SARRAH

Services for Australian Rural and Remote Allied Health

6 July 2021

National Skills Commissioner

Submission provided through: www.nationalskillscommission.gov.au/careworkforce

Submission to Care Workforce Labour Market Study: Discussion Paper

Services for Australian Rural and Remote Allied Health (SARRAH) thanks the National Skills Commission for the opportunity to contribute to the scope and focus of the Care Workforce Labour Market Study (the Study). SARRAH welcomes the Study and believes the approach described in the Discussion Paper will lead to a far clearer understanding of the context, opportunities, risks and case for investment in this important workforce. I apologise for the delay in providing this submission.

The "care" workforce is vital to Australia's social and economic future, to the quality, capacity and sustainability of our major social service systems. It makes up a large portion of the Health and Social Assistance sector, the leading area of jobs growth and demand, long term and encompasses a range of vital and high skilled occupations, career options and pathways for many Australians, including for people who are looking for such employment in large sections of rural and remote Australia where this service capacity is in severe shortage.

The full service capacity and potential of the occupations covered by the term "care and support workforce" has not been utilised to date and the opportunity to build and enable this workforce will substantially help to meeting our growing needs safely and efficiently. SARRAH believes the Study should include Allied Health Assistants, as they have very substantial capability to deliver high value services and care to people in all areas of need identified for the Study.

To reinforce the point, the findings and recommendations of the Aged Care Royal Commission, numerous disability related parliamentary and other reports have pointed to the current inadequacy of access to the enabling, therapeutic, rehabilitative services provided by allied health professionals and assistants.

As background, SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public, community and private sectors, across health, disability, aged care, in veterans' services and other settings. SARRAH works on behalf of rural and remote communities to promote access to allied health services and support equitable and sustainable health and well-being. SARRAH develops and provides services for AHPs to confidently and competently carry out their professional duties in providing a range of clinical and health education services to people who reside in these settings

AHPs are tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury whatever their stage of life or circumstances. SARRAH also places a high value on the Allied Health Assistance (AHA) workforce, which offers great potential to improve service access and distribution and to promote sustainable models of quality care for people who need services, regardless of where they live or other factors that may impede their current access to care and improved well-being. SARRAH maintains that every Australian should have access to equitable health, disability, aged, mental health, veterans' and other services wherever they live.

SARRAHs submission supports two key objectives:

- Improving access to vital allied health services for people who need them; and
- Recognising the Allied Health Assistant (AHA) workforce as a crucial, identifiable, adaptable and highly skilled occupation among the broader health and social assistance and care workforces.

The Prime Minister has set a challenging task *"to undertake an in-depth study of the factors affecting the supply and demand of care workers both in the near term and longer term to 2050"* (page 2 of the Discussion Paper). The Commission is working to a tight timeframe in reporting to the Minister. SARRAH feels the Commission has commenced well, with the Discussion Paper and preparedness to engage meaningfully. The Paper presents a coherent approach, with a scope and balance that should facilitate informed advice and decisions across the immediate and longer-term (to 2050). The approach aligns with SARRAHs view that there is an urgent need to build the "care" workforce, and lay the groundwork for a considered, long-term investment strategy so the future workforce is equipped to deliver on community needs and expectations, including to optimise wellbeing, independence and capacity for the longest time possible. The impact would also contribute to social cohesion, productivity and the sustainability of our service and support systems.

SARRAH supports the broad cross-sector scope of the Study, and the effort to introduce a better balance of integration with adaptability into our workforce development systems. There may be some concern that such an approach involves design complexity however, it also positions us to address existing system constraints that contribute to persistent gaps in the service system and inflexibilities that impede access for many individuals and communities must services that respond to their particular needs.

Care and service models are often designed to meet majority population needs (e.g., are metro-centric or assume predominant culture norms). This design bias can translate into program and funding arrangements tailored to and reinforcing those "norms". Similarly, service and program approaches often apply quite rigid criteria and guidelines on the understanding that this promotes equitable access and addresses the risk of bias. Unfortunately, those process and program attributes may, when viewed from a service access or individual outcome perspective, reinforce service gaps and inequity of access and outcomes. The recognised inadequacy of many mainstream services to deliver comparable outcomes for Aboriginal and Torres Strait Islander people provides a clear example, and this has led to commitments by the Prime Minister and National Cabinet to change how policies and programs are designed and delivered.

SARRAH firmly believes that better community outcomes would be achieved (with the same resource commitment) if there was greater scope for flexible delivery models and approaches. These approaches would still be accountable for safety and quality and, crucially, could be assessed based on equitable outcomes, impact and sustainability, with less emphasis on detailed accounting for inputs as a proxy for these measures.

Such approaches could better enable service mechanisms that support the provision of allied health services by a local, accessible Allied Health Assistant (AHA), to people living in a

remote community. Such service models entail a visiting allied health professional providing assessments and therapeutic programs across a variety of programs such as childhood development, disability support or aged care services, that are then carried out with the client by an AHA working under direction and with the support of the AHP. The AHP receives regular reports from the AHA regarding the client's progress and may physically review the client on a less frequent basis.

By contrast, emphasising uniformity in service design and approach too often leads to no service availability or access as service benchmarks may be impractical in some service environments, be not be viable financially or be inappropriate and unresponsive to community circumstances, culture and needs.

The following attachment addresses each of the Discussion questions posed by the Commission as well as providing some general feedback on the issues and approaches outlined in the Discussion Paper.

We have included a small number of case studies to help illustrate the allied health services and the contribution of AHAs in delivering them. We would be happy to provide more information and examples of help facilitate a focussed discussion with practitioners working in and across relevant sectors if that would help the Commission.

If the Commission would like any further input, SARRAH would welcome the opportunity to be involved. Further information about SARRAH is available at http://www.sarrah.org.au/) and I can be contacted at catherine@sarrah.org.au or by mobile on 0491 209 291.

Yours faithfully,

Catherine Maloney
CEO, SARRAH

ATTACHMENT: SARRAH Submission to Care Workforce Labour Market Study

Feedback: Response to Discussion Questions

Workforce observations

What observations do you have about the job roles in the care and support workforce? Over the past 5 years how have you seen the care and support workforce change? How do you expect the workforce to change in the near-term and out to 2050?

Consider:

- ***emerging/new job roles***
- ***skill change (required and new skills)***
- ***job design***
- ***specialisation and hybridisation of roles***
- ***transferability of skills across different job roles***
- ***skills for person-centred approaches to care and support***
- ***entry pathways***
- ***employment conditions***
- ***workforce leadership and management.***

What do you consider to be the key drivers of change to the care and support workforce into the future? How will the workforce need to adapt?

Allied health access and service shortages

There is a chronic shortage of allied health service capacity and supports across rural and remote Australia. This has major impacts on peoples' opportunities and capacity to access allied health services on an equitable or needs basis.

This long-standing issue was investigated in depth by the previous National Rural Health Commissioner (NRHC) who provided a report to then Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton MP, on the *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*[1] (June 2020). Issues of inadequate allied health services and support have also been highlighted in findings of the Aged Care Royal Commission and aspects of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. The 2021-22 Budget included a range of relevant workforce announcements and increased capacity to respond to these needs.

Rural allied health service shortages are more severe than for either medical or nursing workforces. This also impacts the nature and type of support available to people caring for those with complex needs. There is a risk allied health service capacity could worsen in rural and remote Australia as overall demand increases.

Inability to access allied health services can and does lead to the development and/or worsening of conditions that might have been prevented and/or ameliorated if people had accessed those services. People with disability and/or the older Australians, for example, can be especially disadvantaged, impacting opportunities to retain capacity and independence or pursue and achieve personal, participation and economic goals. Aboriginal and Torres Strait Islander Australians are often especially disadvantaged in this respect.

[1] See https://www1.health.gov.au/internet/main/publishing.nsf/Content/National-Rural-Health-Commissioner-publications (June 2020)

From SARRAHs perspective, a coordinated approach to workforce development to meet the full spectrum of care and support needs of people with regard to aged care, disability, mental health, veterans' care and health more broadly is long overdue

This Study attends to the strategic consideration of capacity, demand and workforce development priorities that has been lacking to date.

Developing the allied and related health and support workforce – with career and role-models, clinical and work experience and pathways options in rural communities - should be an employment priority. The demand for these services, higher illness and disease rates among rural Australians, high costs for visiting services and impacts in terms of lost productivity are all factors associated with the growth or continued shortage of this workforce in rural areas.

Existing workforce and skills shortages, suggest education and skills pathways should be better aligned to build the workforce and increase the capacity and resilience of rural communities. This is likely to require deliberate action to build a workforce that also help underpin, support and complement regional development, attraction and growth in other rural industries/sectors.

Workforce development planning must address size and practitioner skill levels. As mentioned in the covering letter, a balance must be reached – driven by community need, policy objective and program impact primarily. Program requirements and inflexibility can reinforce service fragmentation and promote service gaps, reducing the efficacy of service investments overall. Related to this, they can also obstruct innovative service models from establishing or evolving, which is a major issue in locations where more metro-centric and delineated approaches are neither viable, effective or attuned to community needs.

The following table[2] shows the geographic (mal-)distribution and practitioner to population ratios of a selection of allied health professions. While slightly updated data is now available, it describes the same distribution pattern.

Table 1: Rate of Full Time Equivalent AHPs per 100,000 population by remoteness areas (2016)

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Allied Health Professions	No of FTE professionals per 100,000 population				
Medical Radiation Practitioners	54.93	43.22	30.90	25.19	12.35
Oral Health Practitioners*	82.20	60.42	53.82	42.21	21.74
Occupational Therapists	62.18	47.43	46.52	38.13	22.73
Optometrists*	19.74	15.85	11.46	9.19	3.95
Osteopaths*	7.96	6.17	2.30	NP	NP
Pharmacists	99.35	78.07	78.01	74.89	45.95
Physiotherapists	103.78	66.30	55.44	43.91	40.51
Podiatrists	17.72	17.21	10.97	10.55	5.93
Psychologists	103.17	61.25	45.84	35.40	20.75
Other Health Professions					
Medical Practitioners	440.88	302.44	284.73	331.90	220.34
Nurses and Midwives	1157.15	1105.59	1099.88	1304.78	1192.12

Source: Australian Government Department of Health, 2018

[2] Table reproduced from ***Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review. Services for Australian Rural and Remote Allied Health*** (SARRAH, 2019).

The following table (also reproduced from *Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review*. Services for Australian Rural and Remote Allied Health (page 11) provides a detailed list of allied health professionals and their distribution across NSW. (SARRAH is aware of no information showing a significant shift in this distribution pattern since 2016).

Table 2: NSW AHPs by place of work (remoteness area) 2016 ABS Census

Professions	Remoteness Area				
	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Sonographer	1250	278	27	0	0
Medical Diagnostic Radiographer	2189	462	85	5	0
Medical Radiation Therapist	505	106	0	0	0
Nuclear Medicine Technologist	227	29	3	0	0
Dietitian/Nutritionist	1299	247	39	4	0
Optometrists*	1174	202	30	0	0
Orthoptists	355	36	0	0	0
Orthotist or Prosthetist	76	7	0	0	0
Chiropractor*	1017	199	33	0	0
Osteopath*	273	79	15	0	0
Audiologist	424	100	3	0	0
Speech Pathologist	1674	363	54	8	0
Occupational Therapist	2791	692	103	4	0
Physiotherapist	5032	963	156	3	0
Pharmacist	5458	1084	268	17	3
Podiatrist	757	182	32	0	0
Clinical Psychologist	3381	629	83	6	0
Psychologist	1151	258	50	3	0
Exercise Physiologist	651	128	10	0	0
Social Welfare Professional	240	66	10	0	0
Counsellor	2012	461	71	0	0
Drug and Alcohol Counsellor*	201	136	34	0	4
Rehabilitation Counsellor*	527	106	13	0	0

Source: ABS 3218.0 - remoteness area download

** Optometrists, chiropractors, osteopaths, drug and alcohol counsellors and rehabilitation counsellors are not employed as allied health professions by the NSW Health. These professions are regulated by AHPRA and are considered to be allied health professions more broadly across the heathcare sector.*

*** Art therapy, child life therapy, diversonal therapy, music therapy and welfare are not categorised seperately within ABS Census data and are counted within other professions listed above or have not been included in this dataset acquired from the ABS.*

SARRAH strongly supports development of the AHA workforce, as a complementary and crucial workforce in addition to other clinical, care and support roles – such as enrolled nurses, Aboriginal and Torres Strait Islander health workers and health practitioners, etc.

AHAs work with AHPs to provide services to people with therapeutic and other care needs, their families and others to achieve goals in their life, including daily living, social and community participation, work, leisure, learning and relationships. They offer a broader potential scope of practice, with a basis for skills acquisition and delivery that is readily

amenable to vocational training and micro-credentialing. Together with measures such as the expansion of the Allied Health Rural Generalist Pathway, a local AHA workforce can enable a community who currently lack services to access a substantial spectrum of services sustainably.

CASE STUDY 1

There are several examples in rural NSW where allied health assistant (AHA) roles have been developed in small rural hospitals and multipurpose sites (MPSs) where recruitment of allied health professionals has proven difficult. This should not be seen as workforce substitution as the positions are not "stand-alone" - without the supervision and support of visiting allied health professionals (AHPs) these positions would not exist.

The allied health assistant worked with a range of practitioners across different disciplines, delivering services to aged care residents and a range of ambulatory services such as chronic disease management and paediatrics. The visiting AHP undertook an initial assessment of the client and developed a care plan that the AHA then implemented. The AHA was in regular contact with the AHP with regard to the client's progress and arranged regular reviews with the AHP according to their visiting schedule. Where a client was not progressing as expected, the AHA was responsible for reporting back to the AHP and escalating an early review where needed.

In some instances, the AHA was providing services across several disciplines to the one client, enabling a comprehensive service for the client, and a deeper understanding of the nature of the client's condition by the AHA.

Benefits:

- Improved access to allied health services, particularly in rural communities receiving visiting allied health services. This occurs primarily when the AHA remains on site between visits by AHP services and provides ongoing care, thus enhancing the continuity of allied health service provision
- Increased intensity of clinical care leading to improved patient outcomes. Increasing the frequency of contact with the client between visits by the AHP is likely to increase the therapeutic dose of prescribed intervention as well as increased compliance with the program by the client
- A greater range in service delivery options available to providers of health care, including an opportunity for AHPs to both manage care, by delegating appropriate tasks to the AHA, and provide care, rather than maintaining a sole focus on providing care
- The ability for AHP to fulfil their scope of practice and focus on more complex client needs
- The opportunity to not only increase the quantity of allied health services provided, but to extend and expand those services into areas not previously possible due to resourcing constraints
- Increased patient satisfaction
- A positive impact on the quality of life for clients, particularly those with lower-level needs, such as in rehabilitation settings where utilisation of assistants has led to improved coordination and integration of rehabilitation services, and Development of a broader knowledge and skill base in the health workforce and in addition, the opportunity to build skills within the community.

Reference: Firth A (2012) Delegated clinical roles of Allied Health Assistants: Is the Certificate IV in Allied Health Assistance associated with enhanced clinical practice in rural NSW? Final Report of the Health Education and Training Institute (HETI) Rural Research Capacity Building Program (accessed 05/07/2021 https://www.heti.nsw.gov.au/__data/assets/pdf_file/0009/438849/A-Firth-Final-Report.pdf)

Pressure to meet these service demands will only grow as the Australian population continues to age – this has been reiterated in the Intergenerational Report 2021, released by the Treasurer in late June. Considering downward revisions in population, lower birth and immigration rates, there is increased pressure to maximise skills, productive capacity and labour force participation rates, especially among people of prime working age. Australia cannot afford to underinvest in a workforce that, on any reasonable set of assumptions, will continue to be needed and offer pathways to skills, careers, income, revenue generation, reduced welfare dependency and more. An inadequate response risks workforce shortage, community dissatisfaction and wage pressures without offsetting gains in skills and productive capability.

Further, the timeframes associated with these issues, argue for an assessment of prevailing conditions, regional and international workforce, economic and other trends. Australia has to date been able to access a ready supply of overseas origin care workers. With changing global conditions, including the rise in prosperity of traditional workforce source nations, there is a need to re-assess the extent we may or should rely on that overseas workers into the future. The costs and benefits of investing in domestic skills and workforce development compared with alternate and /or complementary strategies should be assessed rigorously and over the medium to longer term.

Workforce attraction, retention, and development

To what extent are mobility and skills transferability between and across job roles important factors in workforce/worker attraction and retention?
What strategies and tactics are most effective in attracting and retaining a workforce/worker with the right skills?
What barriers exist to entry and establishing career pathways for the care and support workforce/workers?
What role do formal and informal training have in contributing to the supply and ongoing development of the care and support workforce?
Is there anything specific, which has not been previously identified that is a blocker to attraction, retention and/or ongoing workforce development?

A strategy to address workforce shortages in rural and remote Australia is facilitate local access to education and skills-based training, especially in sectors of demand, with the Health and Social Assistance sector a prime example. Rural health workforce advocates and others have long argued that much of the cost and effort involved in attempting to attract and retain skilled workers in communities could be defrayed if local or regionally based opportunities were available. Related benefits include:

- Opening opportunities to a potential workforce already resident, with community ties, many of whom would prefer to stay, especially if training and a job were available;
- Care and support jobs are generally less impacted by seasonal fluctuations, climate variations and shifts in resource process internationally – providing many potential workers with sought after security as well as opportunity;
- Opportunities for people with other commitments such as (unpaid) caring roles, cultural responsibilities which inhibit labour market mobility to work; and
- Work that provides families and businesses with farming or small business commitments with options and extra security through off-farm/business income.

The significance of this workforce to local and regional economic, service and community development should not be undervalued. There are also major benefits for employers in workforce related costs, such as the $30K plus indicative cost of replacing a worker, which can be both more challenging and represent a higher relative cost to service providers operating in smaller communities and markets

Improving education, skills and employment at a local level makes for a simple statement, but in Australia's systems this requires collaboration across multiple spheres of government, portfolios, employers and communities. Nonetheless, the cost of addressing the issue may be much less than the costs resulting from service gaps and depending on expensive visiting service alternatives (to name a few).

A major theme in SARRAHs work has been to support people to make the transition to rural practice and living; many of the issues would be common to the care and support workforce. See - *Strategies for increasing allied health recruitment and retention in Australia: A Rapid Review. Services for Australian Rural and Remote Allied Health (SARRAH, 2019).* The National Rural Health Commissioner (NRHC)[3] also assessed these matters and recommended an integrated suite of measures (complementing others mentioned here) directed at developing and sustaining rural workforce and service capacity. The NRHC highlighted two examples of innovative workforce initiatives tailored to build health (and related care and support) workforces:

- Implementation of the Allied Health Rural Generalist Pathway being managed by SARRAH (and expanded in the 2021-22 Budget, with the addition of AHA positions); and
- Further expansion of the Indigenous Allied Health Australia, National Aboriginal and Torres Strait Islander Health Academy, which includes school-based acquisition of a Cert III AHA qualification, work experience and links to further study and work pathway options.

The Regional Australia Institute - RAI - (Welcome - Regional Australia Institute) monitors and reports on trends in regional jobs (produced by the Commission) points to consistent high demand for H&SA sector jobs in regional, rural and remote Australia. RAI among others also note the availability of education, health and related services as being major factors in peoples' decisions to move to regional Australia or not: for the skilled care and support workforce enabling local skills and workforce may represent a virtuous circle.

As noted elsewhere (such as the following section on *Thin Markets*) service and employment models need to be fit for purpose to their location and service community. Connection to community and breadth of practice are often cited as benefits of working across settings and populations in a community environment. Likewise, education and training initiatives that support broad applicability and transferable skills across are ideal to meet needs efficiently and develop an engaged and capable workforce.

System Settings

In addition to previously identified system complexities (for example, funding, pricing, regulation), are there any other system issues (big or small) that are impacting the care and support workforce and the capacity to deliver quality care and support?

Other system settings that warrant consideration are:

- The availability of adequate service settings, supervisory, training and other assets to support workforce training and growth;
- Reducing/containing overhead costs and administrative burden for practitioners/ services/ employers working across various service systems and settings (e.g., multiple accreditation events required of the same practitioner/individual; and
- Improved articulation and recognition of education, training and skills within and between the schools, VET, university and professional-based CPD systems.

[3] National Rural Health Commissioner's Allied Health Report to the Minister June 2020.pdf

Thin Markets

What strategies, initiatives and organisational structures are effective in improving the availability and sustainability of the care and support workforce in thin markets?

The Commission's definition of thin markets is clear and strongly supported. *"Thin markets are defined as inadequate availability of services resulting in an inability to meet demand"*.

- SARRAH works extensively to support service models that meet community need in circumstances that are frequently described as *thin markets.* The term seems to be used to suggest sustainable or viable service alternatives do not exist. The definition used by the Commission is, in our view, an important and accurate description that identified the central issue to be addressed to enable service delivery.
- In our experience, many so-called thin markets describe either a) models of service delivery that ill-suited to the circumstances or community b) places and populations who have not had services available, tested or otherwise and c) communities that have significant populations with considerable service need and a potential workforce to deliver some of those services, but the fragmented approach to service delivery has precluded viable services from being established or maintained. Unfortunately, many funding sources and grants programs are not designed to address community need.
- As mentioned previously SARRAH is directly involved in implementing innovative workforce and service programs and is aware of other purpose-built service models that are enabling workforce and services access to people with disability, the aged, people requiring mental health services, veterans and others.
- As an example, the Allied Health Rural Generalist Pathway (or AHRGP - Allied Health Rural Generalist Pathway - SARRAH) is such a model. SARRAH is currently implementing the model into private and community-based practices across rural and remote Australia. The 2021-22 Budget included an expansion of the program with 90 additional AHP and 30 new AHA positions to be established in rural and remote mainstream and Aboriginal and/or Torres Strait Islander Community Controlled organisations over 3 years: provide services to all the groups identified as requiring care in the Study.

Noting the commentary on demand in the discussion paper, and the demographics and health and wellbeing outcomes of people in rural and remote Australia, there is clearly a high level of need and potential demand for services across aged care, health, disability, mental health and veterans' care. Data about service occasions provided in these areas would generally reflect access and should not be confused with need or demand.

The National Rural Health Commissioners report on Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia recommended that 'service and learning consortia' could improve service sustainability in smaller markets through the provision of care across service and funding streams.
A major impediment to this is that grants that could contribution to the development of an integrated model are rarely coordinated, flexible or open enough to meet the cross-sector, cross-program focus needed to underpin potential models of service and workforce development; despite substantial funding sources that could be directed to the purpose.

Existing structures and mainstream models have been unsuccessful to date, particularly with respect to development of the Aboriginal and Torres Strait Islander workforce.
While rural and remote warrants specific consideration, particularly with respect to market forces, it is also essential to consider access in metropolitan contexts, including for Aboriginal and Torres Strait Islander peoples.

Technology

What role do you see for technology in enabling the care and support workforce?
Consider:

- ***training and skills acquisition for the workforce***
- ***optimising the delivery of care and support***
- ***enhancing care and support activities***
- ***monitoring and enhancing quality***
- ***potential change in ways people access services***
- ***provider resource management***
- ***technology adoption factors.***

There is no sound reason why a greater use of technology could not contribute substantially to develop this workforce and to assist with ongoing service provision: provided it is developed as an adjunct to complement, reinforce safe and high quality face-to-face / in-person services.

It should not be seen as a replacement or panacea for existing gaps, and safe application/use will vary, but technology including digital health developments, provide opportunities for training service delivery, consultation and supervision.

Monitoring Framework

There are many challenges in ensuring a ready workforce to deliver the essential services Australians require. There is an ongoing need to monitor and assess pressures in the care and support workforce. What should be included in a workforce monitoring framework?
Consider:

- ***key elements of the framework***
- ***data required, new or existing, to support the framework***
- ***information needed for the framework to be an effective input into planning for, and development of, the care and support workforce.***

SARRAH welcomes the prospect of a monitoring framework that encompasses measures of workforce *and* service supply and distribution
Workforce capacity (skill, scope of practice, remote access measures etc) and demand/ need
Provide the basis for cost/expenditure monitoring but with clearer links to capacity, delivery and impact measurement.

Given inevitable pressure on budgetary and service systems these measures would provide the basis for greater planning, controls and service configurations that maximise investment into areas such as prevention which are crucial to sustainability but have difficult in competing for resources for more and immediate and tangible expenditure items (such as emergency room capacity, which is higher because of a failure to invest in preventive measures.) This same rationale applies to investments in workforce skills and structures that maximise positive outcomes, including containing crisis driven future outlays.

These might be, for example, developed around a framework of target-based improvements in reference to a clear and measurable policy target or goal, such as has been developed in relation to the Closing the Gap agenda nationally.

Data

What workforce data gaps have you observed and how could these be addressed?

Significant investment is required to improve workforce data availability with a focus on particular challenges, including AHAs and self-regulated AHPs especially.

In terms of AHPs a good overview of the availability and limitations of existing data was produced by the National Rural Health Commissioner in February 2020 - *Review of rural allied health evidence to inform policy development for addressing access, distribution and quality*[4]. Clearly the focus is not explicitly on the AHA workforce, however the challenges in relation to the self-regulated AHPs would be indicative, at least, of the challenges in attaining reliable data on the AHA workforce. That the data does demonstrate is the extent of potential service demand that might be ameliorated by an increase in the AHA workforce.

The AIHW, in consultation with the Australian Chief Allied Health Officer (CAHO) among others, are currently looking at options to address these data gaps. That work is likely to take years as the systems that support data collection in other areas of health and related service provision (e.g., MBS, practice support payments and programs, the MyHealth record etc) are either not available to or not as well supported at present.

We understand the NDIA has substantial participant and service data holdings that could substantially assist in identifying service (and potentially workforce) availability and gaps. Our understanding is that the Commission may have greater access to that data than other stakeholders might have.

The lack of reasonably robust and complete workforce data seems to be a factor in the apparently anomalous situations and decisions when service need, and workforce development decisions and investments are made. For example:

- An option under active consideration in the current Review of the AHA VET training program is to reduce training options in podiatry care. On face value this appears reasonable considering extremely low enrolments.
- The decision to remove the option may be reasonable, however the need for accessible and regular podiatry services in rural and remote communities appears to be very high given rates of lower leg amputations that are around 20 times higher or more than in metropolitan communities[5]. Podiatry care can be crucial in preventing such situations and AHAs with appropriate training and supervisory support can provide this care.
- So low enrolments on their own can be a very poor indicator of community need or demand. Often training may 'appear' to be available in the system but it may not be offered by RTOs where that skill could be most useful, the course is on scope but there are no teachers, supervisors or even overarching services to raise awareness, facilitate or link the training to service, and so on.
- Anecdotal feedback from remote service providers however suggests a far greater interest in such training were it accessible.

Similarly, there are also acute shortages in allied health services in rural and remote areas across Australian jurisdictions, AHAs do not always feature on the various Skills in demand lists and so benefit from promotion, training subsidies and so forth despite community need.

Better data would help to address these system-based disconnections and impediments to effective and efficient matching of need, workforce and service.

General and other comments

In addition to delivering skills and employment for people living in rural areas directly, allied health service providers (AHPs and AHAs) support economic participation, recovery and

[4] NRHC Report Literature Review February 2020.pdf (health.gov.au)

[5] See the Australian Commission on Safety and Quality in Health Care for this and other examples of highly differential health outcomes and incidents by location in the following and predecessor reports - Fourth Atlas 2021 | Australian Commission on Safety and Quality in Health Care. There appears to be a high correlation between poor outcomes and key workforce shortages in many cases. poor o

participation across the population and impacting the productivity of every industry sector. AHP services and therapies:

- Contribute to reducing prevalence and impact of disease, including chronic disease which costs the national economy $billions per year in direct health costs, absenteeism and lost productivity;
- Aids in rehabilitation and recovery, increasing the capacity for individuals to maintain self-reliance, be less dependent on public outlays on publicly funded services (including income support) and contribute revenue;
- Could potentially further reduce the high rate of avoidable hospitalisations and strain on available local services, that can be particularly high in rural and remote Australia – and correlating broadly with areas where allied health service access is relatively poor.
- If and where available, improve the community outcomes and cost-effectiveness of national health and other priorities and strategies including in primary health care, the NDIS and aged care – which are much needed in rural communities.

CASE STUDY 2

IN 2008 – 09 TAFE NSW (Riverina Campus) ran a certificate III in Allied Health Assistance offered via the VET program delivered through local high schools as part of the Higher School Certificate.

Two graduates of this level III qualification were successfully employed directly from school into AHA jobs at a local subacute care facility, out-performing experienced care workers in disability and aged care, who also applied for the positions. This was associated with their specific understanding of the AHA's scope of service and how they reinforced the work of AHPs. Once employed, both AHAs were supported to undertake their level IV AHA training in the workplace and both were successful in completing this training.

This is an example of a pathway whereby local students can access gainful local employment directly from school without needing to leave home.
Another is the Indigenous Allied Health Australia, Health Academy model.

The Commission may find the following infographic useful. We would be happy to provide more examples, if this would assist.

Comments on the Discussion Paper

The following comments refer to specific aspects of the Discussion Paper. The relevant section is identified by the numbering.

1.1 **The Overview** provides clear and concise context establishing why the Study is needed. However, the phrasing "labour shortages are emerging" understates the situation in rural and remote areas notwithstanding the acknowledged they can be more pronounced in those locations. Allied health services (including those delivered by VET trained occupations) have been in chronic shortage for years.

1.3 **Terms of Reference**: We understand these are set and are not open to amendment.

- There are several issues relevant to the objective of the Study but are not identified explicitly in the Terms of Reference. These could be helpfully considered in the Study.
- In establishing occupational profiles, examine some of the factors that may be highly variable on a regional or other basis: this may point to both enablers and obstacles to workforce development, choice, opportunity etc.
- The Commission know the assumptions and methodology used to develop workforce projections. A concern for SARRAH is that employers and others reporting demand etc are more likely to identify occupations where there is a well-established occupation profile (e.g., nurse) and expectation of service and workforce than if that workforce is under-represented. For example, every community is likely to have had exposure to and service expectations related to nurse provided care. In part this reflects the broadly equitable distribution of nurses nationally on a population basis (if not a geographic basis); whereas for many occupations – including AHAs and AHPs many communities have little or no experience of these services and, if known of, may have no or little expectation that they will be available or provided in the community. This may have nothing to do with community-based need (such as the low level of audiology services in Aboriginal communities with very high hearing loss and ear infections), however may not be picked up in (potential or desirable) jobs projections if need /potential demand were considered. This (potential) discrepancy is reinforced through existing service and funding being directed to identified gaps rather others that may be more severe but have not been 'identified' or targeted for specific funding.
- Considering labour pipeline supply, capacity – is the Certificate Course offered; is there a trainer; are there local clinical services where supervisors and clinical placements/exposure can be sourced etc. Often the absence of even one of these 'assets' means no workforce development opportunity can exist.
- SARRAH strongly supports investigation into the actual presence and efficacy/linkages of skills and training pathway.
- One issue (identified in the current Review of the AHA curricula by SkillsIQ) is the articulation (or lack of articulation) between some training, including the Cert III and Cert IV AHA curricula. Both Certs offer valuable opportunities for workforce entrants, but they are not well articulated (so add cost and inefficiency). Articulation within VET offerings and between VET and higher education would enable pathways and facilitate greater skills usage, development, retention etc.
- SARRAH strongly supports the focus on coherent workforce planning and the need to ensure adequate, quality data is identified and made available (progressively, given current gaps) to inform it.

- SARRAH encourages the Commission to consider closely the workforce related Recommendations of the Aged Care and Disability Royal Commissions and Government's response (including gaps), the developing NDIS National Workforce Strategy, the soon-to-be-finalised National Aboriginal and Torres Strait Islander Health Workforce Strategy; the Mental Health Workforce Strategy and many other plans and strategies, together with the JobMaker and other funding and program initiatives that are available. It is imperative that these can be identified and drawn on to support an integrated and effective investment in high demand areas such as the broader "Care" workforce.

2.1 **The Approach** outlined appears to be logical and deliberate. SARRAH would welcome the opportunity to assist at any stage of the Study, including by providing case studies or other material if we are able to.

Re: Research and synthesis the following references might be added to the list at Appendix A:

- https://sarrah.org.au/our-work/policy-and-strategy/publications/138-strategies-for-increasing-allied-health-recruitment-and-retention-in-rural-australia
- SARRAH Summit 2020 Report - SARRAH
- National Rural Health Commissioner's Allied Health Report to the Minister June 2020.pdf
- Workforce Development Strategy - Indigenous Allied Health Australia: Indigenous Allied Health Australia (iaha.com.au)
- IAHA National Aboriginal and Torres Strait Islander Health Academy - Indigenous Allied Health Australia: Indigenous Allied Health Australia
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (to be released),
- Allied Health Assistance Workforce Report

Further information on Allied Health Assistants is also available at Allied Health Assistant Network of Australia / www.AHANA.com.au

2.2 We strongly suggest that the Allied Health Assistant workforce (Cert III and Cert IV) be added to the occupations in focus.

We would also suggest that across the occupations being considered that (to the extent possible) these are compared in terms of:

- Numbers and distribution – preferably against a broader location population profile.
- The availability of training options (actual offered as well as being on an RTOs "scope") – especially for VET trained occupations.
- Training place enrolments.
- Job ads, filling and retention rates (if available).
- Service access and related care outcomes (it may be possible to utilise indicative material that correlates with the presence or lack of a given workforce/skill area – e.g., amputation rates if the availability of podiatry care, preventable hospitalisations etc, vs workforce presence/shortages.)
- Access to MBS items for allied health or other services – as an indicator or potential service demand and shortage. Despite higher chronic disease rates in rural areas, access to these services can by 15-20 times higher on a per head of population basis in metropolitan areas.

- SARRAH understand it can be difficult to obtain or analyse this information and would be happy to help if the Commission would like to follow up with us.
- SARRAH also notes the Commission's concern that many occupations are involved in care and that decisions key considerations influenced the selection of occupations.
- The tension between developing highly specialised occupations and those with a broader set of skills, is inherent in the health and associated services sector. It is an area of dynamic and constant attention, with the recent trend being generally to ensure the availability of generalist workforces (such as in medicine and more recently allied health) as a means of ensuring service coverage and access, especially outside of metropolitan areas.
- Re: point 2, Number of Workers – SARRAH suggests that in addition to staff/occupation numbers, consideration also be given (if possible) to service/skills capacity and the extent of contracted service coverage (e.g., regular or infrequent visiting service contractors).

2.4 Themes

- Re: sustained growth: This is a crucial focus for the Study and SARRAH would encourage the Commission to consider not only the drivers of service and workforce demand (e.g., NDIS participant numbers and population ageing), but to also identify approaches and strategies that could ameliorate the extent and cost of that demand (sustainability), while improving the wellbeing and independence of the population. For example:
- The NDIS as an insurance scheme was designed and costed on a basis that included assumptions about the efficacy of therapeutic and other services that would aid independent living, increase skills and capacity to participate and earn income and/or otherwise maintain independence and capacity for longer;
- Similar strategies should underpin healthy ageing policies and programs; workplace rehabilitation programs; childhood development programs etc.
- It is important that the impact of access and investment in effective therapies, equipment are factored into longer-term cost-benefit assessments /analysis, especially given the timeframe to 2050 and to need to develop a workforce e plan that contributes to optimal human outcomes while putting downward pressure on longer-term, avoidable costs.

Again, SARRAH welcomes the approach of taking a holistic view across sectors in considering the workforce implications.

The Challenges and Opportunities section (page 7) identified the key issues clearly and well.