Submission to Senate Standing Committee on Community Affairs Inquiry into Provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians

Allied Health Professions Australia

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This submission has been developed in consultation with AHPA's allied health association members.

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About AHPA and allied health

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 130,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, providing services including diagnostic and first-contact services, preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

Introduction

General practitioners do not work in a vacuum. Continually addressing the needs and issues of GPs does a disservice not only to them, but more importantly to all Australians who need to obtain the best care they can. GPs do not do medical imaging, provide speech therapy, prescribe spectacles or hearing aids, deliver physical therapy programs, assess people's homes for safety and modification, fit prosthetic limbs, provide social work services or many of the other vital services undertaken by allied health.

AHPA therefore welcomes the opportunity to comment on the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians. Our submission to the Inquiry addresses Terms of Reference #a (the current state of outer metropolitan, rural and regional GPs and related services) and #b (any other related matters impacting outer metropolitan, rural and regional access to quality health services).

Various inquiries and Government-appointed entities, including most recently the Primary Health Reform Steering Group, have concluded that our current health system is not fit for purpose, and that significant reforms are urgently required for Australia to be able to provide a truly equitable primary health care system that is capable of enabling the wellbeing of all people in the context of increasing local, national and global challenges.[1]

AHPA strongly endorses these conclusions. We emphasise that the burden of inequities in current primary healthcare falls particularly on people who not only tend to live in outer metropolitan, regional or rural areas, but who often experience pre-existing disadvantage. We refer to relevant examples throughout the submission.

[1] *Discussion paper to inform the development of the Primary Health Reform Steering Group recommendations on the Australian Government's Primary Health Care 10 Year Plan*, 2021.

Key allied workforce issues, especially in rural areas, include the challenge of recruiting practitioners, particularly from some professions; lack of education and work placement opportunities in areas with need; professional isolation and lack of peer support; together with a limited or complete lack of availability of more complex and diverse clinical expertise when required. We also note that the challenges of delivering coordinated care to rural and remote regions have been known for at least 50 years and that the National Rural Health Commissioner's recommendations are yet to be fully implemented.[2]

We contend that a significant contributor to these continuing inequities is the GP-centric nature of the primary health system which is reflected in primary healthcare governance structures, funding and policy. While of course general practitioners should continue to play an important role in primary healthcare, privileging their role at the centre inhibits the development and implementation of innovative solutions to inequities in service provision.

Innovative solutions must be informed by a vision of a genuinely integrated system with the concept of person-centered health care journeys at its core. A key element of necessary reforms is full recognition of the value and breadth of allied health, and consequent strategies to strengthen the role of allied health services in primary health care. AHPA proposes a shift in policy and practice to bring allied health in from the periphery of primary healthcare, not out of any narrow or sectarian professional interests, but rather because as outlined below, in multiple ways, allied health typifies the desired approaches to health service provision.

The value of allied health in primary healthcare

Allied health professionals already work alongside medical practitioners and nurses as formal or informal members of primary health teams. They provide highly valued contributions to positive client outcomes for those with chronic diseases and conditions, early developmental needs, progressive health conditions, and mental illness. Our practitioners' flexibility and adaptability prepare them for a future system that will rely on seamless transitions to and from quality secondary care and tertiary care sectors and within primary care, so that people receive a continuum of health services according to their needs and throughout the life course. Allied health's model of strength in professional diversity is ideally suited for a future primary health system that we argue should be organised around multidisciplinary care teams and values interprofessional practice collaboration.[3]

In addition, allied health spans a broad range of professional practices which, both singly and together, challenge any simple body-mind binary notion of health and are predisposed to prioritise holistic, preventive and lifelong care. For example, practitioners such as physiotherapists, exercise physiologists, diabetes educators, occupational therapists, speech pathologists, podiatrists, osteopaths, social workers and music therapists can treat ageing clients within frameworks of wellness and recovery, and reablement and wellbeing, leading to improvements in quality of life and reducing hospital admissions. However, allied health is poorly

[2] Report for the Minister for Regional Health, Regional Communications and Local Government by the National Rural Health Commissioner, *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* (June 2020 ['NRHC'], Recommendations 1-3.
[3] 'Interprofessional practice' is defined here as 'the spectrum of care models from multi-disciplinary to transdisciplinary within a system that has mechanisms in place to activate the appropriate team to meet patient needs and preferences, from traditional GP-nurse teams and variations of this such as GP-physiotherapist teams to chronic disease models and other team-based care involving combinations of health and other professionals [including various allied health]' (*Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care*, New Zealand Institute of Economic Research report to Allied Health Aotearoa New Zealand, 23 June 2021, 1-2).

integrated into the aged care sector and only a few allied health treatments are funded under the Medicare Benefits Schedule.

Allied health practitioners, even without full integration into the current primary health system, frequently 'fill the gap' by providing treatment to people with limited access to health care or at risk of poorer health outcomes. A recent New Zealand report on the role of allied health professions in sustainable integrated health care observes that a visit to a GP can represent a form of unmet need that is better addressed by allied health practitioners.[4] The report indicates some support from GPs for this approach, and concludes that it would be not only more efficient but also better aligned with increasing patient expectations of more person-centered care.[5]

One illustration is the role of allied health in chronic disease management, outlined below ('Funding mechanisms'). There are many other examples of allied health practice which, with reasonable investment, can be tailored and embedded to deliver equitable and approachable services for people living with disadvantage. However, this also requires addressing the disconnects and disparities in the current health system.

One illustration concerns people with dementia. There is currently a high dependence on restraints to manage patients with challenging behaviours, including people with dementia. Following the recommendations of the Royal Commission into Aged Care Quality and Safety, the Aged Care Quality and Safety Commission, the Australian Commission on Safety and Quality in Health Care, and the NDIS Quality and Safeguards Commission are collaborating to align and strengthen regulatory approaches to the use of chemical and physical restraints.

Better access to services provided by allied health professionals trained in behaviour support helps to avoid dependence on restraints. Via increased funding for high quality care and through developing and implementing a best practice needs assessment and care planning tool, significant improvements can be made to the health and wellbeing of people with dementia. Cognitive rehabilitation, such as treatment provided through occupational therapy, psychology, social work, speech pathology, and music and creative arts therapy, can be valuable in the early stages of dementia where new strategies can still be learnt.

Allied health support for physical reablement is also important for greater mobility and pain management, which can also help reduce verbal and physical aggression. However, people with dementia do not routinely have access to allied health services for the purpose of reablement and rehabilitation, particularly if they are in residential aged care homes (RACHs). There is currently no way for people in RACHs to access funded allied health cognitive rehabilitation.

Increasing utilisation of allied health would also be cost efficient for the broader primary health system. Cost-efficiency should be understood as not simply concerned with financial expenditure in any narrow sense, but also with best value for public health system resources. The concept of 'best value' can encompass three types of efficiency: technical efficiency (usually the dominant and narrowest interpretation, concerned with reducing resource waste); productive efficiency (putting health care resources to their best possible use); and allocative efficiency (determining the best value of inputs).[6]

Efficiency would be further enhanced if allied health practitioners were enabled to perform at the top of their scope of practice or to expand their scope. For example, paramedics form an

[4] *Hidden in plain sight*, 15-18.
[5] Ibid.
[6] *Hidden in plain sight*, 26-27.

important part of the allied health workforce, practising not only in State-based ambulance services but also in primary care settings, including GP clinics, hospitals, schools, rural and remote communities, disability, aged care, and community contexts. However, the role, education and clinical practice of paramedics is poorly understood by policy makers. This has resulted in underutilisation of paramedic knowledge and skills, particularly in remote, rural and disadvantaged communities where paramedic practitioners could help to address GP shortages.

Integrating the provision of allied health services to achieve consistent availability throughout Australia will drive improvements in patients' experience of care and improve the health of populations. However, on several key indicators such as workforce planning, digitalisation and data collection, funded infrastructure support for allied health services lags behind that for other health providers. For example, allied health cannot seamlessly join up with other forms of primary health care when there is unmet need for diverse allied health services that is well known anecdotally but has not been systematically charted, let alone redressed via resourcing.

The full value of the 'allied' meaning in 'allied health' can only be practically realised through system restructuring to ensure that allied health is properly resourced and embedded in the broader primary health matrix.

Function creep

A successfully reformed health system should recognise the expertise and professional credentials of allied health practitioners and accord them their own place and status in the integrated framework, rather than subsuming their practice under GP-centric structures.

The fact that general practitioners are a key element of primary health provision need not – and should not, for best health practice – lead to function creep where general practice is equated with health practice in general. Nevertheless, the current model of primary care is largely based on a model of mono-disciplinary general practices which does not support a concept of person-centered, holistic care. For example, the fact that GP consultations are typically short makes them especially unsuitable for people with multiple or complex conditions. A GP-centered system also does not prioritise prevention as the most efficient health approach (see 'Insufficient focus on prevention' below).

Current funding models are also GP-centric, which contributes to the prohibitive cost of allied health care for low-income patients (see 'Funding mechanisms' below). In these situations, some GPs' reluctance to refer their patients to allied health may be well-founded.

Function creep is also demonstrated by the overly broad gatekeeper function of GPs. The current structure of many Medicare Benefit Schedule (MBS) items requires general practitioners to play an intermediary referral role before patients can receive allied health services under the MBS. This primarily administrative support role for GPs is profoundly inefficient and adds costs and time delays, without necessarily enhancing the quality of care. Simple changes to the service conditions for a range of MBS items would provide significant improvements to the efficiency of our health system, and free up GP time for medical matters.

Current referral requirements also fail to recognise the expertise of allied health practitioners in their relationship with specialist providers. For example, physiotherapists, osteopaths and chiropractors are likely to provide the primary point of contact for patient care with respect to musculoskeletal interventions. Those allied health professionals have the skill and scope of practice to diagnose the issue and to determine whether additional diagnostic imaging services

may be required. Those allied health practitioners may also determine that immediate referral to an orthopaedic surgeon is required. However, current MBS service conditions slow down the referral process and add financial costs by requiring the consumer to first see a GP for the required referral.

Another example concerns audiologists, where under current requirements a patient must be referred to an audiologist by a medical practitioner or specialist. For instance, an adult who has their hearing assessed by an audiologist working in a hospital, and who is identified as requiring hearing aids, will need to obtain a referral from a medical practitioner to access the Office of Hearing Services Voucher scheme, and will then require a second hearing assessment prior to being fitted with the aids. Patients identified by an audiologist as having a disorder that is most appropriately treated by surgery must similarly return to their general practitioner to obtain the required referral to an ENT surgeon.

These requirements not only prolong the treatment pathway and add unnecessary costs for both providers and patients – they may also compromise health care, including preventive strategies. An example is a child in a remote community, diagnosed by an audiologist with otitis media with accompanying hearing loss and requiring hearing aids. The local nurse must then organise for the child to be seen by the next visiting medical officer so that a referral can be made to the ENT to obtain clearance to fit the hearing aids. It is not inconceivable that there will be a six to twelve-month delay before the hearing aids are actually fitted. This is not patient-centered care.

Under a more efficient and equitable Australian health system, all allied health practitioners with demonstrated clinical expertise would also make direct referrals for imaging and pathology services, and to other health professionals where appropriate and within their scope of practice, while maintaining communication with the whole team supporting the patient.

The primary healthcare system is not genuinely integrated

General practices are generally not well integrated with primary health services provided by practitioners other than GPs. Medical training and professional development mean that GPs can often be unaware of the existence and value of allied health services.[7] Many types of allied health practice are not enabled to participate in dominant primary health communication channels, or to easily share patient records.

The lack of a level playing field in digital health is currently one of the biggest obstacles to bringing allied health into primary health care as a full and equal partner. Although an integrated approach has been the rhetoric for more than a decade, there has been no funded commitment to fully address the issue.

Similarly, data collection systems are heavily medico-centric. The marginalisation of allied health in health data extends beyond the absence of reliable national records of patient outcomes to significant impacts on workforce planning. While AHPA is well aware of the fact of unmet allied health demand, especially in rural and remote locations, there is currently no resourcing for

[7] See eg Dennis, Sarah, Ian Watts, Ying Pan, and Helena Britt (2018), 'The likelihood of general practitioners referring patients to physiotherapists is low for some health problems: Secondary analysis of the Bettering the Evaluation and Care of Health (BEACH) Observational Study,' Journal of Physiotherapy 64 (3): 178, https://doi.org/10.1016/j.jphys.2018.05.006 ; Supper, I., O. Catala, M. Lustman, C. Chemla, Y. Bourgueil, and L. Letrilliart (2015), 'Interprofessional collaboration in primary health care: A review of facilitators and barriers perceived by involved actors,' Journal of Public Health 37 (4): 716, https://doi.org/10.1093/pubmed/fdu102 .

identifying specific shortfalls and the basis of particular practice and sector gaps, let alone for producing and maintaining a detailed map of allied health professionals around Australia. At best, existing health data only focuses on those allied health professions regulated by AHPRA, despite the existence of many self-regulated allied health professions with equivalent standards of training, accreditation, competency and scopes of practice.[8]

It is also vital that the existing research evidence for allied health interventions is built upon, and that data on client outcomes is systematically collected and analysed to demonstrate the efficacy and efficiency of allied health. Similar to the research underpinning medical interventions, this cannot be effectively undertaken without dedicated funding.

Insufficient focus on prevention

One of the most significant failings of our current system is that it is not taking advantage of opportunities to prevent the development of chronic conditions or to support secondary prevention activities that are likely to reduce the incidence of avoidable negative health outcomes. A significant portion of Australia's chronic disease burden could be prevented by screening and early intervention that addresses modifiable risk factors such as lifestyle or behavioural aspects.

For example, nutrition interventions can make a highly efficient contribution to reducing the growing disease burden linked to over/poor nutrition.[9] Once a GP or other health practitioner has identified high levels of risk for the development of a condition such as Type 2 diabetes, effective integration of allied health interventions, including diabetes education and exercise physiology, could prevent the development of the illness.

Similarly, if the person has already developed the illness, the right interventions are likely to reduce further consequences. For instance, exercise and strength training for knee osteoarthritis are highly cost-effective interventions, compared to treatments such as arthroscopy which have been shown to be ineffective.[10] People with Type 2 diabetes – totalling 1,191,919 as registered with the National Diabetes Services Scheme (NDSS) at June 2020[11] – are entitled to one Medicare funded assessment service per year by a diabetes educator (Item 81100), exercise physiologist (81110) or dietitian (81120). However, the total number of MBS assessment services across the three items in the year ending June 2020 was 12,214,[12] indicating that only 1.02% of eligible patients were referred for and received this service in 2019-2020.

Preventive health programs and early intervention programs provided through allied health can maintain and improve patients' strength and functionality and increase their levels of wellness and wellbeing. This also reduces aged care costs, as older Australians can be supported to live independently in the community or at least remain living in their own homes for longer.

[8] https://ahpa.com.au/allied-health-accreditation/ ; NHRC, 24-26.
[9] Dalziel, K., and L. Segal (2007), 'Time to give nutrition interventions a higher profile: Cost-effectiveness of 10 nutrition interventions,' *Health Promotion International* 22 (4).
[10] National Institute for Health Care Management, *The concentration of health care spending* (2012).
[11] https://www.ndss.com.au/about-the-ndss/diabetes-facts-and-figures/diabetes-data-snapshots/.
[12] Department of Human Services, Medicare Benefits Schedule statistics, Report generated 2 August 2021.

Allied health interventions aimed at both primary prevention and amelioration of symptoms thereby produce multiple efficiencies for the health system, including saving the costs of providing medical and hospital services.[13]

Allied health practitioners play a direct service provision role in prevention of disease, and indirectly contribute through education of patients and, where appropriate, their carers. An integrated system that prioritises holistic care and prevention would fund these types of allied health service provision from cradle to grave. In contrast, as detailed below ('Funding mechanisms'), the current approach is at best piecemeal and episodic.

Funding mechanisms are not fit for purpose

A genuinely integrated and collaborative primary healthcare system requires investment that goes beyond episodic direct service provision and also funds multidisciplinary care planning, shared care plans, and care coordination activities such as case conferencing. A classic illustration of the present barriers and inequities concerns people with chronic disease and/or mental illness.

The chronic disease MBS rebate is typically lower, and can be significantly less, than the costs of providing the service. This leads to large out-of-pocket costs for patients. For example, out-of-pocket expenses for chronic health conditions such as arthritis, diabetes, cardiovascular disease and mental illness are all likely to be at least double the average healthcare costs for people with no health condition. Adults with asthma, emphysema and chronic obstructive pulmonary disease have 109% higher household out-of-pocket healthcare expenditure than do those with no health condition, and adults with depression, anxiety and other mental health conditions have 95% higher household out-of-pocket expenditure.[14]

Given that people on lower incomes are much more likely to experience chronic disease than those better off,[15] combined with the reality that access to private health insurance also disproportionately favours those with higher incomes and in metropolitan regions, people with a chronic condition are more likely to forego care, including allied health treatment, because of cost.[16] State-funded community health services may provide some allied health, but the range of services vary from region to region, as do waiting times (often extensive) for access.

The current MBS approach to chronic disease is not simply inefficient in terms of missed opportunities for prevention. Those patients who do manage the out-of-pocket costs are restricted by present MBS funding limits to five consultations per year for chronic disease items and ten per year for Better Access mental health items.

MBS chronic disease management (CDM) funding is also currently capped at funding for 20 minutes, regardless of the type of consultation or the profession of the treating practitioner. This is out of touch with standard practice for allied health services, which typically involve an initial assessment that would normally take between 45 and 60 minutes. That initial consultation is important in laying the foundation for further treatment and establishing the needs of the

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[13] See eg *The value of accredited exercise physiologists to consumers in Australia*, Deloitte Access Economics for Exercise & Sports Science Australia (30 November 2016); Homeming, Lyndon J et al (2012), 'Orthopaedic podiatry triage: process outcomes of a skill mix initiative,' *Australian Health Review* 36(4) 457.
[14] https://www.ncbi.nlm.nih.gov/pubmed/27451858 .
[15] For example, people in the lowest 20 per cent of incomes are about five times more likely to have cardiovascular disease or diabetes than those in the highest 20 per cent (https://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf).
[16] https://www.ncbi.nlm.nih.gov/pubmed/27451858 ; see also Consumers Health Forum of Australia, *Out-of-pocket pain research report* (April 2018).

particular patient. Subsequent chronic disease care sessions frequently exceed the 20-minute time slot currently rebated. The result is either again significant out-of-pocket costs for the consumer, or services being unable to sufficiently deal with the patient's health needs.

The 20-minute limit also fails to account for the complexity of the health needs of many consumers. Co-morbidity is common among people with chronic illnesses, with 90% of people with chronic obstructive pulmonary disease, 85% of people with diabetes, and 82% of people with cancer having two or more chronic diseases.[17]

AHPA strongly contends that the recommendations from the MBS Review Allied Health Reference Group related to allied health services, and the MBS Review Taskforce in relation to mental health, should be fully implemented.[18] While in the long term enhancing MBS items may not be the most appropriate funding model, it should be supported until more appropriate options are developed.

A suite of funding approaches is necessary to enable consistent and high quality allied health services, regardless of postcode. To meet the varying needs of patients and support broad access to allied health services, it is imperative that Australia moves far beyond any simple reliance on fee-for-service models and instead introduces a range of innovative funding models (including block, blended and bundled). These reforms must be accompanied by government commitments to provide greater support for providers and practices, including for models of multidisciplinary and intersectoral team care.

Emergency and disaster preparedness

While we note that the biggest current barrier to an effective national health response is the inability of the States and Territories to collaborate on a consistent approach, the COVID-19 pandemic also starkly highlights the flaws in a medico-centric primary health system.

With all respect to Chief Health Officers, their role as doctors and focus on the most immediate concerns is likely to compromise their understanding of the value of diverse allied health practice and the associated consequences for patients, and for the health system in both the short and long term, if they cannot be treated.

Allied health experience during the COVID-19 pandemic has generally been simply to be told of decisions about restrictions and treatments that are deemed essential. Even here it is often a matter of having to continually ask for information and clarification in different jurisdictions, and then being forced, often under considerable pressure, to try to update information and processes. Allied health peak bodies and practices are usually not consulted until after it is too late, with announcements being made about providing measures such as more mental health services without an understanding of the capacity and distribution of the workforce.

The continuing lack of access to health care interpreters, particularly for private allied health professionals, also compromises equitable health outcomes at any time.

Constraints on future 'solutions'

Possible solutions to lack of access to quality health services tend to be viewed through the existing GP-centric lens. For example, GP clinics are the most ubiquitous primary health structure in Australia, and so in seeking to cast the health service net more widely and consistently it may

[17] http://www.aihw.gov.au/chronic-diseases/comorbidity .
[18] MBS Review Taskforce, *Post-consultation report from the Allied Health Reference Group* (2019); MBS Review Taskforce, *Taskforce findings on primary care*, 23-24.

appear logical to simply increase them as the knots in the net. However, as we have outlined, this strategy risks reproducing some of the same inequities it is meant to address.

It is not at all clear how continuing to replicate the predominant focus on GPs – even as central points of coordination in expanded clinics – will enable allied health professionals to fully contribute at the top of their scope to current health shortages. There are certainly no needs-based, coordinated or effective funding mechanisms and workplace cultures to facilitate co-location of allied health in GP-led clinics, nor to enable team-based, coordinated care as routine practice. For similar reasons, primary health networks do not routinely accommodate the diversity of allied health providers as equal partners.

Reforming the primary health system

A profound shift in the culture of our primary health system is needed. Rather than a model of one-size-fits-all, it is time to identify and roll out a range of bold approaches with commitments to ongoing evaluation, tailoring and funding. One type of rural model is the Allied Health Rural Generalist Workforce and Education Scheme ('AHRGWES'), which needs to shift away from limited pilots and become embedded as a genuine alternative to address local workforce shortages. As part of this consolidation, budget items must be allocated in the AHRGWES for student placements, scholarships for Allied Health Rural Generalists working in private practice and non-government organisations, mentoring, and supervision; as well as, where appropriate to local context, for backfilling, travel and accommodation.

While solutions that might work in some areas are likely to need to be at least adapted for elsewhere, there is utility in considering, modifying and expanding this type of model of training and support, provided that funding is secure, ongoing and tailored to the service.

Another possible example might be along the lines of proposed Rural Area Community Controlled Organisations (RACCHOs),[19] themselves influenced by the success of Aboriginal Community Controlled Health Organisations and community health centres. As with training and student placements, these preferred models or 'provider hubs' should be multidisciplinary, shaped to local context (including outside rural areas) and adaptable.

The resulting more flexible models could work in tandem with the establishment of Service and Learning Consortia as recommended by the National Rural Health Commissioner.[20] This would provide pathways both for school leavers wishing to train as an allied health assistant or practitioner, and for allied health professionals contemplating rural or other specialised practice, such as in an inner urban area with a high number of recently arrived migrants with low socioeconomic status.

Regardless of the specific model, potential single primary health care destinations such as community-based health centres require funding commitments to ensure adequate coverage of the diversity of allied health patient needs. Funding must also be allocated for governance and interdisciplinary collaboration and partnerships. Ongoing professional supervision, support and debriefing within such teams will be essential.

To achieve these changes in interprofessional practice, health provider organisations must work with professional groups to agree on a national competency framework for collaborative practice. They must identify changes to education programmes to support the development of

[19] https://www.ruralhealth.org.au/sites/default/files/Infographic-proposal-for-better-health-care-a4v2.pdf .
[20] NRHC, Recommendation 1, 8-18.

interprofessional collaboration competencies in the workforce, including embedding collaboration and teamwork capabilities in student curricula.[21]

Consistent with the recommendation of the National Rural Health Commissioner, the Commonwealth should develop a National Allied Health Data Strategy which includes building a geospatial Allied Health Minimum Dataset that incorporates comprehensive rural and remote allied health workforce data.[22] This will support allied health workforce analysis and can be used to formulate planning strategies to ensure adequate supply to meet current and projected future demand.

Obstacles to professional pathways and supervision, particularly in rural and remote areas, need to be addressed. Investment is needed to support recruitment, placements and training of students in primary care settings. Delegation frameworks must be put in place to enable appropriate work to be undertaken by allied health assistants and support workers, and to provide career satisfaction for these roles.

All key nodes in the wider care communication system, including My Health Record and secure messaging, must be fully accessible to allied health.

It also remains essential for a unified system response to formally acknowledge and implement the now agreed definition of 'allied health', together with a clear understanding of which forms of allied health treatment need to continue in an emergency or disaster and which aspects can be safely delayed or delivered by telehealth.

There should be a high-level representative of allied health on the Australian Health Protection Principal Committee and in any future disaster planning activities. If the Commonwealth Chief Allied Health Officer, as the lead of around a third of the health workforce, were at similar seniority to the Chief Nurse and Deputy Chief Medical Officers and engaged as they are, this would be very beneficial. Development of allied health emergency policy and practice must be led by Chief Allied Health Officers in partnership with allied health peak bodies and registration boards.

Addressing continuing lack of access to health care interpreters is a matter of urgency, particularly in order to support those during a pandemic or disaster for whom English is at most a second language.

[21] Cf *Hidden in plain sight,* 42-45.
[22] NRHC, Recommendation 3.