Services for Australian Rural and Remote Allied Health Inc

S•A•R•R•A•H

Submission in response to the proposals contained within Australia's Health Workforce Productivity Commission Position Paper

SARRAH represents the interests of individual rural and remote allied health professionals

SARRAH believes there are core underpinning principles to the delivery of health services in rural and remote Australia:

1. *The first is that rural and remote communities in Australia are diverse and not homogeneous. Many Australian rural communities are proudly parochial and "one size fits all" approaches are likely to be treated with cynicism if there is no opportunity for local differences to be included.*
2. *The second principle relates to the common held value that regardless of income, education, culture or geographical position, Australians have a right to accessible health services according to need.*
3. *The third is that the current "silo" approach to health must be eliminated – this is true for workforce education and training, workforce planning, workforce support, funding and governance across jurisdictional boundaries.*

Evident in the position paper that the focus is on medical services and nursing – inclusion of allied health is intended but is not readily backed with data (a major issue for allied health, particularly in rural and remote)

- *Funding priorities do not include or recognize the value of the contribution by allied health to health and wellbeing – prevention, acute services, chronic services, rehabilitation, self management and other consumer education, aged care, mental health, paediatric services, women's health etc. Able to provide cost effective health maintenance / prevention initiatives after thorough training.*
- *For the recruitment and retention of the allied health workforce, industrial systems and awards for health workforce that enable career pathway, increased job satisfaction, recognition of skills and experiences (clinical pathways not just pathways into health service management) are essential.*

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Draft proposals

Draft Proposal 3.1
In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

SARRAH supports this proposal and considers it essential to a national integration of planning for the medical, nursing and allied health professional workforce.

Draft Proposal 3.2
CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

SARRAH supports this proposal. Reviews must include the effect of the implementation on medical, nursing and allied health workforce.

Draft Proposal 4.1
The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.

SARRAH supports this proposal

1. *Must include or have input or consultation with all stakeholders from health workforce*
2. *Historical aspects of professional dominance issues encompassed within the traditional medico-pharmaceutical model of health care must be overcome*

Draft Proposal 5.1
The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- consider the needs of all university-based health workforce areas; and
- consult with vice chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.

1. *The difficulty arises with jurisdictional responsibilities for various sections of the health professional workforce. Whilst medical workforce has traditionally been the responsibility of the Commonwealth, allied health and nursing is largely the responsibility of the states. For the transfer of funding for university based education and training to the Department of Health and*

Ageing, these current jurisdictional barriers and lack of national coordination in workforce planning will need to be overcome.

2. *Evidence suggests (rural medical clinical schools, UDRH's) that rural vacancies will not be filled unless the schools for the health professionals is in a regional university, or students are able to undertake comprehensive rural training. What is needed is clear data on the number of university places required for each profession and a proportional representation in regional universities. It is essential that the rural clinical schools are expanded to encompass training for the allied health professions.*
3. *Rural experience and scholarships should be offered to all health students as there is movement from city to country and vice versa.*
4. *HECS reimbursement scheme (one year reduction in HECS fees for every year spent working in a rural or remote region) for all health professionals working in rural and remote areas would offer greater incentive and contribution to recruitment and retention then undergraduate scholarships.*
5. *Important that the needs of all university based health workforce areas are considered, with input from representatives of those workforce – avoidance of historical dominance issues of powerful lobby groups. Steam line funding between medical vs nursing vs allied health and across jurisdictions and sectors.*
6. *Interdisciplinary training should be core to the educational framework.*
7. *The issue might rather resolve at a schools accreditation level where funding is based on best practice adoptions. Who chooses best practice? May need overarching health professionals' education expert committee.*
8. *The focus must not just be on the numbers of places for training available. Health needs must be considered in addressing education issues – essential that the health workforce is provided to meet the needs of the ageing population and increasing burden of chronic disease, importance of prevention and health promotion – need to train appropriate health workforce as well as adequate numbers across the range of disciplines be they existing or new and emerging professions. Need for best practice selection processes for the selection of students who indicate an interest across the fields; and the provision of incentives and support to encourage professionals to work in key fields*
9. *Regardless of which section of the Australian Government is responsible ultimately following this review the education and training sector must be linked to health services in order to ensure health workforce requirements are met – numbers being trained, competencies being achieved, support for clinical education.*
10. *What are the best models of education to address workforce need? Need to particularly address multidisciplinary team practice, remove silo approach to education of health professional disciplines.*
11. *No assumption that allied health professionals are 'work ready' on graduation if those practitioners are intending to work in isolated rural or remote practices where there is no supervision, mentoring or other supports for their clinical practice and where their management may be by personnel without clear understanding of the unique competencies, skills mix & scope of practice that can be offered by a practitioner from that discipline with further experience under their belt. Unsupported inexperienced health professionals will struggle, potentially high burn out and preference to move to more supportive environment.*

Draft Proposal 5.2
The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and
- Their implications for courses and curricula, accreditation requirements and the like.

SARRAH supports this proposal. Consideration must be given to:

1. *Consideration of issues raised by SARRAH under Proposal 5.1*
2. *Interprofessional education and training, remove the "silos"*
3. *Coordination between the universities, university departments of rural health, rural clinical schools etc for all health students in rural areas – currently the major focus is on medical only. Interdisciplinary networking, education and training, research would go a long way to developing new strategies and service models for health.*
4. *Including the development of vocational training for specialist allied health professionals – rural health and remote health recognised as a specialty practice for the allied health disciplines;*
5. *Pathways should be developed from vocational (VET sector) at high school level to entry level degrees. Qualifications offered under VET sector training should also have specializations (Cert IV and diploma level) to fit with special fields of practice be they discipline specific (e.g. physiotherapy assistant, dental assistant); or area such as rural, Indigenous, mental health, rehabilitation, aged care, paediatric care, welfare; and*
6. *Postgraduate vocational education and training pathways put into place for professionals working in these areas (Current request by Australian College of Rural and Remote Medicine to have rural medicine recognised as a specialty with vocational education pathway to achieve recognition in this specialty should be approved. Similar pathways and recognition then developed for members of the allied health workforce. This would enhance career pathway, job satisfaction and enhance recruitment and retention.)*

Draft Proposal 5.3
To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;
- examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;
- better linking training subsidies to the wider public benefits of having a well trained health workforce; and
- addressing any regulatory impediments to competition in the delivery of clinical training services.

SARRAH supports this proposal provided the policy overcomes current inequities in the support provided for clinical education between the medical workforce and those training as members of the allied health or nursing workforces.

1. *Jurisdictional responsibilities impact on provision of clinical education places for members of the allied health workforce*
2. *Minimal effort is currently put into the clinical education across the range of allied health professionals or the provision of clinical education appropriate to prepare the allied health workforce for rural or remote practice – explicit payments for infrastructure support for the clinical education of allied health would be a real plus.*
3. *Strategies in place to train medical workforce to increase recruitment and retention in rural and remote areas should also encompass the allied health workforce.*
4. *Interprofessional clinical education and training to enhance multidisciplinary team practice*
5. *Better linkages between education, public, private and Commonwealth funded health service sector to enhance or improve clinical education opportunities for all health professionals.*

Draft Proposal 6.1

The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- It would develop uniform national standards upon which professional registration would be based.
- Its implementation should be in a considered and staged manner.

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

SARRAH supports this proposal but recommends that:

1. *the National Accreditation Agency set the process by which courses are accredited to ensure national consistency and mutual recognition of courses and qualifications between states*
2. *must have relevant discipline specific input*

Draft Proposal 6.2

The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.

SARRAH supports this proposal provided there is consultation with the professional groups and across the medical, nursing and allied health disciplines.

Special consideration for rural and remote – an overseas trained health professional placed in these environments where they may be or often are sole practitioners because it is an area of need is not necessarily the best solution for either the practitioner or the community. Registration is only permitted because they agree to work in an area of need – but they would not receive that registration if they wanted to work in a metropolitan

area – implies that areas of need can be serviced by a health professional with a lower level of qualification. Yet – working in a metropolitan centre where there would be greater opportunity for supervision, mentoring and professional development in order to obtain full registration would seem logical. Consideration should only be in the light of broad numbers needed to fill total workforce requirements, not specifically rural and remote.

Draft Proposal 7.1

Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

- *Professional regulation is a barrier*

Different professions – different issues – would need to be investigated and involve much consultation. Is worth exploring.

- *The UK currently has national registration for 7 of the allied health professionals (England, Ireland, Scotland & Wales) undertaken by one registration body.*
- *Is also a pathway being undertaken in New Zealand. Move seen as positive by feedback received. Each profession required to define scope of practice, including areas that were unique to their profession – and what areas overlapped with other professions.*
- *Will need to investigate issues of supervision of processes –jurisdictional and discipline involvement*
- *The ability to work across borders, move around the country at will is benefit for attracting rural workforce especially locums.*

Draft Proposal 7.2

States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

SARRAH believes that this proposal is essential.

Draft Proposal 7.3

Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

1. *Care must be taken with language by which this recommendation and the accompanying information contained within the workforce paper is expressed. It must be clear that the Productivity Commission is NOT just referring to members of the medical profession when discussing the issue of delegation with discounted fees.*
2. *Regulation of task delegation is important in the duty of care legal framework and should be identified in all professional regulation statutes. What about the non-regulated professions? National code of practice is still necessary.*

3. *Allied health professionals may delegate tasks to a therapy assistant – proposal is appropriate in this case – distinction must be made between delegation and referral as it has implications for who has responsibility for outcomes*
4. *Allied health professionals do not generally have tasks delegated to them from members of the medical profession. Intent of recommendation needs to be clarified.*
    a. *Allied health professionals are autonomous health professionals, many are first point of contact professions – no requirement for GP referral*
    b. *Allied health professionals do not work for and on behalf of a GP – GPs refer, allied health professionals report back – are members of a multidisciplinary care team with own roles and skills*
    c. *GPs do not supervise the work of allied health professionals*
    d. *Allied health professionals have historically had responsibility for clinical outcomes and the health and safety of the patient for allied health treatments or interventions*
    e. *Evidence suggests that in some cases best practice for management of a condition is that which is provided by an allied health professional (e.g. pelvic floor exercises for urinary incontinence)*
    f. *Could refer to prescribed items of which the GP is the gatekeeper as per current chronic disease enhanced primary care. Could help focus allied health resources on national priority areas.*
    g. *This issue – that GPs refer to allied health and do not delegate is reflected in MedicarePlus Allied Health and Dental Initiative where implementation of the program resulted in allied health professionals being directly funded by HIC.*

Draft Proposal 8.1
The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- the range of services (type and by provider) covered under the MBS;
- referral arrangements for diagnostic and specialist services already subsidized under the MBS; and
- prescribing rights under the Pharmaceutical Benefits Scheme

It should report publicly on its recommendations to the Minister and the reasoning behind them.

SARRAH supports this recommendation.

1. *The independent standing review body must also include review of uptake of MBS items across Australia.*
2. *Decisions for inclusion or exclusion must be based on evidence and best practice.*

3. *Direct payments must not be restricted to members of the medical workforce if evidence shows that best health outcomes are achieved by services provided by a member of the allied health workforce.*
4. *Recommendations publicly reported should include improvements for uptake; or other packaging; or costing out programs in low uptake communities e.g. no private practice in a community equals no uptake of enhanced primary care or chronic disease team management items, impacting on health outcomes in that community through reduced access to team management for health conditions.*

Draft Proposal 8.2
For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- the service would be billed in the name of the delegating practitioner; and
- rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.

This change should be introduced progressively and its impacts reviewed after three years.

SARRAH supports this proposal but requests that there is further clarification both within the proposal and its rationale:

1. *Delegation (use of language) is the issue being discussed, but this is only one aspect of proposed payments under MBS*
2. *There will continue to be direct payments available (not at discounted rates) to other suitably qualified members of the health workforce where evidence suggests best practice is the intervention or treatment provided by the other suitably qualified health professional (e.g. chronic disease management, enhanced primary care)*
3. *Care must be taken with the language used - lower rates of rebate suggests that the service provided by the other qualified health professional is of a lower standard or rate then if it had been provided by the delegating /referring practitioner. See schedule and rebate fees in recent update enhanced primary care for example – should not be related to GP fees but industry average for standard fee for the profession*
4. *Need to make distinctions where delegation or referral may be more appropriate wording. Medical practitioners refer to allied health professionals but may delegate tasks to a practice nurse or physician's assistant.*

Draft Proposal 9.1
Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

1. *A major issue for the allied health workforce is that the current committee structure has been woefully inadequate. No data has been collected or any analysis of the allied health workforce.*

2. *AHWAC has produced a paper "The Australian Allied Health Workforce" which identifies the lack of consistent, nationally collected data sets across the range of allied health professions. This paper was produced more then 12 months ago and has not yet been endorsed by AHMAC – no action has been taken*
3. *Allied health workforce planning and forward projections of need cannot be undertaken without data on existing workforce to provide evidence of shortages, distribution, supply etc*
4. *Any structure which is adopted must have a focus and the funding to encompass planning across the whole of the health workforce*
5. *Nursing – only a couple of special areas have been considered by AHWAC*
6. *Rationalisation is good, but professional dominance must be addressed – if not the focus will continue to be on medical workforce only.*

Draft Proposal 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- be based on a range of relevant demand and supply scenarios;
- concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and
- be updated regularly, consistent with education and training planning cycles.

    1. *It is essential the allied health professions are considered. Smaller groups may become more essential if their supply is essential to health and well being e.g. diabetes/obesity/chronic disease and podiatry services.* ***The size of the professional group does not diminish its importance in terms of workforce planning.***
    2. *There is an increasing push of graduate entry level education for allied health professions – these need to be included. (e.g audiology is graduate entry only, physiotherapy is becoming increasingly graduate entry level)*

Draft Proposal 10.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

The core principals written at the start of this response are essential for rural and remote areas. Policy development should start with considerations for rural and remote. The resultant health policy is bound to be better for all Australians. "Rural proofing" -consideration taken by all policy makers and implementers of the potential for positive or negative impact by a policy (e.g. changes to Medicare – the MedicarePlus allied health initiative uptake in rural and remote communities is considerably less then in metropolitan areas)

1. *Flexibility of funding and the manner in which health services can be delivered to reflect regional variation and needs*
2. *recognition of the special skills required by members of the rural and remote health professionals workforce (specialist generalist, competencies across a broader range*

of skills then are required by metropolitan counterparts, vocational pathways for medical, nursing and allied health workforce reflecting rural or remote specific skills mix)

3. *The ability of the health workforce to be flexible in terms of the delivery of the unique services offered by each particular discipline – and access to appropriate education and training in for them to do so*
4. *Management of allied health services – not appropriate for medical director or director of nursing to be managing allied health services (whether at local, regional or state level)*
   a. *Is often the case in remote and small rural communities*
   b. *Allied health services must have clinical governance by personnel who understand the role, scope of practice; skills mix, clinical competencies, and support needs of the range of disciplines included under the allied health umbrella.*
5. *Rural and remote – use of information technology to better utilize and expand the use of existing workforce e.g. health service delivery by videoconference – providing specialist services to rural and remote consumers / supporting locally based health professionals with education and training, enhancing level of service provision available to rural and remote consumers. Rural and remote practitioners required to be generalists (covering a range of skills required by their professional discipline). Videoconference links to practitioners located in regional or metropolitan centres which provide more specialist skills within the same discipline, or health professionals of another discipline not locally available. Telecommunications must be of highest standards, best world, better than metropolitan areas!!!*

Draft Proposal 10.2
The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and
- as appropriate, consider major job redesign opportunities specific to rural and remote areas.

1. *Changes in workforce – the development of new professions, changes in existing professions must not impact on the health outcomes of rural and remote Australia.*
   a. *avoidance of the term substitution for workforce – substitution implies a lesser quality service and could impact on health outcomes*
   b. *Therapy assistants or generic therapists are not a substitute for a qualified allied health professional workforce. They can have a very valuable role in assisting the qualified staff to deliver a service and improving the health outcomes but they are not a solution to workforce shortages.*
2. *Management structures in place that support and enable the rural and remote health workforce to provide services that meet the needs of the community*
3. *job redesign must be done in consultation with existing workforce not imposed on rural and remote communities by bureaucrats, academics or fund holders who do not have understanding of the range of skills provided by the existing disciplines*
4. *Flexibility is the key – job redesign must not result in poorer health outcomes, decreased job satisfaction, increased workload or other negative impact for rural and*

remote communities. ***Whilst job redesign may be appropriate – Substitution is not the key!!!!!***

5. *Therapy assistants are a valuable resource but need to be thoroughly trained with regards to competencies, responsibilities and role and be properly managed with supervision, limitations of role, support, on going training provided*
6. *Better use of existing workforce can be made if the full range of skills and scope of practice, extended scope of practice potential and clinical competencies of the range of disciplines is fully understood – multi-skill is not necessarily the answer if a professional who can do a 'little of this and a little of that' results in poorer health outcomes of the community being served. Implications for the rural and remote health workforce that are already required to be generalist across the range of clinical and management skills required of their particular profession*

Draft Proposal 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- the provision of financial incentives through the MBS rebate structure versus practice grants; and
- 'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

1. *Must encompass whole of health workforce – not just medical – and across public, private and Australian Government funded sectors.*

Draft Proposal 11.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

Indigenous health must not just be considered under special needs – requires whole of government approach to address socio-economic determinants of health as well as the provision of health services

- *The provision of culturally appropriate health services to Indigenous communities is essential*
- *Strategies need to be put into place to increase the numbers of Indigenous people taking up a career in one of the allied health disciplines.*
- *Further enhance and expand on community control and ownership / responsibility through Community Controlled Health Organisation programs and funding.*
- *Increased Indigenous health / cultural awareness and safety / working with interpreters etc components of undergraduate health professional curricula across all health professional disciplines*