Services for Australian Rural and Remote Allied Health Inc

Submission in response to

The Health Workforce

Productivity Commission Issues Paper

July 2005

Services for Australian Rural and Remote Allied Health Inc (SARRAH) welcomes the decision by the Council of Australian Governments (CoAG) to commission an examination of health workforce issues over the next ten years, and the consideration being given specifically to:

- factors affecting the supply of, and demand for, health professionals;
- the current structure and distribution of the health workforce and its efficiency and effectiveness;
- the efficacy of health workforce planning and its linkages to health services planning and the education sector;
- workforce-related policy measures that would help to ensure efficient and effective delivery of quality health services in an environment of demographic change, technological advances and rising health costs; and
- the particular health workforce needs of people in rural, remote and outer metropolitan areas, and of Indigenous Australians.

SARRAH is recognised at national and at State/Territory level as a peak body representing the interests of rural and remote allied health professionals. Its membership comprises individuals from a range of professions under the 'allied health' umbrella[*i] who have an interest in the delivery of allied health services in rural and remote communities. SARRAH has a particular interest and experience in the value of a multidisciplinary health workforce, the benchmarking of services for rural and remote communities, and funding frameworks that support adequate benchmarks and integration of services. SARRAH has successfully provided a common voice for the rural and remote allied health workforce in dialogue with the Department of Health and Ageing, and in a number of jurisdictional rural workforce forums (see attachment 1),

SARRAH takes the view that equitable levels of health care are a right of citizenship irrespective of place of residence. We recognise that the federation supports this notion in principle through the Commonwealth and State roles in health care across the nation. We are concerned that a number of features in the current health service funding processes between the Australian and State Governments fail to provide: adequate levels of all health workforce, and efficient integration between services. Without going into detail, from the rural and remote allied workforce perspective, these concerns currently involve: the integration of primary, secondary, tertiary health care, rehabilitation, and the support of disabled (physically, intellectually or mentally) and socially dysfunctional residents; the integration of Commonwealth and State subsidy of health and disability services some of which currently lies in the provinces

---

[*] *By undertaking the straightforward, pragmatic process described in the SARRAH discussion document the following health professions will be considered as clinical and diagnostic allied health professionals: audiology, clinical psychology, dietetics, hospital pharmacy, occupational therapy, optometry, orthoptics, orthotics and prosthetics, physiotherapy, podiatry, radiography, social work and speech pathology[*].*

Health professionals must meet the following criteria in order to be part of the clinical and diagnostic allied health professional workforce:

- *Health Professionals involved in direct client contact providing direct treatment, intervention or assistance, assessment, patient management and education, working in both primary and secondary care;*
- *Health Professionals who are tertiary trained doing recognised university degrees*
- *Health Professionals who are required to obtain specific qualifications to either obtain State or Territory registration; license or accreditation to practice; or to join a professional association;*
- *Health Professionals who work directly with each other and the medical and nursing professions as part of a multidisciplinary team to achieve best practice outcomes for the client*
- *Health Professionals who actively participate as members of a multidisciplinary Primary Health Care Team*
- *Health Professionals who have chosen to come together to form a collaborative position to work towards a specific policy / goal*
- *Health Professionals who are **eligible** to provide services directly to the public sector*

of education and family departments rather than health specifically; and the integration of cross border services which includes registration of professionals.

While these concerns will be outstanding, additional questions need to be asked in relation to problems with current and future workforce and the responses considered when designing solutions to address the issues:

1) What are the dimensions of the Australian health workforce over the next 30 years, given the current population growth and fertility rate?
    i. Who are our workforce competitors outside the health sector?
    ii. How can we compete with the attractiveness of those occupations above health?
    iii. How can we become net exporters of healthcare?
    iv. What are the options for increasing Full time equivalents rather than decreasing?
2) What are the dimensions of the Australian population over the next 30 years?
    i. Where will they live, by age;
    ii. How many will be traveling around rural and remote Australia;
    iii. How many will be self funded retirees;
    iv. What are the expected changes in proportions of services e.g. midwifery and child health compared to geriatric?
3) What are the economic dimensions of Australia over the next 30 years?
    i. At current usage what are the health costs of the population?
    ii. At improved rural and remote equities what are the health costs?
    iii. What are the potential health costs of the domestic traveling population?
    iv. What are the expected changes in taxation revenue?
    v. What are the contingency options for economic 'blow outs' in health care i.e. poorer government surplus to fund the increasing product cost (demand – supply curve blowout), who is going to loose funding and why – rural health, research, primary health care, tertiary health care?

Issues

The allied health workforce

Many of the matters encompassed by the terms of reference have already been intensively analysed by governments and professional organisations. Over recent years, numerous reviews and studies have detailed a range of concerns about, and possible solutions to, various aspects of workforce arrangements. In response, there has been a variety of initiatives, from governments, and from professional, regulatory, educational and service delivery entities. However, SARRAH would argue that the emphasis has been placed on the medical profession and more recently issues relating to nursing. There has been minimal work done at either the national or state level with regards to the allied health workforce.

In a discussion paper produced by SARRAH in 2004, a classification system for 'allied health' has been proposed. SARRAH believes that much of the issues in relation to the lack of direction in workforce analysis and planning for the allied health workforce relates to the lack of clarity surrounding the use of the term, the multiple professions included (allied health = health professionals who are not a doctor or a nurse) and the complex nature of attempting to collect data and plan for such a complex and disparate group.

The impact of allied health services on health and wellbeing.

Allied health professionals play a highly significant role in health service delivery and in health outcomes. As primary care practitioners, they assist the management of the range of chronic and complex health conditions. As rehabilitation and mental health

practitioners they assist people with disability with the restoration of normal function, adaptation to permanent disability, and optimisation of quality of life. The client of an allied health professional is likely to include a carer, the whole family, and wider social processes.

Due to the broad nature of the work of allied health professionals they are able to play a vital role in health promotion, injury prevention and maintaining community well being. The skills of allied health professionals are valuable in the work to minimise complications of chronic conditions such as diabetes, cardiovascular disease, stroke, respiratory disease, arthritis, and mental health conditions.

As the Australian population ages, the demand on allied health services will increase, It is essential that government policy in health and in the education sector in preparing for health service demand in the future, take a proactive view in dealing with issues relating to the allied health workforce and the demand for allied health services in the future.

Comments on some allied health skill shortages

The Department of Employment and Workplace Relations (DEWR) in 2005 identifies the shortages of allied health professionals (in particular, dentists, pharmacists (hospital/retail), occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists and sonographers) in Australia. However, these figures do not give the breakdown for shortages in the rural and remote regions. For example: It has recently come to the attention of the press in Tasmania that Tasmanian budget estimates show a 17% vacancy rate for allied health professionals in the public sector in Tasmania. Recruitment and retention of allied health professionals in Tasmania and the Northern Territory is made more difficult because of the lack of education training facilities in the majority of the clinical health professions concerned. Lack of attention by state governments past and present in Tasmania have done nothing to address these issues in terms of scholarship or bursary assistance for Tasmanian undergraduates to move to the mainland to undertake the necessary undergraduate degree. Award structures do not reflect the shortage, the difficulty in recruiting or retaining, or give the necessary career pathway reflecting increasing experience and skills in the specific discipline.

It must be noted that whilst the Health Workforce issues paper identifies (Box2) that AHWAC's future work includes an analysis of the allied health workforce, this work has not yet been done and there is no clear indication of when this 'future work' is going to happen. However, shortages in the allied health workforce are impacting now. The lack of information that will be provided by the analysis must not be allowed to impact on how the review is conducted and its outcomes. Allied health make a significant contribution to health and well being and have an essential role to play in the delivery of health services now and in the future. There has been no consistent, national effort to address issues of allied health education and training, recruitment and retention, workforce policy and planning in the past. This must not be allowed to continue into the future. An ageing population is only going to increase the demand for allied health services.

There has been no recognition of these shortages across the allied health professions or commitment to address them through the provision of increased training places in hospitals and measures to boost clinical training places in hospitals. There is minimal recognition and support provided to allied health professionals who take on a role in the supervision of clinical placements, particularly in rural and remote areas. It is essential in order to improve recruitment and retention in rural and remote Australia, that students undertaking allied health undergraduate and entry level training are enabled and supported to undertake quality clinical placements, as

with undergraduate medical students. Supervisors and students need clear direction as to the expected outcomes of the clinical placement, have contact with the university from which the student is placed. Supervisors need to be supported by the line management to undertake the role as student supervisor with recognition in terms of impact on normal workload, remuneration and support and backfill to be able to undertake professional development applicable to student supervision.

'Mal-distribution' of health workers

Allied health services are a fundamental basic health service. There are also some within the allied health workforce who develop recognised specialist skills in particular areas – e.g. musculoskeletal conditions, paediatrics, neurology and rehabilitation, gerontology, women's health, men's health, sports, seating, splinting etc. Allied health professionals, at the basic level, deal in some way with all mild to severe physical and mental health problems, prevention and promotion, screening, and those with permanent disability in the community. Communities need access on their doorsteps (often quite literally) for the service to be effective. Intervention by allied health professionals is often not a single, one off occurrence but will require a number of follow up sessions for treatment, reassessment, monitoring of progress and enabling changes in programs.

A review undertaken by SARRAH in 2003-2004 of data provided by the Australian Bureau of Statistics Census 2001[ii], with all the issues of reliability of census data, particularly for small data cells, clearly indicates that the level of access for populations in rural and remote communities according to the Australian Standard Geographic Classification Remoteness Structure, reduces significantly the more remote the region across the range of core clinical allied health disciplines.

Allied health professionals by state / territory ASGC Remoteness Classification regions

State/ Territory	**Number of Allied Health Professionals**					
	Total number	**Major capital**	**Inner regional**	**Outer regional**	**Remote**	**Very Remote**
New South Wales	16,869	13,302	2925	612	27	3
Victoria	14,223	11,450	2,267	500	6	0
Queensland	8,404	5,573	1,627	1,091	80	33
South Australia	4,579	3,874	326	296	72	11
Western Australia	5,592	4,610	422	331	169	60
Tasmania	1,193	0	903	281	9	0
Northern Territory	443	0	0	285	118	40
ACT	1,024	1021	3	0	0	0
Total:	**52,327**	**39,830 (76% of total)**	**8,473 (16.2% of total)**	**3,396 (6.5% of total)**	**481 (1% of total)**	**147 (0.3% of total)**

Difference in ratio between population and allied health workforce by metropolitan and rural and remote regions across the states and territories

State / Territory	% of major capital population	% of allied health workforce in major capital region	% of rural and remote population	% of allied health workforce in rural and remote regions
NSW	71	79	29	21
Victoria	73.6	80.5	26.4	19.5
Queensland	52	66.3	48	33.7
South Australia	72	84.5	28	15.5
Western Australia	70	82.5	30	17.5
Tasmania	-	-	100	100
Northern territory	-	-	100	100
ACT	100	100	0	0

Allied Health Professionals per 10,000 head of population by State / Territory across the 5 ASGC Remoteness Classification regions

Allied Health Professions	Average across the regions	Major Capital	Inner Regional	Outer Regional	Remote	Very Remote*
New South Wales	15.0	29.3	22.4	12.8	7	3.6
Victoria	17.4	33.5	23.4	20	10.3	0
Queensland	15.4	29.4	17.5	16.4	8	5.5
South Australia	18.9	36.9	18.1	17	16	6.6
Western Australia	20.0	35.7	19.4	18.6	17	9.3
Tasmania	14.9	0	31	18	10.5	0
Northern Territory	19.6	0	0	26	25.3	7.6
Australian Capital Territory	36.4	32.8	40	0	0	0
Average	**18.8**	**32.9**	**24.5**	**18.4**	**13.4**	**4.7**

Number and percentage of allied health professionals by ASCG Remoteness Classification regions

Allied Health Profession	Number (% of total)	Major Capital (% of number)	Inner Regional	Outer Regional	Remote	Very Remote
Audiology	**797 (1.5)**	639 (79)	127	25	6	0
Dietetics	**1996 (3.8)**	1508 (75.6)	302	153	21	12
Hospital pharmacy	**1713 (3.3)**	1367 (79.8)	241	96	6	3
Medical Imaging	**8322 (15.9)**	6321 (76)	1409	507	69	16
Occupational therapy	**5339 (10.2)**	3989 (74.7)	900	374	47	29
Orthoptics	**434 (0.8)**	382 (88)	46	6	0	0
Orthotics/ prosthetics	**356 (0.7)**	288 (80.9)	56	12	0	0
Physiotherapy	**10249(19.6)**	7679 (74.9)	1693	720	125	32
Podiatry	**1750 (3.3)**	1323 (75.6)	305	107	15	0
Psychology	**9318 (17.8)**	7406 (79.5)	1342	489	64	17
Social work	**9108 (17.4)**	6823 (74.9)	1499	674	86	26
Speech Pathology	**3006 (5.7)**	2166 (72)	553	233	42	12
Total:	**52388**	**39891**	**8473**	**3396**	**481**	**147**

Number of allied health professionals by profession across the ASGS Remoteness structure regions by 10,000 head of population in region.

Allied Health Profession	Average	Major Capital	Inner Regional	Outer Regional	Remote	Very Remote
Audiology	**0.42**	0.51	0.33	0.12	0.18	0.00
Dietetics	**1.05**	1.21	0.78	0.76	0.61	0.59
Hospital pharmacy	**0.90**	1.09	0.62	0.48	0.18	0.15
Medical Imaging	**4.39**	5.05	3.62	2.52	2.02	0.78
Occupational therapy	**2.82**	3.19	2.31	1.86	1.37	1.42
Orthoptics	**0.23**	0.31	0.12	0.03	0.00	0.00
Orthotics/ prosthetics	**0.19**	0.23	0.14	0.06	0.00	0.00
Physiotherapy	**5.41**	6.14	4.35	3.58	3.65	1.57
Podiatry	**0.92**	1.06	0.78	0.53	0.44	0.00
Psychology	**4.91**	5.92	3.44	2.43	1.87	0.83
Social work	**4.80**	5.45	3.85	3.36	2.51	1.27
Speech Pathology	**1.59**	1.73	1.42	1.16	1.23	0.59
Average:	**2.30**	**2.66**	**1.81**	**1.41**	**1.17**	**0.60**

Whilst projections have been made for the delivery of medical practitioner services to rural and remote and particularly to supply adequate Indigenous Health services (Issues paper page 18), what projections have been made for future requirements for allied health services?

It is recommended that work be immediately undertaken to develop a benchmark for the individual allied health skills sets (professions) for full time equivalent positions per profession by population, which takes into account the time taken to access service, or deliver the service (i.e. distances to be covered)

Issues arising from a changing role for the public and private hospital Sectors

Under the Enhanced Primary Care MBS funding items for people with chronic and complex care needs (now changed to chronic disease items), the general practitioner is required to have two other health professionals participate in care planning in order to access the relevant MBS item. MedicarePlus allied health initiative relies on delivery of service by private practitioner allied health professionals for the patient to be able to access the service. This is a disadvantage in rural and remote communities, where with increasing remoteness there is an increasing reliance on the public sector for allied health services. In regions where there is limited access to services provided by private practitioners, general practitioners and patients cannot access funding provided under the MedicarePlus items. It is also recognised that 5 allied health services for someone with a chronic and complex condition is not adequate. Follow up treatment or progress assessment will depend on the patient being able to pay for the service.

People who not eligible to access allied health services under funding provided by EPC or More Allied Health Services must either have private health insurance ancillary cover, be able to pay the service charge or be dependent on an often overstretched public sector.

Experience suggests that the goal of MAHS is admirable but the implementation has been very ad hoc, with lack of clear determination of a definition for the allied health

services to be funded under the program, lack of infrastructure support, lack of consultation with stakeholders at national and divisional level, duplication of services named as some of the issues. SARRAH members report examples such as: a district where MAHS funded a Falls Prevention resource development, all of which was freely available from a variety of sources and the focus of a major Queensland Health project at the time. Consultation with the in situ Queensland health employees would have avoided the duplication and allowed MAHS to be spent on something else For example taking resources already developed by Queensland Health and working in the community with them resulting in less duplication of effort and more effective community service. Increased coordination with in situ allied health professionals should be part of reviewing if a MAHS project goes ahead. There is still a potential problem with MAHS creating anti-competitive environments and no barriers to Divisions of General Practice supporting some private practitioners but not others.

Appropriate health workforce skills mix

SARRAH recommends the need for:

- Increased shared education sessions for common subjects across all the health professional workforce, including medical, nursing and allied health disciplines
- Interdisciplinary and multidisciplinary education for training in working in multidisciplinary teams and gaining knowledge of other members of the health workforce roles and scope of practice
- Recognition that the skills required to work in a small rural or remote context are different to those required for a metropolitan centre with requirements for multidisciplinary team practice, management of a service and a broader more generalist range of skills in relation to the specific discipline (the same is true for allied health as it is for general practice. Professionals working in these areas need to have access to postgraduate professional education packages developed specifically in relation to the skills required to work in a rural or remote community.
- Culturally appropriate training, including working with interpreters for health professionals working in Indigenous communities
- The health workforce is required to be prepared to be flexible and responsive in the delivery of health services to meet the needs of different communities and different settings. However, any changes in order to address these needs need to be supported by line management, and in terms policy and financial support.
- Consideration needs to be given when developing policy in relation to health workforce and service delivery of the impact in rural and remote Australia. What may be appropriate in a metropolitan or large urban town may have a negative impact if implemented in a rural or remote community.

Productivity, quality and job satisfaction problems

- *"It has been suggested that, notwithstanding regional differences in health care needs, variations in servicing levels across Australia point to scope for better use of the available workforce. In other words, 'more health' could be obtained with a redistribution of existing resources.*
- *More specifically, widespread rigidities in job descriptions and allowable duties – often underpinned by regulatory, industrial and funding arrangements – reduce the scope to substitute or reallocate staff and detract from productivity." (Productivity Commission Health Workforce Issues paper, p 20)*

What does this mean to the health professionals who are delivering services? What does it mean to the way in which these same health professionals will be required to deliver health services in the future? What are the implications for patient care and

health outcomes? Is substitution or reallocation of staff an economic term, a justification to fill vacancies without consideration of the impact on patient care, health outcomes and on the health professionals concerned? Is the ability to be substituted or reallocated going to add to job satisfaction for a health professional trained with a particular skill set (e.g. discipline)? Do allied health professionals become some sort of assessors and educators, trying to pass on all care to assistants, carers and volunteers? Can this be done? Care must be taken in the use of the work substitute or reallocate staff. It is essential to ensure that staff are properly skilled and trained in order to undertake whatever role they are appointed to, and that the resultant health outcomes for the consumers of the service are not compromised by a substitute who can 'do a bit of physiotherapy, occupational therapy and speech pathology' and can take the place of three fully qualified professionals.

More appropriate would be for policy makers, workforce planners, health service providers, the professional organisations, lobby groups, and the health workforce itself to embark on a period of cultural change. Flexibility is required, best practice in health service delivery is required, consumer access to the range of services is required. The look of the health workforce may well need to change – the development of new professions, expanding the scope of practice of existing professions – but must be done in terms of change management and consultation not imposed on the health workforce. Policy, planning and funding, education providers, employing bodies, the government and non-government sector, professional associations and health professionals must all be aligned to enable and support any necessary change

Funding

How can rural communities improve their economic viability for attracting a range of services?

How can policy and State / Commonwealth health agreements overcome poor economies of scale in rural communities in providing an adequate range of services?

If the answer to this is for everyone to tighten the belt then this will be still more onerous on an already stagnating rural sector. Public sector funding needs to be provided to address the needs of the community, not just the demands of the community. It is well known that communities are vocal in their demands for acute care health services, particularly medical services and increasingly so for nursing. Whilst the outcomes of allied health services on consumer health and well being is becoming increasingly recognised and documented, the need for these services impact more at the primary, community, rehabilitation level – for the majority of the allied health professions people do not die as a result of lack of access (excluding those in mental health services and radiation therapy) whilst their quality of life may be poorer and burden of disease may be higher, the community is less likely to express high demand.

Allied health professionals play a substantial role in health promotion, particularly of the chronic diseases. Investment in allied health services for health promotion activities in view of the ageing population to reduce the burden of disease in the future is clearly indicated.

Another source of tension in the formulation of health policy in general, and workforce policy in particular, is the potential for long term requirements to be subjugated to short term imperatives. Projects, grants, pilots – terms well known to the health workforce – are by nature short term. Lessons learnt, recommendations, outcomes get written up in reports that then get left gathering dust on shelves in various sections of various departments of health. Services provided to communities through the course of the pilot or projects are ceased when the pilot or project

reaches its 'conclusion'. The information contained in the reports and the experiences gained by project / pilot staff are not collated, disseminated, reviewed, further explored, continued or rolled out further as it should be.

Fragmented roles and responsibilities and regulatory arrangements

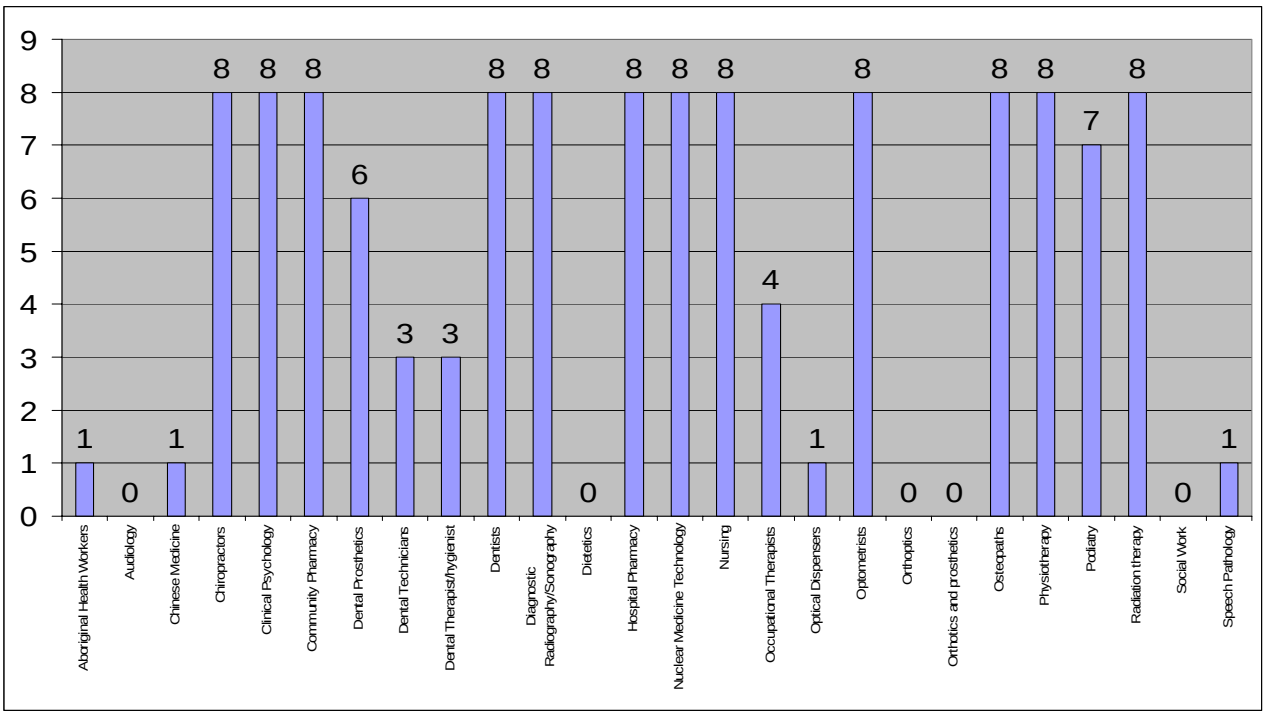
Regulation for the allied health workforce (referring to those health professionals other then medical and nursing who have direct contact with consumers of health services and make a direct impact on health outcomes and consumer well being). For allied health professionals required to provide services across state borders – e.g. NSW/Vic; NT/SA – there is a requirement to be registered in each state, placing an additional financial burden on the health practitioner.

Adams, O'Kane and Lowe in their discussion paper, Clinical allied health professionals – a method of classification[i], found that there is a varying degree of requirements for registration across the allied health workforce:

"More than eighty legislative instruments regulate around a dozen health professions across the states and territories. NSW, Victoria, South Australia and Tasmania have reviewed each piece of health practitioner legislation individually. Queensland, Western Australia, the ACT and the NT each conducted an omnibus review of most or all of their health practitioner legislation:

- *Chiropractors, Physiotherapists, Psychologists, Pharmacists, Radiographers, Optometrists are all required to be registered or have a state issued license to practice*
- *For Occupational Therapists, Social Workers and Speech Pathologists, professionals are required to obtain specific qualification to be members of their respective Professional Associations in order to practice in some or all states.*
- *Audiology, Dietetics, Orthoptics, Orthotics and Prosthetics and Social Work have no requirements to be registered in any state or territory."*

Health Professions requiring registration – maximum is 8 i.e. requiring registration in all states and the territories.



Lack of consistent national data relating to the allied health workforce

Workforce reviews by AMWAC, AHWAC and others attempt to take longer term pressures into account – however it should be noted that AHWAC has only just commenced to produce documentation on the allied health workforce, that this document has yet to be considered by AHMAC and that, whilst the gaps in allied health information and data and other issues have been identified there has not yet been a comprehensive national workforce review of the allied health workforce. The state jurisdictions have done some review of public sector but are not consistent in the professions under review or the data collected.

Data limitations serve to further constrain the usefulness of planning efforts – this is particularly the case for the allied health workforce. There is minimal good quality data available giving comprehensive information about the workforce across public and private sector which has had significant impact on workforce planning for the allied health workforce sector.

Generalist versus specialist

SARRAH in supporting the work of rural and remote allied health professionals recommends that the wider health sector recognises the nature of the work undertaken in these regions. The health professionals work across primary health, secondary health and tertiary care. They can be working in the community, in a community health centre or regional hospital or a mixture of all three. The nature of the work is generalist in nature, but often they are called on to deliver more specialist skills – for example in the area of paediatrics, neurology, musculoskeltal injuries, mental health. The requirements often require a skill mix in the delivery of a clinical service together with the management of a practice. The support and education and training they require has to be seen to be different and more complex then those of professional peers working within the metropolitan setting. The delivery of health care services requires a mix of skills. It is strongly recommended that rural and remote practice be identified as specialties in their own right and that support, career, employment, management, funding and education structures are implemented to support the specialist rural practitioner and the specialist remote practitioner.

Insufficient coordination between governments, planners, educators and service providers

There is:

1. Minimal consultation with those that deliver services with regards to the health service planning. It is also an issue when consultation occurs that issues raised and addressed may be appropriate for a metropolitan / urban region but have questionable or negative impact when implemented in a rural or remote region.
2. Relationship between service delivery and education and training is minimal evidenced by the lack of interprofessional education and training at undergraduate and postgraduate stage versus the drive to work in multidisciplinary teams coordinated / led / assessed as needed by the general practitioner (MedicarePlus Chronic Disease items, Enhanced Primary Care, More Allied Health Services)
3. Lack of coordination and communication between those educating the health professional workforce and those who employ, purchase or otherwise provide the service. Emphasis continues to be on medical workforce supply and demand, with increasing focus on nursing workforce supply and demand. Minimal recognition of the issues surrounding allied health workforce supply and demand currently by governments at all levels, planners and educators. The need to ensure that health professionals being trained at entry level have proficiency and

efficiency in the skill set required to meet the need of the population group being provided the service. Recognition that for rural and remote communities all communities are different and for the health professionals working in the area, ongoing professional development, training and support may be required – flexibility of workforce, but not talking workforce substitution.

4. Recognition of the requirements to provide clinical education for allied health professionals during undergraduate or entry level training – places to undertake clinical placement, clear outcomes and goals for clinical education, support for supervisors.
5. A coordinated, consultative approach to explore flexibility of workforce skills sets to enable the development of new health professional skill sets and expanded scope of practice for existing professions – in order to produce best outcomes for health and well being, not to be used for substitution.
6. A "siloing" approach to workforce planning, education, service delivery and funding despite much talk about the requirements for coordination, collaboration, multidisciplinary team. Planning continues to be focused on a profession by profession approach.

Recommendations:

1. A national overarching vehicle for workforce planning and change

SARRAH strongly recommends that planning processes need to be improved – across whole of workforce and crossing the Federal / State divide. In order for future workforce planning to meet the needs of the community and to enable a responsive adaptation to changing needs, SARRAH believes that there must be an overarching national vehicle for driving comprehensive workforce change, across the range of health professional service providers. There has been minimal planning for future allied health needs. Points raised in the issues paper regarding planning are largely based on findings relating to the medical workforce – as stated in the paper, planning reviews are largely conducted on a profession by profession basis. There is a 'silo' approach to workforce from education and training, recruitment and retention, planning, management and support. Until there is national coordination and collaboration across jurisdictions, between sections in Departments of Health, across the public and private sector and between professions, workforce planning will continue to be piecemeal and compartmentalized.

2. Definition of allied health

A nationally recognized and adopted definition of allied health needs to be developed and utilised in order to be able to target the collection of workforce data, workforce planning, policy, programs and funding. SARRAH recommends the adoption of a series of classifications within the broader 'allied health' workforce as per the Classification of clinical allied health discussion paper developed by Adams, O'Kane and Lowe in 2004. Here allied health is defined into a series of classifications according to scope of practice and education and training requirements:

a. Clinical health professionals – minimum of university undergraduate qualification and have direct contact with consumers of health services and make a direct impact on consumer health and well being

b. Oral health – provide a clinical service focusing on oral health, includes dentists, dental nurses, oral hygienists, dental therapists, dental prosthetics etc

c. Vocationally trained health professionals – work in both clinical and non-clinical roles receiving training in the VET sector – including allied health therapy assistants, Indigenous Health Workers

d. Non-clinical health professions – work with the clinical health professionals including members of the medical and nursing professions to support the delivery of health services – including medical record, hospital librarians, epidemiologists, physicists, biomedical engineers etc

e. Administration – involved in hospital and health service administration

f. Complementary or alternative health professionals

3. National regulation of all disciplines under the allied health umbrella

The development of a consistent national system of regulation for the allied health professions having direct contact and impact on consumers of health services

4. Flexible workforce

- Care needs to be taken in the development of generic health qualifications – need to recognise the professional high level skills provided by each of the health disciplines. Whilst there is some merit in seeking to develop generic health modules in education and training and generic skill sets at the lower end of the health professional scale, care needs to be taken that generic health professionals are not seen as substitutes for the range of health professionals that are required to produce best health outcomes in a range of areas – rehabilitation, disability. Developments of new professions, generic skills must not be allowed to compromise consumer health outcomes, wellbeing or detract from the requirements to provide ongoing professional development, support and career pathways for the health professionals involved.

- A number of states working on the development of and training for allied health therapy assistants. There is a need for a national, consistent approach to the education, training, professional support, career pathway for allied health therapy assistants. Care needs to be taken that models implemented are appropriate for rural and remote regions as well as metropolitan hospitals and clinics.

5. Funding of allied health services in rural and remote communities

SARRAH agrees that the division of funding responsibility across levels of government and between the public and private sectors directly affect the manner in which allied health services are delivered. SARRAH recommends that consideration be given in the development and implementation of programs to ensure that there is a positive impact in rural and remote communities including:

a. Enhancement or expansion of existing services
b. Provision of services not previously available in the community
c. Avoidance of duplication of services under different funding resulting in the withdrawal of or reduced effort to recruit to existing services
d. Equity of access
e. Flexibility of service implementation

For example:

- The restriction of funding to Divisions of General Practice under the More Allied Health Services Program (RRMA 4-7), does not take into account rural and remote regions where allied health services are in critical shortage – e.g.

Launceston (RRMA 2) – allied health professionals (other then psychology and social work) are not trained in Tasmania. The state does not have home based professionals to employ but is required to recruit from the mainland. There is shortages across all professions

- MedicarePlus allied health items – only available to allied health professionals working within the private sector. Rural and remote communities become increasingly dependent on services provided by allied health professionals working within the public sector with increasing rurality. Many consumers and GP's in these small rural and remote regions would be unable to access these items due to lack of access to the appropriate allied health professional mix in the private sector.

6. Consultation with all stakeholders in service delivery

SARRAH recommends that health workforce planning; education and funding must be undertaken in a manner which recognises that the best health outcome for the consumer is the ultimate goal. The approach must be consultative and collaborative and involve all stakeholders, without enabling the dominance of the strong interest groups.

Recognition that all stakeholders are working towards a common goal – that of improved health and well being of the Australian community – and that all stakeholders need to work together in coordinated, collaborative fashion in order to achieve this outcome and to address the issues relating to health workforce.

In order to implement any change in workforce, professional skill sets, flexibility of practice it will be critical to have all stakeholders involved in consultation and development or change will be resisted. It is also critical that impact of any change on services in rural and remote communities is taken into account at this consultation phase – what works in a metropolitan environment may have negative impact in a remote community.

7. Evaluation of current and future allied health initiatives

A range of initiatives to increase access to allied health services have been implemented at a national level. It is essential that these initiatives are evaluated as to their effectiveness and impact on health outcomes. It must also be recognised that where chronic and complex diseases are the target, a program that has been in operation for a short period of time (MAHS, EPC) is not going to make significant impact on health outcomes at this stage and needs to be continued in order to do longitudinal studies

8. Full implementation of existing health workforce frameworks

SARRAH strongly endorses the finding:

> *"The most fundamental requirement for achieving better workforce outcomes seems clear. It is to create incentives and supporting institutional, funding and regulatory arrangements that encourage all parties to work efficiently, effectively and cooperatively to further the interests of patients and the wider community." (Health Professional Workforce Issues paper pg 34)*

- Implementation of the *National Health Workforce Strategic Framework* targeting whole of health professional workforce, not focusing on the traditionally stronger interest groups
- Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (May 2002) – has not yet produced any targeted results increasing the number of Indigenous people taking up an allied health profession as a career, has not yet

substantially produced an increase in allied health services being delivered to Indigenous populations.

- Inconsistency across the States and Territories in terms of focus on allied health service delivery, particularly in rural and remote communities or on addressing recruitment and retention issues.

9. Education and training

- Increased funding and places at tertiary institutions to address critical shortages in the allied health disciplines
- The funding and implementation of incentives to increase the number of rural school leavers taking up a career in an allied health profession (e.g. scholarships)
- The provision of clinical education support for the allied health professions including clinical placements in a range of settings, accommodation and transport support, recognition of the role of the clinical supervisor – financial, education requirements, support to cover additional workload, clear goal setting for outcome of clinical placement
- The development of generic skills modules, interprofessional education to reduce the current 'siloing' approach to health professional education and enhance multidisciplinary team practice
- The provision of postgraduate and ongoing education and training to enable practicing health professionals to obtain, enhance, upgrade skills necessary to their practice requirements
- Development of re-entry programs available for the individual health professional disciplines within the allied health workforce

10. Recruitment and retention incentives for allied health professionals in rural and remote communities

In order to address critical shortages across the range of allied health professions in rural and remote communities there is a requirement to better align the incentives to work in these areas. SARRAH recommends that a coordinated national and state approach be taken to address issues including:

1. Benchmarking for allied health services – to give a numerical indication of requirements for allied health services to address a communities demographics and health status
2. Identification of and funding for increased allied health positions in areas where shortage of positions is identified – shortage of funded public sector positions in rural and remote communities leads to increased stress due to work demands on existing workforce resulting in burnout and staff turnover, difficulty in recruiting to vacant positions
3. Development of incentive packages including HECS reimbursement in return for service in rural or remote area, relocation assistance, family support, access to ongoing education, mentoring, locum support, peer support, retention bonuses.

REFERENCES

[i] Adams R, Lowe S, O'Kane A. Classification of clincial allied health - a discussion paper. In: Services for Australian Rural and Remote Allied Health; 2004.

[ii] Lowe, S; O'Kane A; The Australian Allied Health Workforce, SARRAH, 2004

ATTACHMENT ONE

NATIONAL
COMMITTEE
National Rural Health Alliance (NRHA)
National Arthritis and Musculo-skeletal Conditions Advisory Group (NAMSCAG)
National Rural Health Conference Organising Committee
7th National Allied Health Conference Organising Committee - Hobart 2007
Australian Journal of Rural Health
Speech Pathology Australia Rural and Remote Reference Group
Bush Crisis Line Steering Committee
MedicarePlus Allied Health and Dental Initiative Consultative Group
Health Professions Council of Australia Transformation Group
Allied Health Professions Australia Reference Group
Australian Healthcare Reform Alliance
CONSULTATIONS
Workshops regarding Best Practice, Needs Analysis Models and Performance Indicators for MAHS and WSRGP project
Consultation workshop on National Service Improvement Framesworks for Arthritis and Musculoskeletal Conditions, Asthma, Cardiovascular Disease, Diabetes
Review into the National Rural Health Network and National Undergraduate Rural Health Conference
Primary Care Major Initiatives, Primary Care Policy Branch, Primary Care Division - provision of information regarding allied health initiatives
Graduate Assistance and Partnership Program
PROJECTS AND PROGRAMS
National Rural and Remote Allied Health Advisory Service 2002-2004
Replaced by the National SARRAH Secretariat 2004 and ongoing
Australian Rural and Remote Health Professional Scholarship Scheme
RHSET fund Indigenous Diabetic Foot Project
Regional Health Services funded Central West Division of General Practice Allied Health Mentoring Project
SUBMISSIONS
ACOPRA review into Physiotherapy Competency Standards
Productivity Commission Review into Health Workforce
NEW SOUTH WALES
COMMITTEE
NSW DOH Allied Health Consultative Forum
NSW Rural and Remote Allied Health Conference
Rural Private Access Program NSW Reference Group
CHN Paeds Reference Group
1st NSW Rural Allied Health Conference 2003
Forum on Clinical Placements - NSW Department of Health
2nd NSW Rural Allied Health Conference 2005
3rd Annual Health Professionals Forum - Health Services Union

NORTHERN TERRITORY
COMMITTEE
Central Australian Division of Primary Health Care
RHS -planning study of Allied Health Services in Central Australia - steering group
Primary Health Care Research, Evaluation and Development (PHC RED)
General Practice and Primary Health Care Northern Territory (GPPHCNT)
CADPHC MAHS Working Group
NT Aboriginal Health Forum
NT Aboriginal Health Workforce Imp
WORKSHOPS/WORKING GROUPS
Centre for Remote Health - Masters of Remote Health - Allied Health - partner in development
Centre for Remote Health - Community Rehabilitation Course - partner in development
Health Outcome tools to measure impacts of Allied Health Services in Remote areas of Australia "Measuring what counts"
QUEENSLAND
COMMITTEE
Queensland Health Ministers Rural Advisory Committee
Queensland RPA Program Reference Group
Allied Health staffing level benchmarking project for the North West Queensland Allied Health Service
SUBMISSION
Queensland Centre for Rural and Remote Mental Health
Queensland Health Systems Review
SOUTH AUSTRALIA
COMMITTEE
Committee re Student supervision for rural allied health practioners
TASMANIA
COMMITTEE
University Department of Rural Health Allied Health Thinktank December 2003
Primary Health Care Research Evaluation and Development Reference Group
VICTORIA
COMMITTEE
Multidisciplinary Education for Rural Health Practitioners (MERHP)
Victorian Health Minister's Rural Health Forums
Victorian Rural Health Conference
Victorian Rural and Remote Allied Health Conference 2004
WESTERN AUSTRALIA
COMMITTEE
Regional Health Strategy Advisory Group (currently inactive)

WA Rural Private Access Program Reference Group
WA Rural and Remote Allied Health Forum 2005
WA Allied Health Alliance
Benchmarking allied health services 2 Project management committee