SARRAH
Services for Australian
Rural and Remote Allied Health

Rural Allied Health Quality, Access and Distribution

Options for Commonwealth Government Policy Reform and Investment

Feedback to the Office of the National Rural Health Commissioner

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SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector. SARRAH was established in 1995 and advocates on behalf of rural and remote Australian communities in order for them to have access to allied health services that support equitable and sustainable health and well-being. AHPs are tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury.

SARRAH maintains that every Australian should have access to equitable health services wherever they live, and that allied health professionals deliver services that are fundamental to the well-being of all Australians.

Review of rural allied health evidence to inform policy development for addressing access, distribution and quality

In general SARRAH concurs with the findings of the literature review and subsequent policy implications. In particular SARRAH supports the following areas for future policy and program implementation:

- The establishment of a Commonwealth Chief Allied Health Officer with key responsibilities to improve rural allied health distribution, access and quality (Policy Area 1.1)
- The establishment of a rural college of allied health that will support rural allied health professionals to obtain relevant context-specific qualifications, link them with improved access to professional development and structured training pathways for rural practice, and link rural allied health professionals with local universities for clinical teaching and research opportunities (Policy Area 1.2).
- Expansion of the established Allied Health Rural Generalist Pathway to enable uptake by non-government and private sectors, and grow the number of skilled rural allied health professionals delivering high quality services (Policy Area 3).
- Development of integrated Allied Health hubs that provide a critical mass of allied health professionals to develop and deepen the local workforce, improve patient care coordination and explore opportunities for integration with local service providers (Policy Area 4.1).
- A robust primary health care system that meets the needs of rural communities facilitated by private and non-government sector growth opportunities and integration of private, disability and aged care. This will require localised service development with effective relationships with local practices to improve the engagement of the private sector with government service provisions to address primary health care priorities. Reviewing Medicare benefits to improve viability for private practitioners in rural areas is an integral component of this (Policy Area 4.2).
- Initiatives that enable rural allied health professionals to delivery services by a range of modalities including telehealth (Policy Area 5).

SARRAH offers the following feedback with respect to the literature review.

1.2 Rural allied health and rural community need

The literature review identifies that the rural allied health workforce requires specific skills to meet the demands of rural practice, noting the rural generalist allied health training program offered by James Cook University as the most advanced available. However the literature review fails to acknowledge the significant work undertaken over more than ten years by Queensland Health to design and implement an Allied Health Rural Generalist Pathway

(AHRGP) in health services. SARRAH currently supports the activities of Queensland Health and other health services through the AHRGP National Implementation Project. The Project Governance Group comprises health service providers that are implementing Allied Health Rural Generalist (AHRG) trainee positions, and membership is open to new service providers from all sectors where allied health services are delivered, including disability, aged care and the private sector.

The next stage of implementation has been designed to facilitate uptake by non-government and private sector service providers, and this will be a short- to medium-term focus for SARRAH to grow the number of AHRG trainee positions nationally. Further details regarding progress in this area are provided in our response to Policy Area 3 (pages 13-14 in this document).

The AHRGP is at a critical stage of development in terms of moving to become a nationally relevant strategy for building sustainable rural and remote allied health services, and requires active support and input from all stakeholders, including the Commonwealth.

Recommendation:

That a recommendation is made to the Commonwealth to acknowledge and support the established AHRGP as a foundational element towards national implementation of allied health rural generalism.

3.2.2 Assistants and training local staff to provide allied health services

The literature review states that allied health assistants "…could substitute around 17% of allied health work (same for rural and metropolitan areas)" (page 60). SARRAH is of the view that this statement is misleading. Allied health assistants "support and enhance the work of allied health professionals by undertaking duties within Allied Health practice that facilitate care (for example, administrative or support tasks related to the patient or client) and delivering components of clinical care that are necessary to the treatment episode but do not entail clinical reasoning skills"[1]. To imply that allied health assistants can "substitute" the work of allied health professionals fails to acknowledge that the safe delegation of work to allied health assistants requires a supervising allied health professional to have first undertaken a comprehensive assessment of a patient, developed a care plan, and determined that the allied health assistant has the necessary competencies to carry out elements of that care plan.

In rural settings, allied health assistants located in community hospitals and multipurpose sites play a valuable role in enhancing allied health services by carrying out care plans developed by visiting allied health professionals providing outreach services. This service delivery model enables increased access to allied health services that would otherwise be unavailable in those locations. But it is important to note that allied health assistants are unable to work without input from a supervising allied health professional. For this reason, the use of the term "substitution" in relation to allied health assistant roles is not appropriate.

Recommendation:

Although SARRAH fully supports a focus on building the allied health assistant workforce in rural settings, the language used to describe allied health assistant roles should be modified

[1] Firth, A. (2012) Delegated clinical roles of Allied Health Assistants: Final Report of the Health Education and Training Institute (HETI) Rural Research Capacity Building Program, NSW Health

to reflect the supportive functions of allied health assistants in enhancing the work of allied health professionals. We suggest "…around 17% of an allied health professional's work could be delegated to an allied health assistant."

Policy Option Areas

POLICY AREA 1: RURAL ALLIED HEALTH POLICY, LEADERSHIP AND QUALITY AND SAFETY

1.1 Appointment of a Commonwealth Chief Allied Health Officer

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

SARRAH strongly supports the appointment of a Commonwealth Chief Allied Health Officer (CAHO), and considers that a key result area for the position is to improve rural allied health distribution, access and quality.

Other priorities for the CAHO should include:

- Support the functions of the Australian Allied Health Leadership Forum (AAHLF)
  - Be the primary contact point for AAHLF and funnel for information to/from Commonwealth across relevant agencies responsible for allied health services
  - Improve communications between the Commonwealth and states via the Australian Health Ministers' Advisory Council (AHMAC)
- Provision of advice to the Commonwealth with regard to future policy directions and funding priorities, including funding models and infrastructure for allied health practice
- Establishment of a rural allied health portfolio to support the following functions:
  - Oversee the development of mechanisms to collect allied health workforce and clinical data, that are embedded in policy and supported by government through funding drivers and policy
  - Oversee the reform of allied health funding mechanisms in primary health care, disability and aged care, incorporating private health insurance and Medicare funding arrangements, to improve access in rural and remote Australia
  - Undertake cross-sector consultation to identify common barriers and strategies to address access to allied health services in rural and remote Australia. This includes the establishment of integrated allied health hubs.
  - Support the development of practice models including rural generalists, allied health assistants and telehealth
  - establish a research agenda and rigorous evaluation framework for rural allied health service provision and explore funding opportunities
- Work with stakeholders to establish a rural allied health college, including the expansion of the allied health rural generalist pathway, an accreditation process for rural generalist training programs and other professional development programs with a rural focus
- Work with other agencies and portfolios to improve access to appropriate allied health services for Aboriginal and Torres Strait Islanders, people living in remote regions, and people with chronic and complex needs

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

SARRAH recommends that the Chief Allied Health Officer (CAHO) should be situated to facilitate cross-sector collaboration between the Commonwealth Departments of Health and Ageing, Social Services, Veterans' Affairs, Education, Regional Australia and the National Disability Insurance Agency. The CAHO should also have input to the Council of Australian Governments (COAG) Health Council and Australian Health Ministers' Advisory Council (AHMAC) due to the significant impact of state and Commonwealth policies and programs relevant to allied health services.

A clearly defined office of the CAHO will facilitate reporting by all relevant departments on rural health indicators. It may also serve to bring together peak bodies representing all sectors (aged care, disability, private sector) where allied health service access is relevant.

The CAHO should be adequately resourced to deliver the key result areas outlined in the previous section. This will include a dedicated team of policy officers and support staff to enable the CAHO to function effectively.

1.2 Rural Allied Health College

SARRAH supports the establishment of a rural allied health college as an innovation with great potential to build and support a fit-for-purpose allied health workforce in rural and remote Australia, promoting allied health career pathways for allied health professionals considering a career in rural health.

The establishment of a college, and the embedding of the allied health rural generalist pathway into rural practice, would complement existing specialisation pathways that are offered by the individual professional associations. To this end a college would need to draw clear distinctions between its focus on allied health rural generalism, as opposed to other areas of clinical interest in the allied health sector, to avoid perceptions of duplication of purpose by existing peak bodies and professional associations.

SARRAH notes the functions of a college described on pages 11-12 of the discussion paper, namely:

- Support rural allied health professionals to undertake training to gain accredited rural generalist qualifications
- Act as an accreditation body, maintaining and accrediting post-graduate rural generalist courses against defined standards
- Provide guidance to rural and remote allied health professionals in accessing structured training pathways
- Provide leadership on safety and quality standards common to allied health professionals with rural generalist qualifications and be a mechanism to roll out national rural workforce training and professional development programs
- Act as a central repository for rural allied health workforce data not currently collected as well as central point to share innovative rural allied health service models for application in other rural areas

It should be noted that SARRAH has been offering professional services to rural and remote allied health professionals since its inception in 1995. In addition, SARRAH was funded to establish the National Rural and Remote Allied Health Advisory Service between 2001-2003 to provide expert advice to the Commonwealth and other stakeholders on rural and remote allied health issues. Although this function was not specified in subsequent contracts,

SARRAH has continued to provide this service to the Commonwealth on an informal basis and is widely recognised as Australia's foremost organisation on matters relating to rural and remote allied health.

SARRAH provides leadership, advice and professional development opportunities to allied health professionals through its highly-regarded conferences, policy and advocacy activities, webinars, online resources such as the Transition to Rural Practice toolkit, and the national implementation of the Allied Health Rural Generalist Pathway (AHRGP). Over the next two years SARRAH will continue to lead the national expansion of the AHRGP, with a focus on exploring the applicability of rural generalism in the non-government and private sectors. Further details about the AHRGP are included in Policy Area 3. SARRAH is in the process of revising its membership structure to incorporate the allied health rural generalist pathway, including professional recognition for rural generalists in the form of fellowships.

SARRAH's central role in developing the rural allied health workforce and expanding the AHRGP across sectors should be taken into account when exploring opportunities to establish a rural allied health college.

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

A brief outline of the relative advantages and disadvantages of potential models for the establishment of a college are described in the table below.

Model	Advantages	Disadvantages
Option A: A controlled entity or affiliated entity established by an existing allied health organisation or consortium of organisations	○ Lower start-up costs ○ Sector/Corporate knowledge retained ○ A consortium arrangement may facilitate consensus among stakeholders	○ Risk of duplication of functions with other existing organisations ○ Perception of conflict of interest
Option B: An evolution of an existing organisation or association	○ Low start-up costs ○ Efficient use of time and resources ○ Sector/Corporate knowledge retained ○ May evolve into an independent entity once established	○ Perception of conflict of interest
Option C: An independent entity, supported by: ○ existing allied health peak bodies ○ existing individual members.	○ Ability to build support from stakeholders from ground up ○ No perceived COI	○ higher start-up costs ○ Duplication of functions with existing organisations ○ Time taken to obtain consensus, approvals and procure expertise

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

SARRAH is of the view that Option B represents the most efficient and cost-effective model for the establishment of a rural allied health college.

Option A, as an entity established by a consortium of organisations, may present a viable alternative. However the arrangement would still require an identified lead organisation.

SARRAH *does not support* an independent body described at Option C at this point of time. This represents a more expensive option, and risks duplicating the functions of a number of agencies including SARRAH's role and membership.

An existing organisation could build on present infrastructure to develop a college rather than establishing a new organisation. However the functions of a college would require appropriate resourcing and funding.

Stakeholder agencies, including the members of the Australian Allied Health Leadership Forum, should be involved in the development and ongoing functions of the college, including the accreditation body, advisory bodies, review of accreditation standards and further development of the pathway.

SARRAH is committed to working with the Commonwealth and with stakeholder organisations through its membership of AAHLF, to gain support for the establishment of a college for the benefits it will bring to rural communities and to allied health professionals working in rural and remote Australia.

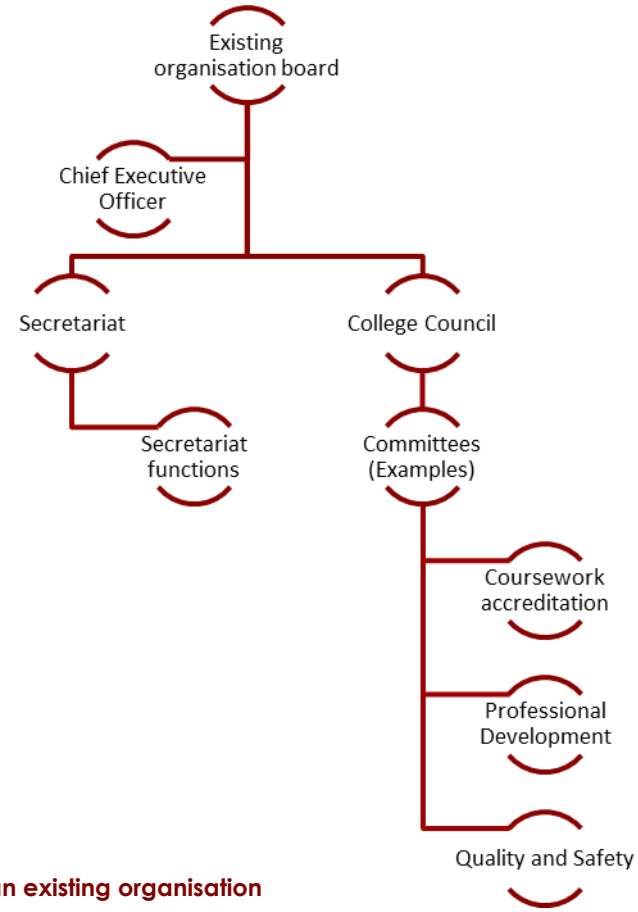

Figure 1: Evolution of an existing organisation

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

SARRAH is of the view that in order to gain support for the establishment of a rural allied health college, its performance indicators should closely reflect implementation of allied health rural generalism as a key workforce strategy.

SARRAH suggests the following amendments to the rural allied health college performance indicators (policy intention section page 16 of the discussion paper):

- Facilitate the implementation of the national rural generalist allied health *pathway* to be clearer around intent and meaning;
- Establishment of quality and safety standards for rural generalist practice
- Oversee accreditation of post graduate rural training courses to meet quality and safety standards particularly in relation to the AHRPG, including AHRGP and ongoing CPD for allied health rural generalists and other rural and remote allied health workforce, to meet quality and safety standards;
- Promote the AHRGP as providing high quality rural context training and career pathways to the current and future rural allied health workforce;
- Provide a central repository to collect, manage and share rural allied health workforce data as an immediate priority (as a more urgent priority than research and innovation) ;
- Establish a research and innovation agenda and identify funding options.

In addition, SARRAH suggests the following performance indicators and activities:

- Grow the number of rural generalist trainee positions, potentially with the assistance of funding through the college
- Develop guidelines for best practice that assist organisations to support workforce initiative
- build relationships, acceptance and support of key stakeholders such as member organisations of the Australian Allied Health leadership Forum (AAHLF)
- College membership numbers
- Evaluate the AHRGP outcomes, including retention figures; increased service delivery in remote locations; increased coverage for remote locations. Improved participation outcomes for rural and remote people following illness, injury or disability.
- Production and provision of effective multi-disciplinary professional development and training programs for the rural allied health workforce
- Development of guidelines and resources to promote the quality and safety of rural allied health services
- Evidence of improved career structures for rural allied health professionals
- Consider the structure of the NDIS outcomes framework which addresses program level outcomes and individual outcomes as a way of capturing the breadth of the impact of the college.
- Develop resources such as the NDIS demand map https://blcw.dss.gov.au/ndis-demand-map/
- Develop a research agenda / activities and links with education providers
- Measure quality of life of allied health professionals – resilience, sustainability (eg workers compensation rates)

The college could play a role in developing the local workforce growth pipeline. Consider starting with allied health assistant training for local rural people and linking in with allied health tertiary training courses delivered in flexible modes so that people do not have to

leave home to complete their qualification. Helping students to do block mode study while potentially continue working as an AHA in their community to enhance their skills and provide service coverage in their community.

Growing the rural allied health workforce is a critical policy approach that needs to be carefully developed and appropriately funded, across all relevant sectors. The universities should be investing in the high school sector but the focus on shifting workforce shortages and maldistribution for the allied health professions needs to start with targeting pre-career remote and rurally located people.

UDRHs could play a role in providing support to the college, not just support to students to undertake rural placement but also support AHRGP trainees and early career allied health rural generalists. UDRHs can also provide possible career pathways for allied health rural generalists in education and research to further facilitate retention of staff but also build research capacity.

1.3 Allied Health Workforce Dataset

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

Benefits:-

- Greatly enhance and support allied health workforce planning and development at the local, regional and national levels
- Improve ability to measure impact of any allied health workforce reforms applied at various levels
- Inform stakeholders (government, NGO, private, consumer) regarding the state of the allied health workforce in particular sectors or geographic settings
- Greater ability of the Commonwealth to plan and support rural allied health workforce developments
- Increases the transparency of service provision accessibility for rural and remote Australians

Challenges

- The challenges are many due to the nature of service delivery in rural and remote communities, including outreach and fly in, fly out services, and the various funding models for the delivery of AH services.
- A data set may be able to be developed but would then need a policy driver linked to funding sources to report on the workforce. This could be driven by the Commonwealth by leveraging indirectly (private) or directly fund (Medicare, NDIS, NGO) these services.
- As a policy issue linking this with the National Allied Health Best Practice Data set to collect some outcome data would also be critical.
- It should be noted that allied health professionals need to be provided with the infrastructure and systems to collect the data.
- Data capture should consider service mapping over time as short funding timeframes (such as PHN-commissioned services) have a substantial impact on continuity of services. Understanding the shifts in the dollars over time will inform policy and practice, as well as increase the transparency of allocation of resources for remote communities.

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

Data collection is problematic as is usually is collected at the main facility and does not always reflect where the service is delivered. This is also true of ABS data and registration data. Professional association data for the self-regulated professions can be misleading as the AHP does not have to be a member of the association.

Notwithstanding, the following sources may be used:

- Australian Bureau of Statistics (ABS)
- Professional registration data with AHPRA,
- Medicare data
- Jurisdictional data DVA items
- NDIS registrations and $ demand
- HWA workforce needs assessments
- PHN needs assessments and commissioning data
- Australian Institute of Health and Welfare
- NGO data bases
- Commonwealth department data bases
- The NDIS demand map https://blcw.dss.gov.au/ndis-demand-map/

POLICY AREA 2: OPPORTUNITIES FOR RURAL ORIGIN AND INDIGENOUS STUDENTS

General Comments:

Growing the rural allied health workforce is complex and linked to broader issues impacting on rural communities. Limited regional development, economic decline and drought have a direct impact on the recruitment and retention of allied health professionals in rural settings. In this light student quotas alone are likely to have little impact on the available workforce if there are no job opportunities. Investment in regional development projects inclusive of the health sector is required to ensure that jobs are available for allied health graduates. This would include investment in regional universities as a means to sustain rural economies and retain local talent.

SARRAH concurs with the view that city-based training presents a number of downstream and upstream barriers for rural communities and economies. Since many communities have limited access to allied health services, young people are not aware of potential career options in the allied health professions. Strong representation to school students about the existence and nature of allied health careers is essential.

Rural students face significant barriers in terms of social and family isolation and the additional costs associated with living away from home while studying. In 2017 the former Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) was subsumed by the Health Workforce Scholarship Program (HWSP). This changed accessibility of scholarship support for rural students of allied health courses. The value of the former NAHSSS program supported students of undergraduate programs to a maximum of $30,000 over three years of full time equivalent studies ($10,000 per annum). By comparison the Commonwealth Department of Education's Rural and Regional Enterprise Scholarships support students to undertake a qualification in Science, Technology, Engineering and Mathematics (STEM), including in the field of health, valued up to $18,000 for full-time study in a four-year degree. This represents a significant reduction in the level of support provided to rural students

considering a career in the allied health professions. It also falls considerably short of the supports available to students of Medicine through the Bonded Medical Program. SARRAH considers that the current scholarship programs available to support students in undergraduate courses are insufficient to overcome the barriers faced by rural students.

2.1 Introduction of Rural Origin Selection Quotas

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

There is limited evidence to support the efficacy of quotas for students of a rural origin as a means to increase the rural workforce pool. Not enough is known about the timeframe between students leaving rural communities to attend university and returning to work in rural and remote locations. If there was evidence (and there is some in medicine) that the regional universities provide greater percentage of workforce for rural/remote than urban universities, then the Commonwealth should focus on strengthening those programs.

Through the RHMT program, the Commonwealth could consider applying tighter targets to support workforce gaps and disciplines in high demand rather than untargeted placements for students who may never work rurally. In the same way UDRHs could support VET students.

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

This is difficult to estimate without adequate workforce data to draw from. An effective allied health workforce data base will identify local trends and inform quotas required for regional training facilities to match regional workforce needs.

Other data that might provide additional information include government programs involving rural allied health services; cross sector placement opportunities in remote areas (education; health; disability; community services and ACCHOs).

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

SARRAH advocates for a scholarship program linked to reducing HECS debts for graduates working in a rural area for a set amount of time as an example of how this might be achieved.

Rather than establishing quotas for students of a rural background to attend city-based training, more emphasis could be placed on incentivising regional universities and rural campuses of metropolitan universities to offer allied health programs using flexible delivery options such as external programs offered by a combination of online modules and block units of face-to-face study to minimise the time spent away from home. Recent developments including simulation-based training and web-conferencing make external study more accessible and feasible. This would significantly reduce barriers for rural students studying in the allied health professions.

University entrance into courses is very competitive and appears to put certain courses out of reach for rural students. SARRAH suggests a ballot system for all applicants above a certain level ATAR would be a fairer way to allocate student places in popular programs.

Quality undergraduate rural clinical placements are also a challenge in providing undergraduate students with early and frequent exposure to rural practice. Concurrent to any discussion about quotas for students of a rural background there needs to be

consideration of issues impacting on the availability of quality undergraduate rural clinical placements.

- Note that GPs are remunerated for clinical teaching but this does not occur for allied health professionals working in private and non-government sectors.
- Note the inability to bill MBS items (or DVA or NDIS) for services delivered by a student and the associated loss of income to that practice.
- Note disparity between jurisdictions relating to Student Placement Agreements and responsibilities of universities and/or providers to deliver student supervision and support

Regardless of the proportion of students, these issues will impact on the effectiveness of quotas for students of a rural background.

SARRAH notes the comments referring to the development of structured pathways and bridging courses from the VET sector such as enabling Certificate IV allied health assistant (AHA) articulation to allied health qualifications as being the responsibility of the education sector (page 18). It is true that there is work to be done by the education sector to recognise prior learning of AHAs with certificate IV qualifications as credit toward three-year science degrees that then articulate with an entry--level Master's Program in an allied health discipline. However, finding roles in industry for diploma- or degree-qualified assistants is beyond the scope of the education sector. The particular skills and competencies of allied health assistants with additional credentials lend themselves very well to care coordination and case management roles in health. Incentivising the health, disability and primary health care sectors to utilise workers with specific health-related qualifications in care coordination roles (for example in the disability and aged care sectors) will drive demand and create incentives for AHAs to build on their qualifications.

2.2 Opportunities for rural origin Aboriginal and Torres Strait Islander people

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

In general, SARRAH supports the Indigenous Allied Health Association (IAHA) in its approach to the development of the Aboriginal and Torres Strait Islander allied health workforce. Advice from IAHA informs us that growing the Aboriginal and Torres Strait Islander allied health workforce will require the support of mainstream allied health teaching, training and service delivery resources. To this end, earlier comments about flexible options for course delivery and defining career pathways for assistant workers towards gaining an allied health degree are also relevant to grow the Aboriginal and Torres Strait Islander workforce. Such developments will reduce barriers for rural origin Aboriginal and Torres Strait Islander people to obtain allied health qualifications.

Increasing Commonwealth support for the Aboriginal & Torres Strait Islander Health Practitioner (ATSIHP) profession would help stabilise this profession, result in an increased uptake, and therefore bring more young Aboriginal people into the health workforce who might at a later stage decide to train further to become a doctor, nurse or allied health professional.

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

Cultural safety training, for example IAHA's Cultural Responsiveness Training, can be readily integrated into the Allied Health Rural Generalist Pathway education program.

It will be important in future years to focus on building the status and viability of the ATSIHP workforce trained at the Certificate IV level and registered under AHPRA to deliver a range of clinical services. At present this profession is not well acknowledged or supported in some of the jurisdictions, meaning there is limited motivation for young Aboriginal and Torres Strait islander people to take up the accredited ATSIHP training. But Aboriginal Health Workers (AHWs) and ATSIHPs could constitute critical career entry points for younger Aboriginal and Torres Strait Islander people to gain access to a career in the health sector. Without this step, it may be too much to expect young people to enter tertiary level training courses in the professions, where they might need to leave home to attend a training facility and where they are likely to be members of a small ethnic grouping within the student body.

Instead, as ATSIHP students, their fellow students would all be indigenous. Once they have a foothold as an employee in the health system, workers can then decide at a later stage to take on higher level training as a nurse, doctor or allied health professional, or alternatively they may be happy to remain as an ATIHSP if there is a reasonable career structure developed and sufficient acknowledgement for the role from the employer.

Additional Comments:

SARRAH suggests that better access to the health workforce for younger Aboriginal and Torres Strait Islander people will lead to a greater uptake in health professional roles. We consider that growing the ATSIHP workforce and providing pathways to upskill to other professions is an important avenue to target. A combination of locally available study options with appropriately supported entry pathways, combined with local placements and part-time work in the relevant industry (possibly as an AHA or similar) will facilitate growth in the ATSIHP workforce.

The Institute for Urban Indigenous Health together with the University of Queensland and The Murri School have a training and employment model that could be investigated and scaled up. They have increased allied health employment in their Aboriginal community-controlled health service while creating allied health student training places and increasing the visibility of AH careers in Aboriginal schools. Although not rural, their model is inspirational, and their experience could be adapted to rural contexts.

POLICY AREA 3: STRUCTURED RURAL TRAINING AND CAREER PATHWAYS (MMM2 – 7)

General Comments

There is an established Allied Health Rural Generalist Pathway (AHRGP) that is currently implemented nationally. At the time of writing there are sixty two (62) active Allied Health Rural Generalist (AHRG) trainee positions in Queensland, South Australia, New South Wales, the Northern Territory and Tasmania, in addition to twenty two rural generalists who have completed their training[2].

[2] Allied Health Rural Generalist Training Positions 2015-2016 Implementation Summary

SARRAH reiterates that this pathway must be clearly acknowledged and supported in the final recommendations from the National Rural Health Commissioner to the Minister for Rural Health. Commonwealth support is required to identify more training positions, to gain broad recognition for the pathway and to evaluate its effectiveness in attracting and retaining early-career allied health professionals to rural and remote practice.

AHRG traineeships are available for the following professions:

Nutrition and Dietetics	Occupational Therapy	Pharmacy
Physiotherapy	Podiatry	Radiography
Speech Pathology	Psychology	Social Work

Additional disciplines can be added to this list; however the process requires resources and funding to develop discipline-specific training modules for the education program. SARRAH has commenced discussions with Exercise and Sports Science Australia (ESSA) regarding the prospect of developing a stream for Exercise Physiologists.

The next stage of implementation has been designed to facilitate uptake by non-government and private sector service providers, and this will be a short- to medium-term focus for SARRAH to grow the number of AHRG trainee positions nationally. SARRAH will engage with service providers in the non-government and private sectors, and continue to work with state-based health services, to identify potential training positions and work with providers to facilitate the implementation of the pathway in a way that supports that provider's operating environment.

Consultations to date indicate that non-government and private sector service providers are interested in the concept of an allied health rural generalist pathway to support local workforce development initiatives. Examples include disability service providers, those members of SARRAH who have expressed an interest in implementing the AHRGP in private settings, and discussions with PHNs identifying a growing number of examples of allied health services commissioned to provide broad-based programs tailored to community needs. These existing services and programs may prove suitable pilot sites for rural generalist positions.

SARRAH believes that ongoing local engagement with health services, non-government and private providers facilitated by PHNs and the relevant peak bodies may be an effective approach to establishing new trainee positions. Emerging examples of cross-sector collaboration utilising pooled funding are a means to support small independent implementers to pilot AHRGP trainee positions. To this end the current focus on Rural Allied Health Quality, Access and Distribution may stimulate dialogue among providers about the need for closer collaboration in rural communities to identify local solutions to workforce recruitment and retention issues, providing SARRAH with opportunities to raise awareness of the AHRGP as part of those solutions.

Noting the statement about recognition of the Allied Health Rural Generalist in state enterprise agreements with remuneration that reflects the additional skills required to effectively practice in a rural environment (page 25), SARRAH contends that this also needs to be recognised for funding of services through Commonwealth supported programs such

https://www.health.qld.gov.au/__data/assets/pdf_file/0021/700284/ahrgtpsummary1516.PDF

as NDIS, aged care, Royal Flying Doctors Service, and other non-government organisations including Community Controlled services and commissioners of services such as Primary Health Networks. For example, recognition of rural generalist skills and qualifications could be linked with Medicare rebates and telehealth funding.

3.1 Increasing Opportunities for Home Grown Training (End to end and Immersion Training Opportunities)

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

i) full year training?

ii) full course training?

SARRAH supports the concept of early and frequent exposure to clinical placements in rural settings for undergraduate students. This may be achieved in a variety of settings, with larger providers delivering services in rural communities, and with the support of the UDRH, placing students with smaller providers in the area in a hub-and-spoke model. This could include service delivery into remote locations. However in order to incentivise immersion training opportunities, the issue of remuneration for clinical teaching in non-government and private sector needs to be addressed.

For education providers, course accreditation could include a push to innovation in course delivery and curriculum that addresses the workforce maldistribution- for example with full year or full course training in rural and remote locations.

Full-year training will be difficult to implement alongside requisite coursework. Most professions' coursework includes mandatory clinical domains that undergraduate students are required to have experienced across acute, subacute, community health and primary health care. Ideally undergraduate clinical placements would also expose students to other sectors such as disability and aged care. Achieving all this within a single clinical placement, or in a series of clinical placements, will be a challenge. In addition it is unclear whether opportunities to engage in the breadth of clinical training exist in a single location.

An alternative option is to provide greater support for regional universities and rural campuses of metropolitan universities to partner with UDRHs to deliver full or part undergraduate allied health training programs as well as offering flexible delivery methods. Consideration should also be given to ensure UDRHs have sufficient data (by way of effective workforce databases to target disciplines relevant to areas of need.

The Commonwealth government's multidisciplinary training expansion program has provided nearly four years of new financial support to rural and remote nursing and allied health student placement capacity building. Within the limits of SARRAH's knowledge, the role taken by the UDRHs in provisioning increased number of allied health student training placements and building supervision capacity in the rural and remote allied health workforce has been successful. The allied health academic and professional staff networks that this funding stream has facilitated will further strengthen the rural and remote communities in which the UDRH's operate. The students supported by the funding, learn from both their rural/remote allied health supervisor as well as the rural and remote academics. The funding stream has made incremental increases in length of placement however length of placement is largely beyond the control of the UDRH and rests with the accrediting body and the university curriculum design. SARRAH supports a much more ambitious approach that rewards immersion, earlier training based in local communities and a collaboration to re-orient accrediting bodies towards rural and remote learning by immersion.

SARRAH is aware of excellent examples where the Commonwealth funding has facilitated student sponsorship to participate in significant rural-focused professional development. These include conferences such as the National Rural Health Conference, the SARRAH conference, the IAHA conference, as well contributing to remote communities through marketing health careers at local Indigenous festivals (e.g. Barunga in the Katherine NT region) and Career Expos aimed at high school students. These type of UDRH supported activities align with growing a larger, culturally appropriate and well prepared allied health workforce for remote and rural Australia.

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

SARRAH suggests that programs such as the John Flynn Program need to be targeted toward students with aspirations for a rural career. An alternative solution is to direct universities to collaborate with UDRHs and allied health accrediting bodies to design full immersion clinical placements.

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

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

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

- Targeted funding to UDRHs to provide training beyond student placement programs
- Articulation pathway for allied health assistants to progress to a science degree and entry-level masters to an allied health program. For this to be effective there is a need to resolve industry role recognition for workers holding a Diploma in Allied Health Assistance or a Bachelor Rehabilitation Science. The Commonwealth could consider incentivising employers to develop care coordination roles in primary care, aged care, disability sectors that utilise these qualifications.
- Remuneration for clinical education that takes place in the private sector
- Fast-track activity-based funding of teaching and training in public hospital settings that recognises allied health activity
- Invest in greater support for new graduate rural training places and quality supervision in the workplace. Work closely with the education sector to achieve a good outcome
- Review the findings of the RHMT evaluation being undertaken in 2019/2020
- Evaluation results from students who undertake rural and remote placements demonstrate that many of them experience a shifting of their worldview. However, these are young people who are mobile in their career expectations so consideration should be given to develop strategies to attract the most appropriate and retain them for as long as possible in order to ensure best possible health care delivery across Australia.

3.2 Career pathways in rural allied health (MMM4 – 7)

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

- The HWSP should provide all the support required to the employee as well as the employer to make sure the pathway is fully implemented.
- Caution should be exercised regarding the concept of remote placements to ensure that in instances where scholarships provide support to training positions that are in partnership across agencies, the scholarship holder is an additional (supernumerary) position in remote practice and not a sole practitioner. This is to ensure that appropriate support and supervision arrangements for the trainee are in place. This could be written into program guidelines.
- Expansion of the HWSP to include public and private sector AHPs to avoid ongoing workforce fragmentation in rural locations
- Include support to AHAs to enrol in training
- Provide HECS fee relief for early career graduates working in rural locations
- The scholarship must provide support for collaborative employment and training models and appropriate supports and supervision.

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

SARRAH members have conflicting views about the efficacy of return of service requirements. Evaluation of existing programs is required to draw conclusions about the efficacy of such programs in allied health services.

Programs should target the entire pipeline, starting with rural and remote and Aboriginal Torres Strait Islander high school students and continuing to support mature career allied health professionals through opportunities to develop in areas such as leadership and research.

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

SARRAH refers the Commissioner to the defined roles and responsibilities of stakeholders in the implementation of the established allied health rural generalist pathway:

- An entity responsible for the expansion of the existing AHRGP by engaging with service providers to identify trainee positions and offer support
- A project steering committee including representatives from lead service provider organisations, education providers, professional associations, peak bodies and funders (ie the Commonwealth Department of Health)
- Project sub-committee comprising service organisations implementing the pathway for the purpose of trouble-shooting and network support
- Independent evaluation of outcomes

In addition:

- Linkages with the Quality and Safety Commission and the education sector for the purpose of coursework accreditation
- Linkages with individual professional associations in ongoing development of rural allied health professionals and input into relevant profession-specific standards as required.

The established allied health rural generalist pathway requires the full support of the Commonwealth to facilitate early career allied health professionals establish a career in rural practice

The establishment of a Rural Allied Health College would provide the quality and safety framework by facilitating the further development and accreditation of the AHRGP onto a full national footing to cover the non-government and private sectors as well as public sector workers in rural health. This would include further post graduate training and professional development opportunities, and potentially the establishment of a credentialing system to acknowledge experienced rural practitioners in the field and those undertake ongoing rural health training apart from the rural generalist program

Additional Comments:

SARRAH supports the expansion of the established Allied Health Rural Generalist Pathway (AHRGP) and raises the following points:

- At the time of writing there are sixty two (62) AHRGP trainees working across five jurisdictions;
- Consultations regarding the AHRGP have occurred with multiple groups including the membership of the Australian Allied Health Leadership Forum (AAHLF);
- The project governance group for the AHRGP has identified that the Pathway has broad support within the sector, and that it is the only formal, integrated service, workforce and training pathway known to be implemented and evaluated for the allied health professions;
- The post-graduate education program through James Cook University (JCU) offers training in clinical and professional/service topics for 9 allied health professions;
- An accreditation system for post-graduate allied health rural generalist education programs was developed by the Australian Healthcare and Hospitals Association (AHHA) in 2018 through extensive consultation with professional associations and regulatory bodies, health services, commissioning agencies, consumers and other stakeholders. The system including a competency framework, education framework, and accreditation body and process resources, and is ready to implement when funding is available to support an independent quality assessment process for rural generalist education programs;
- Evidence from Queensland on the 2014-2018 training cohorts indicates that the employment destination of the AHRG trainees at 6 months after separation from the temporary training roles used in the trial is 71% in Queensland Health regional, rural and remote services;
- While the AHRGP is primarily implemented in state-based health services at this time, the model is designed to be applicable in other sectors such as primary health care, disability and aged care. Private and non-government service providers who can offer appropriate supervision and governance arrangements for AHRG trainees can implement the Allied Health Rural Generalist Pathway, including accessing information resources and advice from SARRAH and health service partners. The PGG membership would be broadened to include these stakeholders.

4.1 Integrated Allied Health Hubs

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

SARRAH supports the concept of Integrated Allied Health Hubs serving regional catchment areas as a means to facilitate consortium arrangements for effective pooling of funding and capacity-building.

SARRAH is collaborating with the Regional Australia Institute and the National Rural Health Alliance to investigate sector readiness for building a locally-defined health precinct, inclusive of allied health services, in order to enhance business viability, improve access to health care and improve health outcomes. The project will use participatory action research methods to bring together key health sector businesses and stakeholders in regional communities to engage with each other in order to identify what is needed to establish and grow viable health businesses in rural locations. The research will be conducted in five towns and small cities across northern Australia. It is anticipated that research outcomes will contribute to our understanding of sector readiness in the establishment of integrated allied health hubs.

The interface between IAHHs and existing state-based health services will be critical. Health service delivery varies between states in terms of the extent to which primary care, aged care and disability services are provided. This would require clear business rules for IAHHs that support collaborative efforts between state and Commonwealth-funded services to reduce duplication and/or competition. Close planning and agreement between the Commonwealth and states would need to be achieved to make this work effectively, and to avoid problems like cost shifting and mismatch of services to priority health needs, and to ensure appropriately flexible work practices between different organisations to promote workforce development of suitable scale.

In addition, funding streams across primary health care, aged care and the NDIS, together with their associated governance and accreditation frameworks, need to be streamlined in order that IAHHs can be successful. This is so that clients can move seamlessly as required from one stream to another without the need for multiple assessments, and to reduce the administrative burden on allied health professionals and service managers who may be providing services to clients eligible for services in multiple streams.

Improving the viability of non-government and private sector consortium members includes reducing the administrative burden for services to disability clients by waiving the NDIS registration and accreditation fees, streamlining reporting for NDIS plans and streamlining the process for applying for assistive technology.

Member feedback informs us that certain requirements for clients to utilise "mainstream supports" before turning to the NDIS impose barriers so significant that clients may not access services at all. An example is the requirement that clients with mental health conditions utilise services available through GP mental health care plans prior to applying for support through the NDIS. Since the MBS items available under GP mental health care plans are rebated at significantly lower rates than the market rate, health professionals find it necessary to charge a service gap in order to remain viable. This creates a cost impost to the client, which for some is too great, and so they do not access primary health care services at all, and are subsequently prevented from accessing the NDIS. Given the significant differences

in funding arrangements for services under the NDIS, SARRAH suggests that such prerequisites to accessing NDIS services should be removed.

Industrial provisions are often a barrier to consortium arrangements between government departments and the non-government sector. Flexible procurement arrangements would assist consortia to negotiate effective agreements that allow pooling of funds to occur. The approach needs to consider allied health professional skills and capacity to engage on the cross-sector agenda. This is complex because collaborators may also be competitors in private sector. One solution is to ensure that allied health-specific leadership and management capacity is built into the IAHH structure to enable peer relationship building and that technical and clinical governance aspects are appropriately designed. This includes effective workforce design and development to optimise the recruitment and retention of the allied health workforce.

Integrated allied health hubs need to be co-designed with local services so as not to "squeeze out" existing private sector clinics. SARRAH is concerned about the prospect of a large national corporate organisation taking a contract to operate a hub and subsequently putting pressure on local health professionals to work under their umbrella, such that local small businesses become unviable. To bolster the viability of rural allied health practices operating in a location where an IAHH is proposed, the Commonwealth should consider protections for local businesses such as supplementary funding, infrastructure grants, loading of fee schedules based on rurality, and practice incentive payments to ensure that local practices are not disadvantaged by the establishment of an IAHH.

Clear guidelines for managing workers compensation and privately insured patients presenting for services are required. Prioritisation should be based on Commonwealth health priorities otherwise there is a possibility that services will be skewed toward low acuity, low risk clients. The AHRGP provides the framework and guidance on delivery of services which are high priority for the community.

Further, consideration of the challenges faced by clients living with chronic disease and disability in rural and remote locations should be considered to improve access to local allied health services. Our members advise that in rural and remote areas virtually all clients are complex regardless of their condition due to the additional challenges faced because of reduced access to specialist service and fewer resources available to assist them to cope with their condition.

Other factors to consider:

- Consideration should be given to the creation of attractive recruitment packages for prospective hub employees, including relocation assistance, competitive salaries, guaranteed professional support and training allowances
- Structured and supported trans-professional care should be utilised to decrease the time in travel and provide more care. AHAs placed in hubs to support the implementation of patient care plans would provide career pathways for AHAs; provide continuity of care and decrease outreach and travel.
- Clinical education should be incorporated into all of the hub sites as part of funding. Telehealth services need to be funded under Medicare and only utilised as a last resort if face to face services were not available or in instances where telehealth is the normal method of service delivery regardless of geographical location.
- Existing infrastructure needs to be utilised where possible, and care in home where it makes sense, through telehealth and other mechanisms. Present providers and outreach

services are often not well documented but programs like Check Up support these services.
- The elements of the AHRGP support this model of care.
- Take a population health approach, not necessarily "service gap", to identify IAHH locations. Just because a rural community has a physio present doesn't mean they are delivering primary care services.
- Development of IAHHs must be in close collaboration with local regional communities and local government councils, and must cohere closely to the health profile and health needs of each particular region. This work shouldn't be left to PHNs in isolation
- IAHHS would need to consult closely with current local service providers, NGO, private and public sector, to ensure adverse outcomes for established local practitioners are avoided
- IHHAs must address priority health areas and clear measures established early for effective evaluation of the benefits of each IHHA.
- Infrastructure to support data collection and the framework and data sets to evaluate these hubs is essential. This would include the national allied health best practice data set.

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

North and West Remote Health (NWRH)[3] has been delivering community based and outreach allied health, aged care, wellbeing and disability services in regional, rural and remote Australia since 1993. NWRH harnesses the diversity, energy and professionalism of a large team of health care professionals to provide an array of healthcare services to local rural communities[4].

In collaboration with the three local providers in Mt Isa, NWRH, Gidgee Healing, and the public hospital and education department a hybrid model could be created. Sharing staff across the services and embedding education and training and research with the UDRH could provide a great training experience for employees.

A private physiotherapist located in Corowa, NSW, has implemented a number of projects in collaboration with the local PHN and health service. These include a program utilising pooled funding from a former Medicare Local and the local health service to provide physiotherapy services across four communities in rural NSW[5], and a program commissioned by the primary health network to target and reduce or arrest the development of frailty in community-dwelling older people[6].

[3] https://nwrh.com.au/

[4] Stanley-Davies PJ and Battye KM (2004). The Division with the Vision: Development of the North West Queensland Allied Health Service by North and West Queensland Primary Health Care. Evaluation of Stage 1. Townsville: NWQPHC

[5] https://www.aci.health.nsw.gov.au/ie/projects/public-private-rural-physiotherapy-service

[6] http://www.nahc.com.au/3223

Murrumbidgee PHN has developed an allied health wellness and resilience model that includes as an objective to promote networking between existing local allied health service providers to deliver a model of care across the region[7].

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

SARRAH supports the concept of Integrated Allied Health Hubs and the role they may play in growing the allied health workforce. The funding period for the establishment, operation and meaningful evaluation of IAHHs should be sufficient to enable medium- to long-term employment contracts for allied health professionals in the interest of providing job security. In addition, contract renewals for funding of IAHHs need to be finalised well in advance (we suggest twelve months) to afford tenure for employees of IAHHs.

The most likely group to be able to facilitate local tailoring of services is the PHN. However, their knowledge of and level of engagement with the allied health sector varies widely. This does not need to be the only model depending on the community needs and cultural issues. Local workforce development should take priority over fly-in fly-out (FIFO) services. The local model would need to negotiate changing the role and model of FIFO services toward an effective outreach model delivering continuity of care for remote communities. There needs to be funding for the coordination and evaluation arm of these models.

The Commonwealth could consider streamlining accreditation frameworks for Disability, Aged Care and Primary Health Care to simplify administrative requirements and enable allied health professionals engaged by IAHHs to work across funding streams.

Other options include blended funding stream consisting of:

- MBS, disability, DVA and private income streams
- Consider some block-funding of services (supplementary funding or infrastructure or loading or practice incentive payments) to ensure that high-complexity clients can access allied health interventions eg mental health, complex disability clients (need eligibility criteria that prioritise these clients)
- Consider costs of travel to provide outreach services to outlying communities from the hub
- Consider capping cost of consumables for people living in remote locations
- Remuneration for services delivered by AHAs
- Consider teaching and training as part of funding model; linkages with regional training hubs and UDRHs

The Commonwealth could consider redistributing underspends in government programs such as the MBS, NDIS and My Aged Care based on national averages. Where a remote area does not meet the national average spend (due to market failure and lack of service access), the Commonwealth could pay out the difference as a deficit payment to allow a hub organisation operating in a remote region to purchase additional services to meet needs.

[7] https://www.tenderlink.com/mphn/

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

Through the operational guidelines for IAHHs, providers may be incentivised to engage models of care that utilise the assistant workforce, as well as including effective governance arrangements for the safe delegation of work to assistants. An allied health assistant located in a smaller community and supervised remotely would provide better continuity of care for patients. The service model should consider blended revenue streams including Medicare, and support rebates for services delivered by allied health assistants.

In addition, the Commonwealth could support development of:

- National policy on governance of AHA roles
- Promotion and funding of relevant research and trials
- Learning from what the jurisdictions have achieved by developing AHA roles, and then focus support for the private and NGO sectors to integrate assistants into their models in rural service provision

4.2 Viable Rural Markets

General Comments

SARRAH supports the concept of appropriate remuneration for the complexity of work in rural and remote locations. All three options listed at point 3 on page 39 should be considered, with special attention given to unintended consequences arising from funders' definitions of complexity. To this end SARRAH supports loading based on rurality rather than complexity to avoid over-complicating the client's eligibility process.

In addition, SARRAH believes that remuneration for the provision of clinical teaching in the private and non-government sectors should be implemented.

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

The Commonwealth can play an important role in improving the viability of private allied health services in rural and remote locations. This is both in terms of the funding streams accessed by private practitioners, and through incentivising their connection to their local primary health networks. Support of the sector is required in order to facilitate private practices transitioning to electronic medical records. This will also support improved workforce and activity data in the allied health sector.

Access to allied health services can be improved immediately by expanding or uncapping the number of allied health items available to eligible clients under relevant programs included in the Medical Benefits Scheme. Exploring the GP incentive payment programs for their relevance to the allied health sector may improve the level of engagement by private practitioners with primary health care priorities. To ensure quality service provision these rebates and incentives may be linked to relevant quality and safety frameworks, noting some caution in ensuring these frameworks are accessible and affordable for the small businesses that characterise the private sector in rural locations.

In addition, private health insurers should be directed to provide rebates for services delivered by telehealth. This is particularly important for child development services which have been shown to be effectively delivered by telehealth.

SARRAH suggests allowing funding to be combined into one package to deliver services, and allow more streamlined services for the community. The current approaches by different Commonwealth funding agencies create unnecessary complexity and gaps in service which is impossible for the consumer to navigate. It also can mean multiple service providers in a community offering very little, very infrequently at a great cost. If funding is combined, the contractual reporting requirements need to be similarly streamlined.

A short term solution to improve access to allied health services for rural NDIS clients lies in allowing flexibility to enable clients who are not self-managed to utilise local service providers who may not be registered with NDIS.

We note the issue around 19/2 COAG and add that there are limitations in the scope of services delivered by state-based health services that constrain the scope of services that are able to be provided by health services due to operational requirements.

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

- Removing cap for MBS items accessed under Better Access, the Chronic Disease Management Program and Medicare Follow-up
- Incentive payments to existing practices in the form of loading and/or incentive programs similar to those available to GPs
- Allowing flexibility to enable NDIS clients who are not self-managed to utilise local service providers who may not be registered with NDIS

In addition:

- Adopt a "pipeline" approach to rural workforce development; therefore:
    - Support remuneration for clinical training in private practice (balanced by the capacity of that practice to expose students to a broad client population)
    - Support repayment of HECS debt for early career AHPs working rurally
    - Support amendments to 19/2 of the HIA noting the work involved to a) reach local agreements and b) ensure the scope of service delivered by a single employer is addressed.
- Providing HECS loan assistance for rural origin allied health students would be a powerful and positive measure. Support for AHRG training and HECs fees together could be incentive and at least keep them there 3 years. Agree with the three years concept
- Funding greater capacity for rural and remote area clinical placements and quality supervision would meet needs of students, health providers and training institutions, and likely produce more workforce for rural employment.
- SARRAH acknowledges that the Commonwealth RHMT expansion funding has made considerable funds available to universities with a UDRH to support nursing and allied health student placements and workforce capacity building. However there is a need for workforce development above and beyond placements.

Additional Comments

Following from earlier statements regarding the supportive functions of AHAs, it should be noted that growth in roles for AHAs should not detract from the need to grow the allied health professional workforce required for safe and effective delegation of tasks to AHAs.

5.1 Fund eHealth software and systems

5.2 Fund training in telehealth and promote awareness

5.3 Fund virtual training

5.4 Fund allied health services delivered by telehealth

5.5 Fund allied health intra-disciplinary case conferences

General Comments:

SARRAH strongly supports Commonwealth initiatives that enable rural allied health professionals to delivery services by a range of modalities including telehealth. We also agree that telehealth is an important adjunct to allied health service delivery, but does not replace face-to-face consultations with clients. Caution should be exercised to ensure local services offered a blend of face-to-face and telehealth service modalities are prioritised for rural and remote communities over large business models offering telehealth-only services.

SARRAH points out the limitations of private health insurance for people living in rural and remote Australia. For people living in regions of lower socioeconomic demographics and where health services are less accessible, private health insurance represents poor value in view of the high cost of insurance, poor access to services and lower rebates leading to higher out-of-pocket expenses. Private health insurers should provide rebates for allied health services delivered via telehealth as a standard model of service delivery as a critical step to improving access to allied health services for people living in rural and remote Australia. Such issues should not be left to the discretion of the health insurer. This recognition needs to extend beyond private health insurers' own telephony services.

All the options listed for consideration in this policy area are strongly supported by SARRAH for implementation by the Commonwealth.

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

SARRAH reiterates that the established allied health rural generalist pathway includes specific training in the use of telehealth. The discussion paper has already mentioned the resources developed by the Cunningham Centre[8].

SARRAH is aware of some good models where student-led clinics use telehealth at University of Queensland. The university sector should be encouraged to embed these skills in pre-entry training[9].

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

State-based health services have incentivised telehealth consultations for public clinics, similar to the proposed Medicare payments. There are also examples of telehealth models commissioned by PHNs that improve access to GP care for residents of aged care facilities..

[8] https://www.health.qld.gov.au/cunninghamcentre/html/telehealth

[9] https://health-clinics.uq.edu.au/services/telerehabilitation

Rural Workforce Agencies are another avenue to design and implement services delivered by telehealth. This should be applied to disability and aged care services.

GENERAL QUESTIONS

Please describe any other options or considerations for the Commonwealth which could affect distribution, quality and access for rural allied health services.

The current inequities in health outcomes experienced by people living in rural and remote Australia make an imperative of the need to implement the policy reforms proposed in this paper. SARRAH has previously published an economic analysis of the impact of allied health professionals (AHPs) in improving health outcomes and reducing the cost of treating selected chronic diseases, which identified conservative estimated annual savings of $175 million to the Australian healthcare budget from the implementation of eight allied health interventions[10]. The report also found that a significant number of negative health outcomes such as lower limb amputation and kidney failure were reduced when patients are treated by AHPs. The cost of implementing policy reforms will be offset by these savings and the positive impacts on the health and wellbeing of rural and remote communities.

To summarise, SARRAH's key issues are:

- The rural health picture is worse than is should or needs to be.
- Allied health professionals provide services relevant to better health outcomes
- Current funding models do not adequately support the provision of allied health services in rural and remote areas, and market failure is a feature of many contexts
- The Commonwealth has a key leadership role to play in the development of private and non-government allied health services in rural and remote Australia
- The Commonwealth and states must work closely together on this issue.
- The Commonwealth needs to re-double efforts to 'rural proof' its national health programs including Primary Health Care, NDIS and My Aged Care to ensure they are effective in rural communities
- There needs to be robust evaluation and research to support the implementation of the initiatives.

The benefits to be gained by improved access to allied health services for rural and remote Australians is clear, and SARRAH calls for the adoption of all of the policy options outlined here to be implemented by the Commonwealth government.

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[10] Adams, J and Tocchini L (2015) The impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke. A report developed for Services for Australian Rural and Remote Allied Health