the peak body and leading voice for sonographers

Friday, 16 August 2019

Professor Paul Worley
National Rural Health Commissioner
Department of Health
GPO Box 9848
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Email: NRHC@health.gov.au

Dear Professor Worley,

Thank you for the opportunity to consider and provide feedback on the policy options presented in the *Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution (2019)*.

I congratulate you and your team on a well-developed discussion of the challenges that rural and remote areas face attracting allied health professions and the thoughtful options proposed to begin addressing these challenges.

The Australian Sonographers Association (ASA) is very supportive of many of the options presented in the *Discussion Paper*. Such as the establishment of a National Chief Allied Health Officer/Advisor role, establishing a nationally consistent data set for all allied health professions, and establishing new arrangements to support workplaces in rural areas to provide more clinical training placements.

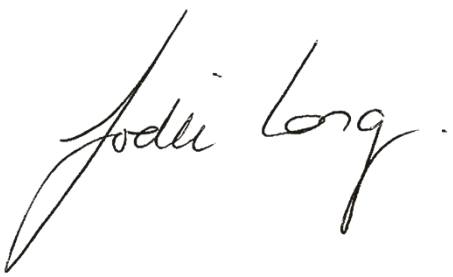
The latter is particularly important for us as the 10-year critical shortage of sonographers in Australia, something that is more pronounced in rural communities, is singularly attributable to the extremely poor availability of student sonographer clinical training placements.

Other options we could benefit from further development, as diagnostic imaging allied health professions may not have been considered in their development. In all of this work, we strongly request that your office continues to engage with the Australian Sonographers Association, as the peak body representing sonographers in all locations of Australia.

Please find attached more detailed feedback against the questions of the *Discussion Paper*. I understand that this response will not be made publicly available. However, we are happy to be noted as an organisation consulted in this work.

If you have any questions on this information, please contact James Brooks-Dowsett, Policy and Advocacy Advisor at the ASA, by phone on (03) 9552 0008, or email to policy@sonographers.org.

Yours sincerely,



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Chief Executive Officer

Question 1.1a: *If the Commonwealth were to appoint a Chief Allied Health Officer/Advisor, what would be their top priorities for improving rural allied health distribution, access and quality in the next five years?*

The ASA supports the appointment of a national Chief Allied Health Officer/Advisor. This is consistent with governance models already in-place for Australia's state and territory Departments of Health.

The top priorities should be:

1. Implement programs that address the workforce shortage of professions with persistent undersupply. Sonography, for example, has been a workforce of shortage for over a decade. This is a shortage, not a maldistribution. It is exaggerated in rural areas and directly impacting rural patients' ability to access quality affordable ultrasound services, required for critical health services such as perinatal maternity care and early cancer diagnosis.
2. Establish a national system to capture workforce data for all allied health professions, not just those registered under AHPRA. This should integrate and build on the various data collection across state and national government agencies, and provide national benchmarking of distribution and supply to enable targeted strategies to improve rural communities access to allied health services.
3. Deploy programs that support rural public and private health services to provide clinical training placements in rural areas for students studying sonography and other allied health professions.
4. Produce a strategy to address the availability of allied health services in rural areas that encompasses all of the health settings, including diagnostic imaging services.

Question 1.1.b: *How could a Chief Allied Health Officer/Advisor position be structured to improve inter-sectoral collaboration?*

This position should be a dedicated position, with a described portfolio of work, within the Commonwealth Department of Health. Ideally working with or reporting the Chief Medical Officer and aligned with regulation, quality practice, health training, rural access and health workforce reform business areas.

The Chief Allied Health Officer/Advisor should capitalise on existing relevant government committees to improve inter-sectorial collaboration. For example, through participation at the Australian Government Diagnostic Imaging Advisory Committee.

This position would need to have strong connections with all allied health peak bodies, such as the Australasian Sonographers Association (ASA); as well as cross-industry bodies such as the Services for Australian Rural and Remote Allied Health (SARRAH), to ensure their work holistically considers allied health professions across the health care continuum and all service settings.

Question 1.2.a-c: *establishing a Rural Allied Health College*

There is insufficient detail on this proposed option for the ASA to provide comment. We have some preliminary concerns that diagnostic imaging allied health professions have not been sufficiently considered in the development of this model.

We request the Government engages with the ASA and other diagnostic imaging peak bodies on the further development of this model.

Question 1.3.a: *What are the benefits and challenges of investing in a unique national rural allied health workforce dataset?*

The Australasian Sonographers Association (ASA) strongly supports the establishment of a process to capture workforce data for all allied health professions.

Currently, the capture of the national workforce in a consistent manner is limited to the professions registered under AHPRA. This current approach disadvantages health services, the governments and other industry representative organisation from being able to properly assess the state of undersupply or maldistribution of health professionals.

The ASA recommends that that national minimum data for allied health professions is collected, with a rural workforce subset. However, even if only national rural allied health workforce data is collected, this would be of great advantage for the health system.

Such a dataset would provide robust intelligence to understand better where the opportunities are to address allied health workforce supply. The data would support the government to make informed decisions on where and what to invest in to achieve the greatest improvement in health outcomes for rural patients.

Question 1.3.b: *What existing rural allied health workforce datasets/structures could be used already as the basis for this national dataset?*

The ASA recommends that an evaluation of existing data collection is performed first. This should then be aggregated and build upon to avoid or at least reduce duplication of work.

At a minimum, this should include:

- Data collection frameworks that were being employed for allied health professions by the former Health Workforce Australia agency.
- Labour market data collected by the Australian Government Department of Employment, Skills, Small and Family Business.
- AHPRA data and other profession-specific registers or data sets (e.g. the Australia - Sonographer Accreditation Registry data).
- State government clinical placement data (e.g. the NSW Government HETI clinical training register).

Question 2.1.a-b: *Quotas*. The ASA has no comment on this item

Question 2.1.c: *Please describe other policy options within the Commonwealth's remit, which could achieve the same result in rural origin student admission rates?*

The ASA's preferred approach to motivate allied health students to stay in rural areas is for them to undertake their clinical training in a rural setting. However, this relies on both public and private practices being supported to provide the clinical training opportunities for these students.

This is further enhanced if they study in the rural setting as well. Many courses are already providing for a significant proportion of coursework to be undertaken as an external student. Many are also utilising online forum, video assessment and other new technologies so that students have the choice to engage with courses away from the main campus.

However, clinical training will always require 'in-person' participation. Depending on the amount of clinical training that is required for a student to graduate, this may require them to move away from a rural environment where they could otherwise complete their studies.

Question 2.2.a-b: The ASA has no comment on these items.

Policy item 2.2: additional comment

The ASA agrees that employing models that support more rural students accessing allied health courses of education is an important component to building the rural allied health workforce.

The ASA, however, suggests that employing programs that support training allied health students in a rural setting achieves greater outcomes for increasing the rural allied health workforce, over attracting more rural students to metropolitan locations to study. With increased numbers of rural allied health education providers and greater availability of online education, increasing the availability of allied health clinical training placements in rural areas would significantly improve the ability of rural students to complete their allied health training close to home.

Local public tertiary hospitals have a limited capacity to provide this clinical training. Programs that support private allied health to provide supervised clinical training are essential to meet the objective of training more allied health students in a rural setting.

Question 3.1.a & b: The ASA has no comment on this item

Question 3.1.c: *Please describe other strategies within the remit of the Commonwealth that could be implemented*

The ASA agrees that employing models that support more rural students accessing allied health courses of education is an important component to building the rural allied health workforce.

The ASA, however, suggests that employing programs that support training allied health students in a rural setting achieves greater outcomes for increasing the rural allied health workforce, over attracting more rural students to metropolitan locations to study. With increased numbers of rural allied health education providers and greater availability of online education, increasing the availability of allied

health clinical training placements in rural areas would significantly improve the ability of rural students to complete their allied health training close to home.

Local public tertiary hospitals have a limited capacity to provide this clinical training. Programs that support private allied health to provide supervised clinical training are essential to meet the objective of training more allied health students in a rural setting.

Many private businesses or sole operators cannot afford to provide clinical supervision placement due to the lost revenue associated reduced productivity while providing clinical training supervision.

To increase the number of allied health student rural placement opportunities, the ASA encourages the Government to also consider the full or partial wage subsidies for clinical supervisors, either through payment to the business or tax subsidy, to reduce the financial and resource burden of providing clinical training placements.

Question 3.2.a: *What are the factors that would need to be considered to ensure the successful expansion and promotion of the Health Workforce Scholarship Program?*

The main limitation of the current application of the HWSP is that it is only paid to the student rather, and is not available to health services to support them to provide clinical training placements. The ASA strongly encourages the Government to explore expanding the application of the HWSP to pay for training and supervision expenses. However, this would need to be for students of all professions eligible for the HSWP, not just those training in rural generalist courses.

It is strongly encouraged that the Government also work with the allied health profession peak bodies, such as the ASA, to promote the HSWP to prospective and existing students, public and private employers and the broader industry.

Question 3.2.b & c: The ASA has no comment on this item

Question 4.1.a-d: *Integrated Allied Health Hubs (IAHHs)*

There is insufficient detail on this proposed option for the ASA to provide firm comment. We have some preliminary concerns that diagnostic imaging allied health professions have not been sufficiently considered in the development of this model.

We request the Government engages with the ASA and other diagnostic imaging peak bodies on the further development of this model.

Question 4.2.a: *Are there other funding channels that could be leveraged or influenced by the Commonwealth to achieve stable, integrated and coordinated allied health services?*

The Government should also consider a bonding incentive scheme for rural and remote areas – similar to the program employed in New Zealand.

This initiative provides funding to incentivise rural and remote workplaces to provide clinical training placements and encourage health professions to remain in rural and remote areas following qualification.

This model provides additional funding per annum to health professions in their 3rd, 4th and 5th years of practice, post qualification, where they:

- Were registered with the scheme as a student.
- Have stayed at the same workplace where they trained for three years after qualification.

For further information on this program visit the New Zealand Voluntary Bonding Scheme website https://www.health.govt.nz/our-work/health-workforce/voluntary-bonding-scheme

Question 4.2.b: *Of the options described above which would be most effective in creating viable rural markets? Please describe the reasons why.*

Of the options presented above, 'option 2. Commonwealth to fund supervisors of allied health students in private practice in MMM 4-7 areas for the time they spend teaching and demonstrating in practice settings', would have significant positive outcomes for all allied health professions, and would be most effective for increasing rural access to quality ultrasound services.

The ASA asserts that increasing the availability of quality clinical training placements in a rural location is one of the most effective models. It will instantly increase the local communities' access to services and employs the 'grow your own' / 'stay where you train' approach to meet the health service needs of rural areas. There is also an increasing amount of evidence in support of this approach.

Question 5a: *Please describe any existing telehealth models that could be adopted in rural areas to improve the access to and delivery of allied health services.*

For several years, the Queensland Government has delivered the Rural and Regional Ultrasound Training Program. It initially provides the student with one on one face to face training in a block placement at a metropolitan site with a sonographer educator. Once the student has achieved base level competencies in examinations agreed by the Educator, they return home, and scans are performed under remote supervision using video conference.

This training model has increased the number of sonography trainees in Queensland and has resulted in improved sonography service access for regional and rural Queensland residents by addressing workforce maldistribution. Of the 24 graduates to date, 17 have remained working in rural and remote areas either in Queensland or interstate. Sixteen separate training sites benefit from increased sonography services as a result of the technology-enabled training program.

In the first three years of the program, over 350 ultrasound examinations were performed at sites that had no sonography services. Over a third of these were obstetrics scans that prevented pregnant women having to travel significant distances to receive a routine part of their antenatal care.

With the program now embedded, approximately 550 scans are performed each by students on the training program. Four sites have been able to introduce a sonography service which previously didn't exist.

Policy item 5: additional comment

The ASA raises the following important point about option '5.6 Invest in point-of-care equipment' concerning ultrasound.

Simple testing, such as blood pressure monitors or blood glucose monitors, can easily be delivered with telehealth support. They require minimal training and are limited in complexity, with a constrained and specific scope of application. Notably many of these and other similar diagnostic screening and monitoring services already available at many pharmacies.

Other more complex point-of-care diagnostic technologies, such as point-of-care ultrasound services require training in the use of technology for a limited scope of practice and will generally be referred on for a comprehensive medical diagnostic ultrasound examination performed by a sonographer.

We strongly recommend the Government engages the ASA if there is any consideration of adding ultrasound to the list of technologies in this model, to avoid unnecessary patient risk.