SARRAH
Services for Australian
Rural and Remote Allied Health

The effectiveness of the Australian Government's Northern Australia agenda

Submission to the Senate Selection Committee Inquiry

September 2019

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Dear Sir or Madam

Services for Australian Rural and Remote Allied Health (SARRAH) - Submission to the Senate Select Committee Inquiry on the effectiveness of the Australian Government's Northern Australia agenda

Thank you for the opportunity to provide a submission to the Select Committee's Inquiry on the effectiveness of the Australian Government's Northern Australia agenda.

SARRAH believes there is an immediate need and substantial benefits to the wellbeing and economic development of northern Australia of building the allied health and service capacity in northern Australia. Doing so would:

- Improve the health and wellbeing of the people living in northern Australia;
- Increase the skilled employment and career opportunities, training pathways and economic circumstances of people involved and the communities they live in;
- Increase the attraction and retention of skilled people working in other sectors to move to and/or remain in northern Australia;
- Increase the skills pool available to and attractiveness of establishing businesses and industry development options in northern Australia; and
- Improve underpinning employment, economic and service security for communities across the north, reducing the relative impact of fluctuations in other industry sectors.

Under the heading *Our Vision* of the 2015 *Our North, Our Future: White Paper on Developing Northern Australia*, was the following statement:

> *The Government has widely discussed the five industry pillars that play to Australia's strengths and have the most potential for growth:*
>
> - *food and agribusiness*
> - *resources and energy*
> - *tourism and hospitality*
> - *international education*
> - ***healthcare, medical research and aged care.***[1]

The objectives of Northern Australia Agenda are entirely consistent with the development of greater allied health service and workforce capacity. In fact, the extent of unmet need and chronic workforce shortages in enabling health services inhibit the workforce and productive capacity of northern Australia. Notwithstanding important investments in health and medical research in northern Australia, far more could be done to advance the self-sufficiency of

[1] https://www.industry.gov.au/sites/g/files/net3906/f/June%202018/document/pdf/nawp-fullreport.pdf (page 3)

northern Australia in meeting this crucial service sector demand and bolstering local economies. Most importantly, health needs to be understood as an essential complement to and not a competitor to growth in other industry sectors.

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.

SARRAH also advocates for allied health services as essential to the building and retention of health, capacity and wellbeing and for recovery and rehabilitation from incapacity and illness. Allied health services contribute directly and substantially to the productive capacity of individuals and communities.

Terms of Reference

Developing the health workforce and service sector across northern Australia provides for:

- Skilled employment, careers and sustainable income for residents of northern Australia; and
- Vital social and economic infrastructure to attract, support and sustain business, industry and workforce development, (re-)location and investment decisions.

As such, SARRAHs submission focuses broadly on the following Terms of Reference:

a. *facilitation of public and private investment in infrastructure and economic development;*
b. *economic and social benefit arising from that investment for Northern Australians, in particular First Nations people;*
c. *funding models and policy measures that capture the full value of existing and emerging industries; and*
d. *measures taken to develop an appropriately skilled workforce.*

Key messages

Allied health professionals (AHPs)[2] 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. A list of the 27 separate professions represented by SARRAH is at Attachment A.

The health and social assistance sector is projected to be the greatest source of employment growth and demand for the next five years – with an additional 250,000 jobs nationally –

[2] Throughout this document the acronym AHP(s) is used as shorthand to refer to allied health profession/al(s). It should not be confused with the acronym used frequently to refer to Aboriginal and Torres Strait Islander Health Practitioners: which are not allied health professionals, but a separate and vital profession and workforce also in high demand and in shortage across northern Australia.

continuing the trend of the past decade[3]. AHPs 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 chronic and acute shortages of allied health professionals across northern (and other parts of rural and remote) Australia – far worse comparatively than for nurses and medical practitioners.

There is a risk that shortages across northern Australia will not improve or may worsen as demand increases nationally and:

- opportunities to work and earn substantial incomes outside of northern Australia also increase, and
- if factors that constrain local health workforce development, workforce attraction and retention are not addressed substantively.

AHP practice and employment contributes economically, especially where the service is based in the community and not provided on a visiting, sporadic or similar basis.

In addition to providing skills and employment directly, allied health services support the health and wellbeing of individual community members, sustaining optimal levels of economic participation and impacting productivity in every 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;
    - Many of these debilitating conditions are more prevalent across northern Australia than in metropolitan and other parts of regional Australia;
- Aid in rehabilitation and recovery, increasing the capacity for individuals to maintain self-reliance, be less dependent on public outlays and funded services (including income support), contribute to increased economic activity and revenue;
- Potentially reduce the high rate of avoidable hospitalisations and strain on available local services which are particularly high in rural and remote Australia: high rates of avoidable hospitalisations correlate broadly with areas of poor access to allied health service; and
- If and where available, improve the community outcomes and cost-effectiveness of other priorities and strategies including primary health care, the NDIS and aged care – which are also much needed.

The health workforce is a highly skilled, high value workforce with direct employment and related downstream economic impacts. Local health workforces are not only likely to be more cost effective in providing quality and sustainable services, but also to contribute more (especially over time) to local economies, communities and further development.

Coherent approaches to build allied health service capacity and resilience would support and complement development in any other rural industry and investment. Such a strategy could be informed by and potentially leverage a range of current processes, including the review being conducted by the National Rural Health Commissioner into *Rural Allied Health*

[3] Source - Australian Government Department of Jobs and Small Business.

Quality, Access and Distribution; Options for Commonwealth Policy and Reform[4] which is considering workforce education, training and distribution options.

Developing the allied and related health and support workforce – with career and role-models, clinical and work experience and pathways options in northern Australia – could be as much an employment priority. The conditions for employment growth in the health and social assistance sector in northern Australia are extremely favourable.

CONTEXT

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.

There is a strong focus in the Northern Australia Agenda on primary industry development. It is an understandable focus and, rightly, involves many portfolio areas, including industry, agriculture, infrastructure, communications, transport, employment and education and training (at the schools, VET and university levels). These contribute to diverse, robust and resilient 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 life 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 northern Australia** and measures to support better distribution and service access would meet economic and employment as well as health objectives.

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

Drivers and demand for allied health & workforce distribution – opportunities?

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**[5]. At an occupation level, the **projected increases** (over and above the existing occupation-level workforce) include, as examples:

- Nutrition professionals - 17.6%
- Medical imaging professionals – 11.3%
- Dental practitioners - 16.7%
- Occupational therapists - 14.6%
- Physiotherapists - 24.9%
- Podiatrists – 17.2%

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

[5] 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

- Audiologists and Speech Pathologists/Therapists - 38.3%.

In northern Australia allied health workforce development and support should be prioritised.

- Shortage of AHPs in northern Australia is long-standing but has been exacerbated and placed in sharper relief by workforce challenges associated with achieving better health and wellbeing among Aboriginal and Torres Strait Islander people, especially living in rural and remote communities; rolling out the NDIS; and growing demand for quality aged care services.
- The Australian Government's National Health Workforce Dataset shows[6] the geographic distribution of allied health professions is heavily skewed toward major population centres.

The following table illustrates the geographic distribution and practitioner to population ratios of a selection of allied health professions and compared with medical practitioners, nurses and midwives.[7]. With the exception of Darwin, Townsville and Cairns almost all of northern Australia would be classified as Remote or Very Remote (noting variations between specific remoteness classification systems).

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 situation could be improved with a clear strategy and better coordination. Health and social service and funding systems are often fragmented and often program reporting and accountability is self-referenced rather than patient or community-centric or outcome focussed. Most service models do not adequately support allied health services in areas such

[6] 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.

[7] 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.

as northern Australia. These approaches often manifest as thin or failed "markets" in places where community need, demand and eligibility might support viable and sustainable local services. The maldistribution (shortage) of allied health professionals is about more than practitioner choice: tailored approaches to community conditions could address current shortages.

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

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**[8]. 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 measures to build allied health service capacity and workforce would be offset by other service savings and/or service improvements and contribute positively to productivity, the health and wellbeing of rural and remote communities.

Potentially preventable hospitalisations are estimated to cost Australia $2.3 billion every year (AIHW). This is 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).[9]

The potentially preventable hospitalisation rate (PPH) per 1,000 population by remoteness area shown below[10]:

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

Importantly, individuals and families make choices about where they (continue or relocate to) live, including whether their children, others in their care and themselves are able to access services that provide adequate security and opportunity. In turn, industry, employers and investors make locational decisions based on the availability of complementary and supporting infrastructure, services and resources, including human resources.

[8] 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

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

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

Economic development, especially in an environment characterised by increasingly rapid shifts in and reliance on knowledge and technology, is competitive and high risk. The availability of high quality and accessible health, education and other social infrastructure and services influences those decisions.

Contextual challenges for allied health

The maldistribution of allied health workforce and services is outlined above. Some of this can be attributed to the realities of working in large, geographically and culturally diverse environments with relatively sparse populations. Rural and remote allied health practitioners also 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[11] (especially among Aboriginal and Torres strait Islander people).

Nonetheless, many allied health professionals choose to practice in rural and remote Australia despite these challenges. More would if the circumstances supported them to do so and many of those factors relate to policy and service settings, and present opportunities to decision-makers.

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[12] 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 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, for example, the Kimberley.

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 private and non-government sectors.

Demand for allied health services is often unidentified or under-identified. Unfortunately, in much of northern Australia, services and professionals needed to make health and eligibility assessments, referrals and so on, are often not available (e.g. for the NDIS or aged care services). This tends to result in fewer services going into communities than would be available in other locations where better assessment options are available.

[11] 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).

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

Employment, support structures and income generating mechanisms for allied health are often 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).

Employment opportunities are also a significant limiting factor. Even if positions exist, they are often isolated, lack experienced supervision and support[13].

There are many examples of allied health positions being advertised in northern Australia, and employers having difficulty filling positions: this may seem contradictory to arguments that of a serious shortage in allied health services and employment opportunities. However, it is crucial to understand the range of factors contributing to this situation. Rather than illustrating the allied health sector is robust, frequent advertising of positions and difficulty filling those positions actually reflects serious underlying problems[14]. For instance:

- Vacancy rates can reflect shortage of qualified or adequately skilled applicants even where a position has already been identified and funding is (at least nominally) available.
    - The available data showing the dramatic drop off in allied health professionals (hence services) as remoteness increases[15], yet health statistics suggest the need for allied health services among rural and remote populations are often higher.
- Issues of professional isolation and comparative lack of supervisory and/or other workforce supports.
- In many cases, applicants are underqualified/inexperienced and if recruited (e.g. evident in NTPHN info) it poses quality service, community and practitioner risks, leading to high churn/turnover and service costs.

Consequently, the population of northern Australia, the industries they work in and generate, the communities they form, and future growth prospects depend to a very great extent on a highly mobile, high churn and short-term, often inexperienced and relatively high cost health workforce.

National skills and labour force data and needs analyses can be misleading. It is crucial that in essential services, like health, that policy and programs are informed by regional needs. State based data is too heavily skewed (say by Perth and the SE of WA) to be meaningful**. It is crucial to assess information on workforce and service level capacity at the region level** at least (e.g. the Kimberley and Pilbara)[16].

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[13] https://sarrah.org.au/system/files/members/rapid_review_-_recruitment_and_retention_strategies_-_final_web_ready.pdf

[14] Ibid. There is a substantial body of information outlining the challenges of workforce attraction and retention in isolated and/or rural and remote positions.

[15] See the distribution by remoteness tables in any of the allied health Fact Sheets published by the Department of Health https://hwd.health.gov.au/publications.html

[16] For example, an insight to the differences in assessment of workforce shortage and need, and the distortions that are associated with state-wide or national assessments determinations, is provided in the following – the more detailed of which (particularly those relating to the NT) provide a more accurate picture for parts of northern Australia. See https://docs.employment.gov.au/documents/health-professions-nt; https://www.ntphn.org.au/files/NT%20PHN%20HWNA%20Priority%20areas%2015022018.pdf; https://docs.employment.gov.au/system/files/doc/other/healthprofessionsqld.pdf;

For example, the Department of Jobs and Small Business rated the Podiatrist workforce (crucial for lower limb health and care) and as having "No shortage" (June 2018)[17], yet at the same time the number of podiatrists in metropolitan and inner regional Australia was 3X the per population rate for very remote Australia, while the rate of lower limb diabetes-related amputation was "*4 times as high in the Northern Territory as the national rate*".[18]

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

Allied health education and employment pathways & opportunities

It is generally well accepted that providing education and training opportunities (in health) in non-metropolitan areas is among the best ways of building a sustainable workforce in those locations. This has been demonstrated with some success by universities such as James Cook University (Qld) and Flinders University (NT) (especially in medicine). Other educational assets such as Charles Darwin University, Batchelor Institute and the Broome Campus of Notre Dame University (with a recently established University Department of Rural Health) provide capacity that could be leveraged substantially more to develop and sustain the allied health workforce across northern Australia. Crucially, this would provide education, training and career opportunities for more locals to enter these pathways and for some of those who would move away to enter study to remain in northern Australia.

The opportunities outlined below are consistent with the needs and strategies identified in key documents, such as the NT Government's NT Health Workforce strategy 2019-2022.[19]

SARRAH believes there is considerable scope to increase the **Allied Health Assistance workforce in northern Australia**, and in doing so, generate education and employment pathways that are accessible to local people and allow 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"[20]. 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 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.

https://docs.employment.gov.au/system/files/doc/other/healthprofessionsqld.pdf; https://docs.employment.gov.au/system/files/doc/other/health_professionals_-_wa_0.pdf; https://www.healthworkforce.com.au/media/Healthworkforce/client/4.%20Workforce_Planning/20181028_HWNA_Report_Updated_FINAL_WEB_Double_Page.pdf

[17] https://docs.employment.gov.au/system/files/doc/other/252611auspodiatrist_0.pdf

[18] See: https://www.aihw.gov.au/getmedia/9292ab2b-4dbb-44ca-846f-832d02db7220/20681.pdf.aspx?inline=true (page v)

[19] https://digitallibrary.health.nt.gov.au/prodjspui/handle/10137/7753

[20] 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

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 enhance the role. 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.

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

There is an established Allied Health Rural Generalist Pathway – developed in Queensland - 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[21].

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 services. The AHRGP may be effective in attracting and retaining early-career allied health professionals to rural and remote practice and there is strong potential for the AHRG model to improve service capacity in the private and community controlled health services across northern Australia.

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 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.

The need for **more Aboriginal and Torres Strait Islander health professionals and workers** is especially acute across northern Australia: with the proportion of the population who are Aboriginal and/or Torres Strait Islander is around 10 per cent in Northern Queensland; 25 per

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

cent in the NT and closer to 40 per cent in northern WA. The health experience and outcomes of people living in rural and remote (northern) Australia, and especially Aboriginal and Torres Strait Islander people have been extensively and repeated documented[22].

There is massive under-representation of Aboriginal and Torres strait Islander people in the health professions – for example, requiring a 6-8 fold increase to reach population parity nationally. This constrains access to care and contributes to poorer health outcomes. In northern Australia reaching population parity would require an increase in the order of 30-40 fold.

SARRAH notes and supports **Indigenous Allied Health Association (IAHA) in its 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. The first IAHA Academy has been established in Darwin and there are prospects for others to be established across northern Australia. Such developments will reduce barriers for rural origin Aboriginal and Torres Strait Islander people to obtain allied health qualifications.

Increasing the Aboriginal and Torres Strait Islander health workforce is crucial to improve access to, quality, cultural safety and responsiveness of health and related social services, such as in disability services, aged care and the justice systems.

Northern Australia agenda - Increasing allied health service and capacity: complementary programs and review processes

There are many existing programs that could potentially be drawn on and/or coordinated, formally or otherwise with the Northern Australia agenda to increase allied health jobs growth and opportunities across northern Australia. Many of these program and initiatives have current and/or regular Grant Funding rounds[23]. For example, 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.

In addition, the Commonwealth is or has recently conducted major review processes that could also facilitate and sustain the development of the allied health workforce and services in northern Australia. For example:

- The current review by Professor Paul Worley, the National Rural Health Commissioner into *Rural Allied Health Quality, Access and Distribution; Options for Commonwealth Policy and Reform*[24] which is considering workforce education, training and distribution options; and

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[22] For examples, see: https://www.aihw.gov.au/reports/australias-health/australias-health-2018-in-brief/contents/about (especially chapters 5 and 6); https://www.pmc.gov.au/sites/default/files/publications/2017-health-performance-framework-report_1.pdf; https://www.safetyandquality.gov.au/publications-and-resources/australian-atlas-healthcare-variation-series; https://www.humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/publications/close-gap-report-our .

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

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

- The Medicare Benefits Schedule (MBS) Review – Report from the Allied health Reference Group (2018)[25], 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 northern and other parts of 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

25 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