Position Paper

Models of Allied Health Care in Rural and Remote Australia

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Contents

Executive Summary ................................................................................................................................. 3
About SARRAH ........................................................................................................................................ 4
Background to Paper .............................................................................................................................. 5
Models of Care – Definition ................................................................................................................... 6
Principles for Effective Models of Allied Health Care in Rural and Remote Areas ....................... 7
Current Models of Allied Health Care in Rural and Remote Areas .................................................. 8
  Private allied health practices ............................................................................................................ 8
  Sessional employment of private practitioners by a third party .................................................... 9
  Centralised rural multi-disciplinary primary health team ............................................................... 10
  Local community multi-disciplinary primary health team ............................................................ 10
  Disease specific health units ........................................................................................................... 11
  Specialist outreach services .......................................................................................................... 11
  Telehealth as a model of care ......................................................................................................... 12
  Delegated models of care .............................................................................................................. 13
  Hospital services ............................................................................................................................ 14
  Education Services ......................................................................................................................... 14
Conclusion ............................................................................................................................................ 15
Appendix A: Guiding Statements for Achieving Effective Models of Allied Health Care .......... 16
Executive Summary

In contemporary Australia access to the services of Allied Health Professionals (AHPs) for many rural and remote residents remains limited compared to services available for people in the major cities and regional towns\(^1\). Rural and remote communities may have little knowledge of the contribution allied health services make to improving health outcomes. People who live in rural and remote areas exhibit higher rates of chronic disease and hospitalizations and lower life expectancies compared to their urban counterparts\(^2,3\). Limited access to allied health services exacerbates the poorer health outcomes experienced by rural and remote Australians.

Services for Australian Rural and Remote Allied Health (SARRAH) has prepared this position paper to demystify rural and remote allied health services for interested stakeholders, increase understanding of current models and identify how they might be further developed to improve health outcomes in rural Australia.

Despite the scarcity of services, there are a variety of ways in which AHPs provide services to rural and remote Australians. This paper provides greater insight into the models of care used by rural and remote AHPs to deliver their services. The paper also critiques these models against a set of principles SARRAH has developed as a guide to further developing models of allied health care for rural and remote areas.

SARRAH has broadly identified 10 models of allied health care used in rural and remote areas, as follows:

1. Private allied health practices;
2. Sessional employment of private practitioners by a third party;
3. Centralised rural multi-disciplinary primary health team;
4. Local community multi-disciplinary primary health team;
5. Disease specific health units;
6. Specialist outreach services;
7. Telehealth as a model of care;
8. Delegated models of care;
9. Hospital services; and
10. Education services.


SARRAH has also developed a set of principles that should underpin the development and application of models of allied health care.

- Consumer focused care;
- Equity in allied health service provision;
- Best practice evidence-based service delivery;
- High professional standards and development;
- Illness prevention and health promotion;
- Integrated multi-disciplinary care;
- Effective management and health planning;
- Inter-sectoral collaboration; and
- Timely and strategic reporting.

Well-planned, coordinated and supported models of allied health care are required to meet the needs of rural and remote communities. SARRAH believes that future health policy should incorporate increased access to allied health services for rural and remote Australians, through further development of models of care that incorporate the principles identified in this paper.

**About SARRAH**

SARRAH is nationally recognised as the peak multi-disciplinary body representing rural and remote AHPs working in the public, private and non-government sectors.

SARRAH exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being. SARRAH also supports AHPs who live and work in rural and remote areas of Australia to confidently and competently carry out their professional duties in providing a variety of health services to people who reside in the bush.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health services are basic and fundamental to Australians’ health care and wellbeing.

SARRAH’s representation comes from a range of allied health professions including but not limited to: Audiology, Audiometry, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology. These AHPs provide a range of assessment, treatment and prevention services for individuals who live in rural and remote Australian communities. AHPs are critical in the management of their clients’ health needs, particularly those with chronic disease and complex care needs.

AHPs work across the health care continuum and they have significant roles in the health care and health education sectors. AHPs, particularly in rural and remote areas, are required to adapt to workforce shortages and are well versed in the interdisciplinary and team approach to health care, especially for management of chronic disease and to improve health behaviour.
Background to Paper

The highest density of health professionals in Australia is found in the major cities close to the centres of professional learning and support, and where there are most opportunities for secure employment (with the exception of Aboriginal Health Workers). As a consequence urban Australians experience better access to AHPs compared to those who live in rural and remote areas. The number of allied health professionals per capita decreases with increasing remoteness. Reduced access to AHPs and the consequent reduced access to allied health services, creates inequities in health care for people who live in rural and remote areas.

Fig 1. Registered AHPS by geographical area in 2013 based on FTE rates per 100,000 of population.

The scarcity of AHPs in rural and remote areas means that many stakeholders - clients, community leaders, employers, policy officers and service agencies - may have little knowledge of the various allied health professions. There is a lack of knowledge about the skills and qualifications of different professions, their relevance for rural populations, and in what capacities they may be employed and utilised to improve health outcomes.

This paper seeks to provide information and insight for all stakeholders into the context of allied health services in rural Australia through a description of current service delivery models. The paper also identifies the extent to which these models of care are also applicable in remote areas. The paper goes further and provides a critique of these models against a set of principles to guide appropriate model development. Increasing understanding in models of allied health care amongst

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stakeholders will support stronger advocacy for improved services and more opportunities for innovative service development in the future.

Models of Care – Definition

A paper of this nature runs into difficulties if it doesn’t clearly define its central term, ‘models of care’. ‘Models of care’ is a term that can be used to describe many and varied aspects of practice, to the point where considerable confusion can arise over what specifically the term ‘model’ is referring to. In addition, the terms ‘models of care’ and ‘models of service’ are sometimes used interchangeably. It is difficult to find a clear definition of ‘model of care’ or ‘model of service in the literature.

Davidson describes great ambiguity, with the term being used variously to describe a philosophy of care, a paradigm, framework, or theory of health care practice⁵. In 2000, Queensland Health defined a model of care as a multifaceted concept broadly defining the way health services are delivered⁶. In 2004 the Waikato Health Board in New Zealand suggested that a model of care outlines best practice patient care delivery through the application of a set of service principles across identified clinical streams and patient flow continuums⁷.

Davidson defines a model of care as:

“…… an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, established best practice and defined standards. It consists of defined core elements and principles and has a framework that provides the structure for the implementation and subsequent evaluation of care”.⁸

Having a clearly defined and articulated model of care, Davidson asserts will help to ensure that all health professionals are actually working toward a common set of goals and are able to evaluate performance on an agreed basis.

For the purposes of this paper, and with reference to the work of Patricia Davidson and others, a model of allied health care means:

The distinct arrangement of service delivery which an allied health profession or professions adhere to and which is recognisable through an articulated philosophy underpinning the service, a set of overarching principles, and defined core elements that distinguish one particular method of service delivery from others at work in the system. A model of care is more than the individual modalities and technologies it uses to implement its service delivery.

Principles for Effective Models of Allied Health Care in Rural and Remote Areas

SARRAH believes the following are important principles that should underpin the development and implementation of all models of allied health care in rural and remote areas.

- **Consumer focused care**: Models of allied health care should develop out of substantive community engagement and consultation and must prioritise the needs of rural and remote clients.

- **Equity in allied health service provision**: Rural and remote models of allied health care should work towards equitable workforce levels comparable with Australian cities, even if the specific modalities of care may differ to those in the cities.

- **Best practice evidence-based service delivery**: Rural and remote models of allied health care should be based on the best available evidence of efficacy, and should continuously seek to monitor and improve the model on the basis of regular review and evaluation.

- **High professional standards and development**: All rural and remote models of allied health care should aim for high professional standards, optimal clinical practice through the provision of appropriate professional development, and support and career opportunities for the workforce.

- **Illness prevention and health promotion**: Rural and remote models of allied health care should have the prevention of illness, the promotion of good health, and the maintenance of independent living at the core of their activities in addition to quality assessment and treatment.

- **Integrated multi-disciplinary care**: Rural and remote models of allied health care should exhibit good communication between the different AHPs involved in care. They should also commit to high quality teamwork with other members of the health team, including medical officers, nurses and Aboriginal health workers.

- **Effective management and health planning**: Although models of care should prioritise client and community care, truly effective health services must also have effective management and planning capacities to meet health challenges with innovative practice to get the best out of the workforce employed for the task.

- **Inter-sectoral collaboration**: Allied health practice should acknowledge and engage the sectors outside health care which have an impact on health outcomes of allied health clients, such as education, employment, transport and local government sectors, as well as link effectively with other elements within the health system.

- **Timely and Strategic reporting**: Effective models of care should measure the effects of what they do, and report these outcomes to the communities being served and to other interested stakeholders. This process has the potential to engage communities in the constant task of improving services and finding new and better ways to meet community needs for health care.
Current Models of Allied Health Care in Rural and Remote Areas

The broad working models of allied health care at play in rural Australia have been summarised and critiqued against the SARRAH principles for effective model development.

Private allied health practices

Current Environment:
There are relatively few private allied health practices in rural Australia compared to urban contexts. Numbers decrease with remoteness as businesses struggle to be financially viable due to the widely dispersed client base, and the physical and time costs of travel for the practitioner and/or clients. Often rural and remote clients have limited capacity to pay for private health care which is not covered by Medicare, and private health insurance coverage is lower in rural and remote areas than in metropolitan Australia. This model of care is also influenced by other financial requirements of small business.

Best Practice Models:

- The best rural private practices use the principles of consumer focussed care, evidenced-based care, health promotion, multi-disciplinary teamwork, and inter-sectoral collaboration in their efforts to provide high quality care to their clients;
- There is very little capacity to monitor efforts amongst private practitioners in areas beyond the quality of clinical care; and
- Privately practicing AHPs are not always rewarded for efforts to integrate these principles, and may suffer financial disadvantage for undertaking additional activities, for example, advocating for a client to receive access to additional services from another provider.

SARRAH supports the expansion of private practice allied health capacity to meet community needs in rural and remote areas. This requires:

- Government reforms to increase funding for consumers to access allied health services;
- Ongoing reform to the Medicare system to include MBS items for allied health services which reflects evidence based clinical best practice;
- Measures that support the ability of private practices to address the broader principles of beyond the medical model of clinical care, such as health promotion and multi-disciplinary team based care, and inter-sectoral engagement; and
- Significant reform of current funding arrangements to increase the number of private allied health practices in rural Australia.
Sessional employment of private practitioners by a third party

Current Environment:
In rural and remote areas government agencies, private businesses (e.g. mining companies), Primary Health Networks, or a not-for-profit organisation (e.g. Aboriginal community controlled health organisation) employ AHPs on a sessional basis. The AHP may be based in the local district or community being serviced, or may visit the district or community to provide services.

For remote areas these services are often delivered on an outreach basis, that is, fly-in-fly-out or drive-in-drive-out arrangements. This reflects a medical model of care in which clinical care is predominant.

Where the AHP is not based in the local district being serviced, they may have limited opportunity to gain sufficient knowledge of the client and their community in order to provide the best informed care. As the employment arrangement is sessional, the employer may provide less professional development resources to support appropriate professional standards of practice.

Best Practice Models:

- The duties of the AHP go beyond clinical assessment and treatment and are inclusive of the important principles of consumer focus, health promotion, inter-agency communication, and effective reporting of the service;
- Consideration is given to governance inclusive of appropriate credentialing and defining scope of practice;
- The funding structure for the AHP enables the implementation of the principles described above, and go beyond payment for direct clinical care; and
- The visiting AHP is familiarised with the local community health team and is supported to fully communicate with, and be fully informed by, this local team in relation to their clients.

SARRAH supports the sessional employment of AHPs in rural and remote areas as a means of ensuring allied health services are available and recognises it is an alternative to traditional employment models for AHPs. However SARRAH urges:

- Priority be given to recruiting and engaging AHPs who are already local residents of these regions. Local knowledge and connection to communities helps avoid a number of service delivery pitfalls; and
- Where this model is used under the National Disability Insurance Scheme, AHPs should be given appropriate funded opportunities to develop an understanding of the communities in which their clients reside, including the local service agencies, and the formal and informal support mechanisms within the community.
Centralised rural multi-disciplinary primary health team

Current Environment:
AHPs working in centralised rural multi-disciplinary primary health teams are usually working from a regional centre on an outreach basis within a state government funded service. They make regular visits to their clients and have capacity for community engagement within the communities they service across the region. Their core practice philosophies tend to centre on primary health care and population health, but may also have a strong medical model influence and clinical dominance. The teams include medical staff, nurses, Aboriginal Health Workers and other AHPs.

Best Practice Models:
- Given AHPs in this model are embedded in a multi-disciplinary team, there is greater amenity within this model to deliver on the key principles for models of care beyond assessment and treatment; and
- AHPs engage in client case conferencing, community health planning, and broader public health discussions of relevance to their client base.

SARRAH supports such models of multi-disciplinary outreach practice as a coherent model to meet consumer needs in a coordinated manner. This requires:
- An adequate range of AHPs included in the team to meet population needs; and
- Capacity for a suitably regular, and frequent visiting schedule.

Local community multi-disciplinary primary health team

Current Environment:
These are locally based teams within individual rural communities or in major towns across remote regions, and are usually services delivered within state health systems. These services tend to be built around nursing professionals, aged care, and other program teams with elements of a voluntary work-force.

There is limited support to build the allied health component within these community health teams, however, they can be inclusive of some allied health positions such as physiotherapy, nutrition or psychology. Included in this model of care are virtual teams where the local private practitioners, GP and AHP are informally but effectively linked with the government service for well-coordinated service provision.

Best Practice Models:
- State health systems support and invest in the allied health component of these teams, building the rural and remote allied health workforce with flow on benefits for other models of allied health care;
- The philosophy and approach of these teams moves beyond the medical model to include population health and primary health care principles; and
• These teams link with other supports in metropolitan areas such as specialist care and the hospital sector.

**SARRAH supports** the establishment and maintenance of such teams wherever possible to build coordinated teams of health professionals as close to rural residents as possible.

### Disease specific health units

**Current Environment:**
AHPs working in rural and remote areas may be employed within multi-disciplinary teams with a single health focus; for example, diabetes, heart disease, ear, or eye health. Aged care may also be considered in this category. These teams may be employed by Commonwealth, state health agencies, or non-government not-for-profit organisations.

**Best Practice Models:**
- Their philosophical base may be singular and defined as selective primary health care, but at their best may take a comprehensive primary health care approach and link effectively with other elements of the health care system;
- They have defined priorities and goals, deliver services which are based on evidence and embed research and evaluation into service delivery; and
- These units commit to the highest possible standards of professional service from their allied health staff, including actively investing in the continuous professional development of their staff.

**SARRAH supports** such models of care which offer specialist allied health and other health professional services to rural and remote Australians. To achieve this, the following is required:
- Investment in, and support of AHPs working in these units, particularly where they are the sole practitioners of their professions; and
- Effective integration with multi-disciplinary health teams and other agencies (including non-health) working in the same communities.

### Specialist outreach services

**Current Environment:**
AHPs with specific specialist skills in their particular disciplines maybe employed or contracted as specialist AHPs in outreach care for rural/remote clients. They may join multi-disciplinary outreach teams of specialists inclusive of medical and specialist nursing staff. The philosophies underpinning these teams have a strong basis in the medical model, but many also have a multi-disciplinary team focus.
Telehealth may increase communication and collaboration between specialists, their rural and remote clients, and the local health practitioners or service organisations delivering day-to-day services in these locations. In this case the telehealth resource is an additional and highly relevant modality for utilisation by the outreach service - it is not a model of care in and of itself.

**Best Practice models:**

- Specialist services are well integrated with local health care teams;
- They take advice from local health professionals and service providers about the best way to deliver their services for the local context; and
- The specialist AHPs also provide training and support to local health workers in their areas of expertise.

**SARRAH believes** such specialist outreach teams are vital services for rural and remote Australians, and are important resources for locally based health care services as well.

**Telehealth as a model of care**

**Current Environment:**
Telehealth is a pivotal new initiative in improving care for rural and remote Australians and one with enormous potential to improve health care efficiencies in the non-urban context. Telehealth involves the delivery of health services via information and communication technologies when the health consumer, and the health service provider, are not in the same location and where the interaction may not be in real time.

There is work currently underway in Queensland and other jurisdictions, on a model of care that is built around the use of telehealth by urban specialists, but in a situation where a local practitioner or allied health assistant trained in telehealth is in attendance, with the client at the other end of the line. This could be called a supported model of telehealth and clearly has great potential. A study undertaken for Feros Australia on the North Coast of NSW\(^9\) has established the benefits of regular use of telehealth for monitoring clients’ clinical conditions in an area of good NBN coverage.

**Best practice models:**

- Telehealth should not be used as a substitute for the provision of face-to-face health care by a health professional to the health consumer. If direct interaction is available, or better health outcomes would be achieved by face to face contact between the health professional and health consumer, then this is the preferred health service delivery model;

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• It will always be fundamental in the practitioner-client relationship that there is an opportunity for face-to-face contact and engagement between the two in some stages of the service delivery; and

• In the case of urban AHP specialists and the use of telehealth, it is critical that rural health practitioners local to clients are also involved at some point in telehealth consultations to ensure information and advice is effectively passed on and received. This is particularly the case where the urban specialist never gets the opportunity to meet with the client in his/her home environment.

SARRAH believes the application of telehealth should be seen as a modality within a broader model of care, given that clients would still on occasions need to visit their GP for effective comprehensive assessment and care. SARRAH also believes it will always be fundamental in the practitioner-client relationship that there is an opportunity for face-to-face contact, and engagement between the two in some stages of the service delivery.

SARRAH has some concern that a poorly conceived vision for telehealth will see positions for rural and remote health professionals sacrificed for a cheaper reliance on the telehealth modality between the city and bush - this would be an inappropriate application of the modality.

Delegated models of care

Current Environment:
In a similar vein to potential telehealth models, delegated models of allied health care are increasingly being considered or trialled for application in rural and remote areas. The focus of this model is the use of allied health assistants, or other members of the local primary health care team, taking on the central hands-on role for the allied health care, whilst the supervising AHPs remain at arm’s length from the day-to-day practice. In this model the AHP role is to train, support, and advise the core practitioner, and the allied health assistant.

Best Practice models:
• Appropriate levels of training and support are provided to the assistant by a professionally qualified practitioner;

• The allied health assistant has a clearly defined scope of practice; and

• The model of care needs to be well integrated with the broader work of local primary health care teams.

SARRAH believes such innovative practice are an important option to ensure many rural and remote clients receive at least some level of regular and accessible allied health care to meet their needs. However, such an approach should not limit the expansion of allied health services provided by AHPs to rural and remote populations.
Hospital services

Current Environment:
Most rural/regional locations around the country have at least one district hospital, and some have major base hospitals as well. AHPs are employed in some of the small hospitals, and are a major presence in all regional base hospitals. The philosophies underpinning hospital models tend to be based on a medical hierarchy of care, and then drill down to multi-disciplinary acute and chronic care at the level of hospital wards. Hospital-employed AHPs have pivotal roles to play in transitional care, in terms of avoiding unnecessary hospitalisations via outpatient care, and contributing to effective discharge planning arrangements for people returning to their community.

Best Practice models:
- Best practice hospital models adopt a continuous learning and best practice work environment, acknowledge AHPs as key resources, and support these AHPs with effective professional development and career opportunities; and
- Take a health promotion focus through effective articulation with community levels of primary health care.

SARRAH believes the strong engagement of AHPs in all hospital settings is needed to achieve effective acute and chronic care, more efficient use of hospital bed space, and better health outcomes for clients. In times of economic rationalisation, allied health staff are vulnerable to funding cuts. Cuts in allied health lead to more expenses at other levels of the health system in terms of poorer health outcomes, higher than necessary levels of disability, and greater need for re-hospitalisation 10.

Education Services

Current Environment:
Allied health service provision within the education system is exceptionally variable across all states and territories, with some jurisdictions directly employing AHPs, such as speech pathologists, occupational therapists and psychologists. In addition, some universities are working in partnership with schools whereby student AHPs provide assessment and therapy services with clinical supervision. Increasingly, due primarily to funding limitations, service delivery models are limited to an assessment and recommendation process, with limited therapy conducted by the AHP.

Best Practice models:
The ‘Response to Intervention’ model is being utilised by the Queensland and Northern Territory Education Departments, and operates on a tiered intervention approach. This model supports

inclusive practice and provides more scope for children requiring intensive therapy to receive it, whilst other students with less significant needs are accommodated through evidence based inclusive teaching practices and targeted planning and programming. South Australia has moved to an integrated health/education speech pathology model, and AHPs are also working out of Children’s Centres in multidisciplinary teams.

**SARRAH supports** the employment of multidisciplinary AHP teams within educational services using service delivery models such as the Response to Intervention model. Allied health care within educational services should promote universal access, capacity building, and provide direct intervention for the students who require it. Such a model lends itself to effective utilisation of the principles of service equity, best practice multi-disciplinary care, and inter-sectoral engagement on health promotion in schools.

**Conclusion**

By identifying and describing the broad models of care by which AHPs currently deliver their services to rural and remote Australians, this paper will increase understanding of the allied health domain for many stakeholders. Through articulating best practice features of these models, it will also assist the further development of allied health services. SARRAH strongly urges all services implementing models of allied health care to apply the principles contained in this paper for quality rural and remote allied health care.
Appendix A: Guiding Statements for Achieving Effective Models of Allied Health Care

SARRAH holds the following broad positions in relation to models of care and effective practice in rural and remote Australia:

- SARRAH promotes models of allied health care that reflect as many as possible of the nine SARRAH principles.

- SARRAH strongly urges Primary Health Care reform that supports better access for rural clients to AHPs on the basis of evidence of efficacy of AHP practice. Such reform would build rural service capacity through enhanced funding potential for private allied health businesses and sessional employment of AHPs in the not-for profit-sector.

- SARRAH supports the expansion of private practice allied health capacity to meet community needs in rural and remote areas. This requires:
  - Government reforms to increase funding for consumers to access allied health services;
  - Ongoing reform to the Medicare system to include MBS items for allied health services which reflects evidence based clinical best practice;
  - Measures that support the ability of private practices to address the broader principles of beyond the medical model of clinical care, such as health promotion and multi-disciplinary team based care, and inter-sectoral engagement; and
  - Significant reform of current funding arrangements to increase the number of private allied health practices in rural Australia.

- SARRAH supports the sessional employment of AHPs in rural and remote areas as a means of ensuring allied health services are available and recognises it is an alternative to traditional employment models for AHPs. SARRAH urges:
  - Priority be given to recruiting and engaging AHPs who are already local residents of these regions. Local knowledge and connection to communities helps avoid a number of service delivery pitfalls; and
  - Where this model is used under the National Disability Insurance Scheme, AHPs should be given appropriate funded opportunities to develop an understanding of the communities in which their clients reside, including the local service agencies, and the formal and informal support mechanisms within the community.

- SARRAH supports such models of multi-disciplinary outreach practice as a coherent model to meet consumer needs in a coordinated manner. This requires an adequate range of AHPs.
included in the team to meet population needs; and capacity for a suitably regular, and frequent visiting schedule.

- SARRAH supports the establishment and maintenance of such teams wherever possible to build coordinated teams of health professionals as close to rural residents as possible.

- SARRAH supports such models of care which offer specialist allied health and other health professional services to rural and remote Australians. This requires investment in, and support of AHPs working in these units, particularly where they are the sole practitioners of their professions. It also requires effective integration with multi-disciplinary health teams and other agencies (including non-health) working in the same communities.

- SARRAH believes specialist outreach teams are vital services for rural and remote Australians, and are important resources for locally based health care services as well.

- SARRAH believes the application of telehealth should be seen as a modality within a broader model of care, given that clients would still on occasions need to visit their GP for effective comprehensive assessment and care. SARRAH also believes it will always be fundamental in the practitioner-client relationship that there is an opportunity for face-to-face contact, and engagement between the two in some stages of the service delivery.
  - SARRAH has some concern that a poorly conceived vision for telehealth will see positions for rural and remote health professionals sacrificed for a cheaper reliance on the telehealth modality between the city and bush - this would be an inappropriate application of the modality.

- SARRAH believes innovative practice such as delegated models of care are an important option to ensure many rural and remote clients receive at least some level of regular and accessible allied health care to meet their needs. However, such an approach should not limit the expansion of allied health services provided by AHPs to rural and remote populations.

- SARRAH believes the strong engagement of AHPs in all hospital settings is needed to achieve effective acute and chronic care, more efficient use of hospital bed space, and better health outcomes for clients. In times of economic rationalisation, allied health staff are vulnerable to funding cuts. Cuts in allied health lead to more expenses at other levels of the health system in terms of poorer health outcomes, higher than necessary levels of disability, and greater need for re-hospitalisation.

- SARRAH supports the employment of multidisciplinary AHP teams within educational services using service delivery models such as the Response to Intervention model. Allied health care within educational services should promote universal access, capacity building, and provide direct intervention for the students who require it. Such a model lends itself to effective utilisation of the principles of service equity, best practice multi-disciplinary care, and inter-sectoral engagement on health promotion in schools.