Services for Australian Rural and Remote Allied Health

Re: Delivering Quality Care More Efficiently– Interim Report

Date: 2 September 2025

To: Productivity Commission

From: Services for Australian Rural and Remote Allied Health (SARRAH)

Contact: [redacted]

Introduction

SARRAH welcomes the opportunity to respond to the Productivity Commission's interim report on *Delivering Quality Care More Efficiently*.

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors including in disability services, primary and other health settings, aged care, early childhood development and other service systems. SARRAH was established in 1995 as a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

Our members are allied health professionals working in rural and remote communities across Australia, where geography, workforce shortages, and fragmented service systems often limit access to quality care.

Allied health professionals play a critical role in delivering preventative, rehabilitative, and therapeutic services that support independence, participation, and wellbeing. They are integral to service provision in the three focus areas of this report: aged care, NDIS and DVA.

However, the current structure of the care economy presents significant barriers to efficient and integrated service delivery, particularly for small providers operating in fee-for-service environments.

SARRAH supports the Commission's focus on improving productivity through reforms that enhance regulatory alignment, collaborative commissioning, and investment in prevention. We offer the following comments in response to the Draft Recommendations.

Response to Draft Recommendation 1.1: Reform of Quality and Safety Regulation

SARRAH supports the Commission's recommendation to pursue greater alignment in quality and safety regulation across the care economy. Fragmented regulatory frameworks create unnecessary administrative burden, reduce workforce mobility, and limit the capacity of providers to deliver high-quality, integrated care—particularly in rural and remote areas.

SARRAH recognises the potential of the proposed actions to streamline worker screening, registration, provider accreditation, and reporting. However, we urge the Commission to ensure that these reforms explicitly include all allied health professionals (not just those regulated under the National Registration and Accreditation Scheme (Ahpra)) as well as allied health assistants.

Key Considerations:

- Inclusion of self-regulated professions: Many allied health professions—such as speech pathology, dietetics, social work, and exercise physiology—are self-regulated and currently excluded from national registration schemes. These professions are essential to rural and remote service delivery across aged care, NDIS and DVA service settings, and must be included in any unified registration or screening framework.
- Recognition of allied health assistants and delegation models: SARRAH supports the creation of a distinct ANZSCO classification for Allied Health Assistants and the development of a national framework that reflects the delegation model between AHPs and AHAs. This model is critical to safe and efficient care delivery in rural and remote settings.
- Support for small providers: Many rural allied health providers are small businesses or sole practitioners. Regulatory reforms must be designed to reduce compliance burden and support participation in quality improvement, rather than creating new barriers to entry or expansion.
- Cross-sector alignment: Allied health professionals often work across multiple sectors—aged care, disability, health, and education—and are subject to different standards and reporting requirements. SARRAH recognises the proposal to streamline regulatory changes across aged care, NDIS, and DVA. Still, a unified approach to quality and safety regulation must be able to accommodate (at a minimum) or expand to include additional requirements of other sectors.

Response to Draft Recommendation 2.1: Embed Collaborative Commissioning

SARRAH supports the Commission's recommendation to embed collaborative commissioning as a mechanism to reduce fragmentation and improve care outcomes. Rural and remote communities often experience significant service gaps, and collaborative, place-based approaches are essential to ensuring that care is responsive, integrated, and culturally appropriate.

Allied health professionals are central to multidisciplinary care and prevention, yet they are frequently excluded from commissioning processes and governance structures. Embedding collaborative commissioning must include mechanisms to ensure allied health representation in planning, decision-making, and funding allocation.

Key Considerations:

- **Inclusion of and enabling allied health in governance and planning:** Collaborative commissioning arrangements between Local Hospital Networks (LHNs), Primary Health Networks (PHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs) must explicitly include allied health providers and peak bodies. This is particularly important in rural and remote areas where allied health services are often delivered by small organisations or sole practitioners.
- **Support for flexible, locally tailored models:** Allied health services are diverse and often delivered outside traditional hospital or medical settings. Collaborative commissioning must support flexible models that reflect local needs, including outreach, telehealth, and community-based care. Flexible models should consider the **scope of practice** required to provide evidence-based services, and not be limited to nominated specific professions.
- **Funding mechanisms that enable participation:** Many allied health providers operate in fee-for-service environments and lack the resources to engage in unfunded planning or commissioning activities. Dedicated funding should be made available to support the participation of allied health professionals in joint governance, needs assessments, and service design.
- **Recognition of allied health in prevention and early intervention:** Allied health professionals play a critical role in preventing hospitalisations and supporting recovery. Collaborative commissioning should prioritise initiatives that integrate allied health into chronic disease management, rehabilitation, and community-based care pathways.
- **Alignment with Closing the Gap priorities**: SARRAH supports the Commission's commitment to embedding the principles of the National Agreement on Closing the Gap and partnering with Aboriginal Community Controlled Health Organisations (ACCHOs). However, we urge that this approach be broadened to include other community-controlled organisations delivering care services—such as those focused on disability support, aged care, and veterans' services—as well as community-controlled peak bodies including Indigenous Allied Health Australia and the Aboriginal and Torres Strait Islander Veterans and Services Association

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Response to Draft Recommendation 3.1: Establish a National Prevention Investment Framework

SARRAH supports the Commission's recommendation to establish a National Prevention Investment Framework. Prevention is a cornerstone of sustainable, high-quality care, and allied health professionals are uniquely positioned to deliver health

promotion, prevention and early intervention services that reduce demand for acute and high-cost care. Furthermore, the role of allied health professionals in rehabilitation is essential to minimise repeat admissions or episodes of care.

In rural and remote communities, where access to hospital-based services is limited, allied health-led prevention is not only cost-effective—it is essential. However, current funding models and policy settings often fail to recognise or support the preventive role of allied health, particularly outside traditional health settings.

Key Considerations:

- **Recognition of allied health in prevention:** Allied health professionals—including physiotherapists, occupational therapists, dietitians, speech pathologists, psychologists, and others—already deliver evidence-based interventions that prevent and manage chronic disease, prevent deterioration, support recovery and self-management, and improve functional outcomes. The Investment Framework must explicitly recognise the role of allied health in prevention across health, disability, aged care, and veterans' services and provide mechanisms for enabling these programs.
- **Support for co-designed community-based solutions:** Prevention is most effective when delivered close to where people live. In rural and remote areas, solutions and program delivery should be codesigned with flexible modes of delivery, including outreach, telehealth, and community-based, being determined by the community based on appetite and internal capacity. The Framework should support co-design processes and consequently flexible service models that reflect local needs and workforce availability.
- **Investment in workforce development**: Effective prevention requires a skilled and sustainable workforce. The Framework should support investment in local workforce models that reflect the scope of preventive activities, including allied health professionals, assistants, peer workers, and Aboriginal health workers. This is particularly critical in rural and remote areas, where workforce shortages and service gaps persist 1. Investment should include training, supervision, and employment pathways to build capacity within communities.
- **Cross-sectoral and long-term funding:** Prevention programs often deliver benefits across multiple sectors and over extended timeframes. The Framework should enable co-funding arrangements that reflect shared benefits and provide long-term investment to support continuity and impact.
- **Inclusion of community-controlled organisations:** Embedding equity and inclusion in the Framework is essential. Aboriginal and Torres Strait Islander community-controlled organisations, Indigenous health professionals, community leaders and organisations must be enabled to continue delivering culturally safe prevention programs.

Conclusion

SARRAH appreciates the Commission's comprehensive analysis and commitment to reform. We welcome further engagement and would be pleased to contribute to implementation planning and stakeholder collaboration.

If you would like to discuss issues raised in SARRAHs response or require further information, please contact [redacted]