Submission
No 456

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Exercise and Sports Science Australia (ESSA)

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Exercise & Sports Science Australia Submission

Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Portfolio Committee No. 2 – Health
Legislative Council, Parliament of NSW

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1.0 About Exercise & Sports Science Australia

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing over 8,000 members, including university qualified Accredited Exercise Physiologists (AEPs), Accredited Sports Scientists (ASpSs), Accredited High-Performance Managers (AHPMs) and Accredited Exercise Scientists (AESs).

AEPs are recognised allied health professionals (AHPs) who provide clinical exercise interventions aimed at primary and secondary prevention; managing acute, sub-acute and chronic disease or injury; and assist in restoring optimal physical function, health and wellness. Exercise physiology is a recognised and funded profession under compensable schemes such as Medicare Benefit Services (MBS), Department of Veteran Affairs (DVA), the National Disability Insurance Scheme (NDIS), private health insurance, and state and territory-based workers' compensation schemes. AEPs are four year trained university professionals.

Accredited Sports Scientists (ASpSs) and Accredited High-Performance Managers (AHPMs) work predominately in high performance/elite sport specialising in applying scientific principles and techniques to assist coaches and athletes to improve their performance, either at an individual level or within the context of a team environment. ESSA is recognised by the Australian Institute of Sport and Sport Australia as the peak accrediting body for physiology/recovery, biomechanics, performance analysis and skill acquisition support personnel working in Australian sports science.

Accredited Exercise Scientists apply the science of exercise to design and deliver physical activity and exercise-based interventions to improve health, fitness, well-being, performance and assist in the prevention of injury and chronic conditions. They coach and motivate to promote self-management of physical activity, exercise and healthy lifestyles and work in the National Disability Insurance Scheme (NDIS) as personal trainers and allied health assistants (AHAs), in fitness businesses, for sporting bodies, in corporate health and as AHAs for exercise physiologists and other allied health professionals. AESs are three year trained university professionals.

ESSA welcomes the opportunity to respond to the Portfolio Committee No. 2 – Health and appear before the Committee, if invited.

2.0 Introduction and Summary of Issues

Health care is not just delivered by doctors and nurses. There is an important third stream of health care provided by allied health professionals, who are just as critical for keeping patients healthy.

A Senate Committee which reported in 2012 on *The factors affecting the supply of health services and medical professionals in rural areas*

> "was **cautioned against regarding AHPs as optional extras that are secondary to providing sufficient numbers of doctors and nurses**. The importance of AHPs to patient welfare was put to the committee by SARRAH [Services for Australian Rural and Remote Allied Health]:
>
> > There can be a perception that allied health services are 'discretionary' in nature. This may be true in some circumstances and not in others, not unlike the medical equivalent...**Few would argue that the work of Optometrists is discretionary, or Exercise Physiologists conducting cardiac rehabilitation or Speech Pathologists treating life threatening swallowing disorders in acute hospitals.**

> The diagnostic professions in radiography and medical technology provide doctors with information vital to medical treatment, and a person whose spinal cord was cut in a car accident would not consider rehabilitation services to be optional[i]

More recently in 2020, the former National Rural Health Commissioner, Emeritus Professor Paul Worley, highlighted the important role of allied health in rural, regional and remote Australia in his final *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*[ii]:

> "**Allied health professionals are essential to the physical, social and psychological wellbeing of people living in rural and remote Australia.** They are **integral to the care of rural and remote communities, whose capacity to achieve optimal health outcomes is limited by inequitable access to appropriate health services**. They are also integral to the economic development of rural and remote populations particularly in relation to workforce participation and educational outcomes.
>
> **There is both an undersupply and a maldistribution of allied health services in rural and remote towns of less than 30,000 people** that can be addressed by an integrated service and learning pathway linked to more and better structured jobs, greater participation of Indigenous Australians, improved access to workforce data and through national allied health leadership."

Further in the report, Emeritus Professor Worley notes:

> "While recognising there is unmet need for allied health services across all of regional, rural and remote Australia, the particular focus of the Commissioner's work has been on **improving access to services for populations living in Modified Monash Model 4-7, where the maldistribution is most pernicious**."

The third health care stream is often neglected and a comment made in **2016** by the former CEO of the National Rural Health Alliance, Gordon Gregory that **"Allied health is still the forgotten professional grouping in health policy matters,[iii]"** still holds true in 2021.

As a small and emerging self-regulated health profession, there is "limited consumer and professional awareness of the exercise physiologist's role[iv]". This submission focuses on the challenges faced by a small and emerging self-regulated health profession (exercise physiology) and the broader allied health sector; and how these challenges impact the health outcomes of rural, regional and remote New South Wales patients.

In addition, this submission demonstrates how rural, regional and remote New South Wales patients are impacted by their participation (or lack of) in regular physical activity and exercise, and the lack of access to allied health services generally, particularly access to services provided by Accredited Exercise Physiologists.

Given the events of 2020, this submission also highlights the impact of the Coronavirus (COVID-19) pandemic on rural, regional and remote New South Wales residents.

The submission relies heavily on a specific workforce planning project for allied health in NSW to identify the workforce requirements to 2030, which aligns with action 7.8 of the NSW *Health Professionals Workforce Plan 2012-2022*[v], namely the *Exercise Physiology - Horizons Scanning and Scenario Generation Report* published in July 2019[vi].

Only the following items from the Terms of Reference are covered in this submission:

(a) health outcomes for people living in rural, regional and remote NSW;
(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;
(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;
(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW;
(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them;
(i) the access and availability of oncology treatment in rural, regional and remote NSW;
(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;
(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous communities.

3.0 Summary of Recommendations

Recommendation 1: That to improve health outcomes and build a more sustainable future, the NSW Minister for Health and Medical Research considers mandating that at least 5 per cent of the NSW Health budget and each local health district's budget are spent on public health initiatives.

Recommendation 2: That additional Integrated Care initiatives, targeting vulnerable populations, including patients with complex and chronic conditions, be established in the rural, regional and remote areas with the greatest health needs.

Recommendation 3: That the NSW Health and its local health districts support the employment of additional AEPs in any new Integrated Care projects (e.g. in health coaching/behavioural change roles); and early intervention and prevention (e.g. pre-diabetes, noting this condition is not covered by Medicare), falls prevention/rehabilitation, COVID-19 rehabilitation, mental health, cancer care, cardiac care, pain management, diabetes, chronic obstructive pulmonary disease and respiratory rehabilitation initiatives.

Recommendation 4: That the NSW Health considers requiring all Rural Adversity Mental Health Coordinators to undertake free Exercise is Medicine® training.

Recommendation 5: That NSW Health resources additional investment in the health needs of NSW farmers either via the National Centre for Farmer Health or via a standalone NSW initiative.

Recommendation 6: That NSW Health investigates how improvements could be made for farmers' access to rehabilitation services.

Recommendation 7: That NSW Health investigates whether a set allocation within this fund could be made for the delivery of allied health services in rural, regional and remote NSW.

Recommendation 8: That NSW Health considers a mechanism to provide access for general practitioners and allied health professionals to access patients' public hospital information.

Recommendation 9: That NSW Health works with peak GP groups (i.e. The Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, NSW Rural Doctors Network) to facilitate a greater take up of *My Health Record.*

Recommendation 10: That the NSW Treasurer via the Council of Council on Federal Financial Relations supports the removal of GST from exercise physiology services.

Recommendation 11: That the NSW Government via the National Cabinet Reform Committees (Health and Rural and Regional Australia) re-investigates funding models that focus on a long-term, whole person and population health perspective.

Recommendation 12: That the NSW Minister for Health and Medical Research and NSW Health through the Health National Cabinet Reform Committee supports a review of restrictions on access to MBS items and encourage the Australian Government to develop agreed clinical governance telehealth standards and move to using blended payments and block funding to support greater access to telehealth by rural, regional and remote patients.

Recommendation 13: That the NSW Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.

Recommendation 14: That the NSW Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) considers additional funding of technology literacy initiatives, especially for those living in rural and remote areas.

Recommendation 15: That the NSW Health and the NSW Chief Health Officer through the Australian Health Protection Principal Committee ensure that definitions of essential health workers and restrictions to services align across all borders so both cross border residents and those health professionals who work across borders are not impacted by further lockdowns.

Recommendation 16: That NSW Health supports and facilitates collaborative, multidisciplinary teams across care settings.

Recommendation 17: That the NSW Government via the National Cabinet Reform Committees (Health and Rural and Regional Australia) requests the Australian Government task and resource Australian Allied Health Leadership Forum (the peak body for stakeholders of the Australian allied health sector and services) to facilitate the collection and dissemination of allied health service improvements and innovations suitable for use in rural, regional and remote areas via a virtual hub/community of practice or alternatively, establish a virtual hub/community of practice for NSW.

Recommendation 18: That the NSW Minister for Health and Medical Research and NSW Health through the Health National Cabinet Reform Committee support initiatives to

- **enhance the regular collection of data on self-regulated health professions via the National Alliance of Self Regulating Health Professions**
- **improve the Australian Bureau of Statistics occupational and industry classification frameworks to more adequately reflect the breadth of the allied health sector**

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- **improve the reporting of private health insurance data on ancillary services provided by self-regulated health professions by the Australian Prudential Regulation Authority.**

Recommendation 19: That the NSW Health considers utilising Accredited Exercise Scientists and exercise science students to work as allied health assistants and Technical Officers in any future surge workforces.

Recommendation 20: That NSW Health maps hospital activities against the scopes of practice of allied health professionals (both Aphra and self-regulated professions) to determine the highest value use of qualified allied health staff in the event of a natural disaster or another pandemic.

Recommendation 21: That NSW Health provides more opportunities for allied health professionals, especially from newer and emerging professions like exercise physiology to be involved in service planning.

Recommendation 22: That NSW Health develops resources and provide opportunities for service leaders to better understand the scopes of practice of allied health professionals.

Recommendation 23: That NSW Health makes improvements to the reporting structure and governance of exercise physiologists; and consider options like establishing cross district clinical leads to support professional development of exercise physiologists employed by NSW Health, especially sole junior practitioners.

Recommendation 24: That the NSW Government considers further tranches of business support initiatives for private allied health practices in the event of further COVID-19 lockdowns.

Recommendation 25: That NSW Health considers requiring all Oncology Nurses to undertake free Exercise is Medicine® training.

Recommendation 26: That NSW Health considers expanding the employment of AEPs in cancer care.

Recommendation 27: That NSW Health considers facilitating the employment of AEPs in palliative care.

Recommendation 28: That NSW Health continues to resource *Respecting the Difference* training.

4.0 Health outcomes for people living in rural, regional and remote NSW

4.1 Health Outcomes and Physical Activity in Rural and Remote Areas

Australians living in rural and remote areas

> 'tend to have lower life expectancy, higher rates of disease and injury, and poorer access to and use of health services than people living in Major cities.
>
> Poorer health outcomes in rural and remote areas may reflect a range of social and other factors that are detrimental to health, including a level of disadvantage related to educational and employment opportunities, income, and access to health services. People living in rural and remote areas may face more occupational and physical risks, for example, from farming or mining work and transport-related accidents, and experience higher rates of other risk factors associated with poorer health, such as tobacco smoking and alcohol misuse[vii]'.

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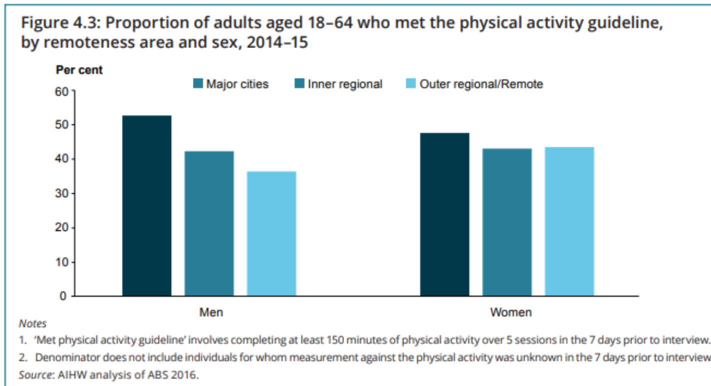
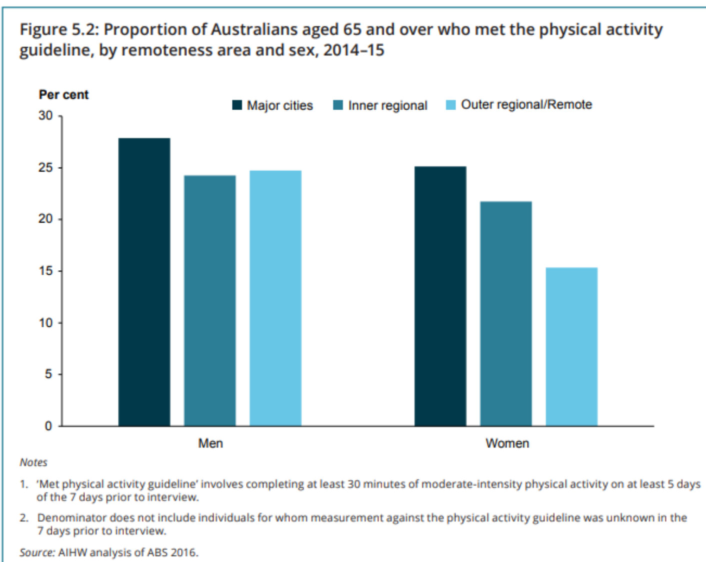
The more remote the population group, the lower the proportion of adult men and women who meet the national physical activity guideline as evidenced in the figure below:

Figure 1: Proportion of adults aged 18–64 who met the physical activity guideline, by remoteness area and sex, 2014–15 (As cited in Australian Institute of Health and Welfare 2018. *Physical activity across the life stages*[viii])



Similarly, fewer adult women aged 65 and over meet the national physical activity guideline as remoteness increases with slight differences for men aged over 65 in outer regional/remote areas:

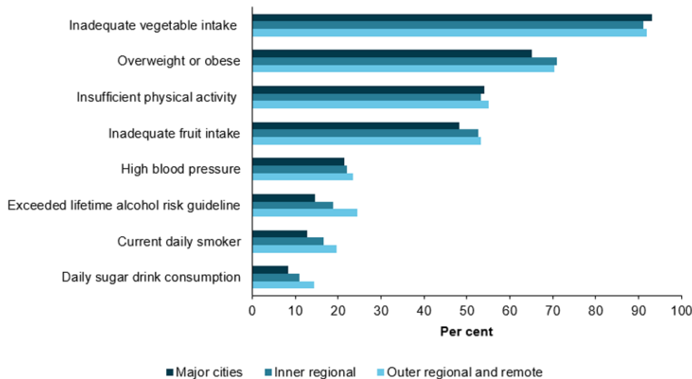
Figure 2: Proportion of adults aged over 65 who met the physical activity guideline, by remoteness area and sex, 2014–15 (As cited in Australian Institute of Health and Welfare 2018. *Physical activity across the life stages*[ix])



The consequences of this physical inactivity contribute towards 10–20% of the individual disease burden from diabetes, bowel cancer, uterine cancer, dementia, breast cancer, coronary heart disease and stroke[x].

Insufficient physical activity is a significant risk factor for those living in rural, regional and remote areas as per the figure below:

Figure 3: Prevalence of health risk factors, by area of remoteness, 2017–18
(As cited in Australian Institute of Health and Welfare 2019. *Rural & remote health*[xi].)



Various studies have demonstrated the cost benefit analyses of allied health interventions with ESSA's 2015 Deloitte commissioned report on *Value of Accredited Exercise Physiologists in Australia* demonstrating a high return on investment for exercise physiology in treating people with chronic conditions, namely pre- diabetes and type II diabetes, mental illness and cardiovascular and other chronic diseases[xii].

A report[xiii] developed for Services for Australian Rural and Remote Allied Health (SARRAH) on allied health interventions (including exercise physiology interventions) targeting type II diabetes, osteoarthritis and post-stroke populations highlighted a significant number of adverse health outcomes were avoided when patients are treated by allied health professionals. The report highlighted significant potential annual savings for the implementation of individual interventions ranging from $5.1 million to $77.9 million per intervention.

4.2 Preventative Healthcare Target

Clinical care only accounts for 20 per cent of the factors influencing an individual's longevity and quality of life[xiv] The need to focus on the remaining 80 per cent of factors (healthy behaviours including physical activity, exercise and diet; social and economic support; and the physical environment) will become more critical as governments recognise the importance of the social determinants of health in supporting health and wellbeing.

Without intervention, the Australian Government will need to double its spending on healthcare per capita over the next 40 years in order to finance the current level of activity[xv]

Western Australian (WA) Government expenditure on health has more than doubled in the past 10 years (as of 2018) yet population health and acute care outcomes have not improved at a comparable rate[xvi]. Without change, health spending is projected to consume 38 per cent of the WA budget by 2026-27, at the expense of other essential services such as education, housing, policing and transport services.

To address this dilemma, the WA Government recently adopted recommendations from a landmark *Sustainable Health Review*[xvii] on what is needed to transform health spending and services to provide high quality healthcare while aiming to build a more sustainable future.

A key recommendation was to increase and support investment in public health, with spending on prevention to be increased to at least five per cent of total health expenditure in WA by 2029 to more than $440 million per year, noting in 2018 that only 1.6 per cent of the total health budget was spent on prevention.

A target of five percent would also be comparable to expenditure by other Commonwealth nations such as Canada and the United Kingdom as per the most recent Organisation for Economic Co-operation and Development (OECD) data available. As of 2017, Australia spent approximately 1.9 per cent of its total health budget[xviii] on preventative care as defined by the Organisation for Economic Co-operation and Development[xix]. This is significantly lower than comparable countries such as Canada (5.8 per cent of expenditure), the United Kingdom (5.2 per cent), Italy (4.2 per cent) and Korea and Finland (both 4 per cent).

Recommendation 1: That to improve health outcomes and build a more sustainable future, the NSW Minister for Health and Medical Research considers mandating that at least 5 per cent of the NSW Health budget and each local health district's budget are spent on public health initiatives.

4.3 Integrated Care

A more significant investment in preventative healthcare in the community would also support one of the NSW Premier's Priorities: Reducing preventable visits to hospital by 5 per cent through to 2023 by caring for people in the community via the Integrated Care program.

ESSA has reviewed the interim report for the Western NSW Integrated Care Strategy[xx] and fully supports the employment of Accredited Exercise Physiologists and a dietitian in the team care approach within the *Expecting Changes healthy weight gain for pregnant women* program in Mudgee. ESSA would also like to see additional Accredited Exercise Physiologists employed in any health coaching role in future Integrated Care projects.

A relatively recent NSW Ministry of Health (NSW Health) rapid evidence check[xxi] (4 May, 2020) on the rehabilitation needs of post-acute COVID-19 patients found **post COVID-19, exercise interventions were one of the keys to recovery**. ESSA foreshadows that Accredited Exercise Physiologists will be integral in supporting the recovery of post-acute COVID-19 patients.

Recommendation 2: That additional Integrated Care initiatives, targeting vulnerable populations, including patients with complex and chronic conditions, be established in the rural, regional and remote areas with the greatest health needs.

Recommendation 3: That the NSW Health and its local health districts support the employment of additional AEPs in any new Integrated Care projects (e.g. in health coaching/behavioural change roles); and early intervention and prevention (e.g. pre-diabetes, noting this condition is not covered by Medicare), falls prevention/rehabilitation, COVID-19 rehabilitation, mental health, cancer care, cardiac care, pain management, diabetes, chronic obstructive pulmonary disease and respiratory rehabilitation initiatives.

4.4 Mental Health

The Rural Adversity Mental Health Program (RAMHP) operates with NSW Health funding under an agreement with the Centre for Rural and Remote Mental Health (CRRMH) which is based in Orange. The program funds one or more RAMHP Coordinators in each of the rural NSW local health districts. 20 Coordinators are based across regional, rural and remote NSW who inform, educate and connect individuals, communities and workplaces with appropriate services and programs.

Exercise plays a huge role in assisting people with mental health conditions manage their health. ESSA manages Exercise is Medicine® Australia (EIM), a global initiative lead by the American College of Sports Medicine. EIM® Australia offers free training on the role that exercise has in the prevention, treatment and management of chronic conditions and assists health professionals to refer patients to appropriately trained allied health professionals to deliver exercise treatment services.

Recommendation 4: That the NSW Health considers requiring all Rural Adversity Mental Health Coordinators to undertake free Exercise is Medicine® training.

4.5 Farmer Health

A 2017 literature review[xxii] highlights the continued higher rates of workplace injuries, traumatic death and suicides in farming populations in Australia and globally.

Agricultural workforces in Australia and abroad experience excessive work-related mortality, are burdened with high rates of physical and mental disease, and have limited access to health services and low health literacy[xxiii]. This results in poor health outcomes for diseases and illnesses readily manageable in urban settings.

Farmers who lived remotely reported worse mental health and wellbeing than remote non-farm workers regardless of financial hardship, rural specific factors e.g. drought worry, or recent adverse events[xxiv].

AEPs provide services through the NSW workers' compensation scheme to rehabilitate injured farmers experiencing physical and/or psychological injuries caused through their work. Access to these services in rural settings is not universally available and diminishes the opportunity for injured workers to restore functional capacity and return to work in a timely manner.

The National Centre for Farmer Health works to improve the health, wellbeing and safety of farmers, farm workers, their families and communities across Australia. Whilst it is a National Centre, it is funded through the Victorian Government's Future Farming Strategy and the Helen and Geoff Handbury Trust, thus its primary focus is on Victorian farmers.

Recommendation 5: That NSW Health resources additional investment in the health needs of NSW farmers either via the National Centre for Farmer Health or via a standalone NSW initiative.

Recommendation 6: That NSW Health investigates how improvements could be made for farmers' access to rehabilitation services.

5.0 Access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services

5.1 Outreach Fund

NSW Rural Doctors Network are the fund holder for NSW for the Rural Health Outreach Fund Program. This program supports the delivery of allied health services into rural, regional, and remote areas of Australia.

Recommendation 7: That NSW Health investigates whether a set allocation within this fund could be made for the delivery of allied health services in rural, regional and remote NSW.

5.2 Health Records

In 2016, Queensland became the first, and remains the only jurisdiction in Australia to allow general practitioners (GPs) (external to the public system) to see a patient's public hospital information, such as pathology and radiology test reports.

Public hospital information is shared through *The Viewer*, a Queensland Health database where information about patients is stored on a read-only, web-based platform.

Access to *The Viewer* has:

- improved collaboration between different parts of the health system
- promoted consistent, timely and more coordinated patient care and
- enhanced the discharge process.

In 2020, Queensland Health released a consultation paper asking for feedback on facilitating access of Aphra registered allied health practitioners to *The Viewer*.

Recommendation 8: That NSW Health considers a mechanism to provide access for general practitioners and allied health professionals to access patients' public hospital information.

Anecdotal information provided to ESSA indicates that many rural GPs do not use the Australian Government's *My Health Record*. Instead, they use a variety of diagnostic imaging platforms which creates an extra burden for allied health professionals to access vital patient information.

Recommendation 9: That NSW Health works with peak GP groups (i.e. The Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, NSW Rural Doctors Network) to facilitate a greater take up of *My Health Record.*

5.3 GST

Exercise physiology services meet the Australian Taxation Office (ATO)'s criteria for listing as an 'other health service' not defined as a medical service in respect to uniform national professional self-regulation of Accredited Exercise Physiologists. Yet despite meeting the ATO's criteria, exercise physiology services are not exempt from GST (apart from Medicare, NDIS residents in residential care facilities, some GST-free hospital treatment and some GST-free residential care).

Exercise physiology is the only standalone profession with a Chronic Disease Management (CDM) Medicare item that is not exempt from GST.

In respect to allied health Medicare items, the exercise physiology Item 10953 was in the top 5 in-scope items for 2016-2017 as per Table 1 below by service volume out of 26 Medical Benefits Scheme (MBS) Items reviewed by the Allied Health Reference Group as part of the *Medicare Benefits Schedule Review*. A second exercise physiology item (8115) for group services for the management of type 2 diabetes was also listed in the top 10 in-scope items by service volume.

Table 1: Top 10 in-scope items by service volume 2016-2017[xxv]

Top 10 in-scope items by service volume in 2016-17

Item	Descriptor	Service volume (FY2016/17) Thousands	Total benefits (FY2016/17) $ millions
10962	Podiatry service to person with chronic condition under a care plan >20 mins	3,010	159.8
10960	Physiotherapy service to person with chronic condition under a care plan >20 mins	2,198	117.3
10954	Dietetics service to person with chronic condition under a care plan >20 mins	415	22.2
10964	Chiropractic service to person with chronic condition under a care plan >20 mins	355	18.8
10953	Exercise physiology service to person with chronic condition under a care plan >20 mins	279	14.9
10966	Osteopathy service to person with chronic condition under a care plan >20 mins	165	8.9
10970	Speech pathology service to person with chronic condition under a care plan >20 mins	157	9.0
10951	Diabetes education service to person with chronic condition under a care plan >20 mins	93	4.9
10958	Occupational therapy service to person with chronic condition under a care plan >20 mins	69	4.2
81115	Exercise physiology group service; 2-12 patients, >=60 mins	55	0.9

Potential discussion points

- Podiatry service had the highest service volume of all in-scope items
- 10965 and 10960 together (podiatry and physiotherapy) represent 75% of in-scope service volume
- 9 out of the top 10 items are for Allied Health individual services (group M3 in MBS)

SOURCE: MBS data, 2011/12 – 2016-17 Australian Government Department of Health | 29

Once Medicare subsidised services are fully utilised, patients then get charged GST for any additional private services needed to complete their treatments. Anecdotal evidence provided to ESSA suggests that many patients simply stop treatment once Medicare benefits are exhausted which compounds their conditions and in some cases, results in hospital admissions that could have been prevented.

To remain competitive with other AHPs like physiotherapists, AEPs often charge patients less because private patients need to pay the extra 10 percent GST charge. AEPs have also reported to ESSA that they could employ more staff to deliver services if the GST was removed.

The professions of

- acupuncture
- chiropody
- herbal medicine and
- naturopathy

are also exempt from GST though they sit outside of both the National Alliance of Self Regulating Health (NASRHP), a formal independent body providing a quality framework for self-regulating health professions and Australian Health Practitioner Regulation Agency (Ahpra) which works with 15 National Boards to regulate registered health practitioners.

Recommendation 10: That the NSW Treasurer via the Council of Council on Federal Financial Relations supports the removal of GST from exercise physiology services.

5.4 Funding Models

Whilst primary healthcare reform has been on the agenda for 15 to 20 years, reform has been slow and incremental apart from 2020, when many advances were made in response to the COVID-19 pandemic.

Little progress has been made on blended funding models and universal voluntary enrolment of patients – recommendations that date back to a 2009 report by the *National Health and Hospitals Reform Commission, A Healthier Future for All Australians*[xxvi].

This report envisaged

- voluntary patient enrolment with a 'healthcare home' to coordinate access to multidisciplinary care
- primary healthcare supported by a mix of fee-for-service
- grants to support multidisciplinary clinical services and care coordination
- outcomes payments to reward good performance, and
- episodic or bundled payments.

The report noted that 'the use of episodic payments would create greater freedom for primary healthcare services to take **a long-term, whole person and population health perspective** that moves away from funding based on single consultations or visits – an approach that can better meet the needs of people with chronic and complex conditions'.

Recommendation 11: That the NSW Government via the National Cabinet Reform Committees (Health and Rural and Regional Australia) re-investigates funding models that focus on a long-term, whole person and population health perspective.

5.5 Telehealth Useage and Barriers

The summarised telehealth uptake of MBS consultations[xxvii] throughout Australia by the University of Queensland's Centre for Online Health during COVID-19 (including the new allied health telehealth items for Chronic Disease Management items) shows that **proportionally more allied health consultations were completed using videoconferencing compared to consultations undertaken by general practitioners and specialist physicians** as per Figures 4, 5 and 6:

Figure 4: Allied Health MBS Telehealth Consultations to October 2020 (does not include any activity claimed using codes that are specifically for mental health interventions)

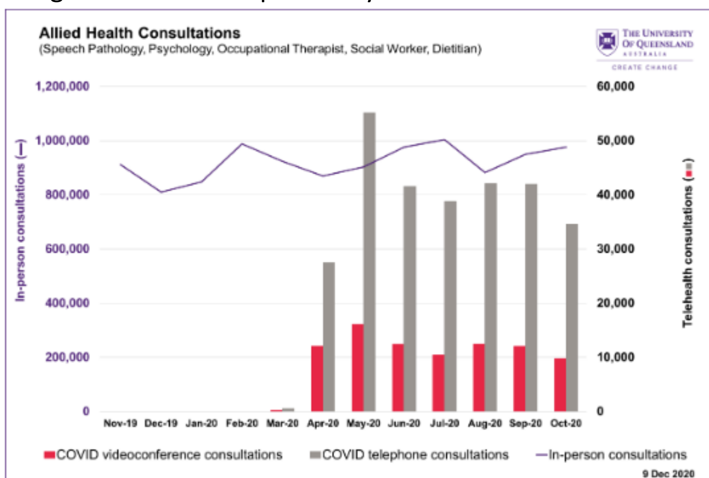


Figure 5: General Practitioner MBS Telehealth Consultations to October 2020

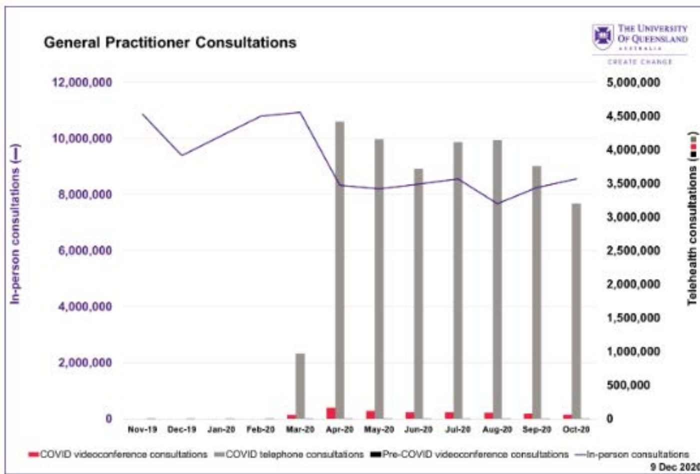
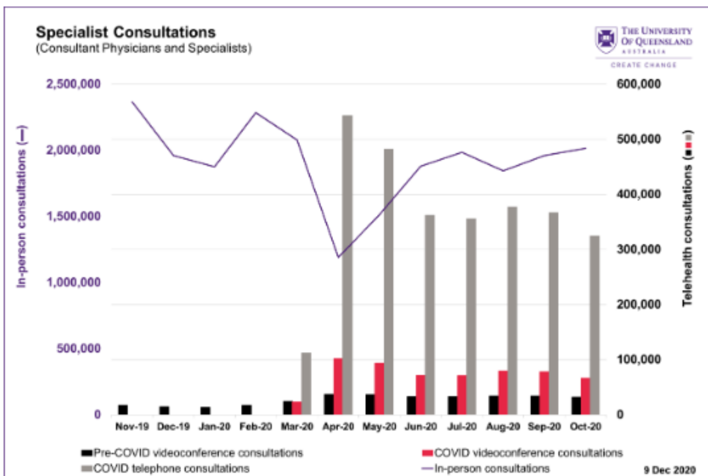


Figure 6: Specialist Consultations MBS Telehealth Consultations to October 2020



Along with other peak professional allied health bodies, ESSA has contributed to an Australian wide survey of telehealth useage by allied health practitioners and their clients during the COVID-19 pandemic. This research by the University of Melbourne will be released in the coming weeks.

Not long after the introduction of telehealth item numbers in March in response to the COVID-19 pandemic, changes were made to **requiring GP providers to have an existing and continuous relationship with a patient in order to provide telehealth services. This is a critical barrier to telehealth** for NSW rural, regional and remote patients.

Mark Diamond, the former National Rural Health Alliance CEO, in an article[xxviii] in September, 2020 expressed his concerns for people in rural, regional and remote Australia, where lesser access to health care already impacts heavily on health outcomes:

> "For many people in remote and very remote Australia, the decision to extend MBS telehealth rebates to GPs until the end of September will have little or no impact.

It is more than **a little ironic that the very people who stand to gain the most from this technological 'genie' will not benefit at all**………………

If the quality of the 'patient centred' relationship is not dependent on having at least one face to face encounter in the preceding 12 months, then why is it a requirement?"

Dr Tim Smyth, health consultant and former Deputy Secretary of the NSW Ministry of Health, in another article in August, 2020[xxix] on the issue stated that restrictions on access to MBS items and other virtual health funding should be based on safety, quality, and comprehensive care, not on protecting current ways from competition:

"to address the concern about the "cowboys", rather than use blunt instruments to restrict access, **we need agreed clinical governance standards and a move to using blended payments and block funding**.

The clinical governance standards need to adopt a patient-centred approach and facilitate innovation, convenience and flexibility while ensuring quality, safety and continuity of care."

Recommendation 12: That the NSW Minister for Health and Medical Research and NSW Health through the Health National Cabinet Reform Committee supports a review of restrictions on access to MBS items and encourage the Australian Government to develop agreed clinical governance telehealth standards and move to using blended payments and block funding to support greater access to telehealth by rural, regional and remote patients.

A second key barrier to accessing telehealth which is critical in rural and remote areas is internet speed. Many rural, regional and remote NSW patients struggled with internet speeds and transitioning to using telehealth platforms (including allied health providers) during the early stages of COVID-19.

In April 2020, the Royal Australian College of General Practitioners in a media release[xxx] acknowledged that some people were not willing to access telehealth without onboarding support:

"**some patients are avoiding consultations because they don't feel comfortable using new technology such as video conferencing**".

A Consumer Health Forum survey, What Australia's Health Panel said about Telehealth - March/April 2020, of 95 members of its Australia's Health Panel found:

"Common problems for telehealth included health professionals not embracing the option effectively, technological problems with phone or internet lines, and concern about missing services that could only be done face-to-face, for example, physical examination."

An Australian systematic review[xxxi] of telehealth interventions used for home based support groups found group videoconferences into the home were feasible, but needs good IT support**. Audio difficulties, including delays, dropouts, and background noise were the most common problems reported**.

Australia's major cities experienced internet congestion[xxxii] from a baseline in mid-February to 30 March, 2020. AEPs operating allied health businesses in some areas reported congestion from home schooling and general demand creating barriers to deliver any telehealth services through videoconferencing.

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In addition, some NSW residents live in blackspots with no access to the NBN, or satellite or mobile phones so internet coverage across NSW is not uniform.

ESSA anticipates the new Statutory Infrastructure Provider (SIP) regime[xxxiii] from 1 July, 2020 requiring NBN Co and equivalent companies to provide a download speed of at least 25 megabits per second and an upload speed of 5Mbps during peak hours will assist with better access.

The cost of accessing the internet was a factor preventing some NSW residents accessing telehealth, with Australia ranked 67th for the average cost of entry level broadband subscriptions according to an international review[xxxiv] of the broadband market in Quarter 2, 2019.

Whilst internet access among older Australians is rising, there are still large gaps in access and technology literacy. A 2018 report[xxxv] for the Australian Government's eSafety Commissioner which surveyed 3,602 Australians over 50 years of age found:

> "A smartphone was the most common device that participants aged 50 years and over had access to, with close to seven-in-ten having access to one. This was followed by laptops, desktops and tablets each of which were owned by over half of the participants. **Nine percent of participants had no access to any of the devices listed."**

More specifically, 30 per cent of those aged 80 years and over, 12 per cent of those aged 70-79 years did not have a digital device at home for personal use. Ownership of a device though did not mean that it was used as "**approximately 30-40% who had never accessed these devices**."

The use of devices by older Australians was linked to digital literacy with "**three-in-ten being highly literate, three-in-ten moderately literate and around one-quarter low in terms of literacy….Three-quarters of the digitally disengaged group were aged 70 years and over**".

The Australian Bureau of Statistics reported that in 2016-2017, those who are 65 years and over are the lowest proportion of internet users (55 per cent). Only 46 per cent of all users accessed the internet for health services or health research[xxxvi].

Recommendation 13: That the NSW Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.

Recommendation 14: That the NSW Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) considers additional funding of technology literacy initiatives, especially for those living in rural and remote areas.

5.6 Essential Health Services

A major issue which has impacted on some rural, regional and remote New South Wales residents in 2020 was (and continues to be) access to health services during the COVID-19 pandemic. Some NSW cross border residents have struggled to access essential allied health services during COVID-19 lockdowns because of inconsistencies in the definition of what is deemed an "essential service"(particularly what is an "essential health service") within each state and territory jurisdiction's legislative framework.

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In a Fact Sheet[xxxvii] produced in March, 2020 by HopgoodGanim Lawyers, the legislative frameworks on what constitutes an essential health service for each jurisdiction are summarised along with specific examples of which services are deemed essential.

This document highlights the inconsistencies around what health services are deemed "essential" within jurisdictions' legislative frameworks:

- New South Wales *Essential Services Act 1988 No 41 (NSW)* – includes the provision of public health services (including hospital or medical services) as essential services;
- the Australian Capital Territory (ACT) has no current legislation which defines essential services
- Western Australia, Tasmania, and the Commonwealth have no definitions of essential services in their relevant legislation
- Victoria – the *Essential Services Commission Act 2001 (Vic)* defines "essential services" but has no specific mention of health services other than a broad catch all of "any other industry prescribed for the purpose of this definition"
- Northern Territory (NT) - hospitals administered under the *Medical Services Act 1982 (NT)* and any other service or facility concerned with the maintenance of public health
- Queensland - securing the essentials of life
- South Australia - a service without which the safety, health or welfare of the community or a section of the community would be endangered or seriously prejudiced.

An article in The Conversation[xxxviii] on 31 March, 2020 also highlighted the inconsistencies in information for the public on essential services information:

> "When it comes to dealing with the COVID-19 pandemic, there are no recent precedents for governments. **There is no pre-determined list in place on what is an essential service.** Instead, 'essential' appears a moving beast that is constantly evolving and that can be confusing".
>
> There was "broad agreement supermarkets, service stations, allied health (pharmacy, chiropractic, physiotherapy, psychology, dental) and banks are essential business and services".

NSW Health includes a broad and comprehensive range of allied health professions in the Allied Health Portfolio of the Workforce Planning and Development Branch as defined by the NSW Treasury Codes:

- Art therapy
- Audiology
- Child Life Therapy
- Counselling
- Diversional Therapy
- Exercise Physiology
- Genetic Counselling
- Music Therapy
- Nuclear Medicine Technology
- Nutrition & Dietetics
- Occupational Therapy
- Radiation Therapy
- Orthoptics
- Orthotics & Prosthetics
- Pharmacy

- Physiotherapy
- Podiatry
- Psychology
- Radiography
- Sexual Assault
- Social Work
- Speech Pathology
- Welfare

Whilst this list was not referenced in various 2020 COVID public health directions, specifically in the *NSW Public Health (COVID-19 Restrictions on Gathering and Movement) Orders*, ESSA received written confirmation from Mr Andrew Davison, the Chief Allied Health Officer, Health System Strategy and Planning, within the NSW Ministry of Health that exercise physiology clinics delivering health services were able to continue operating in lockdowns.

Unfortunately, there have been access issues for NSW residents both within the Queensland/NSW border zone and outside the border zone. These residents have been impacted by an inability to access services provided by some

- health practitioners operating in Queensland and
- health practitioners living in Queensland but delivering services in NSW outside the border zone.

These NSW residents will continue to be impacted should another lockdown in regional Queensland and/or regional NSW occur. This is because Queensland currently defaults to a much narrower range of health professions as "essential" in relation to its border crossing policy. ESSA is also aware of a Queensland based Accredited Exercise Physiologist working in NSW outside of the border zone who had to relocate to Byron Bay to continue operating services to her NSW clients.

Health practitioners living in Albury and working in cross border in allied health businesses in North East Victoria were also impacted by the NSW/VIC border restrictions. ESSA advocated for one NSW headquartered business which was unable to deliver any exercise physiology services from its Wangaratta clinic. This restriction impacted on a wide variety of clients in Wangaratta, including some NDIS clients who are not suitable for telehealth.

In the current Queensland border crossing policy, all the listed "essential health" professions are regulated under the National Registration and Accreditation Scheme (NRAS) administered by Australian Health Practitioner Regulation Agency (Ahpra) [with allied health professions highlighted in blue]:

- dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist)
- medical
- medical radiation practice
- midwifery
- nursing
- occupational therapy
- optometry
- paramedicine
- pharmacy
- physiotherapy
- podiatry
- psychology
- services as a registered NDIS provider under an agreed NDIS plan.

The Queensland policy currently excludes a range of self-regulated allied health professions including exercise physiology, dietetics and speech pathology, all professions which have Medicare item numbers.

A solution to this issue is available from the National Allied Health Chief Officers/Advisors Committee (NAHAC) which collaborated and produced an agreed list of "essential health services" for all jurisdictions. This list was communicated to ESSA on 2 December, 2020 by the peak allied health body for allied health professions (Allied Health Professions Australia). ESSA has been informed at the time of writing this submission that the list is awaiting Australian Health Protection Principal Committee approval.

It is imperative that definitions of essential health workers and restrictions to services need to align across all borders, so both residents and those who work cross-border are not impacted by further lockdowns.

Recommendation 15: That the NSW Health and the NSW Chief Health Officer through the Australian Health Protection Principal Committee ensure that definitions of essential health workers and restrictions to services align across all borders so both cross border residents and those health professionals who work across borders are not impacted by further lockdowns.

6.0 Patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW

6.1 System Wide Factors

The key NSW Health commissioned *Exercise Physiology Horizons Scanning and Scenario Generation Project* report[xxxix] noted that "several system-wide influencing factors require consideration…….:

- The need to shift the provision of service from an institutional focus, towards a **patient-centric model**
- An increasing focus on **early intervention and prevention models of care**
- The impacts of information and community technology (ICT) on the exercise physiology profession, how technology supports their role, its capabilities and challenges with access, and the overarching state-wide eHealth and NSW ICT strategies
- An emphasis on collaborative, multidisciplinary teams across care settings and balancing health profession specialisation with generalisation to address the increased demand for care, particularly amongst patients with complex, long-term conditions and the ageing population
- A need to consider the **geographic distribution of workforce** to align with changing population demographics and health needs
- Broader NSW-wide and national programs of work including, for example, Leading Better Value Care and the National Disability Insurance Scheme (NDIS)."

Recommendations pertaining to many of the factors bolded appear elsewhere in this submission.

Recommendation 16: That NSW Health supports and facilitates collaborative, multidisciplinary teams across care settings.

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6.2 Sharing of Innovations/Policies

One of the positive outcomes of the COVID-19 pandemic has been the speed at which new innovative models of care and policies have been implemented. The transition to full scale telehealth with the introduction of a swathe of additional temporary telehealth allied health items into Medicare Benefit Services on 20 April, 2020 represented a milestone that many healthcare experts predicted would take anywhere from three years to a decade to achieve.

ESSA concurs with the Australian Minister for Health, the Hon. Greg Hunt MP's comments in his Media Release[xl] that

> **"This is an extraordinary feat and a reflection of our doctors' and allied health professionals' commitment to delivering accessible, best-practice care for all patients, during this difficult time."**

International allied health leaders like Ms. Suzanne Rastrick, MBE, the Chief Allied Health Professions Officer for the National Health Service (NHS) in England outlined in a blog[xli] on 21 May 2020, **how the pandemic has influenced new ways of working and how new practices may influence allied health service improvements in the post coronavirus era**. The NHS also established a National Allied Health Professions (AHP) Virtual Hub, a collaborative platform to share examples of changes made by AHPs.

Esteemed specialist medical practitioner in geriatric medicine and epidemiologist, Professor Joseph Ibrahim highlighted the failure of the aged care sector to establish communities of practice to share innovations in his Precis of evidence to the Royal Commission into Aged Care Quality and Safety (published on 12 August, 2020). By the end of May, 2020,

> "Better gathering of field intelligence, better coordination and sharing of information should have been established. In the absence of empirical research data to determine the most effective approach, we rely on lived experience and expert opinion. By this stage, we should have networked all RACFs into groups to share their experiences and innovations. **Establishing a 'Community of Practice' would have achieved this with a small financial investment**."

ESSA applauds the establishment of 30 clinical communities of practice (COP) across key clinical specialities to support the NSW response to COVID-19 and suggests that communities of practice and/or virtual hubs be established to support rural, regional and remote allied health practitioners, especially those working alone without direct clinical supervision by practitioners from the same profession.

ESSA is aware the NSW digital health agency, eHealth NSW joined forces with NSW Health partners and consumers to extend a virtual model of care and established a new unit called the Virtual Care Accelerator to work with NSW Health partners to ensure patients have full access to the best that telehealth-enabled models of care and remote monitoring have to offer, both during the acute response to COVID-19 and beyond. Telestroke which uses of telehealth technology to virtually assess and treat stroke patients in regional and rural NSW was another innovation to launch in 2020.

Another example was the launch of a telehealth hospital, the Sydney Local Health District, Royal Prince Alfred Hospital which was highlighted in a Guardian news article[xlii] on 13 May, 2020:

> "RPA Virtual Hospital opened on 3 February with just six nurses. It now has more than 30 nurses, as well as **medical and allied health teams**, and 600 registered patients. Operating out of Royal Prince Alfred Hospital campus, it functions in many ways like a regular hospital, with a clinical handover, ward rounds, multidisciplinary team meetings and its own governance structures…….
>
> RPA Virtual Hospital is **an example of the pandemic driving innovations that otherwise may have taken years, if not decades, of incremental changes**. Importantly, the developments are not only about policies, programs or technologies, but also **reflect new relationships and ways of working that cross sectors and systems, helping to break down some of the longstanding silos that have held back innovation**."

ESSA contends that much more can be done to share allied healthcare innovations and explore the role of technology in assisting in delivering services to those living in rural and remote communities but the mechanism to share best practices should be facilitated nationally with the support of state and territory governments.

Recommendation 17: That the NSW Government via the National Cabinet Reform Committees (Health and Rural and Regional Australia) requests the Australian Government task and resource Australian Allied Health Leadership Forum (the peak body for stakeholders of the Australian allied health sector and services) to facilitate the collection and dissemination of allied health service improvements and innovations suitable for use in rural, regional and remote areas via a virtual hub/community of practice or alternatively, establish a virtual hub/community of practice for NSW.

7.0 An analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW

7.1 Statistical Frameworks/Data on self-regulated Health Professionals

There have been significant issues with the quality of Australian Government data available for rural health workforce planning over a long period. A Senate Committee report in 2012, *The factors affecting the supply of health services and medical professionals in rural areas* noted "Data about health workforce distribution in Australia varies in quality and in the picture it presents[xliii] and recommended

> "that Rural and Regional Health Australia, as part of the Department of Health and Ageing, prioritise the collection of robust and meaningful data on rural health as part of the forthcoming review of rural health programs."

Unfortunately, little work has been done since 2012 to improve the quality of health workforce data from both the Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS).

The significant gaps in allied health workforce data form one of only three recommendations by Emeritus Professor Worley in his *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* [xliv]

> "Recommendation 3 – Expanding Distribution
> To expand the distribution of the allied health workforce across rural and remote Australia, **it is recommended that, building on current national and jurisdictional initiatives, the Commonwealth develops a National Allied Health Data Strategy**.

This Strategy will include building a geospatial Allied Health Minimum Dataset that incorporates comprehensive rural and remote allied health workforce data. Once established, this data strategy and minimum dataset will inform and improve the design and development of rural and remote allied health workforce planning and policy."

Much of the current health workforce data from the AIHW relies on **annual figures from Australian Health Practitioner Regulation Agency (Ahpra) which only covers those professions regulated by that agency and completely ignores data about other non-Ahpra regulated health professions** i.e. self-regulated health professions. The **Australian Prudential Regulation Authority does not report on data about exercise physiology as a stand alone profession in private health insurance data**.

Exercise physiology is a self-regulated health profession not regulated under the *Health Practitioner Regulation National Law.* It meets the benchmark standards set by the National Alliance of Self Regulating Health Professions (NASRHP) for the regulation and accreditation of practitioners within that profession. Other recognised allied health professions like audiology, dietetics and speech pathology are also self-regulated health professions meeting NASRHP standards. This means **much of the AIHW data excludes workforce data on exercise physiologists, dietitians, speech pathologists, audiologists and other health professionals not regulated by the Ahpra**.

An example on the geographic distribution and practitioner to population ratios of a selection of Ahpra regulated allied health professions (noted in blue) which highlights the decreased availability of allied health services the further an area is from major metropolitan centres (but excludes any data from self-regulating health professions) is below:

Table 2: Employed health professionals, clinical full-time equivalent rate, by remoteness area across Australia, 2017[xlv]

	Remoteness area				
Type of health professional	**Major cities**	**Inner regional**	**Outer regional**	**Remote**	**Very remote**
	Clinical FTE per 100,000[(a)(b)(d)]				
General practitioner (GP)	105.6	109.6	102.9	127.9	149.7
Specialist	143.0	81.5	57.2	54.3	21.8
Nurses and midwives	1006.4	979.2	943.7	1102.9	1172.1
Podiatrists	15.5	15.7	9.6	9.1	8.2
Psychologists	73.1	46.7	34.1	24.6	18.8
Optometrists	17.6	15.1	10.6	6.5	4.1
Dentists	57.1	40.4	34.6	27.8	16.9
Pharmacists	81.8	68.7	66.1	62.2	43.6
Physiotherapists	89.7	60.1	49.1	40.5	41.6
Occupational therapists	52.7	44.2	40.6	27.5	19.2

Notes
(a) Calculations are based on the FTE clinical rate and report the health practitioners (registered health professionals currently employed in their profession and excluding those who are retired, on long leave or seeking employment) working in clinical practice using the Estimated Resident Population as at 2018
(b) Full-time equivalent (FTE) clinical rates are equal to the FTE number per 100,000 population, which is based on total weekly hours worked. For medical practitioners, the standard working week is 40 hours whilst for all other health practitioners the standard week is 38 hours

(c) Remoteness area is derived from remoteness area of main job where available; otherwise, remoteness area of principal practice is used as a proxy. If principal practice details are unavailable, remoteness area of residence is used.
(d) Numbers represent not only those in the labour force, but those employed and working in their registered profession.

(e) Data extracted by the AIHW on 10 December 2019.

Source: Department of Health 2019

There is a **similar pattern of decreasing availability of exercise physiologists and other health professionals the higher the degree of remoteness** in data extracted from the ABS 2016 Population census in a 2019 report[xlvi] developed by Services for Australian Rural and Remote Allied Health and commissioned by the New South Wales (NSW) Ministry of Health in the table below:

Table 3: NSW AHPs by place of work (remoteness area) 2016 Census

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
Allied Health Professions	No of FTE professionals per 100,000 population				
Medical Radiation Practitioners	54.93	43.22	30.90	25.19	12.35
Oral Health Practitioners*	82.20	60.42	53.82	42.21	21.74
Occupational Therapists	62.18	47.43	46.52	38.13	22.73
Optometrists*	19.74	15.85	11.46	9.19	3.95
Osteopaths*	7.96	6.17	2.30	NP	NP
Pharmacists	99.35	78.07	78.01	74.89	45.95
Physiotherapists	103.78	66.30	55.44	43.91	40.51
Podiatrists	17.72	17.21	10.97	10.55	5.93
Psychologists	103.17	61.25	45.84	35.40	20.75
Other Health Professions					
Medical Practitioners	440.88	302.44	284.73	331.90	220.34
Nurses and Midwives	1157.15	1105.59	1099.88	1304.78	1192.12

Source: Australian Government Department of Health, 2018

Australian Bureau of Statistics data also has shortcomings with **exercise physiologists not classified as health professionals in the Australian and New Zealand Standard Classification of Occupations (ANZSCO) framework**. Instead, the profession is grouped within the Natural and Physical Science Professionals category, despite numerous efforts by ESSA to have the profession reclassified.

In a similar vein, **exercise physiology services are not specifically listed in the Australian and New Zealand Standard Industrial Classification (ANZSIC) framework**. Notionally, the best fit for exercise physiology services is within the 91110 Health and Fitness Centres and Gymnasia Operation class. This class consists of units mainly engaged in operating health clubs, fitness centres and gymnasia. Units in this class provide a range of fitness and exercise services.

ESSA has previously made a submission to the ABS *Review of 2021 Census Topics* in 2018 that exercise physiology services should sit within Group 853 ALLIED HEALTH SERVICES: Class 8539 Other Allied Health Services but no changes have been accepted to date.

Recommendation 18: That the NSW Minister for Health and Medical Research and NSW Health through the Health National Cabinet Reform Committee support initiatives to

- **enhance the regular collection of data on self-regulated health professions via the National Alliance of Self Regulating Health Professions**
- **improve the Australian Bureau of Statistics occupational and industry classification frameworks to more adequately reflect the breadth of the allied health sector**
- **improve the reporting of private health insurance data on ancillary services provided by self-regulated health professions by the Australian Prudential Regulation Authority.**

8.0 An examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them

8.1 Surge Workforces

A significant issue for staffing in some rural, regional and remote NSW hospitals is the difficulty in sourcing surge staff in the case of an infectious disease outbreak or a natural disaster.

ESSA suggests that a mapping of hospital activities against the scopes of practice of allied health professionals (both Aphra and self-regulated professions) may assist with planning for the efficient redeployment of public hospital staff during future events. This mapping may also look at circumstances where general practitioners (GPs) and specialists are re-deployed and allied health professionals can assist in managing patients' chronic conditions until GPs and specialists return to their regular roles. It would also ensure that there would be no underutilisation of allied health professionals' scopes of practice.

ESSA was approached by the NSW Health in late August, 2020 to assist in developing an exercise physiology surge COVID-19 testing workforce. A list of potential candidates was forwarded several weeks later. In an ideal pre-COVID-19 world, mapping would have been completed on the scopes of practice of allied health professionals. This mapping would have identified the pre-requisite skills necessary for COVID-19 testing enabling recruitment of a surge workforce to be completed much earlier.

ESSA acknowledges the foresight of NSW Health in calling for allied health assistants to apply for casual surge pool positions. Accredited Exercise Scientists (who are three year university trained) work as allied health assistants (AHAs) in many allied health practices and are ideally placed to join surge workforces and present one possible solution to a surge workforce. In addition, exercise science students are well equipped to provide support as Technical Officers or AHAs.

Recommendation 19: That the NSW Health considers utilising Accredited Exercise Scientists and exercise science students to work as allied health assistants and Technical Officers in any future surge workforces.

Recommendation 20: That NSW Health maps hospital activities against the scopes of practice of allied health professionals (both Aphra and self-regulated professions) to determine the highest value use of qualified allied health staff in the event of a natural disaster or another pandemic.

8.2 Number of AEPs in hospitals and growth in Accredited Exercise Physiologists

As of June 2019, there were 40.4 full time equivalent exercise physiologists employed by NSW Health and a total of 1,881 exercise physiologists accredited with ESSA in NSW[xlvii] [noting not all workplaces require accreditation though it is mandatory to deliver services under compensable schemes such as Medicare Benefit Services (MBS),

Department of Veteran Affairs (DVA), the National Disability Insurance Scheme (NDIS), private health insurance, and state and territory-based workers' compensation schemes].

The ESSA National AEP Hospital Network reported in June 2019[xlviii] that the number of AEPs (not all working full time) in public hospitals in cardiac and pulmonary rehabilitation programs, neurological and musculoskeletal outpatient programs; and diabetes awareness and health and well-being programs in community health settings were as follows:

- Victoria = 98
- NSW = 70
- QLD = 27
- SA = 25
- TAS = 0
- WA = 9

The profession across both Australia and NSW is steadily growing with the following increases shown in the table below:

Table 4: Growth in Accredited Exercise Physiologists – 2011-2019[xlix]

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
No. of Accredited Exercise Physiologists as at 31 Dec each year	2,016	2,509	2,937	3,359	3,637	4,165	4,626	5,101	5,706	6321
Growth		24%	17%	14%	8%	15%	11%	10%	12%	12%
No. of NSW AEPs as at 31 Dec each year	803	n/a	n/a	n/a	n/a	n/a	n/a	1519	2046	2274
								89% since 2011	35%	11%

This growth has largely occurred as a result of the recognition of the role exercise therapy can play in supporting:

- an ageing population in wellness and reablement; and falls prevention/rehabilitation
- people with mental health conditions, especially those with co-morbidities like obesity
- National Disability Insurance Scheme clients
- preventing and managing chronic and complex diseases in areas such as cancer and cardiac care, pain management, diabetes, chronic obstructive pulmonary disease and respiratory rehabilitation.

The recent launch of new temporary physical therapy Medicare items (exercise physiology, occupational therapy and physiotherapy) for people in residential aged care facilities will also assist in the recognition of the value of exercise physiology services and drive further growth in aged care.

The Australian Government's workforce projections show employment in the health care and social assistance sector is projected to make the largest contribution to employment growth (increasing by 252,600 jobs) over the five years to May 2024[l] in the table below:

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Table 5: Workforce projections for employment in the health care to 2024

Occupation Level	Skill Level ANZSCO v1.2	Occupation Code	Occupation	Employment level May 2019 ('000)	Department of Employment, Skills, Small and Family Business Projections		
					Projected employment level May 2024 ('000)	Projected employment growth five years to May 2024 ('000)	Projected employment growth five years to May 2024 (%)
4	1	2349	Other Natural and Physical Science Professionals Occupations in this Group 234911 Conservator 234912 Metallurgist 234913 Meteorologist 234914 Physicist **234915 Exercise Physiologist** 234999 Natural and Physical Science Professionals nec	8.8	9.1	0.4	4.2
4	1	2524	Occupational Therapists	16.3	20.0	3.7	22.4
4	1	2525	Physiotherapists	31.9	39.8	7.9	24.6
4	1	2526	Podiatrists	4.6	5.1	0.5	11.0
4	1	2527	Audiologists and Speech Pathologists \ Therapists	9.2	11.4	2.3	24.5

ESSA contends that the 4.2 percent growth rate of the broader 'Other Natural and Physical Science Professionals' occupational group is an underestimate of the exercise physiologist projected growth, given the higher annual increases in the number of AEPs previously highlighted and the fact that the growth figure is an aggregated figure for a range of Science Professionals.

Whilst there is overall growth in the number of AEPs in NSW, there is a maldistribution of AEPs between metropolitan, rural and remote areas based on the data in Table 3 above and Tables 6 below:

Table 6: Accredited Exercise Physiologists across Australia by place of work (remoteness level) - 2015[li]

DESCRIPTION	POPULATION	PERCENTAGE
Capital city		56
Other metropolitan	More than 100,000	22
Large rural centre	25,000 to 99,999	10
Small rural centre	10,000 to 24,999	4.8
Other rural centre	Less than 10,000	2.4
Remote centre	5,000 to 9,999	1.5
Other remote centre	Less than 5,000	1.2
International		0.3
Not currently working		0.9

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The availability of AEPs (and most other allied health professionals) decreases the further an area is from major metropolitan centres. Across Australia, ESSA has reported that most AEPs are based in the eastern states of New South Wales (34%), Queensland (24%) and Victoria (20%)[lii]. This aligns with the location of the majority of exercise science university courses in Australia.

SARRAH[liii] has confirmed there are "acute shortages of allied health professionals in rural and remote Australia, far worse comparatively than for nurses and medical practitioners. There is a serious risk that this situation could worsen in rural Australia as overall demand increases nationally". These shortages pre-date "the NDIS and the growing attention on access and provision of quality aged care services". Allied health professionals predominately work in major population centres where "financially viable and professionally supported practice is more viable".

8.3 Recruitment and Retention

In respect to the recruitment of allied health professionals within the public system more broadly in rural, regional and remote locations, recruitment to rural and remote positions remains challenging.

Emeritus Professor Paul Worley in his *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*[liv] notes:

> "Extensive research over two decades has demonstrated the connection between rural origin and the retention of rural practitioners. Research has also shown us that **extended rural exposure during training has a positive influence on early-career decision making and higher rates of retention**. However rural students face numerous barriers to accessing tertiary allied health courses and limited options to undertake their training in rural settings. The **majority of rural allied health training consists of short-term placements in MMM2-3 locations, while the greatest need for workforce occurs in MMM4-7 regions. An added complexity is the lack of capacity for practitioners (who are often solo or part-time) in these areas to supervise students**."

A recommendation is made in this report to support improved access of allied health staff in rural, regional and remote locations:

> "Recommendation 1 – Improving Access
> To improve access to allied health services, **it is recommended that the Commonwealth progressively establish, initially through a series of demonstration trial sites, Service and Learning Consortia** across rural and remote Australia. With the support of new and existing program funding, Service and Learning Consortia will **integrate rural and remote 'grow your own' health training systems with networked rural and remote health service systems**.
> Service and Learning Consortia will consist of local private, public and not for profit service providers, training providers, and community representatives collaborating across multi-town and multi-sector networks, according to community need. Once established, Service and Learning Consortia will improve recruitment and retention of allied health professionals by making rural and remote allied health practice and training more attractive and better supported."

ESSA is aware of the following issues from anecdotal evidence from members, allied health workforce experts and a rural recruitment and retention report[lv]:

- many positions are short term contract (non-permanent roles) often supported by short term project funding (an example is known where an allied health position funded for up to four years like Broken Hill was hard to fill)
- many local health districts might employ one relatively junior allied health professional to provide services across a whole region (e.g. one AEP working in mental health across the Hunter and New England district)
- many positions are fractional which does not suit those looking for full time work
- many allied health professionals particularly within the smaller professions (like exercise physiology) work in professional isolation with no peers or clinical leads from the same profession in close proximity
- many allied health professionals are often supervised by nurse managers who do not always understand the full scopes of practice for newer emerging allied health professions (like exercise physiology) and who can sometimes facilitate scope of practice overlap
- allied health roles are not substitutable and cannot be substituted like medical and nursing positions
- limited career pathways and professional development opportunities
- senior staff in decision-making roles often tend to stick to the status quo which limits system change in relation to the employment of newer emerging allied health professionals and limits the development of innovative models of care
- allied health professionals often do not have a voice in local decision-making
- budget pressures and inflexibility in within the system occasionally results in allied health professionals being employed in lower graded positions (e.g. an AEP was employed as an occupational therapy assistant to build the capacity of a unit).

Emeritus Professor Paul Worley confirms many of these issues surrounding the lack of supervision:

> "**Increasing the number and capacity of allied health professionals providing supervision will not only support students but also new graduates and early career allied health professionals** who currently make up a large proportion of the rural allied health workforce and where it is not uncommon for them to be the sole provider for their profession in the town. These **new or recent graduates can experience isolation, burnout and often only have access to minimal and remote supervision**. Understandably, the attraction to, and retention of, allied health professionals in these positions is an ongoing challenge. What has come through strongly in the literature and consultations is that these **unsupported positions are a risk to individual professionals and communities alike**. Safety and quality can be compromised for the worker who is practising in an unsupported environment and for the client who is receiving treatment from an inexperienced or burnt out allied health professional without ready access to appropriate clinical expertise and support."

Recommendation 21: That NSW Health provides more opportunities for allied health professionals, especially from newer and emerging professions like exercise physiology to be involved in service planning.

Recommendation 22: That NSW Health develops resources and provide opportunities for service leaders to better understand the scopes of practice of allied health professionals.

Recommendation 23: That NSW Health makes improvements to the reporting structure and governance of exercise physiologists; and consider options like establishing cross district clinical leads to support professional development of exercise physiologists employed by NSW Health, especially sole junior practitioners.

EXERCISE & SPORTS SCIENCE AUSTRALIA

8.4 COVID-19

An April, 2020 Grattan Institute Report outlined the following predictions in relation to the impact of COVID-19 on health care businesses[lvi]:

> "The situation is less clear when it comes to 'health care and social assistance'. This industry is large and diverse, encompassing nurses in public hospitals, who are very unlikely to lose their jobs during this crisis, as well as workers who are more vulnerable to job loss. For example, **allied health workers in private practice and a range of social care occupations are more at risk of being out of work. Our preferred method suggests about a quarter of jobs in this industry are at risk**."

More than a year and half later, data[lvii] collected by the Australian Bureau of Statistics between 2 December and 9 December, 2020 indicated **the broader health care industry was one of the top growth industries with 28 per cent of businesses having more employees than compared to this time last year and 19 per cent of health care businesses reporting having difficulty finding staff**.

ESSA's internal surveys and anecdotal feedback suggests that the Grattan Institute report predictions more realistic when it comes to the viability of private allied health practices, especially those which experienced multiple phases of lock downs.

Recommendation 24: That the NSW Government considers further tranches of business support initiatives for private allied health practices in the event of further COVID-19 lockdowns.

9.0 The access and availability of oncology treatment in rural, regional and remote NSW

9.1 AEPs in oncology treatment

AEPs play an increasingly important role in cancer rehabilitation. Accredited Exercise Physiologists provide services to those living with cancer in best practice health centres like the Chris O'Brien Lifehouse, Camperdown.

There are a number of important position statements from ESSA[lviii] and the Clinical Oncology Society of Australia[lix] which outline the benefits accrued through exercise following a cancer diagnosis. The ESSA statement notes **"Targeted exercise prescription, which includes the provision of behaviour change advice and support, is needed to ensure greatest benefit (as defined by the patient) in the short and longer term, with low risk of harm."**

Allied health staff support patients through the treatment phase at centres across NSW though these staff could be upskilled on the benefits of exercise for cancer patients.

Recommendation 25: That NSW Health considers requiring all Oncology Nurses to undertake free Exercise is Medicine® training.

Recommendation 26: That NSW Health considers expanding the employment of AEPs in cancer care.

EXERCISE & SPORTS SCIENCE AUSTRALIA

10.0 The access and availability of palliative care and palliative care services in rural, regional and remote NSW

10.1 AHPs in palliatve care

Allied health professionals are recognised as having a role in the *National Palliative Care Strategy 2018*[lx].

A very recent (2020) overview[lxi] of allied health in palliative care in Australia for CareSearch which is funded by the Australian Government Department of Health noted the following:

- access to allied health practitioners is more limited in regional and rural areas
- allied health is a minor workforce component in residential aged care; estimated at 5 per cent in 2016
- only 4 per cent of allied health professionals working in aged care hold specialised qualifications in palliative care
- there are limited positions for allied health professionals within specialist palliative care.

AEPs can assist palliative care patients maintain their quality of life with strengthening exercises, balance training and falls prevention education to help them manage the physical aspects of daily activities, such as walking and transfers.

Recommendation 27: That NSW Health considers facilitating the employment of AEPs in palliative care.

11.0 An examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous communities

11.1 Cultural Safety

> "Aboriginal and Torres Strait Islander people experience a disproportionate burden of illness and social disadvantage compared with non-Indigenous Australians. In addition to this Aboriginal and Torres Strait Islander people experience a much higher level of racism and discrimination. The importance of cultural safety and cultural humility is essential when exploring allied health service provision, for both Aboriginal and Torres Strait Islander AHPs and clients who access allied health services."

To improve health outcomes for indigenous communities, the provision of health services needs to be "responsive to cultural differences and the impacts of conscious and unconscious racism".

NSW Health has mandated that every employee of NSW Health must complete the *Respecting the Difference* training, to increase the cultural competencies and promote greater understanding of the processes and protocols for delivering health services to Aboriginal people. The training includes an online component and a one day face-to-face training.

Recommendation 28: That NSW Health continues to resource *Respecting the Difference* training.

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