CONSULTATION RESPONSE

Allied Health Professions Australia

National Rural Health Commissioner Discussion Paper: Rural Allied Health Quality, Access and Distribution

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Introduction

Allied Health Professions Australia (AHPA) welcomes the opportunity to provide feedback to the Office of the National Rural Health Commissioner on the Discussion Paper for Consultation 'Rural Allied Health Quality, Access and Distribution – Options for Commonwealth Government Policy Reform and Investment'. We acknowledge the significant work undertaken by the Commissioner to engage with the issues impacting rural and remote communities and their access to allied health services. The options presented in the paper represent significant opportunities for providers and consumers in rural and remote communities and we welcome them as valuable policy options to be considered by government.

AHPA is the national peak body representing Australia's allied health professions. We have 20 individual member associations, and a further five affiliate members who represent allied health professions or professions closely aligned with the allied health sector. The AHPA membership collectively represents 120,000 allied health professionals working across a wide range of settings and sectors. While this membership is predominantly located in metropolitan regions, AHPA and its members collectively represent the largest rural and remote membership with some 14,000 allied health professionals working in rural and remote locations across Australia.

AHPA and its member associations are committed to ensuring that all Australians, regardless of their location, can access safe, evidence-based services to support wellness, re-ablement and maintenance of functionality so that they can live life as fully as possible.

This submission has been developed in consultation with AHPA's allied health association members.

Responses

The AHPA response provides feedback on each of the policy areas discussed in the paper:

- Policy Area 1 – Rural allied health policy, leadership and quality and safety
- Policy Area 2 – Opportunities for rural origin and Indigenous students
- Policy Area 3 – Structured rural training and career pathways (MMM2 – 7)
- Policy Area 4 – Sustainable jobs and viable rural markets
- Policy Area 5 – Telehealth allied health services

Policy Area 1

Appointment of a Commonwealth Chief Allied Health Officer

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?

AHPA strongly supports, and has consistently advocated for, the appointment of a dedicated Commonwealth Chief Allied Health Officer (CAHO). Our view is that this role is essential as a means of providing national leadership and advice on policy development, funding, education and service delivery for the allied health sector. The appointment of a dedicated CAHO is an important symbolic acknowledgement of the crucial contribution of the allied health sector as well as a means of realising some of the most important opportunities to better support a strong, well-distributed allied health workforce.

AHPA proposes that the top priorities for a CAHO are as follows:

- **Lead the development of multi-sector strategies to address coordinated workforce and service delivery challenges.** Work with other Commonwealth and jurisdictional funders to support coordination of workforce policy development and program delivery across health, aged care, disability, education and social services.
- **Develop a national allied health database including, but not limited to, data about the rural allied health workforce.** A national dataset would enable extraction of data relating to allied health services in rural areas and support workforce planning nationally. The national workforce dataset would need to encompass all allied health professions, not only those covered by the Australian Health Practitioner Regulation Authority (AHPRA).
- **Develop a rural health career pipeline for allied health practitioners.** A strategic, coordinated approach is required to develop a career pipeline for rural allied health practitioners, with oversight from the CAHO and collaboration from all jurisdictions.
- **Map all scholarship incentive programs for allied health and create a centralised point of coordination.** There is a wide range of programs, including scholarships and incentive programs, to increase the availability of allied health services in rural area. These are currently fragmented and do not necessarily represent the most efficient or effective use of funds. The allied health workforce would benefit from a central point of reference and

coordination for existing and planned programs. It would be appropriate to consider these in the context of rural generalist practice and how that may support improved rural access.

- **Reform the Workforce Incentive Program.** While this initiative includes incentives for general practices to employ allied health professionals, the program replaced the Practice Nurse Incentive Program rather than providing additional funding for allied health and doesn't necessarily result in increased access to needed allied health services.
- **Improve access to digital health for rural allied health consumers and practitioners.** Telehealth is increasingly being recognised as an effective way to improve access to health services in regions or circumstances where access may be limited. However, funding for allied telehealth services is currently restricted and may require initial face-to-face consultations. Funding for telehealth programs needs to consider the additional costs of infrastructure and practitioner training required to optimise services.

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

While AHPA does not seek to diminish the work of the current Chief Allied Health Officer (CAHO), the current CAHO role is only one of many priorities and responsibilities for the incumbent, who is not an allied health professional, leaving little capacity for that role to provide a dedicated focus on allied health issues. AHPA's view is that the CAHO role needs to be one dedicated specifically to allied health, with appropriate staffing supporting the role.

In addition to being a dedicated role with appropriate resourcing, AHPA argues that the role must be positioned so that it can work effectively across the different portfolios representing the diverse work environments of the allied health workforce. These include not only health but also mental health, ageing, disability, veterans' services, education and social services. While some of these programs sit within the Department of Health, other major Commonwealth programs such as disability sit in other Departments.

On that basis, AHPA argues that the most appropriate Department to base the CAHO role in is the Department of Prime Minister and Cabinet. The role needs to be directly involved in strategic planning in the Department to improve involvement in Departmental proposals and funding of allied health initiatives, providing the capacity to drive cross-Department initiatives, including a national allied health workforce strategy. The role also needs to be able to interact with appropriate COAG committees including the health and disability ministers' committees.

Such a role would establish formal links between the Department of Prime Minister and Cabinet, the Department of Health, the Department of Social Services, Department of Veterans Affairs as well as working closely with jurisdictional departments through the National Allied Health Advisors and Chief Officers (NAHAC). We note the recent appointment of Christine Morgan as Australia's national suicide prevention officer as a precedent.

Rural Allied Health College

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

AHPA and its members do not support the establishment of a Rural Allied Health College. Our view is that existing bodies are best placed to deliver the functions of the proposed college outlined in the paper. We argue that there is a significant risk that the establishment of a college would duplicate established structures and programs and further fragment the workforce. While we strongly argue for the need to support the specific needs of the rural and remote allied health workforce, we also note the importance of maintaining and improving connections with the broader workforce. Creating a separate body risks further siloing practitioners.

AHPA also argues that there is not a clear need for an additional body or new system for the accreditation of rural generalist qualifications given the expected low volume of courses likely to be introduced. Instead we argue that the most appropriate structure for accreditation may be the first option suggested i.e. a consortium of organisations where existing accreditation bodies each contribute a representative. This would enable such a dedicated rural health accreditation body to operate while providing direct links with individual professional accreditation bodies.

AHPA does support a range of other functions identified and argues that these should be more fully identified and defined with the aim of clarifying what resourcing might be appropriate and required to support those functions, which body is best placed to deliver that function, and to determine who will provide any funding required to support the function. These functions may include education, coordination of scholarships, recruitment and retention strategies across health, disability and other schemes, evaluation of rural generalist training and potential application in the non-government and private sectors. We note that there is significant crossover between these functions and the priorities identified for the CAHO above.

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.

AHPA does not have a view on the most appropriate model for a College. Our proposed structure for the functions of a college is one whereby the most appropriate existing organisation or body delivers each of the identified functions. Our view is that some of the functions are likely to sit with the CAHO office, provided this is established appropriately.

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

Not applicable.

Allied Health Workforce Dataset

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

AHPA sees significant benefits for all Australian governments in the development of a national allied health workforce dataset. By developing and maintaining a national dataset, all Australian governments would have access to a valuable, centrally managed resource to support policy and program development in key areas such as workforce development and service access for consumers. This resource would be a key part of the portfolio responsibility of the CAHO, providing both a key area of work and a crucial resource to support national workforce initiatives. A national dataset would not only be of value to government policymakers but could also be made available to

other government-funded organisations and statutory bodies involved in planning and market stewardship such as the Primary Health Networks, the National Disability Insurance Agency, and organisations running rural workforce programs.

AHPA sees significant crossover between the development of a national workforce dataset and improved directory information for consumers and other health professionals such as that currently provided by the National Health Services Directory. While the uses of the information differ, there is significant crossover between a directory that displays the service type/hours of access/locations as well as other relevant information such as specialisations, languages spoken and more. However, we also note the importance of developing greater data gathering capacity across the allied health sector and it may be appropriate to consider approaches that seek to gather not only workforce data but also to begin collecting service use and other similar data to inform government policymaking.

AHPA argues that it would not be appropriate to limit the dataset to the rural and remote workforce. Instead, a single national dataset could be developed in such a way as to capture all relevant information needed to support policymaking in rural settings while also allowing a more comprehensive overall picture of the distribution of the allied health workforce. This is particularly important once the ramifications of future widespread take-up of telehealth are taken into account. In such a scenario, a rural community may have good access to some services through telemedicine delivered by non-rural practitioners, and policymakers and health planners would need to be able to understand that level of access.

We argue that it will be essential to ensure that a national workforce dataset encompasses all professions, not only those covered by the Australian Health Practitioner Regulation Authority (AHPRA). A range of key professions remain outside the remit of AHPRA and are excluded from workforce activities undertaken by the Department of Health.

Key things to consider in terms of challenges are the current fragmentation of information and the lack of a current body with the remit to gather data and build relationships with potential data holders (such as those outlined below). Some of the more practical challenges are the differences in how often data is collected, the accuracy and completeness of the data collection (for example, how completely data shows if a provider works in multiple locations or what FTE they might work) as well as differences between where a practice is based and where services might be delivered. Some practitioners provide mobile services, others may provide remote delivery through telehealth. There are examples of the latter across NDIS and private health services.

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

AHPA suggests that the following datasets and structures provide potential inputs into a future national dataset:

1. AHPRA/Department of Health workforce survey data
2. Medicare provider information
3. PHN population health assessments
4. National provider directories including the National Health Service Directory, individual professional association ‘Find a practitioner’ services

5. Professional association member data, particularly from the self-regulating professions
6. Hospital network information
7. Department of Veteran's Affairs allied health dataset
8. Census data
9. Private health insurer data
10. National Disability Insurance Agency (NDIS) Commission registration data

AHPA notes that these datasets provide an incomplete picture but could together contribute to a relatively accurate workforce map. We note that self-regulating professions are not included in current workforce survey work undertaken for the Department of Health and the exact data collected will vary significantly as a result. AHPA argues that it would be appropriate as an immediate first step to ensure that the Department of Health supports the self-regulating professions to collect equivalent data to align with the AHPRA-registered professions. Some key areas of limitations are likely to remain, such as health professionals working in aged care, education and social services.

AHPA notes that there may be opportunities to work with HealthDirect to expand on existing work to source directory information though additional funding would likely be required. We also note the current Primary Care Data Asset being undertaken by the Australian Institute of Health and Welfare (AIHW). This project has identified the strong need for allied health data but is constrained by the lack of current structures for data collection and the inability to fund these. This project does have a broader scope as it is seeking not only to identify the workforce but also to begin gathering service use and other data to support better understanding of the primary care sector.

Policy Area 2

Introduction of Rural Origin Selection Quotas

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

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?

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.

AHPA argues that training health professionals in rural and remote settings is key to attracting and/or keeping practitioners in these areas and likely to be more valuable than quotas. While the introduction of quotas may increase the volume of rural students studying in health courses, it provides no guarantee of an increased rural workforce.

We do support the need to address potential barriers for rural students to study at metropolitan universities and quotas may be part of an overall response. We argue a broader approach may include:

- initially supporting rural-origin students to study allied health courses at metropolitan universities through scholarships and increasing opportunities for clinical placements in rural and remote settings

- increasing opportunities to study in rural and remote locations e.g. funding regional universities to offer increased places in allied health courses and/or supporting metropolitan universities to deliver distance education with on-campus study blocks
- encouraging students from metropolitan areas to enrol in allied health courses at regional universities
- providing incentives for or requiring students in metropolitan courses to undertake clinical practicums in rural and remote settings
- removing uncapped university places in metropolitan areas where there is an oversupply of graduates.

More generally AHPA argues that a strategic, coordinated approach is required to develop a national allied health workforce plan, including a career pipeline for rural allied health practitioners, with oversight from the CAHO and collaboration from all jurisdictions.

A rural allied health career pipeline would:

- begin with educating high school students about allied health careers and encouraging them into the allied health professions that are needed in rural and remote communities
- improve access to allied health education for rural students and provide support through scholarships and other relevant measures
- provide appropriate structures to ensure the availability and growth of rural clinical placement opportunities
- provide support for new graduates to ensure appropriate profession-specific and non-specific supervision is available
- include structures to manage workforce planning across multiple sectors, such as disability aged care and education, in addition to health

AHPA acknowledges that even with such a pipeline in place, there will be challenges developing the allied health workforce in rural and remote areas. Even with improved access to education and clinical training:

- it will still be challenging and expensive to provide adequate clinical training to students in rural and remote settings
- there will be a delay before appropriately trained and experienced practitioners are available to provide services where they are needed
- the number of practitioners required will differ by profession and by area and the number of funded positions available may well not match the need.

AHPA notes that availability of clinical placements is one of the most significant challenges in the education of allied health practitioners. Allied health students are required to undertake a practicum component which is embedded in their university course. In some cases, this must be arranged by the student themselves and many even be a prerequisite for enrolment.

While public health (i.e. hospital placements) are a major source of practicum training, these opportunities are limited and may not represent the most appropriate exposure to the type of work the health and other systems require allied health students to take up (such as aged care and disability). Increased access to placements in private practice is essential, particularly in rural and remote areas. However, many private practices rely on funding sources such as Medicare or DVA, which currently prevent students under direct supervision from directly participating in provision of services. This is highly restrictive and makes it untenable for many practices to offer clinical placements to students.

Opportunities for rural origin Aboriginal and Torres Strait Islander people

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.

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.

AHPA recognises the expertise of Indigenous Allied Health Australia (IAHA) in building the Indigenous allied health workforce and its capabilities through culturally safe training programs. We support IAHA's activities in this area and its involvement in developing:

- IAHHs in rural and remote Indigenous communities
- a pipeline for educating and training future Indigenous allied health professionals, including use of additional Commonwealth funding to expand the National Aboriginal and Torres Strait Islander Allied Health Academy
- workplace training to improve cultural safety for Indigenous patients and allied health providers.

We defer to IAHA in providing guidance about appropriate models and approaches for this part of the allied health workforce.

Policy Area 3

Increasing Opportunities for Home Grown Training

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?

While we defer to the education sector for more comprehensive feedback about key considerations and timeframes around allied health training in rural areas, we note that there are several strategies that will be essential foundations for rural allied health training.

The first of these is the need to address current barriers to participation of students in supervised care delivery in private practice and the non-government sector. Recent changes to disability funding as part of the transition to the National Disability Insurance Scheme have dramatically

reduced the capacity of providers to support clinical placements. Providers no longer have long-term funding commitments making business sustainability far less certain. This in turn limits capacity for those providers to invest in a future workforce. There are also long-standing barriers to student involvement in Medicare and DVA-funded sessions. These collectively provide a major barrier to student placements in some of the key areas of need. We note that these issues are impacting workforce development in all areas but are exacerbated in rural and remote regions. AHPA has undertaken discussion with the Departments of Health, Veterans Affairs and Social Services. However, while there is recognition of the issue, we are not yet aware of any policy responses from government. A first step may be to expand funding for practices and NGOs to remunerate the time spent with students, but longer-term policy work will be required to address the aforementioned barriers and should form part of the focus for the proposed CAHO.

AHPA further argues for the need to provide additional funding or incentives that encourage universities to develop and provide flexible options for undergraduate allied health programs. The current market-driven approach is unlikely to provide the foundation for better access to rural-focused training and is instead most likely to continue to lead to oversupply for some professions in capital cities.

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?

AHPA broadly supports expansion of the John Flynn Program to include allied health students. We recommend that any changes to the John Flynn Program should be part of a coordinated pipeline strategy in which the various current allied health scholarships are identified and evaluated to determine the extent to which they are supporting workforce gaps. We argue that there should be greater coordination and oversight of scholarship programs, ideally through the CAHO office.

We note that an integral part of the John Flynn model is placement with a rural mentor in the same location across successive years. While medicine and nursing programs may have established structures and resources to support this type of scholarship (i.e. funding, community contacts, rural and remote mentors that are available, experienced and supported to take on students, alternate accommodation arrangements), these often do not exist in allied health. Such a program may therefore not readily translate into the allied health context and additional capacity building may be required.

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?

Increasing opportunities for allied health education in rural areas, including clinical placements, will not be achieved by a 'one size fits all' approach. Course requirements are inherently different between professions and challenges also vary with location.

A key issue is the current funding structure for allied health education, which is not driven by local need but rather student demand and the availability of courses. While experience suggests that

increased rural education is essential to increasing the rural workforce, the uptake of allied health courses at regional universities is often low and there are additional costs associated with, and barriers to, providing clinical training in rural and remote areas. Due to the proliferation of metropolitan based courses the pool of suitable, high-quality academics to teach these courses has been critically drained and regional universities in particular can struggle to attract suitable staffing. As a result, these courses are significantly less financially viable than similar courses in metropolitan areas. Metropolitan universities on the other hand have the capacity for far higher levels of enrolment and can more profitably deliver courses. The current combination of uncapped funding and larger potential enrolments in urban centres is likely to continue exacerbating the gap in access between rural and metropolitan locations. AHPA argues that the Commonwealth has significant capacity to better identify future workforce need and provide funding to universities that better seeks to match funding with need, while also addressing the additional costs faced by rural and regional universities.

The lack of clinical placements available for rural allied health students presents a significant challenge and is well recognised. Current barriers to clinical training include:

- limited places available for clinical healthcare placements with private practice and primary care providers struggling to support student placements due to a lack of supervisors as well as private health insurance and MBS/DVA funding criteria that restrict student involvement in service provision
- reliance on the public sector (e.g. regional hospitals) for clinical placements resulting in students gaining exposure primarily in acute care
- few places available for clinical placements outside of health (e.g. in aged care and disability)
- difficulty finding quality clinical supervisors (both in external placements and for university clinics)
- limited access to complex equipment which is often expensive and not available outside metropolitan centres
- the high number of placement hours in some professions to meet clinical training requirements, which may be up to 2000 hours
- simulated clinical experiences and techniques at university campus-based clinics cannot replace the teaching experience of real clinical practice and can only count towards a portion of clinical training hours
- limited accommodation infrastructure available for students living away from home.

Additional funding should be made available for:

- student accommodation infrastructure. Support for allied health clinical placements must match that of medical clinical placements to ensure students living away from home are not disadvantaged by cost of travel and accommodation.
- centralised coordination of scholarships and funding opportunities for rural and remote allied health students. This could also provide a resource mapping available and potential clinical placement opportunities.

AHPA argues that one means of seeking to better align need for allied health roles in rural and remote regions with the structure of education funding and availability of allied health courses may be the provision of HECS debt relief for allied health students who take up positions in rural and remote locations on completion of their studies. This could be an effective way to match potential oversupply in urban centres with gaps in services in rural areas.

Career pathways in rural allied health

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 Health Workforce Scholarship Program is a relatively new initiative to improve access to services by increasing the skills, capacity and/or scope of practice of health professionals in rural and remote areas. In twelve months, the Program provided grants for more than 150 health professionals. While this program is open to allied health professionals, it:

- is not specific to allied health, so allied health applicants are competing with applicants from medicine, nursing and paramedicine for funding
- is not available to practitioners in all allied health professions
- in not available to allied health professionals who work in public health or outside the primary healthcare setting
- may not represent the best or most efficient use of funds in support of allied health.

A central point of coordination for allied health scholarships and funding would highlight specific areas of need and help ensure that programs such as this align with a demonstrated need (rather than inadvertently supporting expansion of services that are not needed in a particular location). We argue this should be a major focus for the CAHO.

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.

AHPA's vision of a career pipeline for allied health professionals is one that provides sufficient direction and oversight. A dedicated CAHO can identify and promote the needs and opportunities of the allied health workforce at a national level and can lead a whole-of-government approach to providing career opportunities.

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?

AHPA acknowledges the work undertaken by Queensland Health to develop and evaluate a rural generalist model. We understand that further roles have been created in a range of other jurisdictions providing expanded understanding of the model's relevance and applicability in other settings. We further understand that Services for Australian Rural and Remote Allied Health (SARRAH) has been funded to test the effectiveness of the model outside jurisdiction-funded roles with scholarships to support private practitioners to participate in the program. This is a positive development as AHPA argues that increased access to allied health services for rural and remote Australians will require a balance between publicly funded allied health roles in hospital networks

and a private practice workforce. We are eager to see how this model might translate to increased recruitment and retention rates outside of jurisdiction-funded roles.

While AHPA is supportive of the program and ongoing work to expand the trialling of the program, our view is that the program is not yet sufficiently matured, or the views of the different jurisdictions about the value of the program sufficiently clear, to warrant the development of a governance model. From our understanding, the program in its current form is heavily dependent on jurisdiction-funded supernumerary allied health roles and there is not yet clear commitment to longer-term funding of these roles in the different jurisdictions. The evaluation of the Queensland trial suggests that retention within the time-limited program was very high and that a high proportion of participants have taken up roles in the same health service or in close regional locations. Yet it isn't clear if this has been sufficient to support a significant expansion of the program. We hope that as the program continues to be trialled, jurisdictions may seek to make longer-term formal commitments to ongoing funding of rural generalist roles.

Given that the program is still being piloted in a range of locations and settings, AHPA argues that it may be appropriate to charge the Chief Allied Health Officer with providing oversight and undertaking formal evaluation of the program, in conjunction with the jurisdictions. AHPA argues that for this model to be effective, it needs to offer clear benefits for funders regardless of whether these are jurisdictions, Commonwealth scholarship providers or private practitioners self-funding participation. There is not yet clear evidence of the jurisdictions seeing the returns from investment in this approach that would be necessary to scale the program up.

As a final note, some AHPA members have raised a need for caution in determining the scope of generalist practice and noting that there can be issues in relying on determinations made by a generalist. Examples provided include incorrect determinations made about a person's vision by a generalist. It will likely be important as the program matures to increase understanding in the professional associations about the role and function of the program and to refine what generalism means across different professions.

Policy Area 4

Integrated Allied Health Hubs

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?

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.

AHPA strongly supports the development of IAHHs as a means of increasing access to allied health services in rural and remote settings. There are significant potential benefits for both consumers and practitioners including opportunities for centralised and coordinated care for services across sectors and formats. However, these opportunities also present challenges. AHPA considers that there are number of factors that would need to be considered regarding development of Integrated Allied Health Hubs (IAHHs).

- In order to determine and prioritise potential IAHH locations, allied health service provision and demand in rural and remote areas should be mapped to identify specific areas of allied health workforce shortage and unmet service needs. This could be based on existing work by PHNs but should also bring in workforce need across disability and aged care as well as looking at the specific needs of indigenous communities.
- Facilities in outer regional, remote and very remote areas are generally small. These facilities lack the economies of scale and scope available to facilities in urban areas. Many facilities in rural and remote areas operate on the cusp of viability.
- Centralised services and management of patient records can result in a collegiate environment providing a network of services and shared care. However, it can also result in services simply being run in parallel, especially when the volume of work is not sufficient to sustain providers in full-time roles a particular area.
- Development of IAHHs should, where possible, use local infrastructure and resources including locally based allied health professionals in preference to visiting service providers. An appropriate model should make provisions for 'virtual hubs' whereby existing services can through contracting arrangements become part of an IAHH.
- Current funding models make it difficult for private providers to engage in training rural allied health professionals and also for providers to work in multiple sectors.

Development of IAHHs would require leadership from other areas in addition to health due to the multiple sources of funding that may be involved, as well as the potential to work with education providers.

- IAHHs should draw from multiple funding sources (e.g. pooled funding from NDIS, health, education, disability, aged care or primary/acute care).
- IAHHs could work with University Departments of Rural Health to provide clinical placements and training opportunities for students undertaking allied health courses.
- Outreach and telehealth would provide important options for extending the distribution of services. These work best if supported by local health workers implementing allied health care plans between visits. The Commonwealth currently funds a range of rural outreach programs which could be expanded to address service coordination roles and effective sustained allied health multi-disciplinary teams.

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?

AHPA argues that the PHN model provides a good example of existing government funding arrangements that support a flexible and regionally focused approach to service development and delivery. AHPA argues that some of the crucial foundations for this type of approach are:

- targeted work to undertake identification of local services and the health needs of the local community as the basis for service planning
- minimum funding periods to ensure services have sufficient time to develop and implement programs

- initial block funding, potentially from multiple sources, including the Commonwealth, NDIS, to support development of service offerings with the aim of transition to funding through regular funding programs such as Medicare, DVA, disability and aged care
- strong connections to existing health and other services.

We note that the Commonwealth's recent Health Care Homes project provides an example of where MBS expenditure was calculated for different patient cohorts and provided as flexible block funding. This approach could be taken across multiple funding sources to provide the necessary funding to support the IAHH with individual service offerings then based on local health needs and delivered through a combination of existing and new services.

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

AHPA supports the use of allied health assistants (AHA) where appropriate, and where appropriate supervision and delegation frameworks are applied. We acknowledge that their use can increase the capacity of allied services in rural and remote areas, enabling services to be provided to a greater number of consumers while allowing the allied health practitioner to focus on more complex therapeutic work. AHAs may:

- undertake therapeutic and/or non-therapeutic tasks
- work as part of a multidisciplinary team or with a specific allied health profession
- work in a variety of settings including primary care, acute care, rehabilitation, aged care and disability.

However, while AHAs are important in the context of rural and remote service delivery, they are directly dependent on the allied health workforce to provide appropriate supervision and guidance. Given the complexity that may be involved in some support tasks, AHAs must be supervised by an allied health practitioner to ensure the highest level of quality care and reduce risk to the AHA and consumer. This includes:

- determining appropriate tasks for AHAs
- defining delivery models, work parameters and delegation processes
- training and assessment of competency.

Given this essential role, AHPA's view is that the most important means for the Commonwealth to support use of allied health assistants is through the development of appropriate funding mechanisms to support the supervising allied health practitioner. This may include provisions for remote supervision such as through telehealth. These funding mechanisms should cover general health needs via Medicare and DVA rebates as well as funding through disability and aged care.

We also argue strongly that AHAs are only part of improving service access and the Commonwealth's priority must remain the development of the allied health workforce. Such development includes building the pipeline to allied health careers (including opportunities for articulation from AHA to allied health professional) and maximising the skills of those already

working in allied health. This will not only increase the number of available allied health practitioners to provide services in rural and remote areas, it will increase the number of practitioners with the skills to provide appropriate supervision to AHAs and further increase the capacity of the allied health workforce.

Viable Rural Markets

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?

AHPA argues that the Commonwealth government has a range of funding channels that could be used to improve access to allied health services for rural and remote communities. While we argue that these may not yet be meeting community needs, building on existing initiatives and programs is likely to be more cost-effective, quick to implement and has the advantage of utilising current infrastructure.

The Workforce Incentive Program (WIP) was established on 1 July 2019 and was presented as a means for the Australian government to support increased access to allied health services by providing funding for general practices to employ allied health professionals. The announcement was generally welcomed by the sector as increased employment of allied health practitioners in general practices is potentially beneficial provided it does not compete with and destabilise existing services. However, despite the promise of the program, AHPA argues that in its current form it is neither effective nor designed to improve access to services needed by a community. The key reasons are the lack of additional funding and the lack of need to demonstrate that employment of an allied health practitioner is addressing a gap in local services.

In terms of funding, the program is based on the continuation of existing funding arrangements and is first and foremost a re-brand of the practice nurse program. Without additional funding in the program, the majority of general practices are unable to employ allied health practitioners as they are utilising their access to incentive funding for existing practice nurse roles. In order to employ allied health practitioners, practices would generally need to reduce employment of practice nurses.

However, even with an expansion of funding AHPA has significant concerns that the program in its current form makes no attempt to align employment with local need or service gaps. Instead it allows general practices to access taxpayer funding for whatever service they deem most appropriate. Without the requirement to demonstrate need, appropriate may well translate to most profitable. While we understand the need to minimise the administrative burden for general practices, we argue that government funds should seek to increase access to services, not potentially create taxpayer-funded competition for existing businesses. The WIP could be a genuine means of improving access to allied health services if funding is increased to support employment of allied health practitioners without reducing practice nurse employment, if practices are required to demonstrate local service gaps (this could be based on PHN population health needs assessments), and if funding could be used to subcontract existing services.

In addition to the Workforce Incentive Program, AHPA argues that PHNs are a viable potential funding channel for allied health services. A range of mental health services are now funded through

PHNs and this is already leading to commissioning of allied health services. PHNs are currently already required to undertake needs assessments, which seek to understand the health needs of their communities and the services available. The commissioning of mental health services has expanded the focus of PHNs from a traditional health focus and AHPA argues that a further expansion to include disability and aged care services would be a logical expansion of the focus of these organisations. By expanding the focus of the PHNs and utilising similar commissioning structures as currently exist for mental health, local allied health services could either be commissioned, or directly provided by the PHN in cases of market failure. Some form of hub or IAHH could be piloted within the current PHN funding structure without significant changes to funding structures required of government.

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

AHPA argues that a combination of multiple approaches may be most effective. The WIP has the capacity to quickly result in increased availability of allied health practitioners in rural markets and, with the support provided through the incentive program, result in viable allied health roles. However, it will only do so with expanded and better targeted funding. In its current form it represents at best no change and at worst a potential destabiliser of existing rural practices.

Expanding the role of PHNs as outlined above has the potential to provide a rapid and appropriate response to local community need. Employment through the WIP will be unlikely to address all issues and instead it may be most appropriate in many regions to have employment through a PHN to address identified service gaps. There is significant crossover between this approach and the IAHH/hub concept and we strongly argue that government should seek to support piloting of different IAHH models, utilising PHNs to test the concept and the capacity of PHNs to deliver these. We note that some structural changes may be required in PHNs to increase knowledge and capacity. This should include increasing the involvement of allied health professionals in the governance of the PHNs, as well as targeted staff recruitment to ensure that PHNs have knowledge and expertise in areas such as disability. Connections should be formed between any pilot projects and the National Disability Insurance Agency (NDIA) to support the PHNs in developing their understanding and capacity in this space.

Policy Area 5

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.

AHPA strongly supports the use of telehealth by allied health practitioners to improve access to services in rural and remote areas. There is published evidence to demonstrate that a wide range of allied health services can be successfully delivered via telehealth, reducing travel time and cost for consumers, while improving outcomes such as health status, health-related behaviours and self-efficacy. Varying models of telehealth have been shown to be clinically effective by researchers, covering health interventions between consumers and health professionals, interactions between health professionals, and applications for telehealth mentoring and supervision. Examples from research literature can be provided by AHPA.

AHPA also notes that a range of existing allied health practices are successfully utilising telehealth delivery methods based around private, MBS Better Access and NDIS funding. AHPA and its member associations have advocated extensively for the federal government to improve access to allied health services via telehealth through Medicare as the models utilised above could translate to other funding streams. We note that eligibility criteria for Medicare Better Access to Mental Health items now allow mental health practitioners to claim rebates for delivery of mental health services via telehealth to people living in rural and remote Australia, and that the current Medicare Review has recommended a similar expansion for other categories of services including chronic disease allied health items.

It should be noted that telehealth has important applications for rural and remote areas, not only to improve access to services but also to provide a demonstrated means of addressing workforce training issues. Examples of additional uses include co-practice and improved models of coordinated care, as well as peer-to-peer support for practitioners, mentoring for early career practitioners and clinical supervision.

AHPA argues that the major current gaps in telehealth access are not the clinical applications but rather the practical issues around funding of service delivery and the need to support implementation through infrastructure and education for providers and consumers. Changes to criteria for MBS items could significantly increase access to allied health services via telehealth, but funding is also needed to support adequate telecommunications infrastructure, a public directory of available telehealth services, training for practitioners regarding available systems and implementation (including regulatory compliance), and training for consumers. The funding of options such as the Healthdirect telehealth solution may be part of that solution but the use of existing consumer solutions such as Skype and Facetime should not be discounted.

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?

AHPA notes that private health insurance is a significant funder of allied health services. While take-up of insurance is much lower in rural and remote areas, it remains a significant funder of allied health services. Unfortunately, insurers do not appear eager to fund telehealth interventions. The Commonwealth could use its influence to require greater access to rebates for telehealth-based interventions for consumers, noting that it currently already funds some telehealth services and is likely to continue to expand access as part of the outcomes of the MBS Review. It is important to note that this will only impact some consumers and is not a replacement for MBS-funded telehealth services.

General Question

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

AHPA argues that improved funding of allied health services for all Australians is the single most important means of increasing access to allied health services in rural communities. We know rural consumers experience higher rates of chronic disease and poorer outcomes, yet access to allied health services remains heavily dependent on the capacity of consumers to privately fund access to

care. Rural consumers are less likely to have private health insurance and less likely to have the capacity to pay for services privately. The implementation of Medicare reform, focused on improved funding of allied health services, must be a major focus for any recommendations to government. Similarly, rebates for DVA services will need to increase and we will need to ensure that older people living in the community and people with disability are getting the funding they need to purchase appropriate allied health services. These factors are crucial to ensuring that rural allied health services are viable.