Response to the *Consultation: Rural Allied Health Quality, Access and Distribution Discussion Paper*

August 2019

Overview

The University of Melbourne welcomes the opportunity to respond to the National Rural Health Commission's Discussion Paper *Rural Allied Health Quality, Access and Distribution*. Improved access to a wide range of quality allied health services can deliver improved health outcomes and greater wellbeing in regional, rural and remote communities.

The University is deeply engaged with the challenges of providing quality healthcare in rural and remote areas, as both a research institution and a provider of education pathways to a number of allied health (and other) professions. Our Department of Rural Health was established in 1999 with funding from the Federal Government to situate professional health, education and research training in a rural context. Based at Shepparton in the Goulburn Valley, the Department has major nodes at Ballarat and Wangaratta, and associations with nearly 40 smaller towns in rural Victoria.

Longstanding issues in relation to workforce shortages and access to rural health have an impact on residents in rural, remote and Aboriginal and Torres Strait Islander communities. The Discussion Paper identifies important policy mechanisms that can develop stronger policy leadership in allied health to increase access, distribution and quality of rural health in rural communities. Priorities include: enabling greater access to rural training; better articulating career pathways; and creating sustainable jobs and viable rural markets.

In particular, we support the work of the National Rural Health Commissioner in identifying policy solutions to address workforce shortages in rural allied health and agree that this will require policy and funding initiatives that articulate clear career pathways into rural allied health, from secondary school through to senior roles, and of changes to funding models that better support the workforce and allow for professional development and career progression, including through access to a rural generalist pathway.

Policy solutions and funding models will need to be more flexible to enable training and service delivery can be adapted to meet local community needs, which vary across rural and remote Australia. An increase in publicly funded allied health positions in rural and remote areas is necessary to increase access, as is the availability of senior allied health positions that enable career progression and require specialist skills including in clinical, management and education roles.

The University also offers some comment on recently announced changes to the Commonwealth Grant Scheme (CGS), which is the primary means by which the Australian Government supports allied health training in Australia's higher education system. In making recommendations to the Australian Government about developing a sustainable rural health workforce, the National Rural Health Commissioner might identify how these broader higher education policy changes will impact on the ability of universities to grow enrolments in allied health training.

We would welcome the opportunity to discuss these issues in more detail with the National Rural Health Commissioner or to otherwise assist in developing recommendations for the Minister responsible for Rural Health.

For more information or to discuss the submission, please contact Professor Shitij Kapur, Dean, Faculty of Medicine, Dentistry and Health Sciences, Assistant Vice-Chancellor (Health) shitij.kapur@unimelb.edu.au.

Response to consultation questions

Policy Area 1: Rural Allied Health Policy, Leadership and 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 appointment of a Chief Allied Health Officer (CAHO) is an important opportunity to provide a voice for allied health nationally. Such an appointment signals an investment in allied health leadership and will help raise the profile of the allied health professions. The position should be held by an allied health professional, with policy development experience, who can provide leadership and enable collaboration across government departments, divisions and branches to influence policy and strategic direction.

A workforce focus

A key priority for the CAHO should be a focus on workforce availability and development. This should include developing publicly-funded allied health positions in rural and remote areas, ensuring that funding models enable allied health professionals to be responsive to community need and can provide patient-centred care appropriate to the local context. The CAHO should also have responsibility for developing an intersectoral workforce plan for allied health professions, including detail regarding rural allied health workforce availability in health, aged care and disability. An important part of this work will be facilitating the development of viable workforce data collection options for self-regulating allied health professions.

Collaborative planning

Establishing a CAHO at a national level also provides opportunities for collaborative service planning for the health, aged care and disability sectors in remote, rural and regional communities and the CAHO should take a lead on establishing fora to enable this. With a comprehensive view of allied health around the country, the CAHO will be well placed to identify and promulgate successful service delivery models in rural communities. Allied health comprises 27 disciplines and it will be necessary to canvas the various professional bodies to understand different viewpoints. The CAHO should also work collaboratively with the States and Territories to prevent the duplication of work, such as developing a standardised national approach to clinical supervision frameworks.

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

Inter-sectoral engagement around rural and remote health workforce is key to the role. The CAHO role should be a senior appointment established in a way that supports collaborative work across Government Departments, at a federal and State level. The appointment should be equivalent to a Deputy Secretary role, with qualifications and experience in an allied health profession an essential criterion for the position. The role will need clear accountabilities and portfolio responsibilities and a remit for decision making.

Community needs

A focus on key community needs rather than specific sectors would assist in inter-sectoral collaboration. Such needs include workforce development, aged care, chronic disease management, disability and children's health needs (regardless of school, health or other setting).

Inter-sectoral engagement

The CAHO will be well-positioned to facilitate regional and cross-sector engagement about workforce models that have worked successfully in specific regions and be an advocate for local management of rural and remote models of care, referral pathways and employment models. A key task will be to ensure that rural health workforce issues are front and centre in policy discussions and to advocate for funding practices more suited for rural and remote practice. This could include the development of new positions to address market failure or enable career pathways. The CAHO can also lead inter-sectoral collaboration to develop innovative approaches to education training that better prepare the workforce for cross-sector practice. Aboriginal Health Services in rural communities could also be supported to extend their allied health services and the CAHO could facilitate inter-sectoral cooperation to help enable this.

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

The University supports the establishment of a Rural Allied Health College as a practical initiative to support a strong rural allied health workforce. A Rural Allied Health College that can provide leadership and bring a dedicated national focus to workforce development in rural communities will play an important role in securing and supporting a sustainable rural allied health workforce.

As noted in the Discussion Paper, a key role for the Rural Allied Health College would be to support rural allied health professionals to undertake training to gain accredited rural generalist qualifications. The Literature Review[1] highlights that recognising the distinctive skills used by rural allied health professionals could be a driver for uptake and retention of rural positions. A Rural Allied Health College could provide leadership in enabling the development of a rural generalist training pathway and training for rural allied health professionals. A College may also serve as a point of centralised knowledge of other training and development pathways, particularly for senior allied health professionals in rural and remote settings.

Other advantages of a Rural Allied Health College include centralising tasks that are currently undertaken by a variety of groups, providing a mechanism through which to ensure all rural allied health professionals are registered and enabling the sharing of information and innovative service models.

Representing a range of disciplines could be a challenge for a Rural Allied Health College, which is why support and 'buy-in' from existing allied health peak bodies is essential. In establishing the College it will be important to address the hierarchy in allied health so that all disciplines are represented and to take learnings from, and build upon, initiatives that are already in place through universities, professional bodies and University Departments of Rural Health.

[1] National Rural Health Commissioner (2019) Discussion Paper for Consultation: Rural Allied Health, Quality, Access and Distribution. P71

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.

The University supports the establishment of a Rural Allied Health College that is new and independent. This will ensure equity across allied health disciplines and sectors, which is critical to the College's capacity to have impact and influence across the rural allied health workforce as a whole.

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

Performance indicators for the effectiveness of the College could include:

- Accreditation of all allied health professions;
- Development of a rural generalist pathway for all allied health disciplines;
- Development of equitable and appropriate funding models for allied health service delivery suited to rural and remote contexts; and
- Development of rural- and remote-appropriate models of care for allied health professions.

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

Access to comprehensive and accurate national workforce data can help to inform policy and funding decisions relating to rural allied health. Critically, it would improve planning in specific regions and by health service sectors. Access to such a dataset would be useful to many stakeholders, including government, local healthcare providers and health researchers at University Departments of Rural Health.

A national rural allied health workforce dataset will enable a clearer understanding of the workforce, including its distribution, trends in retention, length of appointment and movements. Such a dataset will likely improve comprehension of the inequity and maldistribution of the workforce and draw connections between workforce details and information about chronic disease prevention and management in particular areas. It may also provide an additional evidence base to inform broader policy for rural and remote communities, including access to aged care, rehabilitation services and initiatives that provide enhanced quality of life, for both patients and staff.

The creation and upkeep of the dataset will not come without challenges, with a key task being to integrate many sources of data from regional, State and national levels. Consideration should be given to how the dataset can capture not only staff numbers, but also the different work that allied health professionals do, including for example, travel, outreach, education and advocacy. The dataset would need to be resourced to ensure appropriate data collection, curation and maintenance to ensure the dataset remains current.

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

Existing rural allied health workforce datasets that may help form a foundation of a national rural allied health dataset could include State government data about the allied health workforce in key sectors, such as that held by Departments of Health and Education. Information held by APHRA and other allied health peak bodies may also be relevant.

The Australian Government's new Health Demand and Supply Utilisation Patterns Planning (HeaDS UPP) Tool, due for release in mid-2019, would also be a useful starting point, and consideration could be given as to how this best integrates with a unique rural allied health workforce dataset.

Additional comments and feedback related to Policy Area 1:

Research, data and evidence about rural allied health and its workforce are critical to informing sound policy making and supporting leadership of the profession at local and national levels. Publicly funded research can play an important role in enabling the collection and analysis of data and the development of innovative policy. Allied health research should be adequately resourced and prioritised through specific government research funding.

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?

Under the Rural Health Multidisciplinary Training Program, universities are already required to introduce rural origin targets that reflect the demography and profile of its courses. The University has supported this and worked hard to meet our targets as we believe the specificity of a target is useful in driving outcomes. Specific targets for individual allied health courses are difficult to define but at least 15 per cent for urban universities would be reasonable and more for universities based in regional communities.

A broader focus

An approach that focuses only on rural origin students, however, restricts opportunities to other students who may be suited to, or interested in, a rurally-based career. The workforce is now global, people re-locate and move often, and job retention is shorter. Enabling movement between remote, rural and urban settings for training, employment and professional development is important.

We suggest there are a number of other mechanisms that could be implemented or expanded that may have a positive impact on the rural allied health workforce. This could include a greater focus on attracting and selecting students with an interest in rural practice, through for example an interview process that enquires into rural practice intention. An increased focus on part-time and mature age students and greater consideration of international students may also be beneficial.

Structured career pathways

The Discussion Paper notes that the promotion and development of structured pathways between secondary schools, TAFEs and universities was a suggestion raised during consultations. We acknowledge that the Commissioner has chosen not to focus on this opportunity further at this time but would like to emphasise the University's support for clearly articulated career pathways in allied health. Career pathways with variable entry and exit points that enable students to move from secondary school to TAFE courses to undergraduate university courses through to postgraduate courses and specialisations need to be both better articulated and made more accessible in regional settings.

Specific health settings also require different initiatives. For example, in Aboriginal Health, acknowledgement of community-training, work experience and cultural skills in pathways that enable Aboriginal people to be supported while working and studying is important. Development and articulation of these pathways could be enhanced.

Scholarships

Scholarships similar to the John Flynn Placement Program[2], where students regularly return to the same rural community during their training and develop relationships and understanding of that community, may also help attract allied health professionals to a rural career when they do not necessarily come from a rural background.

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?

Identifying the current and future needs of rural and remote communities is key to staffing and training in allied health and should be considered as part of any process to determine quotas.

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.

Structured career pathways

A focus on secondary schools and providing secondary students with clear career pathways into allied health and career progression in rural allied health is important. Investing in pathways from secondary school, to TAFE and university and then into careers with the opportunity for growth and development may attract a wider, more diverse cohort to careers in allied health.

Investment in research regarding allied health workforce

Evidence that suggests that students from a rural region, or who do extensive training in a rural area, are more likely to take up rural practice is more relevant in literature relating to medical training than to allied health training. There is a need to conduct further comprehensive research to understand the impact of rural-origin, the attraction of rural practice to allied health professionals, and the key factors that enable better retention of staff. Our first-hand experience is that this likely includes support, professional development opportunities, career pathways and community connections.

Innovative education

A focus on innovative education in rural settings may attract students who are suited for rural settings. For example, a focus on service learning, student-led services, public health, Aboriginal health and generalist practice in rural courses could be useful. Developing partnerships between regional and metro universities and enabling students to experience placements in both rural and urban settings is an opportunity to provide more students with exposure to rural practice and some of its unique characteristics. University Departments of Rural Health would be well placed to manage these partnerships and develop two-way movement of students and early career professionals.

[2] John Flynn Placement Program. Available from: https://www.jfpp.com.au/about

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

Peak bodies such as Indigenous Allied Health Australia (IAHA) and the National Aboriginal Community Controlled Health Organisation (NACCHO) would provide insight into policy options that would help achieve these aims. We would recommend consultation with these groups.

Community based pathways

In addition, we suggest the development of community-based pathways into allied health professions for Aboriginal and Torres Strait Islander people. Such pathways should respond to local community health needs but also enable Aboriginal and Torres Strait Islander people to be trained in their communities and gain experience as they train and study. This includes supporting secondary students to complete Year 12, providing information about local pathways, implementing work experience programs and presenting career options. The articulation of allied health career pathways also needs to clearly include Aboriginal Health Workers, Community Liaison Roles, Allied Health Assistants, Teaching Assistants and the many community roles that contribute to health and wellbeing in rural and remote communities. Providing work experience and employment opportunities alongside supporting students into TAFE and transition to university is important. Any programs for Aboriginal and Torres Strait Islander students need to be well resourced with the availability of intensive support and scholarships.

Learnings from other programs

There are programs operating within both the health and education sectors that could be studied for transferable learnings in allied health. One education example is the Vocational Education and Training in Schools program. In Victoria, this program enables students to undertake vocational subjects at secondary school which can contribute towards a Victorian Certificate of Education (VCE) or Victorian Certificate of Applied Learning (VCAL) qualification. Such subjects enable students to explore potential career options and may ease transition into further study.

In health, the Rural and Isolated Practice Endorsed Registered Nurses (RIPERN) program endorses registered nurses with additional RIPERN accreditation to administer and supply a range of approved medicines and provide referrals where there is no, or limited, access to general practitioners, nurse practitioners, paramedics or pharmacists. In the same way, training and accreditation could be provided to Aboriginal and Torres Strait Islander allied health professionals in rural and remote communities to deliver additional services, thereby increasing access to allied health in those communities.

Creating employment opportunities

All health and government funded services should be mandated to employ suitably qualified Aboriginal and Torres Strait Islander staff and to create culturally safe work environments. This provides aspiration for students to engage in training, work experience and mentoring programs as well as accessibility for patients.

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.

An example from the Goulburn Valley region in Victoria is the Academy of Sports, Health and Education (ASHE).[3] Based in Shepparton, ASHE is an initiative of Rumbalara Football Netball Club and the University of Melbourne. ASHE uses a whole-of-life support model, providing accessible, culturally-relevant education, training, health and employment opportunities to students. Aboriginal and Torres Strait Islander students can undertake the Victorian Certificate of Applied Learning, Certificate III, Certificate IV and Diploma studies accredited by the local Goulburn Ovens TAFE with extensive support from ASHE. A pathway into and through the Diploma of Nursing and then onto the Bachelor of Nursing at La Trobe University has been developed where students can live in their community, undertake their nursing degree and are supported intensively by ASHE and our University Department of Rural Health. Training is undertaken in a rural setting with support from Aboriginal staff and the program has excellent employment outcomes.

Additional comments and feedback related to Policy Area 2:

Policies for rural allied health students and practitioners should be flexible and enable students from all regions to move in and out of rural practice. A focus on rural-origin students alone restricts opportunities for other students to experience rural practice. Urban-origin students should be encouraged to practice rurally and all allied health professionals should be given the option to move to different employers in both rural and urban areas.

In addition, students and qualified Allied Health professionals based in rural communities should be provided with opportunities to attend metro-based training and education when appropriate and warranted. Rural people can be disadvantaged by studying in rural areas if funding specifies there is no support for metro-based intensives or training in specialist care or tertiary hospitals. One model that could be emulated is the Maternity Connect[4] program, an initiative of the Victorian Department of Health and Human Services, designed to provide clinical exposure placements to midwives and nurses working in rural public maternity services. This program enables upskilling, re-skilling and exposure to specialised care that is not always available in rural areas.

Policy Area 3: Structured Rural Training and Career Pathways

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?**

Resourcing longer training programs

University Departments of Rural Health would be able to offer six month or full year rural training for allied health students, if resourced to do so. Resourcing for teaching as well as providing placement opportunities would be required. The same applies for the delivery of full course training.

Matching training to respond to community need is key to effective and sustainable programs. Students should be taught about different models of care, working in community settings, public health and inequity, working across sectors and practicing in generalist, outreach and clinically complex settings.

[3] https://ashe.unimelb.edu.au/
[4] http://www.westernhealth.org.au/EducationandResearch/Education/Pages/Maternity-Connect-Program.aspx

Quality of placement

Our evidence and experience[5] as a UDRH suggests the type of placement and the impact of the placement are more important than the length of rural training. To be beneficial for the health service hosting a placement, a minimum of four weeks is preferable. We have observed that shorter placements do have an impact on students' interest in undertaking rural practice. Rural placements require students to apply their clinical skills in different types of settings and develop relationships with local practitioners and communities. This has more impact than simply working in an organisation for a long period of time. We suggest more appropriate strategies are to support students to develop relationships in, and connections with, rural communities, such as the John Flynn scholarships. This would provide the opportunity for urban students to work and develop relationships in regional settings and for rural students to experience remote settings.

Professional development for rural and remote practitioners

Creating comprehensive professional development opportunities for rural and remote practitioners is also critical to sustaining a skilled allied health workforce in rural communities. Practitioners should be supported with funding to develop specialist skills outside their region to address a health need in their region. Urban rotations, such as those provided by the Maternity Connect program referenced in Policy Area 2, would be appropriate for allied health practitioners.[6]

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?

Expanding the John Flynn Placement Program to provide opportunities for allied health students would be an effective way to provide students with meaningful exposure to different types of rural practice settings. A key factor in its success would be designing the program to respond to community health needs, resulting in opportunities for students to experience diverse settings, across multiple sectors in different types of practice, while also providing health support to local communities. The program has the potential to provide students from a wide variety of backgrounds with opportunities to experience a different setting – for example, urban students could undertake placements in rural and regional settings and rural and rural-origin students could consider placements in rural settings.

Ensuring that students are selected appropriately for the program is also essential. Students need to have the skills to engage with and build connections to the community. Preparation will be essential and the program should facilitate training about the unique context of rural health service provision. There could be opportunities to develop such training into an introductory or pre-cursor program to a rural generalist pathway as referenced in the Discussion Paper under Policy Area 2. The success of the John Flynn placement program needs to be monitored and evaluated as it is implemented and progresses. Students could be interviewed to assess the impact of rural placement experiences on their intent to practice rurally.

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[5] See: Cosgrave, C., (2018). *Factors determining a 'high-quality' student clinical placement experience in rural public health services: Findings from a Victorian Study*. Wangaratta, The University of Melbourne., and Bradley, D., Bourke, L. and Cosgrave, C. (2017) *Experiences of nursing and allied health students undertaking a rural placement – A study of barriers and enablers. Shepparton*, The University of Melbourne.

[6] See Maternity Connect program: http://www.westernhealth.org.au/EducationandResearch/Education/Pages/Maternity-Connect-Program.aspx

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?**

An important element in workforce development is to provide appropriate training and placement opportunities for students to prepare them for rural practice. To increase the number of rural allied health student placements, consideration would need to be given to non-hospital placements, particularly service learning placements which are known to support work-readiness. Hospital placements are near capacity and as allied health professionals work mostly outside the hospital, students also need to experience training in different settings. Further, education, support and funding for these placements would need to increase to ensure supervisors are trained and have the time to dedicate to education. A supervision payment for allied health supervisors would greatly enhance this and enable allied health practitioners who are in fee-for-service (e.g. NDIS funded, private practice) roles to engage in education.

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

The Health Workforce Scholarship program is designed to enhance access to health services in regional and rural communities by improving the skills, capacity and scope of practice of health professionals in these communities by providing funding for health professionals to access professional development, including postgraduate study.

To expand the program, relevant qualifications and training opportunities with flexible study arrangements need to be available. Access to some courses requires regular attendance at an educational institution, which may not always be possible. Courses that offer study where practitioners can 'fly in fly out' and complete subjects intensively over a week(s) rather than a semester, for instance, may be attractive, as would the availability of online study. E-learning, hospital training programs and UDRHs could assist to provide programs, increasing access across the regions.

Professional development and postgraduate study require an investment of time and resources for both individual practitioners and their employers. Decisions to undertake further study need to be managed in a way that minimises any negative impact on communities. Graduate support programs in hospitals and across regions could support graduate programs offered in regional centres.

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.

As previously discussed, building pathways to a career in allied health needs to start at a secondary school level and support in undertaking training and education at all stages of career development is important. Students undertaking placements in rural areas should be provided with accommodation and other support, while placement supervisors should also receive financial reimbursement to undertake this extra responsibility.

A focus on early career professionals is also essential to improving retention of rural allied health professionals. Graduates commencing entry level jobs in rural areas should be provided with support, mentoring and professional development opportunities. Additional support, such as accommodation assistance, may also assist in recruitment. There also needs to be visible career pathways, including the availability of senior level rural allied health roles and opportunities to take on additional responsibilities, such as complex care support, education or management, so that practitioners can progress their careers while staying in rural areas. Models in related fields offer learnings, such as in nursing where visible career pathways in clinical, education and management roles can help to ensure the sustainability of the workforce.

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?

Access to a recognised qualification that enables accreditation in advanced rural practice is important. Consideration should also be given to ensuring that qualifications that are tailored to particular skills and competencies for specific regions and disciplines are available. UDRHs could be tasked with providing training and education in postgraduate qualifications that are flexible and offered through multiple modes of delivery. Enabling each UDRH or a group of UDRHs to develop an advanced allied health course with a different focus could provide allied health professionals with a choice of different programs suited to different disciplines and skills requirements.

Consideration should also be given to replacing the term 'rural generalist' with the term 'advanced rural practice.' Training pathways can assist rural allied health professionals to advance their skills in particular areas, some specialised, some inter-professional and some generalist. Allied health needs to be viewed as a series of disciplines with specific and needed skills and the term generalist discourages this.

Additional comments and feedback related to Policy Area 3:

A pressing need in rural allied health is to increase jobs in publicly funded rural and remote health services. This enables greater access for rural and remote communities to allied health services but also helps in creating visible career opportunities for professionals who may be considering rural practice. Clearly articulated career pathways are critical to retention of employees and the sustainability of the workforce.

Consideration of areas classified as MMM3, not just MMM4-7 as outlined in the Discussion Paper, would also be worthwhile. While the allied health workforce in these areas is not as small as in remote areas, these communities do experience workplace shortages and a high turnover of staff.

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?

Workforce retention

Integrated Allied Health Hubs would be an effective mechanism by which to increase rural and remote access to allied health services, while also building opportunities for the allied health workforce through bringing together a community of practice, providing shared administration and delivering the benefits of medium and long-term employment contracts. These factors are all contribute to retaining a skilled workforce.

Local flexibility

To be successful, the hubs would need to have regard for the local context in which they are based. Working to the need of the local community rather than simply increasing students and staff numbers will produce more effective solutions. Building some flexibility into the Integrated Allied Health Hubs model will be important to ensuring community needs are addressed. For this reason, Primary Health Network regions are likely to be too big for the hubs to be effective. Consideration of including MMM3 areas for inclusion in the model would also be appropriate, as it may present more opportunities to enable full-time employment for allied health professionals across sectors.

Research and training

The hub model also has the potential to deliver training and professional development and conduct relevant research. With direct funding from the Commonwealth Government, the hubs could operate as Centres of Excellence, conducting research and leading evidence-based practice. The hubs could also provide a base for student training and fund student-led clinics, enabling students in allied health to gain more experience working in a rural setting.

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.

The Multi-Purpose Service model is an example of how collaboration has been enhanced through pooled funding to enable a rural health service to design itself based on community need. The University of Melbourne's Rural Health Academic Network (RHAN) is a network of jointly-funded (UDRH and health service) academics who provide education, research support and assistance with projects in rural health services, which has assisted rural health services improve their service delivery.

Student-led and service-learning programs may also provide relevant insight into collaborative service models and the way in which discrete allied health professions can work in a connected way. The University of Melbourne's UDRH provides service learning placements that involve students of various allied health disciplines undertaking placements in non-health settings, sometimes simultaneously. This involves coordination of the students, supervisors (usually external) and the placement site.

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?

Locally run models are likely to be most effective and collaborative, and funding arrangements need to reflect this. Enabling a place-based, flexible approach to developing allied health hubs that responds to local community needs will be important in determining the success of the hubs. One way to do this could be to remove the need for General Practitioner referral to allied health services and enable allied health professionals to refer to each other. Another mechanism could be removing constraints on the number of visits to an allied health practitioner in management plans. Both these initiatives would help allied health professionals to determine appropriate care that suits the needs of their community.

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

Allied Health Assistants and Allied Health practitioners would be better served by a clear scope of practice distinguishing them from each other and clearer funding of the distinct roles. Where the Allied Health Assistant role is clearly distinguished from the practitioner role, a team can work effectively for the benefit of clients. However, where Allied Health Assistants are used to address workforce shortage or for cost saving, poorer healthcare results. Allied Health Assistant positions can provide careers in themselves or also be a step in a career pathway to an allied health practitioner.

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

The options outlined in the Discussion Paper relating to Commonwealth funding for allied health professionals and patients are all important mechanisms that would increase access to allied health in rural communities, and the University is supportive of these. In particular, support for the workforce and enabling more straightforward and cost effective access for patients may help increase access to allied health services.

Support for the workforce

Increasing support for the allied health workforce is key to ensuring a sustainable sector. Funding positions in public health services in rural and remote communities, as well as improving funding models that enable communities to address local needs in flexible ways are important initiatives to support practitioners. Additionally, acknowledging travel time and expenses incurred by Allied Health practitioners to provide service in rural and remote communities should be considered.

Enabling simpler, less expensive access for patients

Reducing the cost and challenges for patients in accessing the allied health care needs to be a part of any strategy or policy aimed at helping improve allied health outcomes in rural communities. Addressing cost barriers to allied health through enabling Medicare payments or bulk billing opportunities may go some way to enabling greater access, as would improved models for Chronic Disease Management Plans. These plans create challenges currently due to limitations on number of visits and requirements to be referred by and regularly follow up with a General Practitioner. As noted previously, we suggest less reliance on GP referrals and the development of mechanisms that enable allied health professionals to make cross-sector referrals.

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

While we support all the options outlined, as outlined in question 4.2a the most effective are likely to be those which support patients, education and affordable and flexible funding. The Commonwealth should:

- fund supervisors/supervision
- acknowledge and compensate for the complexity of care that increases with rurality
- remove (or increase) caps on the number of services a patient can receive

The Commonwealth should also consider these strategies in MMM3 where there are limited services, outreach services and a limited workforce.

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.

Telehealth has been used in Victoria where rural patients and their families videoconference into multidisciplinary case reviews and management discussions. This provides access to specialist care meetings (e.g. at Peter Mac Cancer Centre in Melbourne) reducing the need for costly and time-consuming travel. In addition, patients have access to webinars and a range of videos and other online resources. Models such as this could be considered for future use in allied health.

Additional comments and feedback related to Policy Area 5:

Adequate funding of allied telehealth services would increase access for rural and remote patients to specialist allied health care, particularly specialised services and practitioners in chronic disease specialists, pain specialists, mental health professionals and services associated with confidential issues (sexual health, drug and alcohol).

Funding for equipment

For telehealth services to be effective, funding is needed for equipment such as eHealth software and systems and point of care equipment to enable allied health services to be delivered via telehealth as well as to support intra-disciplinary case conferences and expert consults via telehealth.

Training

We also emphasise that while telehealth is an important part of allied health service provision in rural and remote areas, it cannot make up for a local workforce shortage. In addition, allied health practitioners using telehealth require access to quality training. Our experience suggests many practitioners do not feel competent in telehealth practice and evidence from the Victorian Department of Health and Human Service (2018) found that telehealth was used for direct service delivery by only 3% of physiotherapy respondents, 12% in Speech Pathology and 9% in Occupational Therapy.[7] Any training needs to be ongoing in order to remain effective and maintain confidence among practitioners.

Broader opportunities

The broader opportunities to use telehealth for specialist training, case conferencing, case reviews and family conferences would also be a positive outcome of any investment in telehealth software, training and infrastructure. Partnerships between metro and rural or remote hospitals could enable rural or remote practitioners to be supported and trained in complex care and specialist practice.

[7] Victorian Department of Health and Human Services (2018) Allied Health Research. Available from: https://www2.health.vic.gov.au/health-workforce/allied-health-workforce/allied-health-research

Further comment - the Commonwealth Grant Scheme and rural allied health

A whole-of-government approach is needed to support increased access to allied health in rural and remote communities. It is important that recommendations made by the National Rural Health Commissioner are cognisant of broader higher education policy which may impact the growth of university training of allied health professionals.

The Commonwealth Grant Scheme (CGS) is the primary means by which the Australian Government supports allied health training in Australia's higher education system. In health courses, the majority of domestic postgraduate coursework students (57 per cent) and the overwhelming majority of domestic bachelor level students (97 per cent) are enrolled in a Commonwealth Supported Place (CSP), and therefore funded through the CGS. The design of the CGS is critically important to the outcomes delivered through the allied health training system. Getting the design of the CGS right should be a key part of the rural allied health strategy.

The Government announced significant changes to the CGS in the 2017/18 Mid-Year Economic and Fiscal Outlook (MYEFO), released in December 2017. These changes included:

- the 'freeze' on CGS funding for bachelor level places, which involved capping the funding provided to a given institution at the level provided in 2017. As of 2020, funding increases will be permitted in line with population growth, contingent upon institutions meeting a set of performance targets.

- The introduction of a competitive reallocation mechanism for postgraduate, sub-bachelor and enabling CSPs, based on institutional performance and labour market needs. Implementation of this new reallocation model will take place from 2020, with 5 per cent of CSPs being reallocated on the basis of new criteria in the first instance. The Government also announced a reduction in allocated postgraduate CSPs in the MYEFO statement.

Both the funding freeze and the reallocation of postgraduate CSPs have the potential to undermine the effectiveness of Australia's allied health training system, impacting the extent to which skills needs in rural and regional communities are met.

Summary of Recommendations

A summary of the University's recommendations to the National Rural Health Commissioner are listed below. These reflect an approach to funding a pipeline of activities that collectively will help improve access to allied health in rural and remote communities.

The University recommends that the Australian Government should:

- provide support for further research regarding allied health training, recruitment and retention of staff to inform future policy.
- enable articulated career pathways for rural students into allied health professions, from secondary school through to TAFE, undergraduate education and higher education.
- provide further support for rural training in allied health.
- provide additional support for graduate rural allied health professionals.
- provide support for the provision of accessible postgraduate training for rural allied health professionals.
- supports initiatives that improve retention of senior allied health professionals by enabling career pathways and specialist training in rural areas.
- trial the establishment of Integrated Allied Health Hubs as a mechanism by which to increase rural and remote access to allied health service, develop local communicates of professional practice and provide a more streamlined, cost-effective service.

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