Services for Australian
Rural and Remote Allied Health

29 February 2024

NSW Government
Special Commission of Inquiry into Healthcare Funding
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Dear Commissioner and Inquiry Team,

Services for Australian Rural and Remote Allied Health (SARRAH) submission to the NSW Special Commission of Inquiry into Healthcare Funding

Thank you for the opportunity to contribute and provide this late submission for consideration in the Special Commission of Inquiry into Healthcare Funding in NSW.

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, early childhood and other service systems. SARRAH was established in 1995 as a network of rurally based allied health professionals to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. We continue to do that. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAH has a substantial network of members working across rural and remote NSW and have a well-established and collaborative working relationship with relevant areas of the NSW public health service.

In addition to the opportunity to provide this submission, we would like to acknowledge and thank the Special Commission for extending an invitation to SARRAH representatives to provide evidence at the Commission's hearings scheduled for the week 18-22 March 2024 in Wagga Wagga. We very much appreciate the invitation from the Commission's Principal Solicitor Stuart Jacobs. Regrettably, due to conflicting commitments and pressures we do not currently have the capacity to attend or support SARRAH representative witnesses at the hearings. However, we have used the Attachment to Mr Jacobs letter identifying key topics for the hearings to organise our comments in the attachment to this covering letter.

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We note that SARRAH receives no Commonwealth or other government financial assistance to support its representational, advisory, general membership engagement or support, advocacy, or related operational activities.

SARRAHs comments in relation to those issues are provided in Attachment A. We regret that we are unable to provide a more detailed response at this time.

If you would like to discuss issues raised in SARRAHs response or require further information, please contact [redacted]

Yours Sincerely

Catherine Maloney
Chief Executive Officer

Attachment A

SARRAH Submission to the NSW Special Commission of Inquiry into Healthcare Funding

General context and overview of rural and remote allied health workforce issues

Critical shortages in Allied Health across rural and remote Australia

The following comments reflect the national situation, but apply equally to rural, regional and remote NSW.

Critical health and related service and support systems cannot be delivered without a skilled workforce, even with technological enablers. Similarly, full utilisation of the skills and potential of that workforce need to be deployed at the best possible time and in the places they are needed most. **Maldistribution of allied health workforce leads to disparate service access and outcomes, which leads to avoidable costs (e.g. avoidable hospitalisations, severity of disease and disability) and loss of health, well-being, participation and productivity**.

The NSW health system faces shortages of allied health workforce across rural and remote locations. The NSW governments has introduced a range of workforce attraction, retention and support measures, some of which include allied health. Importantly, however, every jurisdiction in Australia and the private and community sectors are competing for this same workforce. The employers/sectors that are most likely to compete effectively in this environment will focus on broad and sustained workforce and career development approaches, which have tended to be the exception rather than the norm for allied health in the public and other service sectors.

It is also critical to note that around 60-70% of allied health professionals work in the private and community sectors. The maldistribution of allied health professionals (concentration in major cities) is acute and at least as severe outside the public system as within it. A major implication of this is that primary health care and other allied health interventions that could/should be delivered through community and private primary care are not provided - due to workforce and service shortages/ unavailability, cost (comparatively little allied health servicing is subsidised through the MBS and is extremely targeted) and a range of other factors. **This inevitably contributes to avoidable presentations at public hospitals, including emergency departments**. Similarly, untreated conditions that could have been addressed through allied health services in the community (including aged care settings etc) contribute to higher avoidable hospitalisation rates, intrusive and costly interventions and poorer health and well-being for people.

Workforce and service demand across the health and social sector continues to lead all other sectors and is projected to continue to do so[1]. Within the sector, **demand for allied health is as strong or stronger than for all other occupations, and greater capacity**

[1] Jobs and Skills Australia: https://www.jobsandskills.gov.au/data/employment-projections

is needed to meet demand across the health sector, in disability services, aged care, veterans, early childhood development and more.

The evidence in support of immediate action to build and distribute the allied health workforce is compelling. Gaps in workforce capacity and service access are already well known and have been for decades

The NSW Government is involved in the ealry development stages of a National Allied Health Workofrce Strategy – the first in Australia's history and a welcome, long overdue response to persistent and widespread advocacy to this purpose. It is critical that this Straegy has NSW Government support, including to promote meaningful commiotments from all governments notably the Commonwealth and is developed as a matter of urgency. It must consider and help address issues of workofrce pathway development and growth as well as distribution.

Development and distribution of a skilled allied health professional and assistant workforce must be prioritised.

A further complication is that **allied health workforce and service demand is increasing rapidly and comes on top of chronic and severe existing workforce shortages**. While the shortage in rural and remote GP and other medical workforce receives close political, media and community attention, workforce and service shortages of AHPs and other health professionals attract considerably less attention – despite increasing calls for multi-disciplinary and team-based approaches to care. Medical professionals make up fewer than 15%of the health professional workforce Nonetheless, as mentioned above the accessibility or otherwise of allied health services impact demand on acute and sub-acute hospital-based care, aged care, primary healthcare, disability support, veterans' services, education, workers' compensation, occupational rehabilitation and more.

On a per head of population basis, the maldistribution of allied health professions is particularly severe. Figure 1 shows the distribution by remoteness (where MMM1 is inner metropolitan and MMM7 is very remote) for a selection of AHPS, compared with GPs. The pattern would be reflected in any updated information available. The pattern would also be reflected in NSW.

Figure 1: **Health professionals by remoteness – MM 1 to7**

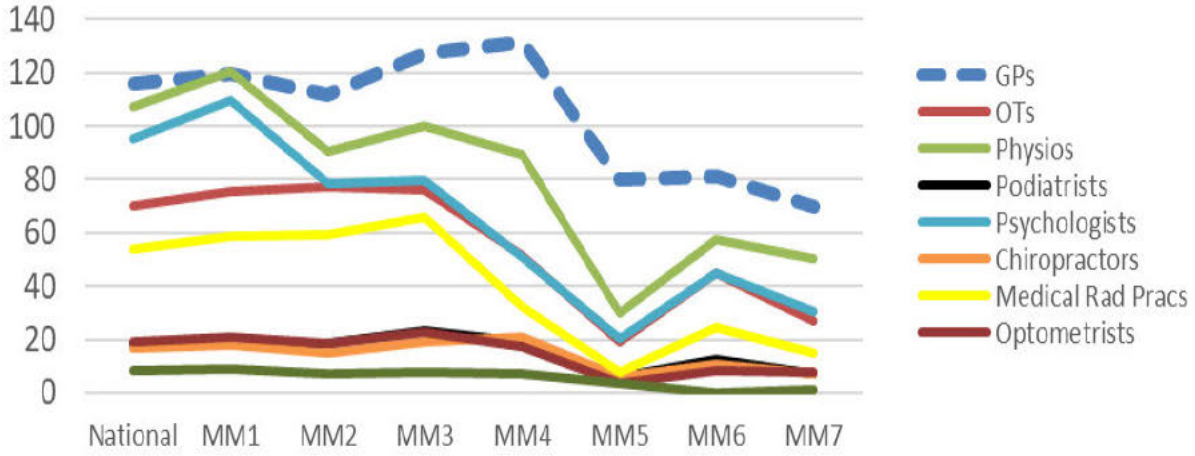

Figure 1. Health professionals by remoteness - MM1-7. FTE per 100,000 population – 2019[2]

Other research reinforces the evidence of maldistribution[3]. Analysis by SARRAH also indicates maldistribution of some allied health professions has worsened over the past decade and become more concentrated in the major capital cities.

Allied health professions are leading forecast growth, with the demand for several professions projected to increase by over 25 per cent over the five-year period. Table 2 illustrates the high demand growth for allied health professions (bolded). Several other professional groups are included for comparative purposes.

Table 1 Projected Employment Growth for the five years to November 2026: National Skills Commission: selected.

Profession	Projected increase
Audiologists and Speech Pathologists	**34.7%**
Podiatrists	**31.8%**
Physiotherapists	**28.7%**
Dental Practitioners	**27.8%**
Social Workers	**23.2%**
Early Childhood Teachers	21.6%
Optometrists and Orthoptists	**15.1%**
Drillers, Miners, and Shot Firers	14.9%
Medical Imaging Professionals	**14.7%**
Registered Nurses	13.9%
Psychologists and Psychotherapists	**13.3%**
General Practitioners and RMOs	10.2%
Accountants	9.2%
TOTAL PROJECTED EMPLOYMENT GROWTH – AUSTRALIA	**9.1%**
Pharmacists	**9%**
Ambulance Officers and Paramedics	**8.4%**
Industrial, Mechanical and Production Engineers	5.5%

Source: National Skills Commission's Employment Projections

SARRAH estimates that around 100,000 or more of the 301,000 health and social services sector jobs are needed in regional, rural, and remote Australia. Demand for skilled workers, including in health and social/community services is extremely strong in rural Australia, and is not being met.

[2] More recent national data is available. However, analysis indicates the pattern has not changed significantly since 2019 and SARRAH understands that for some professions (at least) distribution has become more concentrated in major cities over the past decade.

[3] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0291962

SARRAH is also advocating for support to build the Allied Health Assistant (AHA) workforce. AHAs exemplify the evolving structure and nature of Australia's employment and service demand profile. **The potential of the AHA workforce to expand service reach and continuity of care, working under the direction of AHPs, is enormous, especially in rural and remote Australia. There are examples of this workforce being used to good effect in the NSW health service.**

However, to enable the development of this workforce, focussed and coordinated action is needed between the VET sector, employers, and others to improve training and work opportunities and capacity. For individuals, AHA qualifications provide the basis for skilled job in high demand, adaptable to a range of settings as well as mobility and a pathway for career progression (across and through health, disability, aged care, and other settings). SARRAH addressed these issues in a submission to the recent NSW VET Review.

- The relationship between the Allied Health Professional (AHP) and the Allied Health Assistant (AHA) involves the delegation of therapeutic tasks and is a defining feature and fundamental to the definition of an allied health assistant role and patient safety. While allied health assistants work within clearly defined parameters, the role is often flexible, involving a mix of direct patient care and indirect support activities. The mix of duties is determined by a range of factors including the model of care, the needs of the professional/s delegating work to the allied health assistant, and the types of services delivered by the allied health team.
- At present, neither AHAs nor Therapy Assistants (an outdated role description currently embedded in the Australian and New Zealand Standard Classification of Occupations (ANZSCO)) [4] are included on the Australian Government's Skills Priority List (SPL). The SPL is managed by Jobs and Skills Australia. This situation has implications which can result in AHA trainees and/or employers from accessing training subsidies and other supports. Unfortunately, the ANZSCO (and consequently the SPL) is based on the labour market classifications determined over 20 years ago. An extensive major review is underway. On 18 December 2023 the ABS released proposed changes indicating they expect to recognise Allied Health Assistant as an occupation. This is an important although belated development.

All of these issues will be relevant across rural and remote NSW, including the area covered by the MHLD.

The following comments are framed against preliminary topics identified by the Special Inquiry for consideration during the public hearings in Murrumbidgee Local Health District, as at 12 February 2024.

1. Any workforce challenges, including in relation to recruitment, retention, shortages, and premium labour. (TOR F)

[4] For a detailed explanation of this issue, see SARRAHs submission to the *ANZSCO comprehensive review – consultation round 2 (August 2023)*. A relevant excerpt (from page 3) follows:
The coding for Therapy Aide places it in the occupation group "Nursing Support and Personal Care Workers", along with 423311 Hospital Orderly, 423312 Nursing Support Worker and 423313 Personal Care Assistant. SARRAH suggests this does not accurately reflect the nature of the role, which is to provide direct patient therapy and/or interventions under the delegation of an allied health professional to assist with therapeutic and program related tasks. "Delegation" is the process by which an allied health professional allocates clinical and health-related tasks to an allied health assistant with appropriate education, knowledge, and skills to undertake the task.

The introductory material above provides an overview of the status and some of the major contextual drivers that impact allied health workforce and service capacity in NSW Health and more broadly. In addition, SARRAH undertook extensive work for the NSW Ministry of Health in preparing the report Strategies for Increasing Allied Health Recruitment and Retention in rural Australia: A Rapid Review (2019). The content of that report remains relevant.

2. The interaction between the primary and public hospital system, including issues of demand, equity of access, funding, scope of practice, and the role of multidisciplinary community healthcare. (TOR A, B and C)

Please refer to our opening comments in the context setting material to this Attachment.

In addition:

- The need for improved interactions between and complementarity of service systems is widely recognised as an immediate and system-wide issue. Addressing it needs to be enabled by broader policy and funding frameworks that enable integration and patient care, in line with recent directions set established policy and be by First Ministers in National Cabinet, as evidenced by the communique issued in December 2023 which identified Health as the top priority in 2023 and stated *"Australians rightly want a whole-of-system approach to healthcare, where primary care and hospitals are connected and able to provide optimal models of care in the right place and the right time."*
- Relationships of this kind vary substantially across locations. Clarity and consistency of role and shared objectives are among the factors impacting relationships and conditions conducive to collaborative and effective interactions.
- The ANAOs audit of *Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks* (released 27 February) clearly demonstrates the need for the Commonwealth to clarify the role and performance expectations of PHNs and the Department's management of network. Provided the very serious issues identified in the report are addressed, the underlying situation in which more constructive, integrated approaches to health system access and delivery should emerge in the Murrumbidgee and elsewhere.

Similarly, there are (overdue) developments within the PHN network which the NSW Government and other public health authorities might encourage which should contribute to more accessible, comprehensive and preventive primary care services that will put downward pressure on avoidable demand for public health emergency and other services. An important example is the PHN Networks *Allied Health in Primary Care Engagement Framework* (February 2023), which essentially acknowledges and seeks to address the inadequacy of the PHN focus on allied health service access or capacity to date. The Framework is a welcome development. Addressing it will require a significant shift from the Commonwealth to recognise and resource access to primary health care services (including resourcing for PHNs) that include the entire primary health workforce, including but not exclusively medical practitioners.

3. The effectiveness and limitations of current funding models and opportunities for improvement. (TOR A,C and H)

SARRAH makes no comment on the internal funding of NSW public allied health workforce capacity and positions other than to suggest performance and service gaps in this regard should be oversighted and reviewed on a state-wide basis lead allied health professional and senior administrative staff.

SARRAH would strongly encourage the NSW Government to impress upon the Commonwealth and other jurisdictions the need to ensure allied health service and workforce capacity and access is specifically considered and embedded in the next National Health Reform Agreement, with appropriate obligations on all parties to ensure services in public health are accessible and high quality and similarly in primary health care as a means of containing avoidable demand on public hospital and other services.

4. Existing procurement processes and any opportunities for improvement, and any impacts of supply chain disruptions. (TOR E and H)

- No comment.

5. Education and training opportunities and limitations within MLHD, including the 'Grow Your Own' program and the collaboration between UNSW Sydney and the Murrumbidgee Local Health District (MLHD) to attract, train, retain, and support rural generalist doctors who work in the MLHD. (TOR F, G and H)

SARRAH understands there are several very positive education and training partnerships and initiatives being progressed in the Murrumbidgee, including an allied health related measures established several years ago (which attracted a HETI Award) also referred to as the Murrumbidgee model – not to be confused with the current initiative involving medical practitioners. We strongly encourage all parties to work together to develop comprehensive rurally and regionally based health workforce development programs and pathways.

6. Virtual care services, including virtual care for chronic disease management, virtual hubs trial and virtual nurse assistants. (TOR F and H)

Virtual care options – including in the provision of allied health services by qualified professionals and assistants - are potentially valuable complements and enablers of effective patient-centred care. They can contribute to the quality, continuity and outcomes of care. However, they can improve and extend practice and should not be considered as an alternative to face-to-face or in-person modes of service.

7. Linking virtual care with metropolitan tertiary networks for provision of technology assisted access to specialist care, and opportunities to improve patient outcomes and staff training, development and retention. (TOR A, F and H)

Fine – potentially very valuable, subject to the above answer.

8. The delivery of integrated care across the primary, secondary, acute, and aged care systems, including any barriers and opportunities for improvements to minimise the effect of fragmentation. (TOR B, C and H)

SARRAH strongly recommends that these issues be promoted for consideration by NSW and other jurisdictions in any future negotiations of the National Health Reform Agreement.

9. Any particular issues arising from the MLHD geographic boundaries, including in relation to employee staffing/retention, and funding. (TOR A, B and F)

No specific comment. Broader issues addressed elsewhere.

10. Opportunities for, and any barriers to, collaboration between LHDs. (TOR B)

- No comment.

11. The effect of the Collaborative Agreement between the Murrumbidgee Primary Health Network (MPHN) and MLHD. (TOR B)

SARRAH is not in a position to comment specifically on the relationship between MPHN and MLHD, however, refers to the material provided in response to issue No. 2 above.

12. The role of the 33 different Local Health Advisory Committees within MLDH. (TOR B)

- No comment.

13. The Murrumbidgee Health and Knowledge Precinct (TOR B and H).

- No comment.