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7 August 2019

Emeritus Professor Paul Worley
National Rural Health Commissioner
C/- The Commonwealth Department of Health

By email: NRHC@health.gov.au

Dear Professor Worley,

**Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution
Options for Commonwealth Government Policy Reform and Investment**

The University of Sydney welcomes the opportunity to make a submission in response to your Discussion Paper focused on developing sound policy advice for the Commonwealth Minister for Regional Services, the Hon. Mark Coulton MP, to strengthen rural allied health services.

The University's mission is to – for the benefit of Australia and the wider world – create and sustain a university in which the brightest researchers and most promising students can thrive and realise their full potential, whatever their social or cultural backgrounds. To these ends, we deliver professionally recognised coursework and higher degree by research programs in medicine, dentistry, nursing and midwifery; and in 'allied health' disciplines including pharmacy, oral health, clinical psychology, social work, physiotherapy, rehabilitation counselling, exercise and sports science, exercise physiology, diagnostic radiography, occupational therapy, speech pathology, nutrition and dietetics.

While unashamedly metropolitan-based, we have longstanding and deep connections across rural NSW and a continuing substantial rural health footprint comprising: the [Broken Hill University Department of Rural Health \(Broken Hill UDRH\)](#) established in 1996; the [Lismore University Centre for Rural Health \(UCHR Lismore\)](#) founded in 2001; our [School of Rural Health, Dubbo and Orange](#) opened in 2003/04; and three Commonwealth medical regional training hubs also based in Broken Hill, Dubbo/Orange and Lismore, and established from 2016. Our [School of Public Health](#), [Poche Centre for Indigenous Health](#) and other university centres also make significant contributions to improving the health and employment outcomes for Aboriginal and Torres Strait Islander people living in rural communities through extensive educational, research and community outreach programs.

With some 300 staff, tutors and affiliated academics based across our network of rural health campuses we are deeply committed to helping address the health, workforce and service disparities that too many rural communities continue to endure. We are very keen, therefore, to work with you, the Commonwealth and other stakeholders to achieve the ambitious vision for a much stronger rural allied health sector that you have set out in your Discussion Paper.

We have prepared our submission in close consultation with academic and professional staff leaders from across our health faculties, schools and centres, as well as with our staff responsible for leading the work of our rural sites. The Broken Hill UDRH will provide its own submission, given its unique perspectives and extensive experience building and delivering sustainable models of health education and training in the Far West of NSW. We have also helped to develop Universities Australia's submission, which we broadly endorse.

The 'three pillars' for a sustainable, high quality rural allied health service highlighted in the Discussion Paper are supported: increased rural origin participation; increased high quality education and training for allied health students in rural communities; and increased sustainability, critical mass and viability of allied health careers in rural Australia. However, we particularly welcome the Discussion Paper's recognition that while building rural Australia's capacity to 'grow its own' health workforce will be an important part of the solution, a multi-pronged approach will be required. This includes strengthening national allied health leadership and coordination, enhancing rural immersion opportunities for city-origin allied health students, growing the availability of viable rural allied health jobs and training pathways, and investing in new technology and training capacity to support new models of care and help bridge geographic barriers.

We know from more than two decades of experience delivering short- and long-term rural placements (LTRP) for students from across the health disciplines that the completion of LTRPs impacts very positively on graduates' attitudes towards working rurally and the likelihood that they will pursue rural careers. From surveys conducted with students contemplating and completing rural placements we have a good sense of the key factors that influence their decisions to undertake such placements and when making employment choices following graduation.

For students considering rural placements, financial burdens remain a key concern for many, regardless of their geographic origin. This is especially so for students who have caring responsibilities and who would need to forego paid employment to complete a rural placement, while still needing to find money for accommodation, transport and living expenses while on placement. For graduates, key concerns include: the availability of postgraduate employment opportunities; work-life balance; availability of recreational activities; career advancement prospects and the location preferences of their partners.

Between 2016 and 2018 – with support through the Commonwealth's Rural Health Multidisciplinary Training (RHMT) program – we facilitated some 20,000 'multidisciplinary' student placement weeks across our rural sites, with students drawn from many universities completing placements of an average duration of almost five weeks. In line with the targets set by the RHMT, this represented a doubling of these placements within three years. While it is still early days in the expansion of multidisciplinary rural placements, an analysis of students completing such placements through UDRHs between January 2016 and February 2019 found that 72 percent reported being encouraged by their placement to consider a regional-remote position post-graduation. This represented a 27 percent increase as 45 percent had reported interest in working rurally at the commencement of their rural placements. The surveyed students also reported a high level of overall satisfaction with all aspects of their rural immersion experience. For example, 92 percent said they were satisfied with their workplace supervision and 80 percent were satisfied with the accommodation provided.

Nevertheless, there is a need for more research to identify evidence about the ideal duration for rural placements in different disciplines in terms of influencing student attitudes towards working rurally and impacting actual employment outcomes. Additional and stable funding is required to support and coordinate longitudinal research of this type of across all health professions.

The establishment of the RHMT program in 2016 was designed to consolidate and provide flexibility in how universities used the previously separate funding schemes for the Rural Clinical Schools (RCS) and University Departments of Rural Health (UDRH). We believe strongly that policy initiatives arising from your advice to the Minister for Regional Services should seek to further consolidate this policy direction towards inter-disciplinary rural health education and workforce development, including medicine, dentistry, allied health and nursing and midwifery.

The policy reforms the Commonwealth adopts in response to your report should specifically encourage and support intersectoral, multi-disciplinary and inter-disciplinary initiatives of the type that your Discussion Paper notes are currently exemplified across the network of UDRH, including the two we lead from Broken Hill and Lismore. The UDRH/UCRHs provide full year and short-term placements for medical students and variable term placement for allied health, dentistry, nursing and midwifery students, and host the medical-focused Regional Training Hubs. The UDRH and RCS network could be built upon as exemplars of a pipeline approach to truly multi- and inter-disciplinary education; supporting school, VET, under-graduate, post-graduate education and continuing professional development, through highly collaborative models embedded within local rural communities and their health service networks.

In addition to our detailed submission attached, we have attached an integrated set of ten rural allied health policy design principles that emerged from our consultations about your Discussion Paper across our network of health professional education experts. We trust that these principles – combined with the more detailed comments in our submission – are helpful.

We look forward to working with you, the Minister for Regional Services, the Commonwealth Department of Health and other key stakeholders to help strengthen the quality, accessibility and distribution of allied health services across rural Australia.

Yours sincerely,

(Signature removed)

Stephen Garton

Attachments

- A University of Sydney: Ten integrated rural allied health policy design principles
- B University of Sydney submission in response to:
Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution Options for Commonwealth Government Policy Reform and Investment

Attachment A

Ten integrated rural allied health policy design principles

1. **Community-led**
The need for Commonwealth health workforce policy to engage meaningfully with (and be led by) rural communities and to take a holistic, long-term approach to building and sustaining health services that meet the needs of local communities and patients.
2. **Build on existing capacity and raise awareness about opportunities**
The importance of building on existing infrastructure and capacity – adopting a phased approach to gradually expanding the capacity for rural student education opportunities, whilst investing simultaneously in raising awareness and aspirations about rural allied health careers and pathways with prospective students in schools and communities.
3. **Enhance collaboration**
The need for more collaboration to leverage resources and build critical mass and viable models of care and student supervision – especially between metropolitan and regional universities, public and private health services, government agencies and communities.
4. **Holistic approach**
The need for intersectoral and multidisciplinary approaches to service delivery, integrated with education and research – recognising the important roles that all health professions, research and continuing professional development play in delivering community health and patient care.
5. **Quality educational models**
The importance of stressing and maintaining quality, breadth and depth of health education, recognising the continuing value of students having exposure to city-based education and major tertiary care centres.
6. **Supportive accreditation and professional recognition**
The importance of the accrediting and professional bodies getting behind and facilitating long-term rural placements and the notion of rural specialisation in allied health and other health professions.
7. **Expand career pathways, rural immersion and the pipeline of allied health jobs**
The need to create sustainable post-graduation training opportunities and allied health career pathways in rural areas and to increase the availability and duration of rural placements for allied health students.
8. **Integrate students into rural health workplaces and use them as advocates**
The advantages of considering students in the design of service provision and service sites, and building support for students as a benefit, not a burden in the delivery of healthcare in rural communities. Support rural allied health professionals to supervise students and use students and recent graduates working in rural communities to promote rural allied health careers and pathways to prospective students.
9. **Avoid unintended consequences**
For example, introducing blunt institutional enrolment quotas for rural origin and Aboriginal and Torres Strait Islander students in allied health courses could work against collaboration, not see enrolment numbers improve overall, and could see entry standards and completion rates fall. Policy design needs to incentivise positive and collaborative behaviour towards the goal of growing a quality rural allied health workforce sustainably.
10. **Support and incentivise flexible course and service delivery, utilising technology to enable new delivery models**
The importance of leveraging the scale of educational institutions to meet the diverse needs of rural origin and metropolitan students, and of ensuring ready access to cutting-edge technology and support infrastructure (including training) for new models of rural allied healthcare delivery.

The University of Sydney's submission in response to the National Rural Health Commissioner's [Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution, Options for Commonwealth Government Policy Reform and Investment](#), August 2019

Responses to consultation questions

Policy Area 1: Rural allied health policy, leadership, quality and safety

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

The proposal to establish a Chief Allied Health Officer/Advisor to strengthen allied health leadership, inter-sectoral and disciplinary collaboration and representation at the Commonwealth level is strongly supported so long as it is implemented with a light touch that seeks to minimise bureaucracy and maximises the allocation of resources available for service delivery. The appointment should be at the same level as the Chief Medical Officer and the Chief Nursing and Midwifery Officer.

The high-level general priorities for a national rural allied health strategy outlined in the Discussion Paper are also supported: rural origin students; extended rural education and training experiences; rural jobs and career paths; the integration and improved coordination of health services; and the leveraging of available funding sources to help build critical mass, encourage multidisciplinary team-based care, supervision and training, and to strengthen rural communities of practice.

Of course, any national framework for rural allied health education, training and workforce development will need to be embedded as a core component of the broader national health workforce strategy.

Top priorities for the next five years

1. Needs analysis

Base planning on analysis of current community demographics and predicted need for prevention/early intervention/integrated across the lifespan in combination with a strong understanding of the contribution that allied health professionals can make. For example, it is impossible to over-estimate the important contribution of allied health to the restoration of function for rural residents who have had a stroke, to the diagnosis and management of speech disorders which are very prevalent among rural primary schoolchildren and lead to major life disadvantage, to improving nutrition and oral health in isolated communities, and to the mobility of patients with musculoskeletal impairments following injury or joint replacement. Further, access to allied health services, as provided by the NDIS, is predicted to result in a doubling of the allied health workforce, and the increasing presence of chronic disease in the community has led the World Health Organization to identify keeping people well and avoid hospitalisation as a key health outcome.

2. Allied health workforce mapping

Map the current national allied health workforce to identify gaps and priorities to link with the needs analysis to develop strategies that are relevant to different types of communities.

3. Recognise and accommodate the diversity of allied health professions

Build a national allied health strategy tailored to the diversity and specific context of allied health education and rural practice. Adopting approaches that may have worked for medicine and nursing to address workforce maldistribution will not be as effective for the allied health professions unless the

strategy is informed by key differences between the allied health professions and compared to other health professionals.

4. Build rural allied health jobs and post-graduation pathways

Build rural jobs and career paths with specific attention to the private sector, NGOs and programs, e.g. My Aged Care and NDIS, in addition to the public/acute care sector. Invest in developing a range of rural career pathways, including a sustainable business model for allied health professionals in rural sites. Develop postgraduate programs in speciality areas such as mental health, aged care, disability, primary health care, and areas of health technology and business management in which allied health expertise is necessary.

5. Phase in a pre-professional entry rural education strategy for allied health

Develop a pre-professional entry rural education strategy that can be phased in over the next 5-10 years, which builds on existing capacity provided by the regional universities, the UDRH and Rural Clinical School network, and which responds to the unique accreditation requirements of each allied health profession and capitalises on the valuable contribution that students can make to the provision of allied health care in rural communities. Specific initiatives should include:

- Rural origin students (pathways, pre-year 10 advice/outreach, relocation options or other outreach).
- Create vacationer program that Year 9 - 11 high school students can apply for to get acquainted with potential careers in allied health care professions by incentivising current allied health professionals to take on these students as mentees.
- Enhanced funding for UDRHs and Schools of Rural Health; work with universities to develop and implement six-month or year-long innovative placements for allied health students in rural areas (in coordination with accrediting bodies); drawing on the extended rural placement model already in place for medical students and supported by the RHMT program.
- Continue to promote multidisciplinary education for the current and emerging workforce as part of the national accreditation standards for new and existing health professionals.
- Enhance and co-ordinate the investment in allied health students who want to work rurally, offer scholarships to complete post graduate qualifications, offer scholarships to support living costs in rural and remote areas (<https://onlinelibrary.wiley.com/doi/full/10.1111/ajr.12487>), including loan repayment schemes.
- Advocate/implement telehealth and other digital health strategies to increase access to health care and to provide mentoring and support to all health clinicians by incentivising mentors from metropolitan areas to take on rural mentees.
- Ensure undergraduate and postgraduate allied health programs include a component and exposure to telehealth.
- Review the merits of the restrictions currently placed on international students undertaking clinical placements through entities supported by Commonwealth funding under the RHMT Program to align with the Prime Minister's and Minister for Education's current policy focus on boosting the numbers of international students studying in rural Australia.

Discipline/Centre specific elaboration on points relevant to recommended **Priority #5** are provided below.

Sydney Pharmacy School

In addition to enhancing and coordinating the investment in allied health students who want to live in rural areas, initiatives to promote retention of allied health practitioners should also be developed. Here, a 'whole-person' approach and investment in connectedness and liveability may be required from the Government. Further, in utilising telehealth technology to mentor health clinicians, use of telehealth could also complement preceptorship by existing allied health clinicians currently practising in the field with a focus on support for perpetuating a culture of service through preceptorship post-graduation.

Broken Hill UDRH

An allied health education and training re-design could be informed by the Rural Clinical School program that has contributed to a shift from rural clinical placements that follow processes set by metropolitan-based universities, to programs designed to better suit the needs of rural and remote areas. This would include education provision and extended immersive placements (≥6 months) in rural and remote locations. Extended placements would enable the provision of integrated theoretical components of core university curriculum, and the provision of regionally relevant education on site in

communities relating to rural and remote health and allied health practice (population health, primary health care, Indigenous health, health care complexity, inter-professional practice). Both elements could be facilitated and delivered by academic staff employed through the UDRH.

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

The position would need to be at a level comparable to other similar positions (Chief Medical Officer, Chief Nursing and Midwifery Officer) with the same status and an equal voice/place within the policy making processes. The position would need clear terms of reference and lines of authority, including having key responsibilities for the provision of advice to the Commonwealth about rural allied health services, workforce, education and training.

The Commonwealth cannot assume that one allied health professional understands all potential contributions/skill sets of every other allied health discipline. A multi-disciplinary governance and consultation approach will need to be core to the work of the Chief Allied Health Officer, who may, for example, chair an advisory board comprising all state/territory Chief Allied Health Officers and include additional rural and educational representatives to ensure comprehensive coverage.

Important to note also that allied health organisations do not exist in all jurisdictions, are likely to be influential mainly in health service areas concentrating on acute care and rehabilitation and may not have strong cross-sectoral understanding. Engagement of the national allied health professional associations will be critical for ensuring this understanding is developed, otherwise we risk only focusing on tertiary intervention, and rural communities will lose important opportunities to improve and maintain health and well-being and quality of life.

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

While concerned about the potential for the creation of further complexity and bureaucracy, we are open to the concept of a Rural Allied Health College being established to raise the standing and profile of rural allied health professions choosing to specialise in rural practice by, *inter alia*: facilitating the implementation of national rural allied health programs; accrediting post-graduate rural training courses to meet quality and safety standards; promoting high-quality rural context training and career pathways; and providing a central repository to collect, manage and share rural allied health workforce data, research and innovation.

We understand that the main models under consideration for establishing such a College include:

- a controlled entity or affiliated entity established by an existing allied health organisation or consortium of organisations.
- an evolution of an existing organisation or association.
- an independent entity, supported by:
 - existing allied health peak bodies
 - existing individual members.

With the exception of physiotherapy, allied health professions in Australia have not had career pathway structures that provide sufficient opportunities to be recognised as specialists even though experienced allied health professionals become specialists. Interested allied health professionals tend to 'self-specialise' by undertaking formal and informal professional development of their skills.

The equivalent body for allied health would be those professional associations that look after accreditation of education, development of resources, advocacy, and advice on quality standards and practice issues and professional support networks. Some associations have found that there is little demand for formal post-graduate credentialing of specialists within the allied health professions, including those that have sought to recognise specialities previously (e.g. physiotherapy). The reasons for this warrant further investigation. Reasons might include lack of career path, lack of access to promotion, and lack of mechanisms for obtaining promotion or increased income as a result of post-graduate credentialing; other reasons may also exist.

It is important to bear in mind here that strategies are also aimed at the *retention* of allied health practitioners. Factors such as increased income may be effective for the recruitment but could

potentially be inversely proportional to retention duration. For this reason, a 'whole-person' approach and investment in enhancing the liveability within the community for long-term retention should be considered and may require a concerted effort and planning across sectors.

If a national Allied Health College is established, we strongly recommend that the name should better reflect the functions of a body that oversees accreditation, quality and resourcing, e.g. "Rural Allied Health Professional Association". It would be important that the College's charter is clearly about enabling and facilitating high quality rural health practice rather than 'gate keeping' and restricting access through staking a claim to and patrolling the boundaries of an area of practice.

Extended scope of practice and transdisciplinary practice imply a need for permeable boundaries between all health professionals. The organisation should also encompass allied health assistants and Aboriginal health workers' allied health practice, and include a mandate for research and student involvement, i.e. preparation of the future rural allied health workforce. An understanding of how allied health contributes to better outcomes for individuals and communities across multiple sectors will be critical, as well as understanding of the diversity of allied health professions and their related contributions.

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

While an independent entity is preferred as the ultimate structure that the College should take, perhaps the best potential body to nurture the College is Services for Australian Rural and Remote Allied Health (SARRAH), with potential collaboration with the Australian Rural Health Education Network (AHREN) and other existing health profession peak bodies that have a clear interest in rural health service delivery. Support from AHREN to oversee the Rural Allied Health College would be advantageous, as its membership (comprising UDRHs) are located in all states and territories and the UDRHs are embedded with and understand the needs of the rural communities they serve. UDRHs are also well connected to rural practitioners, local schools and service providers, in addition to a range of universities that deliver clinical education for all health disciplines.

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

The number of:

- new postgraduate courses developed, e.g. in mental health, digital health, aged care, disability etc;
- participants accessing and completing postgraduate courses;
- new education programs that are multidisciplinary;
- scholarships offered and taken up to support allied health practitioners to complete these courses;
- structured new graduate support programs in rural areas;
- new allied rural health positions created in the public sector;
- new pathways to specialised rural allied health positions created;
- new recruitment and retention data of graduates to rural areas;
- increased industry connections with health services; and
- at a broader level, long-term impact on client/patient outcomes e.g. access to allied health services.

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

Benefits

The benefits of establishing and maintaining a comprehensive national allied health workforce dataset are well explained in the Discussion Paper. They were also becoming clearly apparent when Health Workforce Australia existed and was developing and maintaining such data for all health disciplines. Knowledge of the workforce gaps enables better investment where AHPs are currently located. Knowledge of existing workforce enables access to services for people seeking care. Comprehensive workforce data combined with demographic and population health data enables better planning by health services, education providers and individuals. It also assists health practitioners for referral and team-based care.

Challenges

A key challenge will be to identify allied health professionals because not all are registered professions. Some are successfully self-regulated and/or have been somehow determined that malpractice may not pose a sufficiently severe threat to public safety, and therefore they have not been included in the national registration scheme. Registration with AHPRA has been used to 'count' allied health professionals in multiple contexts and is not an appropriate metric for all allied health professions. Some non-AHPRA professionals could be counted via professional association membership but membership is not always required for practice, only eligibility for membership. The cross sectoral nature of allied health practice, i.e. locating all the public and private/NGO contexts in which they practise and counting them will be challenging. The location of where such a dataset might reside will also be crucial - to avoid there being further fragmentation with different bodies looking after different but overlapping datasets. A model worth examining is that of the European Observatory on Health Systems and Policies. Other challenges include:

- Limited up-to-date information e.g. Primary Health Network surveys may indicate saturation of allied health professionals in a region, yet client and waitlists feedback may indicate the opposite.
- Responsibility of collection and maintaining that dataset - key is that there is a lead agency with the authority to pull data together and generate reports, noting that all collections need to follow the FAIR principles (i.e. Findable, Accessible, Interoperable, and Reusable).
- Contribution/compliance by all relevant bodies.
- The need aggregated dataset including NGOs and private as well as public sector
- Some current datasets are limited by boundaries (state, association, local health district and PHN regions).
- Typical costs associated with dataset stewardship and management expertise.

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

- AHPRA data for all allied professions regulated under the national registration scheme.
- Association bodies (e.g. Exercise and Sports Science Australia (ESSA), the Australian Physiotherapy Association (APA), Occupational Therapy Australia (OTA), Speech Pathology Australia (SPA), Dieticians Association of Australia (DAA), the Australian Clinical Psychology Association (ACPA), the Australian Association of Social Workers (AASW), Services for Rural and Remote Allied Health (SARRAH).
- Data from the Commonwealth's Health Demand and Supply Utilisation Patterns Planning Tool (HeaDS UPP) and develop an Allied Health component, ABS data, national institute of health and welfare data and GIS data.
- MBS/PBS and ABS data stratified by location, population size, socio-demographics. (We note here that hardly any allied health is funded through MBS.)
- Longitudinal data, which tracks health students through enrolment, completion, registration and career progression and practice type and setting etc. The single student identification number currently under development by the Department of Education and Training should be helpful for tracking health student outcomes.
- The NDIS provider register and the data emerging about allied health service usage and projected demand (<https://blcw.dss.gov.au/ndis-demand-map/>)

Discipline specific feedback, Dietetics

As Accredited Practising Dietitians (APDs) are self-regulated and outside the national registration scheme there is no Government-held data, so the profession tends to be relatively invisible when it comes to workforce planning. The profession has a register of all APDs but the state and territory systems do not enforce APD status so the true workforce is not readily apparent. The data is also not readily available in the Census. Recently a PhD candidate at the University of Sydney completed Geographic Information System (GIS) entries for the dietetic workforce throughout Australia based on the DAA data. The results of that study may be of use and interest to the National Rural Health Commissioner and other stakeholders interested in the distribution of the allied health workforce.

Please provide any additional comments and feedback related to this Policy Area.

No further comments.

Policy Area 2: Opportunities for Rural Origin and Indigenous Students

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

Notwithstanding the widespread use of enrolment targets by the Commonwealth Departments of Health and Education, we remain far from convinced that they are an effective policy mechanism – particularly if implemented bluntly with insufficient regard for potential unintended consequences, or without complementary measures to boost the numbers of suitably prepared prospective students.

For example, when low-SES, Aboriginal and Torres Strait Islander, Rural, Regional and Remote student enrolment targets were implemented as part of the compact funding agreements with universities, some metropolitan universities competed aggressively for a finite pool of suitably qualified students who were already highly likely to have enrolled in a regional university. The overall numbers and proportions of students enrolled from these backgrounds did not increase substantially. The measure placed enormous pressure on some universities to reduce their entry standards, while the focus on enrolments ignored the fact that increasing the numbers of students from disadvantaged backgrounds who successfully complete their studies is far more important than the numbers of enrolments. Increased attrition rates followed at some universities, with very negative financial and other consequences for the students and the Government due to the funding invested in these students through the Commonwealth Grants Scheme, the HECS-HELP and student income support system.

There is also evidence that those who complete a long-term rural placement (regardless of whether they are of rural origin or not) are far more likely to work rurally, than those who did not complete a rural placement. Careful design of any rural origin enrolment quotas will therefore be vital and require close consultation with higher education providers. There is also a need for more research to identify evidence about the ideal duration for rural placements in different disciplines in terms of influencing student attitudes towards working rurally and impacting employment outcomes post-graduation.

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

For reasons including those raised in our responses to Questions 2.1.a above and 2.1.c below, the introduction of more enrolment targets for allied health courses is not endorsed. If such quotas are to be introduced, they will need to be designed very carefully in consultation with higher education providers to minimise the risks of unintended consequences and to reward provider behaviour that contributes positively to achieving the overarching policy objectives of strengthening the rural allied health workforce and services.

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

We welcome the Discussion Paper's recognition that lifting rates of rural origin student enrolments in tertiary allied health courses can only be part of the solution to the persistent health workforce maldistribution challenges facing rural communities. An integrated, long-term approach is required, which includes measures to strengthen course completion rates for rural origin allied health students and to improve the availability of allied health post-registration training and professional career pathways in rural communities.

In terms of other policy options within the Commonwealth's remit, which could help boost rural origin student enrolment rates in allied health courses, the national network of University Departments of Rural Health and Rural Clinical Schools has great potential – if adequately resourced – to build on the considerable activities already being pursued by many of them to help boost secondary school completion rates and academic preparedness, and to raise awareness and aspiration about rural allied health careers and pathways amongst prospective students.

For example, with modest additional funding support the UDRHs and Rural Clinical Schools could build more structured opportunities for current allied health students and recent graduates to act as ambassadors to promote allied health study and career pathways to school and mature age prospective students residing in rural communities. Incentives could also be provided to encourage universities to partner with regional vocational education providers to establish clearer pathways for entry to university-level allied health courses for older prospective students.

Various university 'widening participation' initiatives supported by the Federal Department of Education's Higher Education Participation and Partnership Program (HEPPP) have been independently evaluated as having a substantial positive impact in disadvantaged communities. However, securing stable long-term funding for these programs has been challenging for universities, due to the numerous cuts and changes to the program's parameters since it was established in 2011. There remains some capacity in the HEPPP for the Minister for Education to support partnership projects involving multiple universities, schools and other organisations that seek to address the educational needs of disadvantaged communities. Funding from the HEPPP and other similar equity programs could be targeted strategically to support the school and community outreach activities of university collaborations through the network of UDRHs and Rural Clinical Schools.

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

In addition to the comments below on placement length, education and trainee experience, and employment on completion, we believe that increasing the number of scholarships in general is a positive step, as financial stress is one of the main challenges faced by Aboriginal and Torres Strait Island students. In addition to more scholarships, reducing the threshold for students to be able to claim Abstudy and/or the Residential Cost Option through Centrelink would alleviate some of the financial pressure placed on families when a student commences further study. Further, there could also be some relaxation on the limit of additional income a student can receive before their Abstudy is affected - i.e. smaller valued scholarships should not affect the students' Abstudy payment.

- Long term rural placements – similar to those which are already relatively widely available for pre-registration medical students.
- Expand support for blended employment and education approaches similar to that used for many years in our *Graduate Diploma in Indigenous Health Promotion* delivered through the University of Sydney School of Public Health.
 - <https://sydney.edu.au/courses/courses/pc/graduate-diploma-in-indigenous-health-promotion.html>
- CSU Wagga Wagga (in partnership with NSW Health) runs the successful Djirruwang Program. A three-year block release program providing tertiary qualifications – Bachelor of Health Science (Mental Health). This program provides clinically based tertiary level mental health training for Aboriginal and Torres Strait Islander people.
 - <https://news.csu.edu.au/latest-news/indigenous/21-years-for-djirruwang-program>
- Guarantee of employment on completion.
- Working with existing allied health staff as a trainee.

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

- School based apprentice and traineeship program – combination of work, training (TAFE) and school. Students complete the program whilst at school and this can count towards the HSC (ATAR). All work is paid and on successful completion of the program, students receive a nationally recognised qualification.
 - Suggest increase to funding to allow more Indigenous specific apprenticeships & traineeships as places in this program are limited. Should also lead into guaranteed employment on completion, e.g. the Far West Local Health District deliberately allocates half the places to Indigenous students.
 - Suggest that any policy relating to employment of Indigenous apprentices and trainees, include a recommendation that a minimum of 50% of places be allocated to Indigenous students.
<https://sbatinnsw.info/>

- Alternative pathways – such as the Allied Health Assistant (AHA) or Health Service Assistant (HSA) course through TAFE. Participants receive a nationally recognised TAFE qualification and can do the program whilst still at school during year 11 and 12. These pathways include a theoretical component as well as 100 hours of on-the-job training, which is paid employment. After successful completion, students can be employed as an Allied Health Assistant. This work experience, and qualification may be an incentive for the student to go on to further study. Any qualification can be recognised as prior learning in some circumstances and lead to a credit against a degree program of study.
- Aboriginal Health Practitioner Model – Aboriginal Health Practitioners work to improve health outcomes for Indigenous people. All AHPs have a Cert IV in Aboriginal/Torres Strait Islander Health Care (Practice) and must be registered with the Australian Health Practitioners Registration Agency. AHPs play an important role in closing the gap in health outcomes by providing culturally appropriate health care, both in Aboriginal Medical Services as well as mainstream organisations.
 - Despite being qualified, AHPs don't always receive recognition for their qualifications
 - There should be more opportunities for Aboriginal Health Practitioners to be involved in the clinical practice side of things & for there to be guaranteed employment on completion of training.
- There is a (law enforcement / justice / emergency services) program - IPROWD - which is known to be successful and could provide some ideas for adapting a similar model relating to health.
 - <https://www.tafensw.edu.au/iprowd>
- The Poche Centre at the University of Sydney administers a scholarship program that collaborates with industry and community partners, and TAFE NSW, to provide Aboriginal and Torres Strait Islander students the opportunity to earn a VET qualification to then work in Indigenous health care. In the four years between 2015 and 2018, more than 200 scholarship students gained 451 TAFE qualifications, with an average completion of 97%. This is three times the national completion rate for the same cohort studying at TAFE. The program partners with local health services and state and federal health councils/associations to ensure students have employment opportunities and support during their studies, and career pathways afterwards. The Poche Centre co-designs an educational pathway for the students which aims to maximise successful engagement and completion for Indigenous students located in regional and remote communities, and tenders out the VET award component each year, for delivery of distance learning and block release intensive study. <https://sydney.edu.au/medicine-health/our-research/research-centres/the-poche-centre-for-indigenous-health.html>

Please provide any additional comments and feedback related to this Policy Area.

No additional comments.

Policy Area 3: Structured Rural Training and Career Pathways (MMM2 – 7)

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

- i) full year training?**
- ii) full course training?**

We have been developing our Rural Clinical Schools and UDRH/UCRH to include allied health student placements which offer training opportunities in regional, rural and remote NSW.

We fully support partnerships between metropolitan and regional universities, managed/supported through UDRHs, which support students from a variety of universities, not only those of the 'lead' university of each UDRH.

The **UCRH Lismore** in Northern NSW is a good example of this - it is a joint venture between the University of Sydney, Western Sydney University, the University of Wollongong and Southern Cross University and operates in close collaboration with the Northern NSW Local Health District and all providers of health services on the NSW North Coast.

The UCRH acknowledges that while the origin of students is the strongest predictor of a rural career, it is also important to create opportunities for students from metropolitan areas to undertake rural placements, and vice versa. Further, the UCRH experience is that short stay rural training placements also have some benefits, with many examples of medical and allied health students who have pursued a rural career following a short rural placement.

It is therefore important that short-stay rural training placement should be part of the mix of strategies, recognising that the current priority gap is in full year and in full course training.

The UCRH Lismore, which advocates for increased support for both full year and full course training, has provided some key strategies and considerations for provision of comprehensive allied health training in rural areas.

- No one university offers every allied health profession, so it would be necessary to partner with different universities for different disciplines.
- Close collaboration is needed between all universities, discipline representative/accreditation bodies, UDRHs, service providers/communities, and hospitals.
- Broad range of curriculum changes needed to align with revised accreditation requirements.
- Distance supervision is the main model for some disciplines due to the shortage of staff on the ground able to take clinical placements. There is a need to review resourcing for clinical education:
 - Part time staff
 - Limited access to certain specialities
 - Remuneration, training, recognition and ongoing support for supervisors (e.g. the majority of sole practitioners/small business owners cannot afford to take students)
 - Training/identification of high-quality supervisors
- Scholarships may be needed to support supervisors in the extension of their training. E.g. in psychology, supervisors have additional training requirements imposed by their registration board, and the training is expensive.
- A good organisational structure and adequate resources are needed for placements and supervision, particularly in specialties needed in the area (OT, psychology), as personnel in these disciplines are generally so busy that they cannot take students or there is no one of that profession to supervise a student.
- Access should be made available for students to complete course work via telehealth/access/training.

Additional comments from our **School of Pharmacy** include:

- i) Full year training can occur at a post-graduate level as part of the internship. Integration of the intern year into the curriculum in Australia is still in its infancy for Pharmacy. Greater support required for development and implementation of quality standards and accreditation for supervisors and incentivisation for students to forego wages which would otherwise be earned during the intern year to undertake an internship as part of University coursework.
- ii) Full course training may involve placement of students who are more experienced and of higher calibre.

Our **School of Psychology** also notes that full year training could occur within a post-graduation registrar program that leads to an endorsed area of practice in clinical psychology (although this currently sits outside university training it is part of the psychology training pathway).

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

Our strong preference is for providing longer clinical placement experiences for students regardless of their origin e.g. 3-12 months. In **Psychology**, there are examples of city-based students completing a rural placement for 3 months and then going back to work in the placement site (as with the other allied health disciplines, they need employment opportunities).

We are acutely aware that current (and previous) allied health students will often have to expend their own funds for these rural placement experiences (where in many places there is no accommodation for allied health students) and that they are not graduating into high-paying jobs. We fully support the John Flynn Placement Program being expanded to include placement scholarships for rural allied health students and provides the following comments:

UCRH

John Flynn scholarships or similar placements should be managed through the UDRHs, which are well established to support students within a rural and remote environment. They should not be arranged independently by students or universities.

Schools of Pharmacy and Psychology

Student demand and career outcomes - if students remain in the region upon graduation, they will also be involved in training future cohorts.

Nutrition and Dietetics

This program should be expanded to allied health students, but two weeks is fairly short. Many nutrition and dietetic students spend 6 to 10 weeks in rural locations already.

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

- i) **increase the number of allied health courses and training available in rural locations?**
- ii) **increase the number of allied health student rural placement opportunities?**

We welcome the Discussion Paper's recognition that while building rural Australia's capacity to 'grow its own' health workforce will be an important part of the solution, this will not be sufficient, and that enhancing rural immersion opportunities for city-origin allied health students and growing the availability of viable post-graduation rural allied health jobs and training pathways will also be critical. We also note the following discipline specific comments:

School of Pharmacy

- i) Attract the necessary personnel (academics, practitioners); incentivise (as above Question 2.1.c), increase liveability in the area; provide leadership opportunities to drive and implement ongoing and lasting changes to the area.
- ii) Funding, grading and remuneration of the "rural generalist" specialty (as above, Question 1.2.a); clear career progression and advancement pathways including leadership opportunities.
- iii) Maintain the number of Pharmacy courses across Australia (i.e. no increase) as there is currently a saturation of courses with some not sustainable.

Nutrition and Dietetics and all allied health

Funding is required for student accommodation in rural placements.

UCRH Lismore

Impose quotas for student numbers and funding conditions for CSPs for metropolitan universities.

Occupational Therapy

Potential to develop flexible delivery allied health courses through the larger universities that allow students from various locations to engage in student remotely.

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

We note that the Health Workforce Scholarship Program has just entered its third and final year of the \$33 million funding allocation, and that delivery of the program in NSW is via the NSW Rural Doctors Network. We offer the following comments regarding further expansion and promotion of this program to allied health professionals:

School of Pharmacy

The Health Workforce Scholarship Program is excellent to attract health professionals, however, we should also consider retention data (if any) and strategies.

UCRH Lismore

- On-ground mentoring opportunities should be provided for clinicians e.g. new graduate groups.
- Rural students should be assisted to access housing and social support.
- Looking at pathways.
- A central location is required for information on all available scholarships.
- Consideration should be given to offering scholarships outside the public and acute care sectors, specifically aged care, disability care and social services in the community.

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

Our **School of Pharmacy** encourages the implementation of retention strategies (discussed above in 3.2.a) to support existing allied health practitioners currently practising in the field and examine as case studies.

The **Broken Hill UDRH** nominates the provision of additional financial supports to cover costs associated with the release of rural and remote staff to undertake additional study and skills acquisition.

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

We provide the following comments in regard to the composition of an appropriate governance model for rural generalist training (which also supports skills extension for existing qualified rural allied health workers):

School of Pharmacy

This requires consultation with the relevant professional organisations and current rural allied health workers.

Nutrition and Dietetics

Does not consider this model appropriate in Nutrition and Dietetics, however, does support expanded scope of practice to allow prescribing for diabetes and hyperlipidemia treatment would be appropriate training and take some pressure off GPs.

Please provide any additional comments and feedback related to this Policy Area.

Broken Hill UDRH

The UDRH notes that there is a lack of evidence that identifies how long a placement should be to impact rural intent to practise. Additional research is required to determine the impact of immersion placements from 3-12 months for allied health professionals, acknowledging that Social Work placements are already 3-4 months in duration.

Financial burdens/concerns for students seeking to engage in immersion placements also need to be considered especially when these students may have to leave casual or part-time employment to undertake these placements.

Policy Area 4: Sustainable jobs and viable rural markets

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

In proposing the concept of Integrated Allied Health Hubs (IAHH), the Commissioner notes that “UDRHs and IAHHs could work together providing placement, service-based learning and immersion training opportunities for students as described in Policy Areas 2 and 3.” (p.35) As such, we consider that the factors required to support the development of IAHHs to service regional catchments should include:

- Shared governance and funding support to underpin coordination, strategy development and implementation.
- Policies, processes and coordination for infrastructure, sustainability and equity.
- Funding to be based on equity of allied health services and community need.
- Strong relationships with UDRH/UCRH/Rural Clinical School education and training programs and placements.
- Ensuring the IAHHs link well with Medical Rural Training Hubs, PHNs and other entities/initiatives intended to integrate and build sustainable rural health services and professional pathways.
- Funding to support a large number of IAHHs across Australia, with significant flexibility in size and service mix to suit local contexts and ensure coverage across regional and remote Australia.
- The need for financial incentives, e.g. through tax, practice incentive payments, the Government forgiving the loans of allied health graduates who commit to working in rural areas, and the establishment of a rural bonding program for allied health students similar to the scheme already in place for medical students.
- Strategy, leadership, expertise and ongoing training of allied health assistants (which can include allied health placement students).
- Capacity building and telehealth for any short-falls in the meantime (where possible).

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

We strongly support the Discussion Paper’s focus on increasing the sustainability and viability of allied health jobs in rural Australia. This is arguable the most important policy area requiring attention, because without a critical mass of rural allied health employment opportunities there is little point boosting the numbers of graduates keen to work rurally.

We currently operate three significant rural health education and research service models that could be scaled up or adapted under the proposed IAHH principles.

- The focus of the **Broken Hill University Department of Rural Health** is to establish relevant teaching and support environments, promote opportunities for student placements in the region, and deliver a successful rural and remote placement program for medical, dental, nursing and allied health students. The BHUDRH has a strong population health focus and supports existing rural and remote health providers to improve health service development, especially in public health and primary healthcare. The BHUDRH’s research and development team provides comprehensive research training for GPs, primary healthcare workers, Indigenous mental health trainees and professional development support for local health professionals in far western NSW.
- The **University Centre for Rural Health** in Lismore is also a multidisciplinary centre for education in rural health for medical, dental, nursing and allied health students, as well as continuing professional development for rural health practitioners. The UCRH also provides continuous multidisciplinary service-led student placements in schools and aged care settings. The UCRH is a joint venture between the University of Sydney, Western Sydney University, the University of Wollongong and Southern Cross University and operates in close

collaboration with the Northern NSW Local Health District and all providers of health services on the NSW North Coast.

- The **School of Rural Health, Dubbo and Orange**, while currently focused on delivering high-quality extended rural placements for students enrolled in the Sydney Medical Program, also supports clinical placements in the region for students in allied health and other disciplines. As the School of Rural Health looks to deliver the Sydney Medical Program end-to-end to 24 commencing Commonwealth-Supported Students from 2021 as part of the Murray-Darling Medical Schools' Network, it also provides a strong base from which the provision of longer-term integrated rural clinical education experiences for allied health, dentistry and nursing students could be scaled up.
- Since 2018, the **BHUDRH**, the **UCRH** and the **School of Rural Health** have entered into collaborations with the relevant Local Health Districts to establish Integrated Regional Training Pathways, with Rural Training Hubs funded by the Australian Government. The Hubs make use of the University facilities in these locations, and have been able to create an increasing number of advanced training posts in fields such as Emergency Medicine and Oncology. These represent a first step in generating career pathways for medical graduates in rural Australia, and serve as a model for analogous developments supporting rural career pathways for other health professions.

Other health service models to note (and support) include:

- In Lismore NSW, a proposed Centre for Excellence in Aboriginal Health in association with the (Sydney) University Centre for Rural Health, will provide a multi-disciplinary clinical service, education and research centre.
- The Southern Cross University Health Clinic provides a dedicated health care service to SCU students and staff, and the Lismore and Gold Coast communities.

Tax incentives to fund training facilities, and increasing collaboration between rural/regional and metropolitan universities are also strongly supported, noting the student requirement for metropolitan placements and the need to factor in spending time in a tertiary care centre.

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

We support, in principle, the position that funding arrangements must meet the diverse patient care needs of different regional communities while also ensuring funding equity to meet the training needs of the allied health workforce. To reach this point, we note that initially, the Commonwealth would need to consult, review and cost the needs of each region and allocate funding for allied health services accordingly, in addition to engaging on many levels.

There is a need to understand the demographics of the community (including issues of equity/inequity in access to and quality of services for different communities) and subsequently the gaps in allied health services, while aiming for the allied health workforce to work at full scope of practice. While consideration of some funding for innovation and cost-saving interventions would also be supported, so too would be the need for equity across the allied health disciplines, noting that allied health is quite flexible and can provide multidisciplinary supervision of students or of allied health assistants.

For some allied health professions, an alternative model is to switch the focus from end-to-end training to training placements after learning the foundations of that discipline. This would mean that instead of trying to fit so much into initial training, perhaps offer a graduate year or internship and make this a requirement of registration, e.g. doctors and pharmacists already do this, while nurses have a transition year after completing their degree, and psychologists have a registrar program that is required in order to gain the endorsed area of practice in clinical psychology, overseen by the Psychology Board of Australia. This will also account for the need to factor in spending time in a major tertiary care centre as part of the educational requirement. We also note that there are barriers unrelated to funding, one of which is an employment pathway and that these are not full-time jobs.

UCRH LISMORE

A further suggestion from UCRH is to remove or reduce constraints to access to healthcare that result from requirements for GP sign-off for access to Allied Health MBS items. An example might be the employment of an occupational therapist or speech pathologist to work across several small rural towns within local primary schools, preschools or within residential aged care settings.

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

We noted in our response to Question 4.1.b, the establishment and development of two integrated and collaborative health service models which can easily be scaled up. The UDRH/UCRH model is one of a stable of 17 UDRHs across Australia. These UDRHs, as well as some of the Schools of Rural Health currently supported under the RHMT, could very feasibly serve as the 'hubs' that the National Rural Health Commissioner portrays in Figure 1 of the discussion paper. The UDRHs already form a national network with substantial coverage of regional and remote Australia. In establishing a UDRH as an allied health service hub, this provides the flexibility to be able to service more than one area and provide a diverse and/or comprehensive range of allied health services. The UDRH hub would then provide the base on which to establish dedicated full-time allied health assistant roles and also jobs for their partners, which is acknowledged as crucial to attracting and retaining talent.

Within this model, it would be possible to design and support programs that specifically enable and support the engagement of Aboriginal and Torres Strait Islanders to take up training and careers as allied health assistants. Our Poche Centre for Indigenous Health has been very successful in providing VET pathways to allied health qualifications and employment for Aboriginal and Torres Strait Islander students. Its innovative model could be adapted to co-design an appropriate generic allied health assistant training program. This could then be one component in a suite of education opportunities, post-graduate training pathways and jobs, to ensure that the rural allied health workforce has access to further training and career progression.

From these hubs: support can be provided for established allied health professionals in the area, all of whom have the potential to train and lead the next generation in the region; activities can also be run to attract and retain talent, including implementing school-based traineeships, and sensible end-to-end programs including incentives can be packaged to raise the capacity and effectiveness of rural allied health workforce.

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

We note the role of a Community Health Organizer in the United States, whose job description includes the development and coordination of programs designed to promote the organisation and its services to the community and the target population. Other feedback included the expansion of training placements after the training, e.g. in the form more of an internship and notes that for health professionals, accreditation and the access to supervisors are often more important criteria than salaries. One more radical proposal is to consider whether completion of a rural placement is a stipulation of obtaining a final license to practise. It is worthwhile keeping in mind the caveat that some students just cannot complete a rural placement e.g. if they have young children or are carers or have a disability or illness requiring specific care with their health care provider.

In relation to the question more specifically, the **School of Pharmacy** suggests that funding can be recouped through supporting local exports or attracting industry and visitors to the area through investment in the local arts, culture and environment. Benefits of the latter will also contribute to the well-being of local allied health practitioners and residents. Infrastructure to increase "connectedness" and mobility from hubs will also be favourable for professionals considering long-term plans to remain in the area.

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

We note that allied health - more so than medicine which has the advantage of scale - needs resources and leadership and is spread out over at least 26 disciplines. The education perspective is

against an apprenticeship model, as the preference is for students to be exposed to a broad range of clinical settings and experiences (including metropolitan), rather than be based with one practice for six months. (In fact, the graduates would not get registered, as there is a requirement for a specified variety of settings for accreditation.) Further, rural students also need to experience the complexities of working in a metropolitan environment that provides, unlike most rural settings, tertiary services and a case mix that exceeds the routine.

As observed in 4.2.a there are significant constraints about supervision and accreditation and responses to policy option 4.1 and elsewhere, consistently notes the need for extended placements and jobs, and jobs for the partners of health professionals.

In addition to leveraging or repurposing the UDRH model, we are very aware of learning from mistakes in noting what works and what does not work, especially when considering end-to-end programming in a regional or rural setting. We would support any funding attracting allied health academics to move to regional Australia, however the reality is unfortunately, that despite financial incentives and job stability, there are relatively few Australian academics who seek employment in RRR and in fact the opposite is the case as recent job opportunities in metro areas have attracted academic applicants from rural areas

Our **School of Pharmacy** further notes its support for a 'whole-person' approach and all funding options which contribute to increasing the liveability in the rural area, such as services, physical and social environment, connectedness and mobility, and will attract and retain essential personnel which contribute to any viable market.

Our **Discipline of Nutrition and Dietetics** would also like funding to support student training in rural areas.

Please provide any additional comments and feedback related to this Policy Area.

There are key frameworks to be established to support the role out of allied health assistant positions in rural and remote locations that address governance issues in relation to supervision and support for quality practice. The integration of allied health assistant roles with telepractice as the locally based practitioner supporting access to the remotely based allied health professional is a key part of these models to enhance access. Current supervision and delegation frameworks are not addressing these issues and lean towards a risk averse approach to remote supervision. The Commonwealth could fund development of an evidence based rural and remote supervision and delegation framework.

There is also a need to:

- establish allied health communities through service and training hubs to contribute to best practice models for allied health networks, students and professionals;
- review current investments that are directed towards enhancing student placements in rural locations and how similar investments can be maintained to enhance transition from student to new graduate and professional practice (i.e. access to IT, peers, accommodation, education opportunities);
- explore how best to backfill positions so new graduates and experienced professionals can access and participate in continuing professional development, networking opportunities, interprofessional learning etc;
- explore potential to adapt and extend the QLD Rural Generalist Allied Health model to other locations;
- explore federal contributions that could be made to minimise HECs debt for individuals from or going to rural practice; and
- Rural Generalist training – discipline specific competencies for those being exposed to a diverse range of discipline needs (clinical extension skills).

Policy Area 5: Telehealth Allied Health Services

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

We support the investment in telehealth technology for rural allied health services, however, note that students will require training, not just the health practitioners and supervisors utilising this form of health service provision.

There are multiple instances of telehealth applications supporting rural allied health services, for example:

Pharmacy

- My Health Records
- Online pharmacies which can quite easily include capacity for telehealth consultations
- Drone technology
- The Digital health CRC is working with Sisu Wellness and Priceline Pharmacy to identify those with, or at risk of, chronic disease and ensure they are appropriately managed or referred on to an appropriate health professional.

Dietetics

Dietetic consultation is well suited to telehealth, funding permitted, as patient counselling is at the centre. USyd has published a model of integrating technology into medical nutrition therapy that could be developed further so all care is remote.

Chen J, Gemming L, Hanning R, Allman-Farinelli M. Smartphone apps and the nutrition care process: Current perspectives and future considerations. *Patient Educ Couns*. 2018 Apr;101(4):750-757.

Mental Health

Clients of a mental health care plan provided by a GP, meet the requirements for 'Better Access Service' for Psychological therapies delivered by telehealth to most rural and regional areas of Australia, as classified by the 'Modified Monash Model' for determining geographical eligible regions. The Australian Psychological Society provides toolkit resources on how to delivery mental health support and therapy via telehealth for registered psychologists, and allied health workers in mental health such as Occupational Therapists and Nurses. Information is obtainable from:

<https://www.psychology.org.au/for-the-public/Medicare-rebates-psychological-services/Medicare-FAQs-for-the-public/Telehealth-services-provided-by-psychologists>

Speech Pathology

Speech pathology services, in addition to other interdisciplinary services for people with traumatic brain injury and their families, has proven effective and should be incorporated as an alternative model of care to traditional face to face models of service delivery.

Rietdijk, R., Togher, L. & Power, E. (2012). Supporting family members of people with traumatic brain injury using telehealth: A systematic review, *Journal of Rehabilitation Medicine*, 44 (11), 913-921.

Musculoskeletal Medicine

Telehealth-based models of care for those suffering from chronic conditions – particularly chronic lower back pain and osteoarthritis – have been implemented successfully by the University through the Faculty of Health Sciences and the Sydney Musculoskeletal Alliance. These models are based on supporting patients to engage in healthy lifestyles (including physical activity) and the remote delivery exercise programs with the support of web-based platforms (e.g. Physitrack®), and have been implemented through robust partnerships with rural Local Health Districts (e.g. WNSWLHD), consumers groups (e.g. Musculoskeletal Australia), and industries in the private sector (e.g. Medibank Private). Allied health and the Sydney Musculoskeletal Alliance at the University of Sydney are well positioned to lead the implementation of educational, training, and research telehealth programs for those living in rural settings suffering from chronic conditions. We further note that we have already embedded digital health into all of our allied health courses.

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

Serious consideration needs to be given to MBS funding of telehealth services. This should, however, be done in the light of a significant review of how telehealth can be applied in the support of genuinely new models of care, not just in replacement of existing face-to-face services. It is also important that we do not only apply a narrow definition of telehealth relating to use of video-conferencing but rather include in any discussion the use of multiple synchronous and asynchronous communication technologies. This may include lower cost and increasingly sophisticated tools such as Interactive Voice Response Systems (IVR).

When considered in the broader context of service redesign and a broad definition of telehealth, it will be possible to make significant savings that can potentially be used to support MBS funding of high-touch synchronous face-to-face telehealth when other aspects of the therapeutic dialogue such as routine medication or exercise reminders are replaced by low cost and highly scalable technologies such as IVR.

There are a number of models emerging that support this approach including the CardioCompass project in Boston where graduate students use a mix of voice and automated interaction with high risk patients identified from their Electronic Medical Record to maintain compliance with medication and lifestyle modifications to reduce impact of chronic diseases such as cardiovascular disease and diabetes. In this model substantial cost savings have been made through reduced need for high-cost medical services. Allied Health Professionals are well placed to provide these emerging navigator roles within new models of care.

Pharmacy

If the same level of quality of medical services is expected regardless despite the medium (telehealth), a new section for inclusion in the MBS should be considered.

Dietetics

There should be MBS and private compensation.

Please provide any additional comments and feedback related to this Policy Area.

There are very disadvantaged communities in rural areas. By not expanding MBS, health care delivery is confined to the hospitals, and primary health care is private health care for allied health. This goes completely against the World Health Organization aims and priority for critical need for keeping people well and functioning in the community.

Expanding systems like healthdirect Video Call is a good policy, however it is currently hampered by the lack of interoperability of health record software. It is important that these systems permit roaming provider profiles and patient records. The current state-wide dental eRecord system in NSW, Titanium implemented in 2018 and 2019, for instance, does not support patients having one record in the public system that roams with them when treated in different locations (a new record is created when a patient is treated in a different LHD or in a tertiary care centre). No medical history is imported from the medical record system and the software doesn't connect to My Health Record (MHR). As it does not support the use of diagnostic terminologies that map to ICD or SNOMED, even future compatibility with medical record systems is questionable. This inhibits the use of an electronic health record.

There is substantial scope for the use of digital technologies such as telehealth to support rural allied health services. As mentioned above, it is important, however, that the role of telehealth is considered alongside the development of new models of care that can improve the efficiency of service as well as patient outcomes. It is important that telehealth and other technologies are not simply used as a tool to replace existing rural face-to-face services as this is likely to have a negative impact on outcomes.

Regarding telehealth, it is likely we will also see a major shift in the cost and usability of telehealth technologies and, as mentioned above, traditional telehealth systems will be supplemented by other tools such as Interactive Voice Response Systems.

UCRH Lismore

There is ample technology available and sitting unused in public facilities due to lack of skills and training for staff and lack of funding models to support the delivery of care via the available technology. Workforce capability to use available technology, and funding models are the priority need ahead of new software and systems. Training in telehealth could be provided by UDRHs or other education organisations based in regional centres, organisations that have first-hand experience of delivery of services in these locations – if there was funding to support this training and funding to support delivery of telehealth services. The examples in point 5.6 seem more relevant to medicine than allied health. Workforce development and skills needs to be a priority ahead of new technology – our workforce is under-developed in the use of existing technology, so expending scarce funds on new technology should be of lower priority than workforce development.

Faculty of Health Sciences

Points 5.1 and 5.2 - The availability of eHealth software and systems must be accompanied by provider training in both the technology and in video-based communication. Many providers are uncomfortable delivering advice or care over video, with research showing that providers are concerned about their personal safety and professionalism when using telehealth. Thus, training should encompass how best to integrate the technology safely and effectively into work.

General question

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

No further comments.