

HPCA

Health Professions Council of Australia Ltd

Submission to

Productivity Commission Health Workforce Study

From the Health Professions Council of Australia Ltd

THE ALLIED HEALTH PROFESSIONAL WORKFORCE IN AUSTRALIA: Challenges and Opportunities

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Comprising: Audiological Society of Australia, Australasian Podiatry Council, Australian Association of Social Workers, Australian Institute of Radiography, Australian Orthotic and Prosthetic Association, Australian Physiotherapy Association, Australian Psychological Society, Dietitians Association of Australia, OT AUSTRALIA, Speech Pathology Australia, Society of Hospital Pharmacists of Australia, The Orthoptic Association of Australia and incorporating HPCARRAC (HPCA Rural & Remote Advisory Committee)

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Introduction

The Health Professions Council of Australia (HPCA) is the national peak body for allied health professional associations.

Several of its member organisations will forward individual submissions to the Productivity Commission as part of the health workforce study. The HPCA's submission deals with issues common to the allied health professions as a whole.

Australia has at least 90,000 allied health professionals. Together with doctors and nurses, they provide the essential skills on which Australia's health system is based. Best practice management of certain conditions is unachievable without the specific contribution of university-trained, autonomous allied health professionals.

There is widespread agreement that Australia faces a critical shortage of allied health professionals, and that changes are urgently needed in many areas affecting the allied health workforce – notably on skills recognition, data collection, education, regulation and workforce structures.

This paper briefly summarises key challenges and constraints, and recommends major directions for change.

It should be noted that HPCA member organisations are already major agents of change within their professions, developing new visions for the future, providing linkages between educators and employers and keeping their members up-to-date on the latest research and on innovative clinical practice. The professional associations are not, as some submissions to the Productivity Commission seem to imply, locked into traditional mind-sets or the need to overly protect their professional 'turf'. They are not 'part of the problem'.

The HPCA and its member organisations can and should play a crucial role in solving Australia's current health workforce difficulties.

The HPCA welcomed the opportunity to meet with members of the Health Workforce Study team in May 2005, and would be pleased to provide additional information after the release of the Commission's draft report in October 2005.

Key Recommendations and Comments

On Skills Recognition:

1. To facilitate closer working relationships between allied health, government agencies, universities and other health professions, the HPCA seeks government support and funding for the establishment in Canberra of a National Allied Health Liaison Office (NAHLO). This Office will provide an essential forum for dealing with a wide range of allied health issues at a national level. Specifically, the creation of NAHLO will enable the following:
 - A greater emphasis on, and investment in, preventative health strategies. In the longer term, health costs would be reduced if Australia had a better balance between preventative and remedial services, including recognition of the significant role that allied health professionals play in preventative health care, especially in relation to health problems associated with chronic disease, ageing, obesity and other population-wide health issues.
 - Improve and facilitate cross-discipline continuing professional development (CPD) in relation to primary healthcare. All health professionals need ongoing education in order to ensure quality of care to clients and consumers. Consumers also need more education on the role of allied health professionals in primary health care. NAHLO, with input from the HPCA, could make a significant contribution to such initiatives.
 - Identify opportunities for enhanced cross-discipline practice between allied health and other health professions, to offset current medical and nursing workforce shortages. For instance, some allied health professionals are already employed in emergency departments of some metropolitan hospitals. Their skills and contributions complement those of medical and nursing staff, and can be particularly helpful for 'social' admissions where community support can be a more appropriate option than hospital admission.
2. HPCA does not support the untested concept of university trained, degree qualified generic health workers. The proposed work substitution by such generic health workers would destabilise the current allied health workforce and create additional regulatory and administrative frameworks which would increase pressure on our already stressed health system. Moreover, HPCA contends that such generic health workers will not possess adequate competencies to practice across the various allied health disciplines.
3. HPCA supports entry level cross-discipline education for some common subjects currently offered at some Australian universities. HPCA would welcome additional coordination and financial assistance for this type of common entry level education as it provides a mature and stable framework for multidisciplinary client care between professionals.
4. HPCA recognises that the use of non-tertiary trained support staff is supported in some allied health professions, so long as they are adequately trained, qualified and supervised.

On Health Workforce Data:

1. The Commonwealth Government should establish a single national statutory authority for the health workforce. This agency would be responsible for the collection, analysis and dissemination of health workforce research data throughout Australia. It would also provide policy advice to key government departments and would link with the allied health professions through the proposed National Allied Health Liaison Office. Such an agency, if established, would need to ensure the following:
 - Nationally consistent, systematic and comprehensive workforce data on all health professions, including allied health and those practitioners not in clinical practice.
 - All supply and demand studies are inclusive of specialties within all health professions and recognise the need for further education to develop such specialist skills.
 - All health workforce data collection is expanded and coordinated, to ensure that it is compatible with the AHMAC minimum data set project outcomes.
 - Results and data from prevalence studies, especially in relation to major chronic medical disease categories, are examined by the agency to shed light on their workforce requirements.

On Education:

1. The Commonwealth Government should move the allied health professions from clusters 5 and 6 and relocate them all in cluster 9 on the Commonwealth Course Contribution Schedule. This would mean that students of the allied health professions are funded at the same level as students of dentistry and medicine. Increases in allied health education funding will ensure the following:
 - Recognition and support for allied health clinical education at entry level in accordance with the National Health Workforce Strategic Framework, in particular, in relation to strategies associated with Guiding Principles 1 and 4.
 - Targeted support to cover additional accommodation and living expenses for allied health students undertaking clinical education a significant distance away from the educational institution.
 - Clinical supervision for allied health students is a fully recognised and funded activity in hospitals and other public health facilities.
2. The Federal Government needs to introduce a range of measures to address the adverse impact of increasingly high student fees on allied health career pathways in order to ensure adequacy of supply of allied health professionals, especially in rural and remote regions of Australia. Such measures include, but are not limited to, student education contribution/loan reimbursement schemes and targeted scholarship programs.

On Workforce Structure:

1. Allied health should have representation through the HPCA on the Australian Health Workforce Advisory Committee (AHWAC) to ensure adequate and relevant consultation on workforce planning issues. In particular, the following contributions can be made by HPCA through AHWAC:
 - Identification of issues and strategies to address the structural barriers and other restrictions affecting health programs run by different government agencies.
 - Innovations to increase health workforce productivity, leading to job satisfaction and staff retention.
 - Measures to provide a more flexible and family friendly working environment. The feminisation of the health workforce, as alluded to in the Productivity Commission issues paper, is not a new phenomenon within the allied health professions. The vast majority of the allied health workforce is female, and the professions have developed innovative strategies in response to this gender balance, some of which provide useful case studies for health workforce recruitment, retention and re-entry.
2. Individual professions must have uniform regulation across Australia to ensure that clients and consumers are not exposed to possible harm. This can be either statutory registration or recognised self-regulation, but not a mix of the two within one profession, as is the case at present with some allied health professions.

On Workforce Participation and Workforce Distribution:

1. In future Australian Healthcare Agreements, the Federal Government should provide financial and other incentives to the state/territory governments on strategies for increased workforce participation. Specific strategies may include, but are not limited to:
 - 'Attract back to practice' schemes for those clinicians on extended leave and those working overseas, as a useful short term measure to increase the local supply of allied health professionals.
 - Projects to examine increased career choices and improved career paths for allied health practitioners, similar to the medical careers project undertaken by the Australian Medical Workforce Advisory Committee (AMWAC).
 - Initiatives to provide family friendly employment conditions, such as the provision of child care at all public hospitals. The aim is to increase 'attractiveness to participate' at all stages of life.
 - Initiatives to recruit retain and provide on-going support to allied health professionals, particularly new graduates, working in rural, remote and outer metropolitan areas. Such initiatives could include a five-year moratorium on allied health professional course fees, financial assistance with CPD, mentoring, and on-line education and training.

Workforce Challenges and Opportunities – discussion of key issues affecting Australia’s Allied Health Professionals

Skills Recognition

Allied health professions make a crucial contribution to Australia’s health care services; but their skills are frequently undervalued.

Allied health professionals are highly skilled, tertiary trained autonomous professionals. An increasing number have post-graduate specialist qualifications and play a crucial role in research, management and health policy.

The Federal Government, however, remains overly focussed on medical practitioners and on medical solutions to health problems. This adds to costs, reduces consumer choice, and fails to recognise that best practice often requires a multidisciplinary approach. Although some slight softening of this rigid attitude has been evident recently, such as in the Strengthening Medicare initiative, the Government and the Department of Health and Ageing still appear to be reluctant to fully recognise the role of allied health professionals alongside doctors and nurses.

With increasing pressure on general practice, doctors also need to give greater recognition to the key role that allied health professionals can play in the prevention and management of disease. Allied health professionals are independent primary care practitioners; although they work closely with their medical colleagues, they do not believe that General Practitioners need to be the ‘gatekeepers’ to allied health.

To facilitate closer working relationships between allied health, government agencies, universities, doctors and other sectors of the health workforce, the HPCA seeks government support and funding for the establishment in Canberra of a National Allied Health Liaison Office (NAHLO). This Office would provide an essential forum for dealing with a wide range of allied health issues at a national level. For example, it would foster multidisciplinary health services and programs, facilitate data collection, provide specialised input on educational issues, and help ensure that primary health care recognises the latest research on the efficacy and cost effectiveness of allied health clinical approaches. An HPCA proposal for funding NAHLO has been put to the Federal Government.¹

The HPCA recommends a greater emphasis and investment on preventative health strategies, in which allied health plays a significant role. There is in Australia a strong political focus on hospitals (the bigger, more complex and more expensive the better) and on high level clinical activities. A better balance between preventative and remedial services would ultimately lead to savings on the health dollar. Such an approach takes political courage, vision and a long term strategy which does not sit well with short term needs.

Two key demographic trends in Australia are population ageing and the increasing numbers of people who are overweight or obese. In the interests of cost saving and best practice care, doctors and the Federal Government need to recognise the major

¹ HPCA 2003: The case for establishing a National Allied Health Liaison Office.

role that allied health professionals can play in preventing and managing these issues.

The growth of specialisation is a factor to be recognised in a number of allied health professions. It is therefore essential that all supply and demand studies are inclusive of allied health specialties, and that the need for further education to develop specialist skills be recognised.

As skills develop, the scope of allied health practice is expanding. Allied health professionals are already taking roles in emergency departments and specialist clinics, thereby easing the pressure on medical and nursing staff. HPCA member associations are leading the way in developing flexible and innovative approaches to service delivery, and setting new directions for their professions. There are a number of procedures and practices currently undertaken by medical practitioners which could be undertaken by allied health professionals, with a consequent increase in workplace productivity, flexibility and job satisfaction. Allied health professionals employed in the emergency departments of metropolitan hospitals are particularly helpful for 'social' admissions where community support such as diabetes education can be a more appropriate option than hospital admission.

While the allied health professions move to expand their skills base and specialisations, other interests are promoting the concept of 'generic' allied health professionals, seen as a 'cheap' quick fix to workforce shortages.

HPCA does not support proposals for the introduction of tertiary-trained generic health workers, as they would destabilise the current allied health workforce and create additional regulatory and administrative frameworks within our already overstretched health system. Allied health professionals are already working closely with medical and nursing staff, and a new category of health workers would introduce uncertainty between the professions, leading to the destabilisation of the current health workforce.

HPCA recognises that the use of non-tertiary trained support staff is supported in some allied health professions, so long as they are adequately trained, qualified and supervised.

Health Workforce Data

Much of the data collected on the allied health workforce is of poor quality. It is inconsistent across the professions and jurisdictions, making health workforce planning very difficult.

Workforce data for some allied health professions has in the past been assembled by the Australian Institute of Health and Welfare (AIHW), but this has been based on infrequently collected and sometimes inconsistent data from a variety of State organisations. Some recent AIHW allied health studies have also been hampered by lack of funding.

Collection of national allied health workforce data is difficult; there is not necessarily consistency between data collecting agencies and funding for data collection and analysis is inadequate.

As discussed earlier, the HPCA believes that data collection, among other things, would be greatly improved if a National Allied Health Liaison Office (NAHLO) was established in Canberra.

There is an urgent need for comprehensive workforce studies of key health professions other than doctors and nurses in the light of the changing health services environment. Detailed and uniform workforce studies are required across all allied health professions, regardless of registration status.

There is an urgent need to understand in detail the extent, causes and impact of health professional workforce shortages; and to project and plan for future needs.

HPCA welcomes the launch by the Australian Health Ministers' Advisory Council (AHMAC) of a project to draft a national minimum data set for the health workforce.

Research is also needed in relation to demand and not just workforce supply, in order to shed light on workforce requirements. Such workforce demands can be estimated using prevalence studies for all major diagnostic groups.

The HPCA believes there would be value in establishing a national statutory authority for the health workforce. This new authority would be charged with the collection, analysis and dissemination of health workforce research data throughout Australia. It would forge strong links with the allied health professions through the proposed National Allied Health Liaison Office (NAHLO). In addition, the authority would advise other government departments such as the Department of Science, Education and Training and the Department of Treasury and Finance. It would report directly to the Australian Health Ministers Conference and have key input into health workforce policy and planning matters.

All allied health registration authorities should be required and funded to collect data that is compatible with the AHMAC minimum data set project outcomes, and meets the needs of the proposed National Health Workforce Authority. Since not all allied health professions are registered, the government should also where needed fund professional associations to conduct workforce supply studies. This initiative can be coordinated through the HPCA to ensure compatibility.

Education

Australia needs more allied health professionals. However, decisions on how many students to enrol at universities are not based on need but on commercial concerns.

A key step in tackling the allied health workforce shortage is addressing the communication gaps between workforce planners and the educational institutions.

As the AHMAC submission to the Productivity Commission notes:

'Nationally, the Department of Education, Science and Training (DEST) has policy responsibility for higher education. There are no formal linkages between State and Territory health agencies and DEST...Engagement of DEST on health workforce issues through State and Territory Education and Training agencies has had limited success.'

Health Ministers met with Minister Nelson in July 2004 because of their concerns about the health/education and training interface and decision making on health workforce issues...the fact that such meetings are required suggests the limitations of current arrangements.²

Better coordination is needed between the government and university sectors on university intake levels, with governments – in consultation with the HPCA - providing greater direction and increased funding to universities on areas of workforce shortage and desirable intake levels. As discussed earlier in this submission, the HPCA proposes the establishment of a single national statutory authority for the health workforce, to improve coordination, data collection and policy development.

Allied health professional associations do not in any way control or restrict entry to tertiary courses. They do, however, work to maintain good lines of communication between allied health professionals and the universities.

Of particular importance to HPCA member organisations are the inadequate funding levels for allied health education, difficulties in the provision of clinical education, and the impact of increasingly higher fees.

The HPCA contends that allied health undergraduate courses must be funded at an equivalent level to courses for medical undergraduates. Without additional funding, the current crisis in clinical education could lead to a collapse in the supply of allied health professionals.

Under the New Commonwealth Grants Scheme, institutions receive Full Time Student Unit (FTSU) funding to an agreed (and previously negotiated) number.

Allied health professions are currently placed in clusters 5 and 6. This means that they receive a Commonwealth contribution only half of that for Medicine, which is in cluster 9 along with Dentistry and Veterinary Science. Nursing, classified as a National Priority, attracts a government contribution about a third higher than that for the allied health professions.

The Commonwealth Government should move the allied health professions from clusters 5 and 6, and relocate them all in cluster 9 on the Commonwealth Course Contribution Schedule. The HPCA contends that the clinical component of mainstream allied health courses is comparable to that of Medicine, and that therefore the Commonwealth Government contribution per student should be equivalent to that of Medicine.

In contrast to Medicine and Nursing, there is little or no direct support through the health system for clinical education within the allied health professions. Students of many allied health disciplines are required to complete up to 1,000 hours of clinical education as part of their entry-level education; and some disciplines require a post-graduate 'intern' year before the students are qualified to practice independently.

Clinical practice requires rapid, efficient, high level clinical, moral and ethical decision-making. These factors are almost impossible to simulate in classroom settings. Only in actual clinical settings can students gain real-time experience in clinical decision-making. Hands-on clinical experience is an integral, yet costly, part of entry-level education. Computer-based learning experiences can enhance but not substitute for hands-on training in a hospital or other clinical environment.

² Productivity Commission website - <http://www.pc.gov.au/study/healthworkforce/subs/sub010.pdf>

Universities are facing major difficulties in providing clinical education for health students, since there is no recognised funding for it either in the education or health budgets.

For many allied health professions, public hospitals provide the bulk of undergraduate clinical education. Private clinics rarely provide clinical education opportunities for students, but benefit when highly trained graduates leave the public system to seek higher incomes in the private sector.

It should be noted that the allied health professions have a range of needs in relation to hands-on experience for students. The HPCA has prepared a detailed discussion paper on the current problems in clinical education.³ This discussion paper highlights the need for innovation in the way professional practice placements are structured.

The impact of increasingly high HECS-HELP (Higher Education Loan Programme) and Masters Entry fees also need to be considered in relation to allied health workforce shortages in the future. Students who have incurred substantial debts to obtain their qualifications are increasingly likely to make their career choices based on potential financial returns rather than altruistic motives such as the public good. This could exacerbate the shortage of skilled professionals in high-need areas where pay rates can be modest, such as aged care, rural and regional services and many public hospitals.

The Commonwealth Government needs to reduce this adverse impact on allied health career pathways by modifying the funding policies that are leading to these high student fees. A five-year moratorium on student fees for allied health tertiary courses would be beneficial.

HPCA supports inter-disciplinary undergraduate education, through shared common modules taught to students across health disciplines. This approach provides the basis for multidisciplinary teamwork between professionals upon their entry to the health workforce. There are several successful examples of inter-disciplinary undergraduate education and these should be given greater government recognition and funding. HPCA is ideally suited to facilitate such inter-disciplinary approaches, through the proposed National Allied Health Liaison Office.

Work should continue on the development of core multidisciplinary subjects at university entry level, to provide a common foundation for all health professionals prior to specialisation in individual disciplines.

Decisions about allied health professional courses need to be based on workforce planning needs, not just on commercial considerations. Student intakes should not be increased unless adequate clinical education can be provided to all students.

There is a need to develop structures to support the delivery of clinical education, particularly in rural, remote and Indigenous communities. This is necessary and can be facilitated by the use of private health services as clinical training sites, thus reducing barriers to clinical education in such settings.

Funds must be provided to explore innovative models of education, such as on-line distance learning and simulated clinical experience, in order to address the training and distribution of allied health professionals at both undergraduate and post-

³ HPCA discussion paper (2005): Solving the crisis in clinical education for Australia's health professions.

graduate levels. On-line learning does not, however, reduce the need for hands-on clinical education.

It is evident that workforce supply is affected in states and territories that do not offer undergraduate university courses. Practitioners are more likely to practice where they train, therefore limiting supply of allied health professionals in states and territories where there are few or no training courses.

HPCA supports pilots of cross-discipline support for allied health professionals, especially in areas such as inter-disciplinary communication. However, discipline-specific support such as supervision and mentoring must be made available and adequately funded for all allied health professionals, particularly those in rural and remote Australia.

HPCA believes that continuing professional development (CPD) is an essential mechanism to ensure quality of care and optimum health outcomes for clients. Employers should actively encourage and fund their allied health professionals to participate in CPD, especially in rural and remote Australia.

Workforce Structure

Because of rapid changes in health knowledge, technology, consumer demand and funding pressures, hospitals and other health workplaces have needed to become more flexible in structure.

As previously noted, the allied health professions are themselves evolving more flexible and specialised roles. Many allied health professionals have moved out of direct clinical practice and have taken on key health management and planning responsibilities. These enhanced skills need to be recognised, welcomed and used to the full. At present, this does not always happen. Allied health professionals also provide services in sectors other than health, in such settings as schools, disability services and factories.

Within the health sector, structural problems between programs are a barrier to the most effective use of allied health professionals, who are already in critically short supply.

Australia's current health system cannot be considered an integrated whole: rather, it is a collection of programs, initiatives and arrangements between the Commonwealth, state/territory and sometimes local governments. This situation creates duplication and hinders coordination, cooperation and innovation within the system.

There is a notable lack of integration across the continuum of health care. Silos of private and public care, primary clinical care, aged care, community health and public health are causing far more waste and lack of efficiency than the much touted 'barriers' between different professions.

For example, patients being discharged home after a total hip replacement surgery can access equipment such as shower chairs through the hospital, their local community health centre or via the Department of Veterans' Affairs. Each equipment centre has its own eligibility guidelines, waiting lists and procedural requirements.

The HPCA recommends that structural barriers between health programs run by different government agencies be addressed and removed. This will not only improve patient care and reduce costs, but will increase health workforce productivity and therefore job satisfaction and staff retention.

There are particular difficulties in relation to allied health professionals employed on projects with short-term funding. Such projects may or may not have sustainable outcomes, are often not well integrated with other services, can mask the need for (and at times damage) long term services and can add to the complexity of workforce planning. In addition, they exacerbate the problem of recruitment and retention of allied health professionals.

The rise in chronic disease, the emphasis on lifestyle prescriptions and the need for a whole of population approach will increase demand for allied health services. Many people with chronic illness could avoid the need to be routinely treated in hospitals if the correct structures were in place to support them.

As already noted, workforce shortages faced by allied health professionals are far more complex than the supply/demand equation. The existing infrastructural networks of tertiary education, workplace demands, childcare and taxation are inadequate, particularly for those allied health professions which have a high percentage of female and part-time workers.

To ensure adequate consultation on health workforce planning, the HPCA believes that allied health should have representation through the HPCA on the Australian Health Workforce Advisory Committee (AHWAC).

A specific structural problem relates to registration of some allied health professions. While some have a national system of State-based Registration Boards, others have a mix of Registration and accreditation by professional associations. It is important that throughout Australia there are adequate and comparable accreditation systems in place to protect consumers. HPCA member organisations seeking changes in registration arrangements for their profession have set out their views in individual submissions to the Productivity Commission.

Workforce Participation

There are a number of other factors that impact on the current shortage – notably retention and re-entry issues, gender balance, professional development, mentoring and support.

Many allied health professions have identified the urgent need for retention strategies to minimise the loss of experienced and hard to replace professionals.

Factors influencing professional attrition rates can include:

- lack of appropriate award structures, leading to loss of professional supervision, inadequate recognition of skills, limited career progression and enhancement;
- stress and burnout, often related to waiting list and caseload demands, isolation and lack of locum provision; and
- specific factors affecting recruitment and retention in rural and remote areas.

It is clear that for many professions, high attrition rates are related to poor career paths and inadequate pay. In order to achieve better remuneration and career prospects, many experienced allied health professionals are choosing to move out of clinical areas into such fields as management and education, resulting in shortages of clinical practitioners.

In a study which is relevant to many allied health professions, the most important factors in the retention of, and job satisfaction for, Victorian hospital pharmacists in both metropolitan and rural areas have been identified as:

- the availability of sufficient and suitably qualified staff;
- hospital management's support for the practice of hospital pharmacy; and
- professional development opportunities and access to organised continuing education.

Hospital pharmacists in rural areas indicated that the availability of locum and relieving pharmacists was a crucial issue for them.⁴

The HPCA urges the Commonwealth Government to investigate the efficacy of 'attract back to practice' schemes in Australia and overseas, as a useful short term measure to increase the supply of allied health professionals.

After a period of absence, allied health professionals can find it difficult to re-enter the workforce - especially in the acute health sector - where they have to balance work, professional development requirements and family commitments. As a result, many are opting for part time work, where available. This may financially disadvantage them in relation to tax, welfare and childcare arrangements, and so may further discourage their participation in the workforce. The issue can be of particular importance in allied health professions with a high percentage of female practitioners. Family-friendly and flexible working arrangements and formal re-entry programs are therefore crucial to ensure maximal participation in the workforce.

⁴ Kainey S. Hospital pharmacy in rural Victoria. Melbourne: Society of Hospital Pharmacists of Australia (Victoria); 2002.

Workforce Distribution

It is widely recognised that people living in rural and remote areas tend to have much poorer access to allied health professionals. This is reflected in generally poorer health among rural communities.

Rural and remote Australia experiences chronic workforce shortages. Programs such as the More Allied Health Services (MAHS) will not succeed without an adequate supply of allied health professionals in targeted areas. Greater input from allied health professionals and consumers into service delivery decisions would also improve the MAHS program. At present, such decisions are primarily made by General Practitioners.

The plight of indigenous communities is of particular concern to the Health Professions Council of Australia, which urges the Commonwealth Government to substantially increase access to allied health services as a way of improving the health of indigenous people.

Rural and remote areas have less allied health professionals per head of population than do urban areas. Indigenous communities in remote areas often have very little or no access to allied health professionals. Allied health professionals can substantially contribute to improved standards of indigenous health by working closely with Aboriginal Healthcare Workers.

Rural areas frequently attract new allied health graduates (those who have graduated in the past two years), often because the positions on offer tend to be at base grade level. In spite of this low grading, rural practitioners are often expected to work at a much higher skill level, without adequate professional support and across a broader range of activity than would be expected in metropolitan areas. The resulting staff burn-out lead to constant turnover and chronic staff shortage in rural areas. These factors are detrimental for continuity of care, professional networks and relationships.

To address these issues, it is essential that new graduates are provided with adequate supervision, support and mentoring, wherever they practice.

Measures proposed to attract and support allied health professionals working beyond the cities include HEC reimbursement schemes, bonded scholarships, assistance with continuing professional development, mentoring, and on-line education and training.

CONCLUDING STATEMENT

Allied health professionals are crucial to Australia's health services. For too long, however, the Commonwealth Government has focussed almost exclusively on the medical and nursing professions in its health workforce research and planning. One result has been the burgeoning health costs of hospitals and acute clinical services.

Greater access to allied health services will strengthen preventative as well as remedial health care, and so will help limit health costs across Australia.

To improve access, current and future allied health workforce shortages must be addressed, together with issues relating to clinical education, data collection, career prospects, recruitment and retention.

The Health Professions Council of Australia welcomes the Government's increasing recognition of the importance of allied health, and offers maximum support to the Productivity Commission in its current research study.

About the HPCA

The Health Professions Council of Australia is the national peak body for major health professions other than medical practitioners and nurses. It works to represent the interests of the non-medical health professions sector, particularly to the Commonwealth Government; and to provide a vehicle for liaison and discussion between the professions themselves.

Members of the HPCA are national organisations representing specific professions, with membership across Australia in both urban and rural areas. Collectively, they represent about 50,000 allied health professionals. Each has internal systems and networks for liaising with their members, ensuring that the HPCA has input from allied health professionals right across Australia who together provide a vast wealth of skills, experience and opinion.

Current membership of the HPCA represents the following professions:

- Audiologists
- Dietitians
- Occupational Therapists
- Orthoptists
- Orthotists and Prosthetists
- Pharmacists
- Physiotherapists
- Podiatrists,
- Psychologists
- Radiographers
- Radiation Therapists
- Social Workers
- Speech Pathologists.

More details about the HPCA and its member organisations can be found at:
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