SARRAH

Services for Australian Rural and Remote Allied Health

22 December 2023

Committee Secretary
Commonwealth Covid-19 Response Inquiry
Department of the Prime Minister and Cabinet

Submitted via Inquiry website

Services for Australian Rural and Remote Allied Health (SARRAH) submission: COVID-19 Response Inquiry Panel

Thank you for the opportunity to contribute to Commonwealth COVID-19 Response Inquiry. We regret that we were unable to provide a response before now, however hope you will accept the information provided and that the Panel will consider the information in their deliberations.

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.

SARRAHs membership includes individual allied health professionals from over 20 distinct allied health professions who work across the public, private and community-based health and social support systems; allied health students; educators; service delivery organisations; Local Health Districts and more.

We note the inquiry areas of review are deliberately broad to encourage a wide range of stakeholder views and evidence on:

- both the health and non-health responses
- responsibilities of the Commonwealth Government and the role of state and territory governments
- how national governance arrangements including National Cabinet, informed decisions by governments.

Our submission highlights the potential contribution allied health professionals

- could have played as part of Australia's early and ongoing response to COVID had that contribution been recognised and facilitated and

- recommends detailed work be undertaken by Governments nationally, working with all health professions, to ensure the full capacity of Australia's highly trained and skilled workforce is utilised to best effect and within their scopes of practice – both to support future pandemic preparedness and capacity AND to improve health care access and outcomes generally.

SARRAH believes this approach will better enable our health system(s) to deal with the continuing impacts of the COVID-19 pandemic and enhance our preparedness to respond optimally and most efficiently at a system level to future pandemic and similar threats.

Allied health – summary and context

There are over 200,000 allied health professionals in Australia, including professions registered under the National Registration and Accreditation Scheme administered by Ahpra and self-regulated allied health professions, such as (for example) speech pathologists, audiologists, exercise physiologists, dietitians and social workers[1]. As a group, allied health professionals represent the second largest health professional workforce. While allied health professions represent a diverse range of skills and expertise, a simple summary description is that [redacted][2].

Allied health professionals are amongst the most in-demand workforces in Australia and the National Skills Commission projects that demand for some allied health professions will lead the Health and Social Assistance Sector (including all health professions) and be 3-4 times higher than that for jobs growth across the economy as a whole[3].

However, the allied health workforce is severely maldistributed with critical, long-term shortages in rural outside of metropolitan cities. On a per head of population basis, the maldistribution of allied health professions is about twice as severe as for General Practitioners. This has major implications for access to services needed by people who are particularly vulnerable to the impacts of COVID and for people requiring support to recovery from Long-COVID.

Early efforts from the Australian allied health sector to support Australia's COVID response

By late February 2020 the Australian Allied Health Leadership Forum (AAHLF)[4] (now the Australian Allied Health Leadership Alliance) of which SARRAH was a member, was engaging

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[1] A summary overview of allied health professions can be found at https://www.health.gov.au/health-topics/allied-health/about and a description of the workforce can be found at https://www.health.gov.au/health-topics/allied-health/in-australia.

[2] See https://ahpa.com.au/what-is-allied-health/. Unfortunately, meaningful discussion of the role allied health professions (AHPs) in delivering services in a pandemic situation (or effective person-centred and contemporary, team-based healthcare) has tended to be distracted by lesser priority and technical issues such what professions are considered to be "allied health", rather than focus on the impactful and proven contributions professions within the "Allied health" term make. (Those issues also contribute to and are continued by the lack of detailed, national allied health workforce (especially for self-regulated professions). Similarly, frequently these issues represent policy and administrative decisions and concerns, within the purview of government(s) rather than clinical or profession specific control or concern. In enabling health systems to deliver the best possible access and outcomes for the population, such factors should not be a primary consideration, especially in the context of a threatening global pandemic.

[3] https://labourmarketinsights.gov.au/industries/industry-details?industryCode=Q

[4] Australian Allied Health Leadership Forum consists of Australia's allied health peak organisations, including the Australian Council of Deans of Health Sciences (ACDHS); Allied Health Professions Australia (AHPA); Indigenous Allied Health Australia (IAHA); National Allied Health Advisors and Chief Officers Committee (NAHAC); and Services for Australian Rural

regularly with senior Commonwealth Department of Health officials; seeking to contribute meaningful options for more effective allied health professional utilisation in meeting the emerging demands of the pandemic, including:

- to contain pressure on hospitals
- improve throughput and
- enable discharge of patients from hospital to safe community care options.

Allied health peak bodies and practitioners were regular contributors and active participants in the frequent national engagement webinars/fora hosted by the Commonwealth Department of Health. We understand state and Territory based chief allied health officers and equivalents were also closely involved in their jurisdiction processes.

- Despite these efforts and tangible contributions many tens of thousands of allied health professionals potentially could have made providing clinical care to Covid impacted and other patients, that contribution was generally under-recognised and in frequently ignored, hindered or not allowed.

As the pandemic progressed and efforts shifted to encompass more than the initial crisis response, the implications of long-COVID and repeated infections led to some reassessment.

- The incorporation of allied health expertise, capability and treatment efficacy gained more traction and was better incorporated into some jurisdiction health system responses, notably with the establishment of several state and territory long-COVID clinics.
- The Commonwealth Government's response included allowing telehealth to provide (limited) pre-COVID level allied health services for which MBS subsidies apply (such as Chronic Disease Management items and Mental Health Better Access).
- Eventually decisions were made to accept that vaccinations could be provided by a range of practitioners, including pharmacists and nurse practitioners (for example), working within their scopes of practice. This expanded and facilitates quicker access to quality care and eases demand on GPs and others who would otherwise be further stretched.

However, the Commonwealth has not otherwise responded as yet to facilitate better access to allied health services in the primary health care as it might relate to preventing, managing or recovering from COVID. There is considerable potential for that access to be facilitated and to improve treatment capacity and outcomes.

The potential role of allied health in meeting the challenges of a pandemic

The following summarises the roles AHPs should be facilitated to contribute in:

1. Reducing demand for hospital admissions by maintaining the health of vulnerable populations (a fundamental function of AHPs working in primary health)
2. Enabling throughput / reducing length of stay for patients requiring hospitalisation and
3. Facilitating discharge from hospital through post-acute, community-based care that aids recovery.

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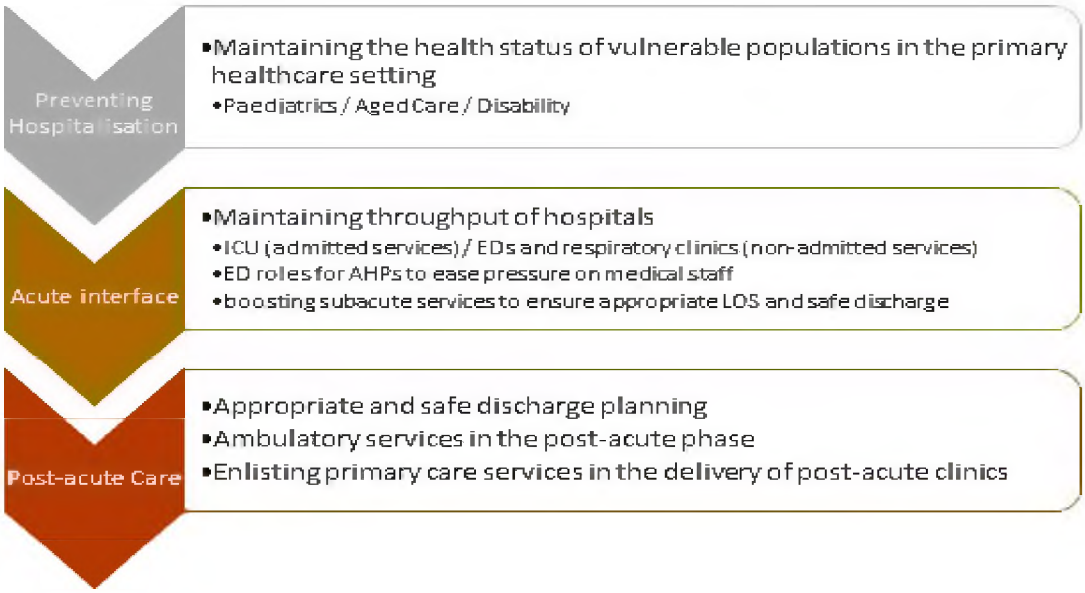
and Remote Allied Health (SARRAH). The peaks now come together as the Australian Allied Health Leadership Alliance (AAHLA), with NAHAC as an observer.

These roles are fundamental to the practice of many AHPs, improving both patient outcomes and health system efficiency[5]. However, they are not always well understood or prioritised in health services. The challenges posed by the COVID-19 pandemic and system sustainability means leveraging these assets is more crucial than ever to bolster overall system capacity and reduce demand and pressure on acute health resources and staff.

Coordinated planning and utilisation of AHP capacity would help maintain community health, promote recovery and contain the impact of COVID-19 on service system capacity and cost. Key areas of AHP practice and expertise as they relate to managing the response to COVID-19 across the care continuum is summarised in Diagram 1.

Diagram 1: Allied health role managing upstream and downstream impacts of COVID-19



AHPs provide vital services in the prevention, treatment and recovery of patients from injury, illness and disease, including COVID-19.

The capacity of the more than 200,000 AHPs practicing in Australia to reduce the impact of and aid recovery from the COVID-19 pandemic should not be overlooked, underestimated or underutilised.

Diagram 2 illustrates the breadth and continuum of care needs COVID-19 patients will face/are facing - from the need to access acute care services through potentially prolonged and complex recovery pathways. For each "wave" illustrated one or more forms of AHP intervention/care is likely to be required to support patient recovery.

[5] Efficiency is understood to include the effectiveness of interventions to deliver a positive impact on patient outcome as well as the application of resources to attain that result.

Diagram 2: The longer-term impact of COVID-19 – demonstrates why AHPs need to be an integral part of the response.[6]

In addition to providing this submission, SARRAH would welcome the opportunity to provide further evidence to the Inquiry.

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

Yours Sincerely

[redacted]

Cath Maloney
Chief Executive Officer

[6] https://justanoldcountrydoctor.com/2020/04/14/will-health-care-infrastructure-survive-the-covid-19-pandemic/ accessed 16 April 2020