment of individual allied health professionals would be resource intensive and not sustainable for allied health.

---

[6] The Skilled Labour Market: A pictorial overview of trends and shortages https://docs.employment.gov.au/documents/skilled-labour-market-pictorial-overview-trends-and-shortages [accessed 27 January 2017]

[7] Department of Employment, Skills Small and Family Business June 2018 **Occupational skill shortages information** https://www.employment.gov.au/occupational-skill-shortages-information#health-and-social-assistance-occupations (accessed 31 July .2019)

[8] Department of Employment, Skills Small and Family Business June 2018 **Occupational skill shortages information** https://www.employment.gov.au/occupational-skill-shortages-information#health-and-social-assistance-occupations (accessed 31 July .2019)

Policy Area 4: Sustainable Jobs and Viable Rural Markets

The notion of viable markets for allied health service provision in many remote and rural communities is challenging. The marketised approach underpinning funding models has further disadvantaged many communities.

Question 4.1.a: *What are the factors that would need to be considered to support the development of IAHHs which service regional catchments of Australia?*

Broadly, the factors that would need to be considered to support the development if IAHHs to service 'regional' catchments include the availability of local services, the proximity to nearby services, local community requirements and available workforce and the local population size/demography.

Utilising the infrastructure and capacity of existing RHMT programs would provide an integrated workforce and service hub for students. Expanding the Regional Training Hubs (RTH) developed to provide rurally based training options for medical graduates would then provide a model to develop the rural allied health workforce post entry training and career development. The possibility to develop RTHs in or near any planned IAHH would also warrant exploration.

The use of the term 'regional catchments' perhaps infers the hub would be based in larger regional centres. It would be important to conduct further stakeholder consultation on the size of the communities in which to situate the IAH hubs. Concurrent identification of service models that can effectively operate in differing sized communities to produce acceptable and accessible services for the people in that community is also required. One option to consider is the previous Commonwealth Regional Health Service (RHS) program which focused on communities of 5,000 or less. If this were to be adopted, it would be important to allow consideration for exceptions in terms of distance, context and community need.

Under the RHS program, Elaine Ashworth developed a successful allied health workforce and service model based at Mount Isa to serve the surrounding smaller north western Queensland communities. See Battye et al [9] for an evaluation of this program.

Co-designing any planned IAHH with community members would be important. ACDHS understands that both IAHA and SARRAH have been exploring various models of allied health hubs and would refer to submissions made by both organisations.

McGrail and Humphreys (2009) described four factors to consider in their work on access to primary care

> "…*access to health services is a function of several factors, including appropriate supply (**availability**), reasonable distance/time impedance to available services (**proximity)**, the level and nature of need for those seeking care (**health needs**) and the ability of individuals to access care at a time of need (**mobility**)".* [10]

The authors recommend a suite of measures may be more appropriate than using a single measure to base decisions about rural health programs and resource allocations. From the work of McGrail and Humphreys, factors to consider in the development of Integrated Allied Health Hubs (IAHHs) include

- Appropriate supply (availability)

[9] Battye and Mc Taggart (2003) Development of a model for sustainable delivery of outreach allied health services to remote North-West Queensland, Australia https://www.researchgate.net/publication/7859240_Development_of_a_model_for_sustainable_delivery_of_outreach_allied_health_services_to_remote_North-West_Queensland_Australia

10 Mc Grail and Humphreys 2009 The index of rural Access: an innovative integrated approach for measuring primary care access.

https://www.researchgate.net/publication/26688319_The_index_of_rural_access_An_innovative_integrated_approach_for_measuring_primary_care_access

[accessed 4 August 2019].

- Reasonable distance/time impedance to available services (proximity)
- The level and nature of need for those seeking health care (health needs)
- The ability of individuals to access care at the time of need (mobility)

Available funding streams would then need to be considered to develop both sustainable service and workforce models. Establishing the best funding mechanism to establish *each* IAHH would then be important. It is feasible that each of the three mechanisms listed in the discussion paper may be required depending on the context of the proposed IAHH site. It would be valuable to implement and evaluate each model within common evaluation framework to inform the model and funding of additional IAHHS following the initial roll out.

Question 4.1.b: *Please describe any examples of integrated and collaborative service models that could be scaled up and or adapted under the proposed IAHHs principles in this options paper.*

Question 4.1.c: *How could Government structure funding arrangements to allow the flexibility necessary for regions to manage funding in the way that suits the specific needs of their communities?*

Allied health leadership and governance.
Structure the funding to include allied health leadership positions within IAHHs.
The potential complexity of IAHH service provision across sectors and settings will require allied health leadership and governance. This is critical in an organization with multi-professional allied health teams and should be reflected in both funding and performance indicators.
As noted above in 4.1.a, analysis of available services to ensure existing services are not adversely impacted, would be important.

Allied health leadership and governance was an important foundation of the successful RHS funded North and West Allied Health service developed by Ashworth and colleagues.[11] Reporting to allied health managers and the value of allied health leadership positions are recurring themes in the allied health literature.

Integrated Allied Health Hubs (IAHH) co-design
Consultation and co-design with community members and existing service providers to clearly identify local service gaps should inform any establishment of IAHHs. Identify available funding streams, including service and workforce incentives/enablers and structure funding to meet identified service gaps.

Question 4.1.d: *What kinds of Commonwealth support for allied health assistants could raise the capacity and effectiveness of rural allied health workforce?*

Establishing allied health assistant (AHA) positions in addition to allied health professional (eg speech pathology, podiatry or physiotherapy) positions as part of any IAHH could add value, but will require appropriate allied health staffing and ensuring appropriate allied health clinical governance structures are in place to support the AHA. Allied Health Assistants are not stand alone providers and do not provide a substitute for the expertise and clinical reasoning of the Allied Health professional. AHA's work under delegation of the appropriately qualified allied health professional to provide specified services for which the AHA has been deemed competent.

Allied health assistance courses are available at certificate III and IV level within the VET sector yet many AHA roles to not mandate these qualifications. Also important to note is the hard barrier between VET

[11] Ashworth, Battye and Symons (2004 SARRAH conference paper) Applying the evidence—recruiting and retaining allied health professionals in a remote area https://sarrah.org.au/sites/default/files/docs/applying_the_evidence.pdf

sector qualifications in AHA and entry into the majority, if not all, of the university level programs for the professions of allied health. Anecdotal feedback from assistants who have completed VET sector qualifications suggest that to then add another 4 years of study to existing qualifications is not optimal and in many cases not feasible. Options for articulating qualifications for a pathway from AHA to AHP have and are being explored.

Members would also welcome consideration be given to the inclusion of Aboriginal Health Workers/ Aboriginal Therapy Assistants and would defer to IAHA for advice re appropriate workforce and service models.

Question 4.2.a: *Are there other funding channels that could be leveraged or influenced by the Commonwealth to achieve stable, integrated and coordinated allied health services?*

ACDHS members welcome implementation of options improve access to Commonwealth funding for allied health professionals and patients in MMM 4-7 areas as listed in the discussion paper.

Additional options could include the allocation by the Commonwealth of **block funding via special grants** to state and territories for small rural health services that is quarantined and reportable, to provide allied health services (through employment or contracted services strategies).

Question 4.2.b: *Of the options described above which would be most effective in creating viable rural markets? Please describe the reasons why.*

As allied health service provision in rural, regional and remote communities has long been based on public sector service provision, prioritizing **option 1** to address the unintended consequences of section 19(2) of the HIA in rural areas is an important first step. This would allow the aggregation of state and federally funded work into single-employer rural jobs and provide a solid basis for stable, integrated and coordinated allied health services which are necessary attributes underpinning the creation of a viable rural market. Joint use of available infrastructure, business and HR supports are just a few advantages to be gained.

Then to complement the growing workforce and service capacity gained by the aggregation of state and federally funded work into single employer jobs, the next option to explore is **option 4**. That is, to remove caps on the number of allied health services any one patient within MMM4- 7 can receive for items under MBS items as described above.

Option 3 could be concurrently introduced with Option 4 to compensate for the complexity that increases with rurality of practice

Option 2 should be considered for introduction when there is sufficient local workforce capacity to provide and supervise student placements

Introduce **option 5** when/if there is failed repeated recruitment to the established positions or growing/unmet service need.

Policy Area 5: Telehealth Allied Health Services

A cautionary comment: that telehealth services should not evolve to a replace local service options.

Question 5a: Please describe any existing telehealth models that could be adopted in rural areas to improve the access to and delivery of allied health services.

While noting the above cautionary comment, ACDHS members support and encourage the funding and implementation of all 6 options listed within the remit of the Commonwealth Department of Health. ACDHS notes that a similar cautionary approach was adopted in the MBS review allied health recommendations which specified eligibility of the local service provider defined as having provided two face to face services prior to the implementation of telehealth delivered services. ACDHS, while understanding the underpinning intent, perceived this to be a further barrier to improving service accessibility.

Recognising the challenges in remote, rural and regional service provision, the Allied Health Rural Generalist program specifies telehealth as one of four key service strategies

- Telehealth.
- Delegation to support workers (e.g. allied health assistants).
- Extended scope of practice including skill sharing (trans-professional practice).
- Partnerships across agencies and sectors etc. that use shared care or collaborative practice models for complex or low frequency clinical presentations.

Resources for telehealth education have been developed across a number of jurisdictions. For example, the Allied Health Telehealth Capacity Building Scoping Project is a joint initiative of the Allied Health Professions' Office of Queensland (AHPOQ), Health Service and Clinical Innovation Division, Department of Health and the Cunningham Centre, Darling Downs Hospital and Health Service (DDHHS).[12]

Examples of existing telehealth models that could be adopted in rural areas to improve the access to and delivery of allied health services have been implemented and evaluated within a number of the Queensland Health Allied Health Rural Generalist training positions. ACDHS recommends referring to the work of the Allied Health Professions' Office of Queensland on the Allied Health Rural Generalist Pathway[13] and the evaluations of telehealth enabled services strategies developed by AHRG trainees.

Many examples of telehealth service provision will require funding of two health professionals- both the sender and receiver sites for example to

- connect with allied health professionals in metropolitan areas
    - funding for the RRR site should include options for Allied Health Professional, Aboriginal and Torres Strait Islander Health Practitioners, Allied Health Assistants, Aboriginal Health Workers
- make telehealth services more accessible to people who struggle to use these services such as individuals with communication, cognitive or physical impairments
    - *Example*
      Edith Cowan University (WA) have completed a very small feasibility study (N= 11) with Aboriginal people who have a communication disorder after stroke or TBI. It was completed in the metropolitan area, however half of the participants received services through telehealth in which an Aboriginal Research Assistant attended the session face to face and the Speech Pathologists joined the session through a computer.

[12] Allied Health Telehealth Capacity Building Implementation Plan https://www.health.qld.gov.au/cunninghamcentre/html/telehealth [accessed 2 August 2019]

[13] Allied Health Rural Generalist Pathway https://www.health.qld.gov.au/ahwac/html/rural-remote [accessed 2 August 2019]

The model was seen as acceptable to participants and clinicians involved.
In using telehealth, with allied health services potentially being provided by clinician from a metro or larger regional area, funding models for these services would need to be provided. For example, if a clinician from a hospital in a metro area provided services to an individual in a remote area, funding for this service would need to be provided although structures may/ may not be in place to facilitate this process currently.

Question 5b: *The difficulties in making changes to the MBS are recognised. In relation to Policy Area 5, are there alternative arrangements not involving MBS that could achieve the same outcomes?*

The funding of telehealth service provision within MBS was key discussion point at the MBS allied health review consultation in Melbourne in March 2019. An important enabler in the private sector is to fund dual and concurrent claims for MBS telehealth items.

Alternative funding arrangements are likely to draw upon collaborative arrangements discussed developing viable markets section 4.2 of the discussion paper.

Thank you once again for the opportunity to provide this response on behalf of the Australian Council of Deans of Health Sciences. As a member of the Australian Allied Health Forum (AAHLF), we look forward to discussing the findings at scheduled AAHLF meeting on 2 September 2019.

ACDHS AUSTRALIAN COUNCIL OF DEANS OF HEALTH SCIENCES