SARRAH
Services for Australian
Rural and Remote Allied Health

Jobs for the Future in Regional Areas

Submission to the Senate Selection Committee Inquiry

September 2019

Services for Australian Rural and Remote Allied Health
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Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public 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.

Submission to the inquiry into the Jobs for the Future in Regional Areas

Thank you for the opportunity to provide a submission to the Jobs for the Future in Regional Areas inquiry. As a national organisation formed by people living and working in rural, with the aim of improving the quality of life, well-being, resilience, and capability of people and communities in rural and remote Australia SARRAH welcomes this Inquiry.

Terms of Reference

SARRAH's submission focuses on:

- high demand for skilled allied health services and professionals in rural Australia and the associated health, wellbeing, capacity enabling, economic and employment opportunities for rural communities; and
- opportunities to improve the distribution and viability of allied health practice in rural Australia.

As such, our submission deals substantially with several aspects of the Terms of Reference. Our submission provides an overarching perspective on the value of allied health services and capacity in rural communities relevant to the Inquiry ToR, in particular:

a. new industries and employment opportunities that can be created in the regions; and

e. measures to guide the transition into new industries and employment, including:

i) community infrastructure to attract investment and job creation;

iii) meaningful community consultation to guide the transition; and

iv) the role of vocational education providers, including TAFE, in enabling reskilling and retraining;

g. any related matters.

SUMMARY OF KEY POINTS

Allied health professionals (AHPs) provide a wide range of services and supports across all stages of the lifecycle and in every health and associated service setting, including disability services, aged care and schools.

The health and social assistance sector is projected by the Commonwealth Government to be the greatest source of employment growth and demand for the next five years – with an additional 250,000 jobs – continuing the trend of the past decade.

Allied health professionals are among the professions with the highest rates of growing demand – for example: Physiotherapists - 24.9%; Audiologists and Speech Pathologists /Therapists - 38.3%; and Nutrition professionals - 17.6%.

There are already acute shortages of allied health professionals in rural and remote Australia – far worse comparatively than for nurses and medical practitioners. There is a serious risk that this situation could worsen in rural Australia as overall demand increases nationally. AHPS practices and employment in rural communities contributes economically, especially where the service is based in the community and not provided on a visiting, sporadic or similar basis.

In addition to delivering skills and employment for people living in rural areas directly, AHPs provide services that support economic participation, recovery and participation across the population and impacting the productivity of every industry sector. AHP services and therapies:

- Contribute to reducing prevalence and impact of disease, including chronic disease which costs the national economy $billions per year in direct health costs, absenteeism and lost productivity;
- Aids in rehabilitation and recovery, increasing the capacity for individuals to maintain self-reliance, be less dependent on public outlays on publicly funded services (including income support) and contribute revenue;
- Could potentially further reduce the high rate of avoidable hospitalisations and strain on available local services, that can be particularly high in rural and remote Australia – and correlating broadly with areas where allied health service access is relatively poor.
- If and where available, improve the community outcomes and cost-effectiveness of national health and other priorities and strategies including in primary health care, the NDIS and aged care – which are much needed in rural communities.

As noted above high and growing demand and workforce and skills shortages, coupled with opportunities to better utilise education and service structures to support rural allied health education and career pathways, presents a coherent opportunity to increase the capacity and resilience of rural communities. This capacity would underpin, support and complement development in any other rural industry and investment.

Developing the allied and related health and support workforce – with career and role-models, clinical and work experience and pathways options in rural communities - should be an employment priority. The demand for these services, the illness and disease rates of rural Australians, the costs of service and the negative impacts for productivity will not reduce if there is not a rural workforce to provide them.

Health and capacity-building: rural industries, community strength and viability

Health services and jobs underpin, enable and complement other industries, employment and sustainable living in rural Australia. They are neither an alternative to nor a drain on other potential industry development, support or employment. Rural communities, including local employers, industries, workers and their families would benefit if better access to allied health services were available.

The focus on primary industry development and the need for skills and workforce capability is a strong, current and important theme in many portfolio areas, including industry, agriculture rural development, employment and education and training (at the schools, VET and university levels). SARRAH appreciates the emphasis and continuing need to re-invest in technical trades, apprenticeships, skills capacity and to strengthen alignment between university education, forecast demand and employability. These contribute to diverse, robust and resilient rural communities and economies, which in turn rely on healthy and engaged families and individuals.

Allied health professionals (AHPs) provide a wide range of services and supports across all stages of the lifecycle and in every health and associated service setting, including disability services, aged care and schools. However, there is an acute shortage of allied health professionals in rural and remote Australia. Measures to support better distribution of this workforce and service access must would meet economic and employment as well as health objective.

Access to allied health services in rural and remote Australia is a chronic issue.

- The shortage of allied health professions in rural and remote Australia pre-dates the NDIS and the growing attention on access and provision of quality aged care services. These developments have intensified awareness of the need for more viable options to support distributed allied health services,employment opportunities and funding supports to enable viable practice in many communities.
- As the Australian Government's National Health Workforce Dataset shows[1] the geographic distribution of many allied health professions is heavily skewed toward major population centres (where financially viable and professionally supported practice is more viable) and often resembles more closely the distribution and shortage patterns of (non-GP) medical specialists than it does other doctors and nurses.

[1] https://hwd.health.gov.au/publications.html#alliedh17

Note – there is no reliable data on the number or location of around half of all allied health professions in Australia. Reliable data is only available for professions registered under the National Registration and Accreditation Scheme (NRAS) for health professions, and so excludes professions such as speech pathologists, audiologists, dieticians, social workers and exercise physiologists to name a few.

Drivers and demand for allied health & workforce distribution

The Commonwealth's own workforce projections show employment in the **health care and social assistance continues to be the fastest growing of any Australian employment sector, with <u>another 250,300</u> jobs projected over the five years to May 2023**[2].

At an occupation level, the **projected increases** (over and above the existing occupation-level workforce) include:

- Nutrition professionals - 17.6%
- Medical imaging professionals – 11.3%
- Dental practitioners - 16.7%
- Occupational therapists - 14.6%
- Physiotherapists - 24.9%
- Podiatrists – 17.2%
- Audiologists and Speech Pathologists/Therapists - 38.3%.

Current and chronic inequities in health outcomes experienced by people living in rural and remote Australia make local service access, including workforce development and support, an imperative.

However, there are severe and ongoing allied health workforce shortages in rural Australia. The current distribution of the allied health workforce and service capacity is heavily skewed toward metropolitan centres and this has serious implications for rural communities that could be further exacerbated by continuing high demand for allied health professionals nationally.

The following table illustrates the geographic distribution and practitioner to population ratios of a selection of allied health professions compared with medical practitioners, nurses and midwives.[3].

The maldistribution (shortage) of allied health professionals is about more than choice.

There is a structural need for employment and income generating opportunities that enable:

a) the distribution of allied health professionals as they currently do the medical and nursing workforce – e.g. hospital employment profiles, general practice supported by Medicare and other assistance measure etc; and
b) service structures that enable viable 'mixed' (cross-sector) practice in rural and remote settings

[2] Department of Jobs and Small Business, 2018, 2018 Employment Projections - for the five years to May 2023 http://lmip.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections

[3] Battye, K., Roufeil, L., Edwards, M., Hardaker, L., Janssen, T., Wilkins, R. (2019). Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review. Services for Australian Rural and Remote Allied Health (SARRAH), page 10.

Table 1: Rate of Full Time Equivalent AHPs per 100,000 population by remoteness areas (2016)

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Allied Health Professions	No of FTE professionals per 100,000 population				
Medical Radiation Practitioners	54.93	43.22	30.90	25.19	12.35
Oral Health Practitioners*	82.20	60.42	53.82	42.21	21.74
Occupational Therapists	62.18	47.43	46.52	38.13	22.73
Optometrists*	19.74	15.85	11.46	9.19	3.95
Osteopaths*	7.96	6.17	2.30	NP	NP
Pharmacists	99.35	78.07	78.01	74.89	45.95
Physiotherapists	103.78	66.30	55.44	43.91	40.51
Podiatrists	17.72	17.21	10.97	10.55	5.93
Psychologists	103.17	61.25	45.84	35.40	20.75
Other Health Professions					
Medical Practitioners	440.88	302.44	284.73	331.90	220.34
Nurses and Midwives	1157.15	1105.59	1099.88	1304.78	1192.12

Source: Australian Government Department of Health, 2018

The rural health picture is worse than it should or needs to be. Current service systems are fragmented and, in combination with existing funding models and program-centric (rather than patient or community-centric) contract and service models do not adequately support the provision of allied health services in rural and remote areas; meaning "market failure" is a feature of many contexts where community need, demand and eligibility could otherwise support viable local services and sustainability

There are many programs and policy review processes currently underway that could inform the work and possible Recommendations of the Inquiry. Some of these are identified toward the end of this submission.

Economic impacts of allied health

Allied health Professional (AHPs) provide services that support economic participation, recovery and participation across the population and impacting the productivity of every industry sector. AHP services and therapies:

- Contribute to reducing prevalence and impact of disease, including chronic disease which costs the national economy $billions per year in direct health costs, absenteeism and lost productivity;
- Aids in rehabilitation and recovery, increasing the capacity for individuals to maintain self-reliance, be less dependent on public outlays on publicly funded services (including income support) and contribute revenue;
- Could potentially further reduce the high rate of avoidable hospitalisations and strain on available local services, that can be particularly high in rural and remote Australia – and correlating broadly with areas where allied health service access is relatively poor.
- If and where available, improve the community outcomes and cost-effectiveness of national health and other priorities and strategies including in primary health care, the NDIS and aged care – which are much needed in rural communities.

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. The analysis estimated, conservatively, **annual savings of $175 million to the Australian healthcare budget from the implementation of eight allied health interventions**[4]. 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. Implementing policy reforms that build allied health service capacity and workforce would involve some cost but these would be by these savings and the positive impacts on the health and wellbeing of rural and remote communities.

Potentially preventable hospitalisations cost the country $2.3 billion every year, according to finder.com.au using data from the Australian Institute of Health and Welfare (AIHW).

The AIHW data on preventable hospitalisations were also more prevalent in rural and remote Australia, correlating broadly with the areas of greatest allied health service and workforce shortage.

There was even greater variation across the more than 300 smaller local areas (SA3s). The age-standardised rates of PPH were more than five times as high in some areas compared with others, ranging from 1,540 per 100,000 people in Barwon–West (Vic) to 9,286 hospitalisations per 100,000 in Alice Springs (NT).[5]

For example: the potentially preventable hospitalisation rate (PPH) per 1,000 population by remoteness area shown below[6]:

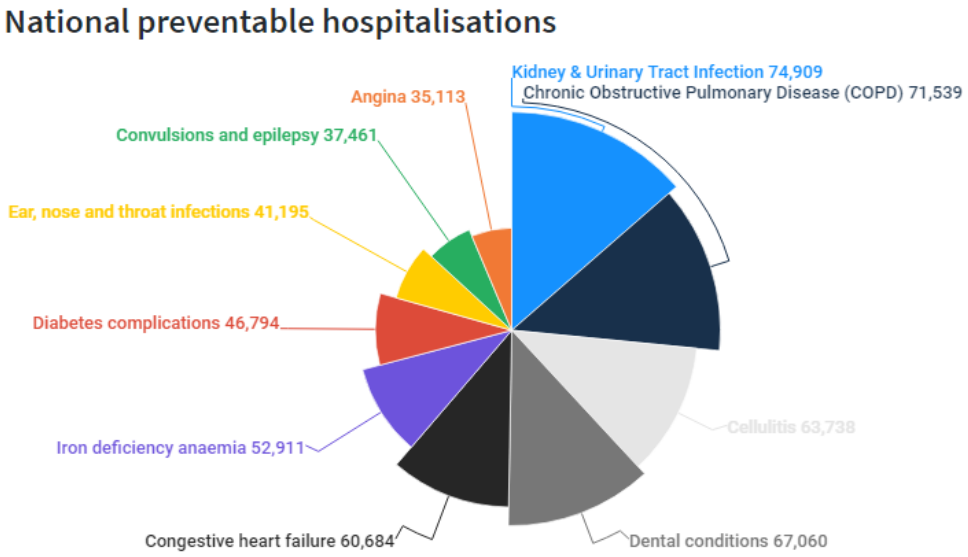
	Major cities	Inner regional	Outer regional	Remote	Very remote
PPH	**25.0**	**27.0**	**29.9**	**39.5**	**60.9**

The following graph illustrates the conditions associated with potentially preventable hospitalisations, many of which could be ameliorated or avoided with adequate allied health and/or other primary health care services.

[4] 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

[5] https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview

[6] Australia's Health 2018 (p. 268) https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf



Source: https://www.finder.com.au/preventable-hospitalisations

Contextual challenges for allied health

Demographic, geographic, lower income and a range of other environmental and structural factors also constrain the distribution of allied health professionals and services.

Rural and remote allied health practitioners face other service and viability challenges including:

- lower population income levels (and demand for Private Health Insurance-supported services etc); and
- higher burdens of chronic disease, disability among this population[7] (especially among Aboriginal and Torres strait Islander people).

Impediments to allied health workforce distribution are systemic and result in chronic differentials in service access health outcomes. This is evident in a wide range of health data published by the Australian Institute of Health and Welfare (AIHW) and others comparing the health and wellbeing of people living in rural Australia compared with the rest of the population. The Australian Atlas of Healthcare Variation Series[8] produced by the Australian Commission on Safety and Quality in Healthcare (ACSQHC) documents vast differences in treatment, health conditions and impacts across Australia, especially between metropolitan and remote locations. The ACSQHC presents a confronting and unfavourable profile of the health outcomes of Australians living in much of rural and remote Australia.

Further, many people living in rural and remote Australia have little or no experience of allied health services and consequently are unlikely to identify these or consider them on an informed basis in planning discussions. This is a major risk especially where few publicly funded or private allied health services are available, as in much of rural and remote Australia.

[7] These statistics are well known and can be readily found in information reported by the Australian Institute of Health and Welfare (AIHW) and the Australian Commission on Quality and Safety in Health Care (ACQSHC).

[8] https://www.safetyandquality.gov.au/publications-and-resources/australian-atlas-healthcare-variation-series

Consequently, there is often unidentified or under-identified demand for allied health services in rural and remote Australia and the employment, support structures and income generating mechanisms are absent or obscure. This could be addressed if more integrated and coordinated and service delivery arrangements were supported (e.g. considering the joint servicing demand of the health system(s), NDIS, aged care and others).

Growing the rural allied health workforce would help sustain rural economies and retain local talent. Despite notable improvements in rural health training, especially for medicine with the Commonwealth's support of the rural medical training pathway, allied health education and training remains relatively under-developed, with 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.

Many of the practice supports available for GPs, such as remuneration for clinical teaching and supervision are not available for allied health professionals working in either private and non-government sectors. Extensions of these supports would assist to establish local practice viability as well as employment and distribution options.

Rural students face significant barriers in terms of social and family isolation and the additional costs associated with living away from home while studying. The experience of many Aboriginal and Torres Strait Islander communities and individuals, especially, is reflected in their massive under-representation in the allied health professions – requiring a 6-8 fold increase to reach population parity.

Tailored, coordinated and 'localised' (place-based) allied health (and other services) are needed to address these issues effectively and sustainably.

Employment opportunities are a significant limiting factor. Even if positions exist, they are often isolated, lack experienced supervision and support.

The expense of delivering services in many remote settings precludes private allied health service provision. Significant travel time and expenses associated with regional, rural and remote services are not sufficiently offset by provisions under present funding instruments to support small rural business models. The significance of these issues could be better appreciated in reflecting on the practicalities of servicing a similar population over an area of several city blocks versus an area the size of Victoria.

Allied health education and employment pathways - opportunities

SARRAH believes there is considerable scope to increase the **Allied Health Assistance workforce in rural Australia**, and in doing so, generate education and employment pathways that are both accessible to people of rural origin and allows them to balance study, work and other responsibilities.

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"[9]. Allied health assistants cannot "substitute" the work of allied health professionals but safe delegation of some aspects of treatment entirely possible for allied health assistants under supervising allied health professional – e.g. following a comprehensive assessment of a

[9] 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

patient, developed a care plan, and it has been 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. There is considerable scope to increase the role

SARRAH advocates more could be done to develop structured pathways and bridging courses from the VET sector such as enabling Certificate IV allied health assistant (AHA) articulation to allied health qualifications.

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.

Another key development is the **Allied Health Rural Generalist Pathway (AHRGP).**

There is an established Allied Health Rural Generalist Pathway that is being implemented in several jurisdictions. 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[10].

SARRAH is currently working with the Commonwealth Department of Health to investigate and promote the AHRG model into the community and private sectors, and continue to work with state-based health service. The AHRGP may be effective 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 is aware of other professional associations interested in developing educational streams.

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

[10] Allied Health Rural Generalist Training Positions 2015-2016 Implementation Summary https://www.health.qld.gov.au/__data/assets/pdf_file/0021/700284/ahrgtpsummary1516.PDF

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.

SARRAH also notes and supports workforce development initiatives being development and promoted by Indigenous Allied Health Association (IAHA) in its approach to the development of the Aboriginal and Torres Strait Islander Health Academy (refer to www.iaha.com.au) – which provide flexible options for course delivery and defining career pathways for assistant workers towards working and potentially gaining an allied health degree. Such developments will reduce barriers for rural origin Aboriginal and Torres Strait Islander people to obtain allied health qualifications.

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.

For education providers, course accreditation could include a push to innovation in course delivery and curriculum that addresses the workforce maldistribution- for example toward full year or full course training in rural and remote locations. SARRAH supports the concept of early and frequent exposure to clinical placements in rural settings for undergraduate students. This would require considerable development, but warrants consideration.

Jobs for the Future in Regional Areas – complementary programs and review processes

There is a host of existing programs that could potentially be drawn on and/or coordinated to contribute to skilled jobs growth in rural and remote Australia, including in allied health careers. Many of these program and initiatives have current Grant Funding rounds[11] open for applications. These include, as examples, the:

- *Regional Employment Trials* (Department of Jobs and Small Business) - a grants program for businesses, not-for-profits and local government agencies to trial local approaches to employment related projects in regional areas;
- *1,000 Jobs Package* (Department of Prime Minister and Cabinet) – a wage subsidy program targeting Community Development Program (CDP) participants in remote Australia – which might feasibly be considered in promoting allied and other health pathways, potentially in connection with the IAHA National Aboriginal and Torres Strait Islander Health Academy Model, recently supported by the Commonwealth.

[11] Refer to the Australian Government Grants Hub - https://www.communitygrants.gov.au/

In addition, the Commonwealth is currently or has recently conducted major review processes that address issues that align with the objectives of the Committee's Inquiry. As examples, SARRAH cites:

- The current review being conducted by Professor Paul Worley, the National Rural Health Commissioner into *Rural Allied Health Quality, Access and Distribution; Options for Commonwealth Policy and Reform*[12] which is considering workforce education, training and distribution options; and
- The Medicare Benefits Schedule (MBS) Review – Report from the Allied health Reference Group (2018)[13], which recommended several options where modifications to the MBS would support rural access to services and rural allied health practice/employment.

SARRAH is committed to promoting the health, well-being and resilience of people living in rural and remote Australia and the strength and viability of their communities. To this end, we work in partnership with governments and other stakeholders and welcome the opportunity to contribute to innovative and coherent initiatives for the benefit of those communities.

If you require further information please contact me at catherine@sarrah.org.au.

Yours Sincerely

Cath Maloney

A/Chief Executive Officer

[12] https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner

[13] https://www1.health.gov.au/internet/main/publishing.nsf/Content/BEB6C6D36DE56438CA258397000F4898/$File/AHRG-Final-Report.pdf

Allied health professions

Allied Health Professionals (AHPs) are qualified to apply their skills to retain, restore or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations. AHPs hold nationally accredited tertiary qualifications (of at least Australian Qualifications Framework (AQF) Level 7 or equivalent), enabling eligibility for membership of their national self-regulating professional association or registration with their national Board. The identity of allied health has emerged from these allied health professions' client focused, inter-professional and collaborative approach that aligns them to their clients, the community, each other and their health professional colleagues.

Services for Australian Rural and Remote Allied Health (SARRAH) represents 27 different allied health professions, including:

- Audiology
- Medical Imaging
- Paramedics
- Chinese Medicine
- Nuclear Medicine
- Pharmacy
- Chiropractic
- Radiation Therapy
- Physiotherapy
- Dental and Oral Health
- Health Promotion
- Podiatry
- Dentistry
- Occupational Therapy
- Prosthetics
- Dietetics and Nutrition
- Optometry
- Psychology
- Diabetes Education
- Orthoptics
- Speech Pathology
- Exercise Physiology
- Orthotics
- Social Work
- Genetic Counselling
- Osteopathy
- Sonography