SARRAH

Services for Australian Rural and Remote Allied Health

Professor Mark Cormack
Unleashing the Potential of our Health Workforce
(Scope of practice review)
ScopeofPracticeReview@Health.gov.au

Dear Professor Cormack

Thank you for the opportunity to contribute to Unleashing the Potential of our Health Workforce - Scope of practice review.

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

SARRAH strongly supports the conduct of this comprehensive review of the health professions' scope of practice. The review documentation identifies the importance of a highly skilled health workforce in achieving the objectives of the Medicare Review Taskforce, that being to strengthen primary care by empowering coordinated teams of multidisciplinary health care professionals to work together to their full scope of practice. With this in mind, and in a context of rapidly evolving technological, demographic, international competition, environmental and other global factors, SARRAH strongly supports the ongoing review of Australia's contemporary and emerging health workforce, skills and productivity capability and supports the relevant government agencies being resourced to conduct this important work.

SARRAH's submission relates to the scope pf practice of the allied health workforce as it relates to rural and remote health service access, quality and distribution. We refer to the former National Rural Health Commissioner's comprehensive *Final report – Improvement of access, quality and distribution of allied health services in regional, rural and remote Australia* (June 2020) as a highly relevant document containing practical strategies for the Australian Government to make both immediate and long-term impacts on allied health services in rural communities. In its response (July 2021) the Government supported a number of key recommendations, notably to appoint a national Chief Allied Health Officer, and SARRAH continues to support the work of Dr Anne-marie Boxall and her team. The government also gave in-principle support to developing a national allied health data strategy and allied health minimum dataset, and SARRAH strongly supports progressing this recommendation as necessary to the development of a National Allied Health Workforce Strategy.

SARRAH'S KEY MESSAGES ARE:

- Aboriginal and Torres Strait Islander peoples, and those living in rural and remote communities, stand to benefit from health professionals working to their full scope of practice as a mechanism to increase access to primary healthcare services, and in particular, to culturally appropriate care.
- Implementing programs to support health professionals working in rural and remote areas to perform at top of scope assumes there is adequate supply of health workforce in the regions. Further work is needed to address workforce shortages in the allied health professions in rural and remote Australia to bolster the available health workforce.

- Robust governance measures are needed to ensure high quality and safety of services provided by health professionals working at the top of their scope. This includes every member of the multidisciplinary team having a clear understanding of other members' roles, and each member having access to appropriate supervision and support and ongoing professional development. In particular, small- and medium-sized service providers will require support to achieve this.
- The Allied Health Rural Generalist Pathway is an example of a best-practice enabler to facilitate health professionals working to top of scope. Additionally, consideration should be given to growing the allied health assistant workforce in a structured way as a means to increasing the capacity and reach of allied health professionals.
- Barriers to enabling health professionals working to full scope of practice include entrenched allied health workforce shortages in rural and remote areas; teaching and training of allied health professionals in primary care settings should be recognised and remunerated as it is for medical workforce; and addressing funding and regulatory barriers to enable health professionals to work across clinical settings in rural and remote areas.
- Enablers of health professionals working to top of scope include Rural Generalism; building the assistant workforce (including training health professionals regarding delegation of clinical tasks); examples of well-functioning block-funded services such as Aboriginal Community-Controlled Organisations; and enabling funding mechanisms that draw from multiple service settings (eg MBS, aged care, disability, veterans and insurance schemes).
- A National Allied Health Workforce Strategy is required to articulate the underpinning principles of clinical governance and scope of practice, as well as supporting the growth of the allied health workforce where it is most needed.

BENEFITS OF EXPANDED SCOPE OF PRACTICE

Who can benefit from health professionals working to their full scope of practice?

SARRAH is of the view that all stakeholders will benefit from health professionals working to full scope of practice. In particular, Aboriginal and Torres Strait Islander peoples, rural and remote Australians and other vulnerable populations and thin market sectors stand to benefit from the available workforce working in culturally safe and responsive ways and to top of scope.

How can these groups benefit? please provide references and any links to any literature or other evidence.

Health professionals working to full scope means that they are able to provide services to broader client populations and people with a wider range of health conditions. This in turn enables increased access to care.

The Australian Institute of Health and Welfare reports health workforce data demonstrating poorer access to care for people living in rural, remote and very remote communities, meaning they need to travel long distances or relocate to attend health services or receive specialised treatment (AIHW 2022c).

In 2016-2021 the clinical FTE per 100,000 population was lowest in small rural towns (MM5), for all health professionals (including GPs) except for pharmacists. (Department of Health and Aged Care 2022a) (Figure 8; Table S5).

ALLIED HEALTH WORKFORCE BY MMM

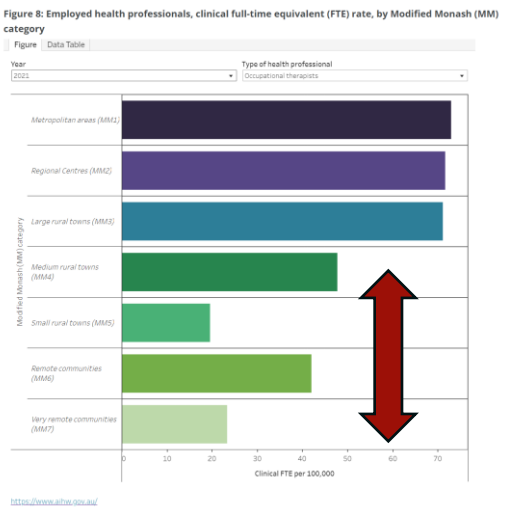

FIGURE 1: OT DISTRIBUTION BY MMM

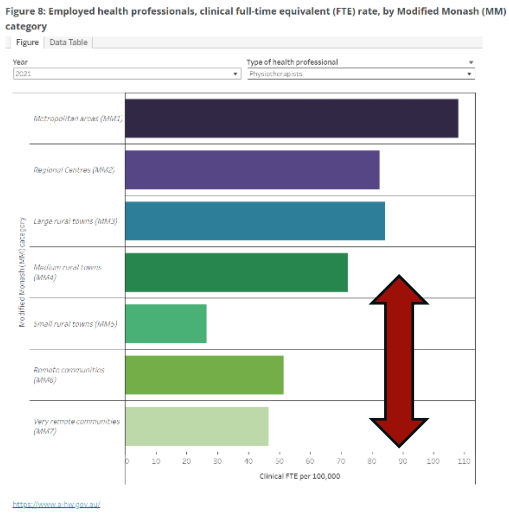

FIGURE 2: PHYSIOTHERAPIST DISTRIBUTION BY MMM

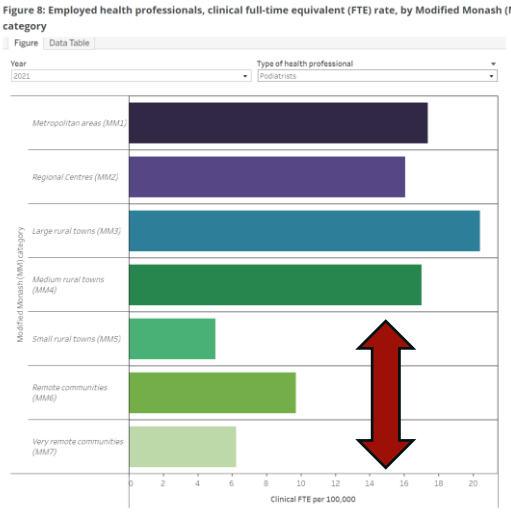

FIGURE 3: PODIATRIST DISTRIBUTION BY MMM

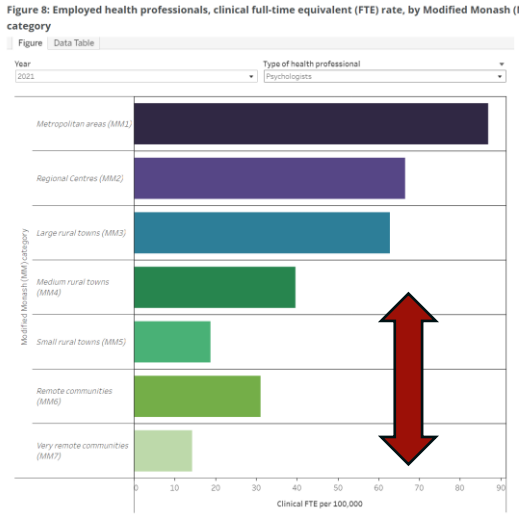

FIGURE 4: PSYCHOLOGIST DISTRIBUTION BY MMM

AIHW data demonstrate that the allied health workforce is unevenly distributed, with fewer health professionals per 100,000 population in rural, remote and very remote areas compared with metropolitan areas. This contrasts with data for GPs and nurses, which demonstrate far greater numbers per head of population, and a more even distribution across MM areas.

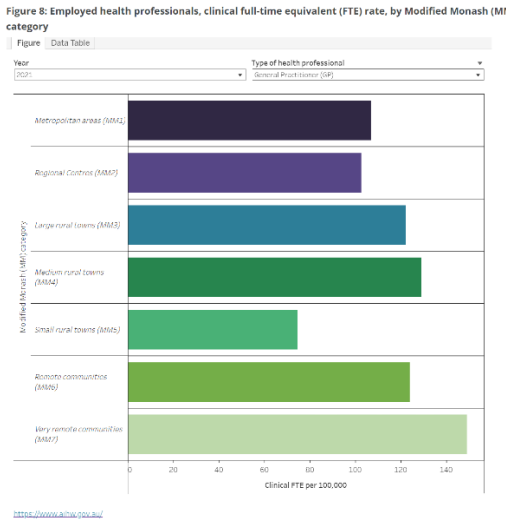

FIGURE 5: GP DISTRIBUTION BY MMM

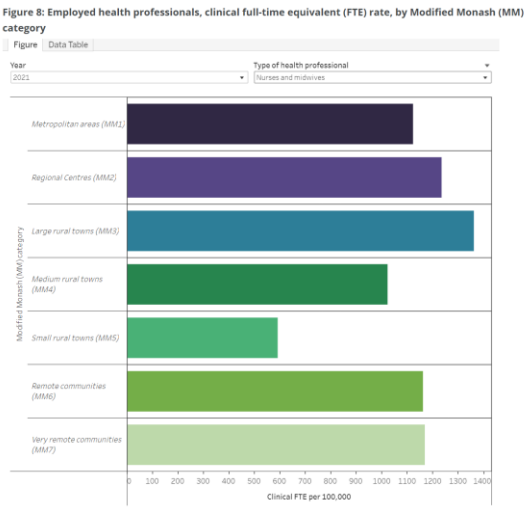

FIGURE 6: NURSING & MIDWIFERY DISTRIBUTION BY MMM

Example: The Podiatry workforce:

- The podiatry workforce has expanded substantially over the past decade, up from 3461 (2010-11) to 5783 (2020-21), an increase of 67%.
- In that period undergraduate student growth grew rapidly from 2010-11 to 2013-14 and has since declined steeply. This means that Podiatry is a relatively young workforce but will age as the rate of growth slows.
- Despite growth in numbers, the overwhelming majority of podiatrists continue to practice in MMM1:
    - The podiatry workforce is now more concentrated in the major capitals (MMM1) – disproportionately so on a population basis - than it was a decade ago:
        - In 2012 –75.6%
        - In 2020 - 82%
- Ahpra registration data shows 4386 registered podiatrists in 2014-15 and 5608 in 2019-20. **That is an overall increase of 27.9% from 2015-20.**
- However, annual growth rates (2015 to 2020) in MMM4 were 3.9% and in MMM5 4.0%.
- **In short, in relative terms, maldistribution of the podiatry workforce is worsening and very substantially.**

Superficial analysis that points to minor shifts in absolute numbers while ignoring the fundamental issues of maldistribution and access, and considering demand and supply drivers over the long-term, is potentially misleading and may reduce the prospects of meaningful action by policy and decision-makers.

There is an immediate need for a National Allied Health Workforce Strategy that recognises the health, economic and other benefits to individuals, communities and the nation in having equitable access to allied health services regardless of where they live. It should be informed by models of care, workforce development and support and innovative funding models that are developed with and work for the communities they are needed in.

The Productivity Commission points to flexible approaches to workforce that allow health professionals to make the most of their skills as key to unlocking workforce potential. Former Commissioner Michael Brennan spoke of the need to look for efficiencies within the healthcare sector as the proportion of the Federal Budget Expenditure of health continues to grow[1] .

Enabling health professionals to work to a full scope of practice is particularly important in rural and remote health so that the available workforce can provide services to a broad range of presenting conditions within their community. Working to a full or extended scope allows rural and remote health professionals to respond to the needs of any client that walks through the door.

Undergraduate degrees alone do not equip new graduate and early career health professionals with the clinical experience to work to their full scope of practice in rural and remote areas. New graduates and early career allied health professionals require rapid upskilling in clinical and non-clinical skills to effectively meet the needs of rural and remote communities. The Allied Health Rural Generalist Pathway is the only post-graduate program supporting early career allied health professionals with an interest in rural practice.

Risks and Challenges

What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Please give examples of your own

Wiggins et al (2022) identified eight factors influencing scope of practice identified across three professions (nursing & midwifery, pharmacy, and physiotherapy) including education, competency, professional identity, role confusion, legislation and regulatory policies, organisational structure, financial factors, and professional and personal factors[2].

[1]Brennan, M (2022) Australia's health workforce — a future looking perspective https://www.pc.gov.au/media-speeches/speeches/future-health-workforce

[2] https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-022-00783-4

Poor clinical governance arrangements in multidisciplinary teams-based care pose a risk to consumers where practitioners working to full scope of practice are desired. Clinical governance is the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to **ensure good clinical outcomes**.[3]

The underpinning principles for supporting excellence and good governance of clinical care include[4]:

- Care is patient centred and there is a focus on the consumer experience throughout the continuum of care;
- A **culture of leadership and excellence** in clinical governance is fostered **at all levels of the organisation**;
- Clinical governance activities are rigorously monitored and reported.

Individual health professionals have a responsibility to ensure they *"Work within, and are supported by, well designed clinical systems to deliver safe, high-quality clinical care.* ***Healthcare providers are responsible for the safety and quality of their own professional practice and codes of conduct."***[5]

Ensuring the safety and quality of services provided by health professionals working to top of scope requires that individual health professionals understand their own scope of practice within their discipline and are able to recognise when they have reached the limits of their clinical expertise or scope of practice, and where to seek support when specialist skills are required. Aligned to the Ahpra Code of Conduct, this responsibility extends to other members of the multidisciplinary team to understand *"…the role of other team members and attend to the responsibilities associated with that role*".[6]

For such teams to operate effectively there needs to be a clarity with respect to each team member's role. Credentialing and Scope of Clinical Practice guidelines (for example, QLD Health's Credentialing and defining the scope of clinical practice Directive[7]) ensures health professionals practise within the bounds of their role/position, education, training, experience and competence, and within the capacity, capability and available support of the facility or service in which they are practising.

A deep understanding of each profession's skills and capabilities will be required to develop clear role descriptions that utilise team members' full scope as they relate to the clinical setting. In a large organisation, such as a state health service, mechanisms exist to oversee and monitor health workforce skills development and scope of practice.

The Ngayubah Gadang Consensus Statement states "*With* ***clearly defined roles, professional autonomy,*** *and communication processes the RRMHT* [Rural and Remote Multidisciplinary Health Team} *works together to provide high quality, holistic person-centred care to their patients and their community."*[8] In the context of rural and remote multidisciplinary team care, achieving this may pose some challenges, particularly in small multidisciplinary teams where there may be only one practitioner of a certain discipline in the team.

Health service providers in rural and remote settings will require additional consideration and support to ensure appropriate governance, supervision and professional development arrangements are in place for each discipline. For example, allied health professionals will require access to a senior clinician of the same discipline to provide supervision and support, reduce professional isolation and help them develop their skills relevant to the clinical setting. These issues have been alluded to in the Strengthening Medicare Taskforce Report (December 2022) but fall short of identifying the specific needs of the allied health workforce within a multidisciplinary team environment.

[3] https://www.safetyandquality.gov.au/our-work/clinical-governance
[4] https://www.health.qld.gov.au/ahwac/html/clin-gov
[5] National Safety and Quality Primary and Community Healthcare Standards (2021) page 9
[6] Ahpra Code of conduct (June 2022) page 16
[7] https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/credentialing-and-defining-the-scope-of-clinical-practice/credentialing,-defining-the-scope-of-clinical-practice-guideline
[8] Ngayubah Gadang Consensus Statement (2023) page 11 (https://www.health.gov.au/resources/publications/the-ngayubah-gadan-consensus-statement-rural-and-remote-multidisciplinary-health-teams?language=en)

The cost of allied health workforce development will need to be factored into the business model for primary care providers and to date this aspect of cost modelling appears to be absent[9].

For the allied health professions, multidisciplinary care is built on *"… the concept of **shared leadership** not restricted to those who hold designated leadership roles, and a shared sense of responsibility for the success of the organisation and its services."*[10] Enabling shared leadership and responsibility will be necessary to achieve all multidisciplinary team members working to top of scope. The Strengthening Medicate Taskforce Report refers to the need to encourage multidisciplinary team-based care, to make it *"…easier for practices to resource team-based care models, …support practices to make the change [and] improve workforce wellbeing and job satisfaction"*[11]. Developing the skills and capabilities of allied health professionals as part of a multidisciplinary team will require explicit consideration.

Other potential barriers for health practitioners working to their full scope or expanded scope of practice include:

- Scope as defined by clinical setting. For example, confining this scope of practice review to primary healthcare settings risks constraining the scope of practice of allied health professionals who may work across primary healthcare, aged care, early childhood early intervention, disability and mental health.
- Scope as defined by funding stream. For example, defining scope of practice within the Medical Benefits Scheme risks constraining the health professional's practice to a narrow set of health conditions.-While specialisation in these conditions is important to ensure high quality and best practice care, the broader health workforce requires training to manage chronic conditions, understanding of escalation processes and access to specialists when required.

Please give any evidence (literature references and links) you are aware of that supports your views. any evidence (literature references and links) you are aware of that supports your views.

Barker R et al Evaluation of the Allied Health Rural Generalist Program 2017-2019 Aust J Rural Health Apr;29(2):158-171. doi: 10.1111/ajr.12745.

Dymmott A et al South Australian Allied Health Rural Generalist Pathway Evaluation: Phase 1 Report (2020) https://doi.org/10.25957/SAKP-AB29

Real life examples

- Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care? (yes/no)
- Please give examples, and any evidence (literature references and links) you have to support your example. Please provide references and links to any literature or other evidence.

Currently there are mechanisms in place to support General Practitioners to work in an extended scope through the GP Rural Generalist Pathway, among others. Similarly, the Allied Health Rural Generalist Pathway provides a mechanism to support an individual allied health professional and their employer to work to the breadth of skills required to meet the needs of their community.

The Allied Health Rural Generalist Pathway is a two-year pathway that comprises formal post-graduate education, structured workplace-based supervision and support and the implementation of a service development project, enabling new graduate and early career allied health professionals to retain the breadth of skills needed to meet the needs of their community. SARRAH is currently implementing a Commonwealth-funded program which supports private and non-government organisations in rural and remote areas to establish the workplace support structures to enable early career allied health professionals to undertake this pathway.

[9] See for example https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/
[10] Allied Health Clinical Governance Framework in Queensland Health (December 2018) page 7 (https://www.health.qld.gov.au/ahwac/html/clin-gov)
[11] https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en

Examples from SARRAH's program display practice examples of health practitioners working to their full or expanded scope of practice include:

- A Pharmacy service providing services across Kimberley, WA reviewing the regions chronic lung protocol. In the past visiting specialists would conduct lung function tests using spirometry. Diagnostic spirometry is the 'gold standard' for diagnosing chronic lung conditions and is essential for the early staging and treatment of COPD and is used to monitor disease progress[12]. Funding for the visiting service has ceased, which means Aboriginal communities are no longer accessing the gold standard diagnostic assessment of chronic lung disease.
  Two early career pharmacists are working with a respiratory physician and local GP to upskill themselves, and Support Workers based in community, in the use of diagnostic spirometry. This is an example of Pharmacists working to an extended scope to provide a necessary service that would otherwise not be available.
- An GP clinic in Western NSW has secured Allied Health Rural Generalist Pathway support packages for two new graduate social workers. With the support provided through the program and external supervision provided by more experienced clinicians, the trainees are developing a new Social Work service. The GP Clinic has found it difficult to secure funding to minimise the out-of-pocket costs for clients. Most MBS items are not available until the Social Workers are Accredited Mental Health Social Workers, a process that will take two years to complete.
  The clinic has approached the PHN for funding, but this has been declined as they are already providing funding to Mental Health programs. Unfortunately, these programs are provided remotely and not face-to-face.
  In the meantime, the clinic is offering their SW service to clients referred by the GP who can afford to pay, as well as NDIS clients.
  Recently the SWs have expanded their scope to include ante-natal and post-natal clients who can access 3 subsidised sessions per year.
  They are in the process of seeking seed funding through the Rural Health Outreach Fund from the relevant rural workforce agency, to provide ongoing Mental Health services.
  The feedback from the organisation is that to respond to the needs of the community, the Social Workers need to work to the full scope of their rural generalist practice and the AHRGP has been really beneficial with upskilling in this area, not to mention the fact that this community has attracted 2 new social workers.
- A Service operating in North West Queensland has implemented a transdisciplinary model of care to help address long wait times for children requiring Speech Pathology services under the NDIS. Due to difficulty recruiting Speech Pathologists in this region Occupational Therapists are undertaking training with Speech Pathology staff to implement safe and simple treatment strategies for speech and language development, while children wait (up to 12 months) to see a Speech Pathologist.
  The Occupational Therapists are already involved with the clients under their NDIS package and so implementing these strategies can occur as part of existing appointments. This is an example of the use of skill sharing across allied health disciplines to improve service delivery.

These examples would not have been possible without the Commonwealth-supported Allied Health Rural Generalist Pathway. It is important that this workforce program continues to be funded.

Allied Health Assistants

An allied health assistant (alternative title Therapy Assistant) works under the delegation of an allied health professional to assist with therapeutic and program related tasks.

Delegation is a defining feature and fundamental to the definition of an allied health assistant role and patient safety. Delegation is defined as the process by which an allied health professional allocates clinical and health-related tasks to an allied health assistant with the appropriate education, knowledge and skills to undertake the tasks. The allied health professional provides the delegation instruction for the task to the allied health assistant,

[12] Lung Foundation, 2023. https://lungfoundation.com.au/health-professionals/conditions/copd/diagnosis/

who accepts and then performs the task with appropriate monitoring by the allied health professional and then provides feedback to the delegating allied health professional.[13]

While allied health assistants work within clearly defined parameters, the role is often flexible, involving a mix of direct patient care and indirect support activities. The mix of duties is determined by a range of factors including the model of care, the needs of the professional/s delegating work to the allied health assistant, and the types of services delivered by the allied health team.

The use of Allied Health Assistants in rural and remote organisations provides an opportunity to improve access and culturally appropriate service delivery in communities where Allied Health Professionals (AHPs) are few, or work on a fly-in-fly-out (FIFO) or drive-in drive-out (DIDO) capacity. An AHA may live in and work in a rural or remote community, anchoring an outreach service provided by AHPs on a FIFO or DIDO basis. This is advantageous because the AHA can carry out the therapeutic programs developed by the AHPs between visits, increasing the clinical contact and dosage of those therapeutic programs.

A strong governance model for the Allied Health Assistant workforce is vital for organisations to establish clear tasks, competencies and reporting lines for Allied Health Assistants to ensure they are working safely within their scope of practice.

SARRAH's Commonwealth-funded *Building the Rural Allied Health Assistant Workforce* (BRAHAW) Program supports rural and remote organisations to establish a governance model for Allied Health Assistants. The program is currently at capacity with all 30 positions filled and a waitlist for more than 70 further positions. This program assists employers establish AHA positions and set up the necessary workplace structures to enable effective training and supervision of AHAs.

Anecdotally we heard from organisations participating in the BRAHAW program who previously utilised AHAs in administration and reception roles, as they were unsure of how to transition these employees into clinical work. One organisation undertaking the program has transitioned an AHA, previously working in an administrative role, to completing Physiotherapy-delegated exercise programs for residents in the local Aged Care facility. This organisation has also been approved to use the AHA to provide Physiotherapy-delegated clinical tasks for NDIS package recipients, where appropriate.

The BRAHAW Program has also had excellent uptake in a number of Aboriginal Community Controlled Organisations. Given the remoteness of Aboriginal Communities, ACCHOs often contract out allied health services to visiting AHPs who may have limited capacity to provide regular face-to-face clinics. In some cases AHPs visit a community once a fortnight or less. The use of local AHAs, especially those who are community members, can improve engagement of Aboriginal clients with visiting AHPs and enable follow-up of clinical interventions between AHP visits.

An organisation currently involved in the program has employed two Allied Health Assistants who are also community members, to work under the supervision of AHPs to assist visiting podiatry and psychology AHPs. The initial feedback from the AHP involved is that the response from the local community to seeing someone they know when they attend clinics has been very positive and improved client engagement. The long-term vision is that these Allied Health Assistant positions could be expanded across other Allied Health Professions, and eventually be a potential pathway for community members to consider going into Allied Health or other Health professions, with a view to increase the number of Health Professionals living and working in their own communities.

Facilitating best practice

What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

- Overcoming acute and longstanding workforce shortages in rural and remote areas. (see AIHW workforce data page 3)

[13] https://www.health.qld.gov.au/ahwac/html/ahassist

- Recognition and remuneration of teaching and training of allied health professionals and assistants in non-government and private settings
    - Improve capacity for rural allied health professionals to offer clinical training to undergraduate students, and consider innovative ways to deliver rural placements for allied health students;
    - Expand the allied health rural generalist pathway as a means to deliver wrap-around support to new graduates and early career allied health professionals;
    - Engagement with NDIS and aged care systems to bolster rural workforce development including student training, clinical placement networks and support for early-career allied health professionals.

  There are no nationally consistent mechanisms to support the professional development of AHPs, particularly those working in primary care settings. Clinical teaching and supervision of junior and early career AHPS on the job, outside of the education sector and state health services, is largely unremunerated. Even within state health services, workforce development programs for allied health professionals vary between jurisdictions, are limited in number and subject to short term funding cycles. Universities report significant challenges identifying sufficient workplaces willing to take undergraduate students to complete clinical placements requirements. Recognising ongoing professional development, teaching and training of the allied health workforce is a key component to building rural and remote workforce capacity.

  A National Allied Health Workforce Strategy is required to articulate the training needs of the allied health workforce, enabling AHPs to work to top of scope, creating career options for AHPs who have committed to working rurally, and developing a broad rural generalist skill set. A National Allied Health Workforce Strategy would also incorporate existing workforce development programs to enable recognition and remuneration for teaching, supervision and other practice supports.
- Funding barriers, for example in MBS, and primary healthcare

  A review of the funding models for allied health services in primary care settings is needed to ensure clients in need can access services:
    - Review the fee-for-service model as the basis for service delivery across different populations and locations as it currently does not work for many patients;
    - Streamline the various regulatory frameworks associated with different funding streams to reduce the administrative load on clinicians;
    - Recognise the cost, both financial and human, of servicing distant and dispersed patient groups, often requiring many hours of unremunerated travel time and the subsequent impact on a clinician's capacity to provide direct clinical care.

  Enacting the recommendations of the MBS Taskforce Allied Health Reference Group Report would go some way to overcoming some of those funding barriers[14].
- Regulatory barriers to enable health professionals to work across clinical settings such as primary and community care, aged care, disability[15].
    - Safeguard existing rural allied health capacity against increased pressure that may exacerbate the maldistribution of the workforce, as practitioners choose to relocate to larger regional centres and/or take up positions in the public system.
    - Cross-sector engagement between government, state health services, primary health networks and the private allied health sector to improve efficient regional service access arrangements.

What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence. Additional views

In addition to addressing barriers to health professionals working to full scope of practice mentioned above, rural generalism is a key enabler:

Allied Health Rural Generalists say:

[14] https://www.health.gov.au/resources/publications/final-report-from-the-allied-health-reference-group
[15] https://sarrah.org.au/publications/tpost/r4a55gj6o1-sarrah-summit-2020-report

"The study of the [allied health rural generalist] pathway and the project provides us with the biggest scope of practice and we learn many things that we haven't had access to before helping to become better practitioners... Provides a great understanding of what's going on in a wider approach... It's a great program and opens the opportunity for me to further study" (*Amy, Central Australian Aboriginal Congress NT*).

"The rural Generalist pathway allowed refine our skills in rural and remote practice and provided us the opportunity to explore project management education and discipline-specific focus areas. The pathway also provided us with the opportunity to undertake a project that met the needs of our organisation and the disability sector." (*Sarah, Carpentaria Therapy Service NT*)

"We don't have enough allied health professionals in rural and remote areas. The AHRG Pathway is a perfect opportunity to offer the experience of work, and structured education, and involves making real change through the [service development] project. The pathway and the project give younger health professionals to really feel that they are part of something significant and not just they are working in a clinic, but the pathway gives the skills that they can grow for better outcomes for everyone not just one patient they are seen in consultation.
"The pathway benefitted me to set myself aside from other employees to offer something more than the job and the education more structured way to build a skill set as a good pharmacist in a remote area not only as a pharmacist but also understanding referral pathways and how the whole health system works. The Pathway provides me an opportunity to get five- or six years of experience on the ground much shorter. " (*Hannah, Kimberley Pharmacy Service WA*)

"Rural Generalism ...means to me as having a confidence to talk with the participants and expanding the scope of my service." (*Meg, Icaria Health VIC*)

Please share with the review any additional comments or suggestions in relation to scope of practice. Further suggestions

A National Allied Health Workforce Strategy is urgently needed to provide clarity regarding the roles and scope of practice of the 25+ allied health professions in Australia.

This workforce strategy will:

- assist policy makers and other health workforce stakeholders understand the many ways in which allied health services can improve health outcomes for consumers and support a well-functioning multidisciplinary team.
- Provide advice required to grow the allied health workforce especially in areas where shortages are acute.
- Provide guidance regarding best practice allied health service models that utilise allied health working at top of scope

SARRAH welcomes the opportunity to contribute further to the review through participation in the relevant stakeholder forums, including to collaborate with other key stakeholders to ensure the issues raised in SARRAHs submission are worked through so as to ensure the accurate and effective representation of the allied health workforce and for the related workforce development, policy, program and investment purposes the review will influence.

If you would like to discuss issues raised in SARRAHs response or require further information, please contact me at catherine@sarrah.org.au or Allan Groth at allan@sarrah.org.au.

Yours Sincerely

Cath Maloney

Chief Executive Officer