SARRAH
Services for Australian Rural and Remote Allied Health

28 January 2022

The Hon. Michael Sukkar MP
Assistant Treasurer
Minister for Housing
Minister for Homelessness, Social and Community Housing

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Services for Australian Rural and Remote Allied Health (SARRAH)
2022-23 Pre-Budget Submission

Dear Assistant Treasurer,

Thank you for the opportunity to contribute to preparations for the 2022-23 Australian Government Budget. We note in calling for submissions the Government emphasises the continuing priorities of job creation, guaranteeing essential services and building a more secure and resilient Australia. The proposals SARRAH puts forward in this submission will contribute directly to each of those objectives.

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 health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by and as a network of rurally based allied health professionals and continues to advocate on behalf of regional, rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. 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.

Allied health practitioners (AHPs) are tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury among all age groups in primary health care and across all key health and associated sectors. Put simply, AHPs deliver care that have profound impacts on the quality of peoples' lives.

However, allied health workforce shortages in regional, rural and remote Australia are severe and longstanding. This directly impacts the level of access people have to essential services (in health, aged care, disability services, veterans' services, child development and more), and contributes to poorer health outcomes, life trajectories and outcomes. These are avoidable. Improving access to these services would reduce pressure on major cost drivers that are subsequently borne by the community, such as potentially preventable hospitalisations and the premature loss of workforce capacity and financial independence.

The 2022-23 Commonwealth Budget is an opportunity to improve access to crucial allied health services in the portfolio areas of Health, Aged Care and Social Services especially. Cost effective investment to increase service access and sustain delivery capacity in rural and remote Australia are both achievable and affordable.

The proposed initiatives address chronic workforce and service issues and would improve access to vital and effective allied health care in health, aged care, disability and other services in rural Australia.

Resilient rural industries, communities and people are central to our national prosperity. They, in turn, depend on services that support their health, well-being, engagement capacity and productivity. Allied health services play a fundamental role in preventing, diagnosing, providing therapeutic and rehabilitative treatment and management for people in terms of illness, disability and disease – but are in chronic short supply in rural and remote Australia.

The 2022-23 SARRAH Budget Submission:

- ✓ Targets areas of chronic skills shortage and projected demand and jobs growth in rural and remote Australia;
- ✓ Promotes small business development, sustainability and employment potential;
- ✓ Improves access to services that support health and wellbeing, independence and capacity.

These factors will strengthen communities and support Government's medium to long-term fiscal objectives. Critically, these measures will improve our capacity to continue to deal with the challenges of COVID and preparedness for similar events in the future.

SARRAHs Submission focuses on capacity-building through measures that recognise and work with the specific context and service realities of rural Australia. They are modest, practical and designed to contribute to immediate practice-level service challenges and bolster local capacity development long-term.

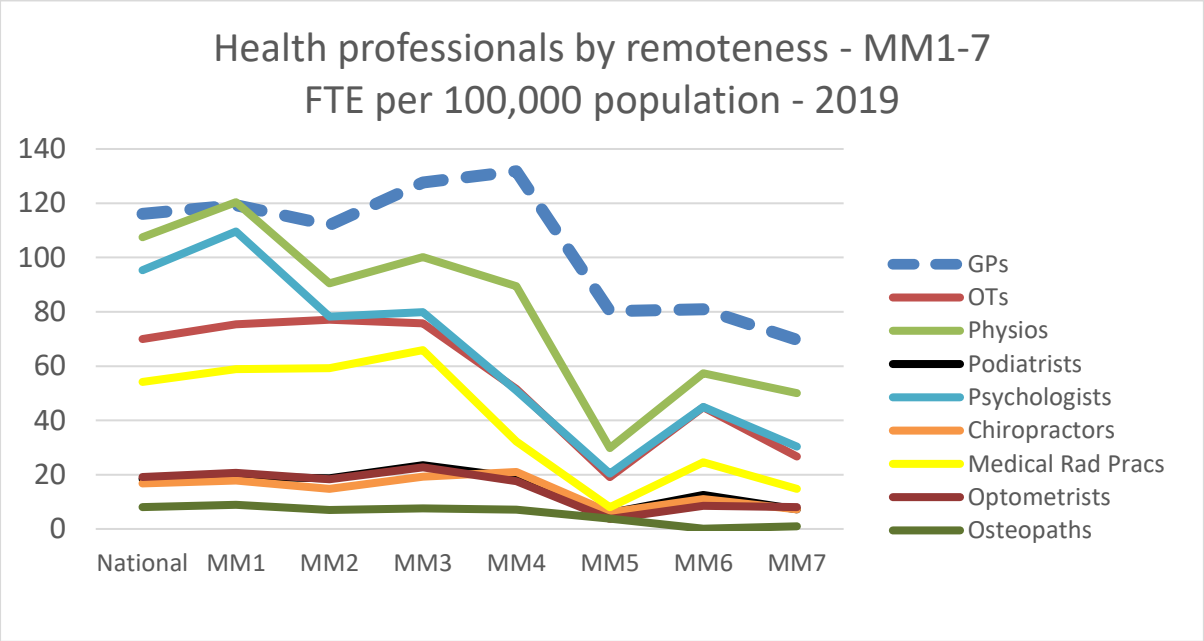
These measures would primarily address needs in the Health, Aged Care and Social Services (NDIS) portfolios, with significant benefits and/or implications for the Education, Skills and Employment and Home Affairs (skilled migration) portfolio areas.

Context: chronic workforce and service shortages and mal-distribution

Rural communities continue to experience a higher prevalence of chronic and other disease, potentially preventable hospitalisations and associated workforce and service shortages. The mal-distribution of AHPs (and associated workforce shortages) in rural and remote Australia are about twice as severe as for medical practitioners with numbers dropping sharply on a per head of population basis with increasing rurality/remoteness.

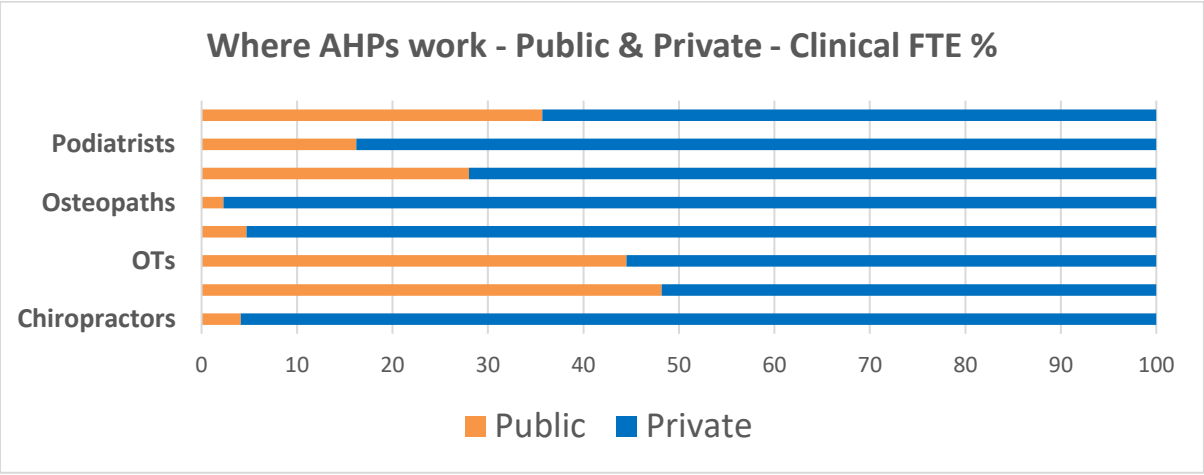
The following graph shows workforce distribution by remoteness (where MMM1 is inner metropolitan and MMM7 is very remote) for a selection of AHPS, compared with GPs. (Source: Department of Health[1])

[1] https://hwd.health.gov.au/



Compounding access issues, health professionals working in remote and very remote settings contend with the challenges of delivering care to a given population that may be spread over an area the size of Victoria, compared with a few square kilometres in a major city: this greatly amplifies the challenges of access for rural and remote residents and effective service delivery. The extent of allied health mal-distribution is also evident in information held on the Department of Health's website.

SARRAH is frequently (and increasingly) contacted by allied health providers from across the country experiencing a crisis in workforce recruitment and retention, with some struggling with vacancy rates of up to 50% of their allied health workforce teams. They often provide services across a variety of settings - from health, disability to aged and community care, even local government, and are seeking advice and support about how to attract and retain allied health professionals in rural locations. Sustainable and community-oriented allied health service provision in rural settings often means providing broadly based, more 'generalist' services to meet the needs of the community.



Source: https://hwd.health.gov.au/resources/publications/factsheet-alld-2019.html

It is imperative that policy and service responses recognise that AHP practice in rural and remote communities frequently involves working across multiple service systems and settings. It is important that the Commonwealth also develops allied health workforce and support structures that more accurately reflect the fact that most AHPs work in areas where the Commonwealth has primary policy and/or regulatory responsibility. The following graph illustrates the point.

Demand is growing

Existing AHP shortages are evident across health, aged care and disability services (notably the NDIS)[2]. For example, increasing and unmet demand from the National Disability Insurance Scheme have been building for years. Preliminary data analysis and anecdotal advice from multiple sources indicate the situation is worsening as service demand in metropolitan centres and the impact of COVID appears to be exacerbating workforce attraction and retention in rural communities.

The National Skills Commission projects the Health and Social Assistance sector will continue to lead employment growth until at least 2025 (and given trends, beyond that). Within this sector, AHPs have among the highest growth demand. With critical workforce shortages now, this level of demand will not be met without deliberate and sustained commitment to workforce development and distribution – with the impacts felt most in rural and remote Australia.

SARRAH proposals for the 2022-23 Budget

Service models and initiatives designed with and for rural and regional communities, which leverage and contribute to local strengths and capacity, are needed to better meet the current and emerging needs and circumstances of rural and remote communities. SARRAH has four specific proposals.

1. ***Further expand the Allied Health Rural Generalist Pathway (AHRGP) and associated Allied Health Assistant (AHA) places, building on the 2021-22 Budget commitment of 90 AHP places and 30 AHA places over 3 years.***

The Government's decision to support the expansion of the AHRGP into the private and community settings as part of the 2021-22 Budget has been well received by the sector, with strong demand for available places.

- The extent of AHP workforce shortages in rural and remote Australia equates to many thousands of professionals.
- Building on previous work, the Program is well established. Demand is high and increasing across various settings and locations nationally. We expect it to be over-subscribed quickly, even without substantial promotion.
- Community need and demand would readily support a major increase in the program, with double or triple the current numbers feasible for intakes commencing January 2023 onwards.
- The expansion of the program would have demonstrable benefits and service access across health, Aged Care and the NDIS, among others.

[2] The evidence is documented in numerous official reports including by the National Rural Health Commissioner, in NDIA utilisation data and reports of the Australian Parliament Joint Standing Committee on the NDIS and in the report of the Aged Care Royal Commission, among others.

2. Develop a governance framework for AHPs working with AHAs.

Allied Health Assistants are a growing and important, workforce with specific skills and capacity (when working with and under the direction of AHPs, including remotely) to deliver enabling and therapeutic care that increases the access, reach, continuity and sustainability of allied health services into rural and remote communities. High quality, proven clinical governance and working arrangements already exist in many public health settings and across a range of AH professions. Similar models are working effectively in many private and community-based settings. Many SARRAH members have developed and/or adopted effective service models working with AHA, expanding their service reach into aged care, rehabilitation, NDIS, school and other settings, often where AH services were not previously available.

- AHAs have skills that can be applied flexibly across settings (health, aged care and NDIS) and may develop skillsets that enable them to work with more than one AHP discipline.
- AHAs are VET trained and, provided training capacity and access is available, enables substantial development of local AH service capacity across rural communities.

Despite these developments many AHPs have been hesitant to incorporate AHAs into their service models due to concerns about their capacity to supervise, the implications for insurance etc. Some of these concerns are being fuelled by the lack of accurate and comprehensive information, confusing insurance conditions by some providers.

SARRAH has addressed these issues with participants in expanding the AHRGP (noted above). There is a clear need for the AH sector (around 220,000 practitioners nationally) to have access to a coherent and facilitative governance framework developed to enable and support AHPs and AHAs to work together effectively and safely in delivering services under the direction of the qualified AHP.

3. Facilitate and support the growth and registration of overseas trained allied health professionals to gain registration to practice fully in (rural) Australia

Successive Australian Governments have drawn on overseas trained doctors to help ameliorate medical workforce shortages in rural and remote Australia.

Despite severe and chronic AHP workforce shortages (described above) no similar program of support has been available to enable AHP immigration, with supported supervision to enable registration to practice in Australia.

Current and worsening workforce shortages indicate Australia could develop and introduce such a program to help address workforce and service shortfalls in the short to medium term at least. The timeframes involved in educating and preparing students for practice mean even a concerted and targeted injection of additional rurally oriented AHP domestic students would not be available to significantly impact service demand in the short-medium term.

At present, rural AHPs can spend tens of thousands of dollars and engage in protracted migration processes attempting to bring in prospective candidates. These costs are often borne by the practitioner / employer without a result.

SARRAH proposes a process be developed to:

- Expedite visa assessment for overseas trained AHPs with professional skills identified on identified on the Skilled Occupations List – prioritising sponsors who are AHPs providing services in an area of workforce need (MMM3-7).
- A return of service obligation may be applied, however SARRAH suggests (based on the evidence of what is effective in attracting and retaining AHPs rurally) that tailored support systems for the supervisor and the OT AHP that enable their transition to / development in rural practice and increase service capacity, may deliver a greater retention outcome, especially if that support includes facilitated (post-Australian registration) access to the AHRGP (described above).

SARRAH notes the numerous visa classes potentially apply Skilled occupation list (homeaffairs.gov.au).

4. ***Update and upgrade the SARRAH Transition Toolkit to Rural and Remote Practice – heavily used resource, now outdated:***

The SARRAH Transition to Rural Practice Toolkit has been a heavily used resource available to early career and other health practitioners commencing or contemplating rural or remote practice. It has also been used extensively by AH students as well as university and other teachers to introduce and build understanding of and potential preparedness to undertake a career in rural health.

The Toolkit which was developed by SARRAH drawing on contributions of content experts in the field, including AH Academics, practitioners, researchers – generally SARRAH members – is in need of substantial content update, noting major developments (in health, aged care, NDIS etc) over recent years.

The Toolkit also needs to be adapted and re-developed to enable multimedia content and access via a range of devices, as used by rural and remote clinicians, students and other users.

Funding support to facilitate the revision, adaptation and development of new expert content, and for technical design, build and maintenance would represent a targeted investment in a proven quality resource, with national, multi-professional and multi-sector reach and relevance.

These initiatives will contribute directly to much needed improvement in AHP access and service capacity in rural and remote Australia. The impact of these initiatives would be further increased if they were introduced in conjunction with an urgent, strategic and resourced:

- A genuine, multi-disciplinary revised Stronger Rural Health Strategy – which includes a comprehensive response to the former NRHCs allied health report;
- Urgent increase in the priority and development of a comprehensive national allied health workforce dataset to support service planning and investment.

SARRAH recommends these initiatives as affordable, capacity building investments that are practical, targeted to areas of current and growing demand and which will contribute to community strength and resilience and put downward pressure on acute health and other services in the medium and long-term. They are urgent, responsive to community need and fiscally responsible.

Further, these initiatives are the necessary complement to other Commonwealth investments, such as the Rural Health Multidisciplinary Training program (RHMTP). Rural university study and clinical placements rely on rurally based practitioners to provide clinical service exposure, experience and future career supports. Increasing the RHMTP investment without supporting an increase in underpinning rural allied health service and workforce capacity is like building a two-legged stool.

SARRAH would welcome the opportunity to elaborate on these proposals or otherwise assist to build the health, capacity and resilience of rural and remote communities. Further information about SARRAH and the work we do is available on our website. If you would like to discuss any of the matters raised in this submission please contact me by email at catherine@sarrah.org.au or call me on 0491 209 291.

Yours sincerely,

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Chief Executive Officer