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Australian Government Department of Health and Aged Care

3 March 2025

Submission to Draft National Allied Health Workforce Strategy

Dear Anita,

Congratulations on your recent appointment and thank you for the opportunity to provide feedback on the final draft of the National Allied Health Workforce Strategy. TAFE Directors Australia (TDA) is the peak national body which represents Australia's national network of publicly owned Technical and Further Education (TAFE) institutes and university TAFE divisions. TDA's National Advisory Council for Allied Health (the Council) brings together experts from across Australian TAFEs to represent and advocate in relation to Allied Health Assistance education programs. This includes providing expert advice on policy and strategy matters relating to Allied Health Assistance training and other TAFE-trained allied health related disciplines.

We acknowledge the significant contributions of the Workforce Strategy Steering Group and Advisory Group in developing this comprehensive strategy, which addresses the challenges faced by the allied health workforce and provides a roadmap for its development over the next decade. This initiative is essential for the growth of the allied health workforce, which will be critical for improving the health and wellbeing of all Australians. However, we remain concerned about the decision to exclude the Allied Health Assistant (AHA) workforce from the scope of the strategy in Draft 2.

We believe that this exclusion undermines the strategy's effectiveness and limits its ability to achieve its stated vision. Over the next decade, the AHA workforce is likely to grow more than any other single allied health professional group, driven by increasing demand from an ageing population and the need to develop financially sustainable service models. Moreover, with the significant Commonwealth investment in services provided by AHAs in the disability, aged care, and primary care sectors, the omission of this critical workforce from a national plan risk constraining the government's ability to meet its own policy priorities.

We also wish to highlight the difference in approach between the development of the National Allied Health Workforce Strategy and the National Nursing Workforce Strategy. The latter has included TAFE-trained enrolled nurses and assistants in nursing within its scope. Additionally, the Strategy

Advisory Group for the nursing strategy included representatives from the TDA National Enrolled Nurse Advisory Council and TDA. In contrast, neither the TDA National Council for Allied Health or HumanAbility, the Jobs and Skills Council established by the Commonwealth to provide sector stewardship for all health and human service workforces, have been represented on any of the strategy advisory groups. This lack of alignment with the nursing workforce strategy risks perpetuating fragmentation within the allied health workforce and further prevents collective action.

While we understand that the strategy is nearing finalisation and that incorporating the AHA workforce in its entirety may not be feasible at this stage, we respectfully request that consideration be given to adjustments that better reflect the importance of the AHA workforce, particularly in relation to the strategy's existing priorities. We offer the following points for your consideration:

1. Include Allied Health Assistants in the scope of the workforce strategy.

We recommend that the AHA workforce be included in the scope of the strategy by amending the sentence on page 7.

Current wording: "It is acknowledged that allied health assistants (AHAs) play an important role in facilitating allied health professionals to work to their full scope of practice, supporting the delivery of allied health services. However, AHAs are not considered in-scope for the purposes of this draft Strategy."

Recommended wording: "Allied Health Assistants (AHAs) work under delegation from allied health professionals and play a crucial role in enabling allied health professionals to work to their full scope of practice, supporting access to allied health services and contributing to innovative models of care. Stakeholders have identified the need for enhanced data collection to better understand the contribution of AHAs to the broader allied health workforce and to inform AHA training and workforce planning initiatives. Additionally, they have highlighted the potential of nationally accredited vocational education and training pathways for AHAs to improve the diversity of the AHP workforce, making these areas essential for inclusion in this strategy."

2. Update the strategy to reflect the role of AHA training and practice in AHP workforce development.

Priorities 3, 4, and 5 already reference the potential of the vocational education sector to create pathways for underrepresented groups in allied health professions, particularly for Aboriginal and Torres Strait Islander people and those living in rural and remote areas. However, this work is further advanced than what is currently reflected in the strategy. Numerous successful pathway programs are already in place, including the IAHA Aboriginal Health Academy and the TAFE NSW Launchpad TVET program. What is required now is the scaling and strengthening of these pathways, which can be achieved through greater collaboration between TAFE, universities, and partners such as IAHA, AHPA and SARRAH with the support of the Commonwealth government.

Recommendation: Edit Priorities 3,4,5 to incorporate the above. Suggested edits are provided in Attachment 1.

3. Update the strategy to include AHAs in the scope of allied health data improvement efforts.

To strengthen and scale TAFE pathways to university allied health programs, improvements to data and better coordination between the education sectors are essential. Without a comprehensive perspective on the entire allied health workforce by including AHA data, the collected data and subsequent workforce intelligence will remain incomplete, negatively impacting multiple areas outlined in the strategy.

Recommendation: Edit Priority 2 of the document to include the above points. Suggested edits are provided in Attachment 1.

The above recommendations represent minimal changes, which we hope will not delay the completion of the strategy. We would welcome the opportunity to engage with your office further to explore ways to enhance the level of engagement with TAFE and AHA workforce representatives. By working together, we can improve understanding of the value of AHAs and the range of co-benefits that can be achieved by growing a well-trained AHA workforce in Australia.

The value of Allied Health Assistants includes:

- **Creating a stable local workforce in communities** – Especially in rural areas where allied health professionals may only visit, AHAs provide a stable, continuous workforce that enhances service sustainability and continuity of care.
- **Supporting a more diverse allied health workforce** – VET-trained AHAs reflect the diversity of the broader community and enhance the person-centredness of care. An AHA career providing opportunities for individuals who may not pursue university qualifications, such as mature-aged students, those with caregiving responsibilities or people who don't have the financial resources to undertake extended university study, to have a purposeful allied health job.
- **Improving job satisfaction and morale among allied health professionals** – By delegating routine tasks to AHAs, AHPs can focus on their full scope of practice, leading to increased job satisfaction and providing flexibility to pursue leadership or research.
- **Building workforce capacity** – The AHA workforce contributes to the overall growth and capacity of the allied health workforce, fostering a more united and collaborative approach to addressing workforce needs.
- **Enabling a more effective multidisciplinary model of care** – AHAs support healthcare teams and are increasingly undertaking multidisciplinary support roles which enhance the delivery of care and services, particularly in settings such as homes and schools.
- **Supporting community wealth and reducing health inequalities** – The creation of AHA roles in health, disability, and aged care services fosters local employment, improving health literacy and contributes to better social determinants of health.

We look forward to continuing our contribution to the strategy as it progresses into its implementation phase. For further information, please do contact me at ceo@tda.edu.au or Dr Nerida Volker at nerida.volker1@tafensw.edu.au .

Sincerely,

Jenny Dodd
CEO
TAFE Directors Australia

Dr Nerida Volker
Chair
TDA National Council for Allied Health

Attachment 1 Foreword to the draft National Allied Health Workforce Strategy

Australia's health, disability and social service systems are among the best in the world. Allied health professionals play a critical role in these systems, using their specialised skills to prevent, diagnose and treat a range conditions and illnesses for consumers across the lifespan. The demand for allied health services has surged in response to the changing needs of the population. This includes a growing emphasis on early years, disability supports, chronic disease management and healthy aging, all of which benefit from multidisciplinary models of care. Although the allied health workforce is growing rapidly, including a growing allied health assistant workforce, this growth has not kept up with demand, resulting in a national shortage and maldistribution of many allied health professions across Australia. This has flow-on effects to consumers and their development, health and wellbeing outcomes.

Australia's National Allied Health Workforce Strategy (the draft Strategy) recommends priorities to address current and future allied health workforce issues in Australia over the next 10 years. A key goal outlined in this draft Strategy is to enable long-term workforce planning to help ensure a sustainable supply of well-qualified allied health professionals that better matches the existing and predicted population needs.

The Department of Health and Aged Care has worked closely with state and territory governments and other Commonwealth agencies to develop the draft Strategy. This work occurred through a Steering Group[1] formed under the Health Workforce Taskforce[2] and included close collaboration with allied health peak bodies and other organisations with an interest in allied health. The draft Strategy reflects engagement with a diverse range of allied health professionals and policymakers, consumers and other stakeholders. These stakeholders live and work across Australia and have brought invaluable perspectives and insights from their professional and personal experiences of allied health care in different sectors to shape this future-focused draft Strategy. This includes input from Aboriginal and Torres Strait Islander peoples; people receiving or delivering health care in regional, rural or remote areas; a wide range of consumers, including carers; and those who are culturally and linguistically diverse.

The draft Strategy is being publicly released to support consultation with the sector, with feedback to inform the finalised National Allied Health Workforce Strategy (finalised Strategy). Once the finalised Strategy has been endorsed by Commonwealth and state and territory governments, the next step will be to implement the Strategy over the next decade. This will involve continued collaboration with governments and the broader allied health sector, as well as with Aboriginal and Torres Strait Islander organisations.

[1] The Steering Group comprises: Chief Allied Health Officers from each jurisdiction and the Commonwealth, the Allied Health Deputy National Rural Health Commissioner, and representatives from Australian Government Departments of Education, Veterans' Affairs, Social Services, Employment and Workplace Relations, and the National Disability Insurance Agency.

[2] The Health Workforce Taskforce provides advice and recommendations to the Health Ministers' Meeting (HMM) on priority workforce matters. Health Workforce Taskforce members include officers from the Commonwealth, and all state and territory jurisdictions.

The Steering Group extends its sincere appreciation to all individuals, organisations and agencies that contributed to the development of this inaugural draft National Allied Health Workforce Strategy.

Introduction

The allied health workforce

Allied health professionals collectively form the largest health workforce in primary care and the second-largest clinical workforce in Australia (DoHAC 2022a). Allied health professionals practice in many parts of the health sector – including primary care, hospital and acute care, aged care and rehabilitation – and a wide range of other sectors such as disability, justice, mental health, social services and education. They may work independently, in multidisciplinary teams, or alongside other health workforces.

The purpose of the National Allied Health Workforce Strategy is not to identify strategies for each individual allied health profession, but instead, to consider strategies that apply to the overarching allied health workforce.

Encompassing a broad range of highly trained health professionals with university-level qualifications, most allied health professions provide one or more of the following services:

- assessment and diagnosis
- therapy and rehabilitation
- education or counselling
- manufacture and/or prescription of aids, equipment and assistive technology (Turnbull et al. 2009).

The allied health workforce in Australia is regulated by:

- the National Regulation and Accreditation Scheme (NRAS), which is administered by the Australian Health Practitioner Regulation Agency (Ahpra); or
- self-regulation by a professional association that certifies qualifications, sets and maintains standards and oversees professional development.

While this draft Strategy does not attempt to identify an exhaustive list of individual allied health professions, examples of self-regulated allied health professions include audiologists, dietitians, exercise physiologists, social workers and speech pathologists. Examples of allied health professions that are regulated through the NRAS include chiropractors, medical radiation practitioners, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists.

It is important to note that stakeholder consultation provided insights regarding the unique challenges faced by different allied health professionals. For example, stakeholders raised concerns that smaller and self-regulated professions experience lower profiles in the community compared with their Ahpra-regulated colleagues. Workplace settings (i.e., private sector versus public sector) can also have a bearing on workforce challenges (i.e., allied health professionals working in the private sector may not have access to the same entitlements and mentorship

opportunities as those working in more hierarchical public health services). While the draft strategy will not address these profession specific concerns, it is important to acknowledge the diverse challenges that the allied health sector faces.

It is acknowledged that allied health assistants (AHAs) play an important role in facilitating allied health professionals to work to their full scope of practice, supporting delivery of allied health services. However, AHAs are not considered in-scope for the purposes of this draft Strategy.

The need for a National Allied Health Workforce Strategy

Allied Health in demand

Allied health professionals play a significant role in disease prevention and early intervention through screening and early detection of conditions, and by assisting patients to reduce risk factors, prescribing health promotion activities, and managing complex and chronic health issues (Davis et al. 2017). Additionally, allied health professionals are the second largest group in the care and support workforce, delivering services in aged care, disability and veteran care (NSC 2021). Allied health professionals deliver essential mental health and social supports to the community, enabling patients to maximise social, recreational and workforce participation. Allied health services are critical in supporting the goals of early childhood intervention frameworks, which aim to lay the foundations in infancy and childhood for positive development, health and wellbeing across the lifespan.

Demand for health services, including allied health, is rising due to Australia's growing and ageing population, and will continue for the foreseeable future. When considering Medicare-subsidised primary care services alone, more than 2.4 million Australians with chronic disease accessed Medicare-subsidised allied health services in 2019 at a cost of approximately $448.2 million (AIHW 2022a, AIHW 2022b). Furthermore, four out of the five top causes of disease in Australia require ongoing support from multidisciplinary teams that include allied health services (AIHW 2024). These figures underscore the importance of allied health primary care services, and the urgent need to ensure evidence-based workforce planning can continue to uplift and better distribute the allied health workforce.

Allied health shortages and maldistribution of the workforce

Although allied health professionals play crucial roles in the health and broader social system, national shortages in some professions (AGJSA 2023) – which are often exacerbated in regional, rural, and remote areas – mean that waitlists to access services are common (VAHI 2023). Consequently, consumers may not be able to access essential services close to home. Shortages result from numerous and compounding challenges; some of which are common across the broader health workforce, while others are unique to allied health. (Scanlan et al. 2010, Keane et al. 2012, Terry et al. 2021). Workforce shortages contribute to reduced access to care and poorer outcomes for consumers, increased workloads for health practitioners, and overuse of higher-cost services such as hospital care (Kruk 2023).

Retention of allied health workers is of particular concern and is negatively influenced by factors including lack of workforce supports, high clinical caseloads, and insufficient career development opportunities. Difficulties in recruiting allied health workers to rural and remote areas also

increases the need to focus on retention of people already practising in these areas. Some important issues raised during the consultations for draft Strategy included reduced attraction into the allied health workforce or to working in rural and remote areas; attrition from the workforce due to culturally unsafe workplaces, burnout, lack of lateral and vertical career progression, and lack of desire to stay long-term in a rural or remote area; and recruitment competition between sectors.

Allied health workforce inequities

One of the most impactful determinants of health for Aboriginal and Torres Strait Islander peoples is racism. A key principle of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 (the Framework) is the importance of culture and recognition that increasing Aboriginal and Torres Strait Islander health workforce participation is an essential element for all health workforce initiatives, settings and strategies. The Framework puts culture at the centre, emphasising its positive impact on Aboriginal and Torres Strait Islander health, highlighting the need for culturally appropriate, relevant, and safe workplaces and service delivery.

The draft Strategy aligns with and actively supports the goals of the Framework to improve cultural safety and grow the Aboriginal and Torres Strait Islander allied health workforce, with responsibility for this seen at all levels, from the individual through to organisational and whole-of-system reform. The draft Strategy recognises that Aboriginal Community Controlled Health Organisations (ACCHOs) are integral to the Australian health system (NACCHO 2021). ACCHOs support engagement of a strong Aboriginal Torres Strait Islander allied health workforce that has the knowledge, skills, and experience to deliver culturally safe and responsive holistic care and services.

The National Agreement on Closing the Gap (National Agreement on Closing the Gap 2020) highlights the importance of genuine partnership between governments and Aboriginal and Torres Strait Islander peoples to share decision making on programs impacting Aboriginal and Torres Strait Islander peoples. Actions that impact the Aboriginal and Torres Strait Islander allied health workforce will be developed in partnership with Aboriginal and Torres Strait Islander peaks.

Australia's first draft National Allied Health Workforce Strategy

The Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners, led by Ms Robyn Kruk AO, recommended the development of a national strategy for allied health, to better support planning for Australia's future allied health workforce needs (Kruk 2023).

Complementing the National Medical Workforce Strategy 2021-2031, and National Nursing Workforce Strategy (which is currently under development), the draft Strategy outlines priorities and recommended actions that aim to secure an adequate supply of highly trained allied health professionals whose services can be accessed equitably across the country. The draft Strategy highlights what is needed from a national perspective to address today's pressing workforce issues and to lay the foundations for long-term policy reform.

This draft Strategy applies broadly to all professions recognised as allied health by the Australian Government, state and territory governments, non-government organisations, primary health networks, allied health peak bodies, universities, private health insurers, and the private sector – including the various industries where allied health professionals are employed.

Extensive stakeholder consultation and research has informed the development of the draft Strategy. An environmental scan of the allied health sector provided a starting point to better understand the state of the Australian allied health workforce and consider the impact of relevant policies and reforms underway across the range of sectors where allied health professionals work. Additional literature has been identified to highlight allied health workforce challenges and potential solutions.

Public and targeted stakeholder consultations were held throughout the evidence collection and drafting phase to identify workforce barriers and enablers, test proposed recommendations, and seek input on the structure and content of the draft Strategy.

A cross-government Strategy Steering Group and an intra-sectoral Strategy Advisory Group[3] have provided continual guidance to contextualise and draw out the issues that have been raised, and to shape the draft Strategy's priorities, objectives, recommended actions and supporting content.

The draft Strategy reflects the shared experiences of consumers and allied health professionals, and the collective expertise of workforce planners, policymakers and academics. It has been developed with the allied health workforce, for the allied health workforce.

Strategy overview

Vision

Australians have access to high-value, client-centred and culturally safe allied health services with a growing, valued and supported allied health workforce that reflects the needs of our communities and the diversity of our population, including Aboriginal and Torres Strait Islander peoples.

Priorities

The draft Strategy identifies **five strategic priorities** that call out the need to highlight and optimise the benefits of allied health care, and to plan for, train, grow, distribute and retain a diverse workforce that meets the future demand for allied health services. The underlying challenges that give rise to the strategic priorities have informed each priority's objectives and actions.

[3] The Advisory Group comprises: Allied Health Professions Australia; Australian Council of Deans of Health Sciences; Catholic Health Australia Allied Health Group; Conjoint Allied Health Professors; Services for Australian Rural and Remote Allied Health; National Alliance of Self-Regulating Health Professions; Office of the National Rural Health Commissioner; Primary Health Network Steering Team Allied Health Framework and Health Services Union.

1. **Enhance the impact of the allied health workforce~~professionals~~:** Promote recognition and understanding of the allied health workforce, and optimise and value its contribution to service delivery in all sectors.

2. **Improve national allied health workforce data and planning:** Enhance national allied health workforce data collection to enable evidence-based and coordinated workforce planning.

3. **Build a sustainable allied health workforce:** Build, support and retain a workforce through improved training and career pathways that enable the workforce to meet the needs of the diverse communities accessing allied health care in different sectors.

4. **Grow, support and retain the Aboriginal and Torres Strait Islander allied health workforce:** Attract, grow and retain the Aboriginal and Torres Strait Islander allied health workforce and ensure culturally safe environments for allied health students, professionals and consumers.

5. **Grow, support and retain regional, rural, and remote allied health workforces:** Using proven strategies that address workforce maldistribution, develop and support regional, rural, and remote allied health workforces and enable allied health practitioners to provide high quality services and meet the needs of their communities.

Policy contexts for the draft Strategy

The allied health workforce operates in a complex environment and implementation of the final National Allied Health Workforce Strategy must occur in parallel with existing and future policies across the many and varied settings within which allied health professionals work. Moreover, large policy reforms occurring during the life of the finalised Strategy may present opportunities – as well as challenges – in achieving objectives. The draft Strategy has been developed with awareness of three policy contexts: reforms to regulation, future workforce capabilities, and cross-sectoral policy alignment.

Policy context one: Reforms to regulation

Allied health professionals work in a context of regulation and accreditation, standard setting and guidance, and a scope of practice associated with each of the various allied health professions. These mechanisms exist to support the supply of highly trained health professionals, as well as the quality and safety of allied health service delivery.

However, inconsistencies in regulation between Ahpra and self-regulated professions have generated some challenges for self-regulated professions, such as lack of access to government income streams and reduced data collection capability, which inhibits workforce supply and demand modelling. As these issues have been reflected in the Scope of Practice Review (DoHAC 2024a) and the NRAS Complexity Review (DoHAC 2024b), the resulting reforms may influence some of the draft Strategy's priorities, particularly in relation to workforce planning.

Survey data indicates that 8-10% of the Australian allied health workforce are internationally qualified (Keane et al. 2011, Whitford et al. 2012). These allied health professionals play an important role in supplementing the nationally trained workforce when the domestic supply

cannot meet community need. Activities to build the allied health workforce through migration are underway following the Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners (Kruk 2023).

There is currently no nationally agreed definition of 'allied health' which can create confusion when governments are developing policies that impact allied health professions. Establishing greater consensus on this could provide clarity for all stakeholders and policymakers, help strengthen the profile of the allied health workforce, and support data-driven workforce planning.

Policy context two: Future workforce capabilities

Teaching, training, recruiting and retaining allied health professionals occurs over time and across educational, vocational, professional and employment organisations, all of which have some responsibility and impact upon the workforce pipeline. This includes attracting students to tertiary education in an allied health profession, providing opportunities for graduating students to enter the allied health workforce, and establishing professional development pathways for all career phases to ensure core clinical skills are continually enhanced.

Allied health professionals also need to adapt to significant social, demographic, economic and climate changes (Naughtin et al. 2022). Along with rapidly advancing digital technologies, these factors have led to a need for development of broader workforce capabilities that enable allied health professionals to deliver increasingly collaborative clinical services (Bradd et al. 2018). These capabilities include non-clinical skills such as digital literacy, innovation and adoption of new technologies; multidisciplinary team and interprofessional practice skills; and system navigation knowledge.

In the years to come, healthcare is likely to become increasingly digitised, presenting both opportunities and challenges (DoHAC 2023a). Many consumers will benefit through increased access to information, digital tools and digitally facilitated services. Allied health professionals will benefit through ready access to patient information and research, improved workflows, efficient clinical recording and enhanced communication and messaging pathways. To take advantage of these benefits, all settings and sectors must develop digital maturity and allied health professionals must build digital capability.

Multidisciplinary or integrated team-based models of care are becoming more common (DoHAC 2023b, DoHAC 2024c, DoHAC 2024d, DoHAC 2024e) and can improve allied health staff satisfaction (Pomare et al. 2020). Team-based care can benefit from organisational, communication and leadership skills (Tandan et al. 2024) and increased knowledge of the role of other professions delivering care (Seaton et al. 2021). Supporting multidisciplinary care has many benefits including improvements in patient experiences and health outcomes (Tandan et al. 2024).

Policy context three: Cross-sectoral policy alignment

Allied health service delivery occurs in the context of broader health and social service systems and must be connected effectively as part of cross-sectoral policy alignment. This will support

workforce recruitment and retention and enable the mobility of allied health professionals without causing imbalances in the growth or distribution of the workforce in particular sectors.

Major workforce reforms at federal, state and territory levels are in development or have been published; these require consideration when implementing the finalised Strategy and include:

- Aged Care Workforce Action Plan: 2022-2025
- Australia's Disability Strategy 2021-2031
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
- National Disability Insurance Scheme Review
- National Disability Insurance Scheme National Workforce Plan: 2021-2025
- Future focused primary health care: Australia's Primary Health Care 10-Year Plan 2022-2032
- National Agreement on Closing the Gap 2020
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031
- National Digital Health Strategy 2023-2028 and the National Digital Health Workforce and Education Roadmap
- National Mental Health Workforce Strategy 2022-2032
- National Preventive Health Strategy 2021-2030
- National Nursing Workforce Strategy (currently under development)
- National Medical Workforce Strategy 2021-2031
- Nurse Practitioner Workforce Plan
- Unleashing the Potential of Our Health Workforce (Scope of Practice) Review
- Review of the complexity in the NRAS
- Review of MBS allied health services chronic disease management services
- Mid-Term Review of the National Health Reform Agreement Addendum 2020-2025
- Royal Commission into Aged Care Quality and Safety
- Australian Universities Accord Final Report
- Independent Review of Health Practitioner Regulatory Settings (Kruk Review)
- Working Better for Medicare Review Final Report.

The National Allied Health Workforce Priorities

Priority One: Enhance the impact of the allied health workforce~~professionals~~

Objective

Optimise allied health practice, leadership and research capability to improve service delivery in all sectors.

Actions

The Partners to the Strategy will collaborate to:

1.1 Promote awareness of allied health professions and training pathways

1.2 Grow research that focuses on allied health workforce capability, models of care and their contribution to best-practice healthcare

1.3 Implement tailored and meaningful funding mechanisms, subsidies and incentives to better facilitate integration of allied health professionals into broader healthcare teams

1.4 Design accreditation standards and professional capability frameworks to better equip allied health professionals with the skills required to deliver contemporary evidence-based care

1.5 Develop allied health leadership capability

Why change is required

1.1 Promote awareness of allied health professions and training pathways

Allied health professionals provide invaluable services to the community and contribute significantly to public health outcomes (Davis et al. 2017). The roles of allied health professions are diverse and supported by their specialised knowledge and skills, which can overlap between professions. For example, some physiotherapists and podiatrists may have specific skills in foot biomechanics, while speech pathologists and occupational therapists working in paediatrics may share knowledge of sensory dysfunction. Some allied health professions are also becoming increasingly specialised (Skinner et al. 2015). An example of this is where a psychologist and dietitian may specialise and work as a team in treating patients with eating disorders. Allied health clinicians offer significant value in working in a multidisciplinary approach where the skills of each team member contribute benefits to the overall care of the individual.

As allied health professionals expand their scopes of practice, professional boundaries are likely to become increasingly blurred. Confusion regarding the scope of allied health roles has been noted amongst health professionals (McLaughlin et al. 2008, Doekhie et al. 2017, Nancarrow et al. 2017, Sangaleti et al. 2017). This lack of interprofessional knowledge is likely to limit collaborative care and reduce the quality of services.

Many allied health professionals also believe that the Australian community do not understand profession-specific roles (Nancarrow et al. 2017, Jolliffe et al. 2024). This has been identified as a barrier to allied health university applications (Wallis et al. 2023). This challenge has been echoed in stakeholder consultations, particularly with regards to smaller allied health professions. Non-optimal recruitment and attrition in the allied health workforce (Yeoh et al. 2024) presents a significant risk to workforce sustainability and causes substantial losses to Commonwealth training investments (Leach et al. 2010).

While acknowledging that promoting and describing the value of profession specific allied health contributions will not directly grow the health workforce, it is likely to improve service quality and utilisation, and support multidisciplinary practice. ***Recognising and promoting the value of allied health professions and training pathways*** will provide many benefits, particularly in relation to attracting students to allied health training programs and supporting recruitment and retention of the workforce.

1.2 Grow research that focuses on allied health workforce capability, models of care and their contribution to best-practice healthcare

To meet the complex needs of consumers with comorbidities and chronic conditions, there is an increasing focus on multidisciplinary care. To maximise the benefits of multidisciplinary care, consumers and all members of the care team must understand what allied health has to offer. Research demonstrates that allied health interventions and models of care are effective and offer immense value to communities. ***Showcasing, building on, and incentivising allied health research*** will highlight its positive impact on consumers, and challenge policymakers to translate research into future policy decisions. Benefits will include improved outcomes at the individual, organisational and systems level. Likewise, research specific to the different allied health professions and their various interventions will inform best practice, demonstrate the value they bring to the healthcare system and help to identify areas of unmet need.

1.3 Implement tailored and meaningful funding mechanisms, subsidies and incentives to better facilitate integration of allied health professionals into broader healthcare

A review of attrition of allied health workforce indicated that remuneration can influence feelings of recognition and job satisfaction among allied health professionals (Yeoh et al. 2024).

Remuneration can vary according to profession, role, workplace setting and sector. Some allied health stakeholders noted that pay ceilings can be reached early in careers and remuneration in many sectors may not accurately reflect seniority and experience.

Stakeholder consultations also highlighted that some self-regulated allied health professionals are not able to access – or do not have streamlined access to – government funding that is available to other allied health professionals. This can impact professional recognition and business viability.

Funding models vary across Commonwealth, state and territory programs, which can influence the sectors that allied health professionals choose to work in.

Designing new ***allied health funding mechanisms, subsidies and incentives*** could assist in addressing these barriers.

Australia's Primary Care 10 Year Plan 2022-2032 (DoHAC 2022b) acknowledges that current funding models do not sufficiently incentivise team-based care within practices, across different workforces, healthcare and related care systems. Funding models, therefore, need to incentivise and support multidisciplinary team-based approaches.

1.4 Design accreditation standards and professional capability frameworks to better equip allied health professionals with the skills required to deliver contemporary evidence-based care

Accreditation standards ensure that those who complete an allied health program, graduate with the knowledge, skills and professional attributes required to safely and effectively practise in

Australia (Ahpra 2023).

Similarly, professional standards outline the knowledge, skills and attributes an allied health professional practising in Australia must demonstrate and apply, at any point in their career, with relevance to their role and work context. Feedback from consultations suggest that current programs of study and professional standards may not be keeping abreast of evidence-based care, which can mean that allied health professionals do not have the skills to work to their full potential and deliver contemporary care.

1.5 Develop allied health leadership capacity

Over the last 15 years, an increasing number of allied health leadership roles have emerged, and organisational structures are beginning to recognise the importance of allied health leadership (Bradd et al. 2018). Barriers to full realisation of leadership potential include the diversity of allied health as a professional cohort, lack of recognition of the value of allied health, complex health systems and reforms, and advancing digital technologies. The ***development of leadership capability*** may support allied health professionals to take on more prominent roles as innovators and strategic planners, enhance the careers and impact of allied health professionals and, in turn, improve healthcare delivery.

Priority One: What success will look like

Addressing the actions in Priority One will improve the recognition of the vast contribution of allied health professionals to service delivery and patient outcomes. Proportionate representation of allied health, in both research and leadership, can enable codesign of models of care and workforce incentives that can benefit the workforce and consumers. To better retain the workforce, it is vital that allied health professionals feel – and are – better understood, represented and equipped to participate in best-practice models of care.

Priority Two: Improve national allied health workforce data and planning

Objective

Enhance national allied health workforce data collection to enable coordinated and evidence-based workforce planning.

Actions

The Partners to the Strategy will collaborate to:

2.1 Develop and implement a national allied health workforce data set to have consistent collection across self-regulated and Ahpra-registered professions and the allied health assistant workforce

2.2 Improve visibility and understanding of training and workforce supply, distribution and activity across allied health professions and the sectors they work in

2.3 Complete supply and needs-based demand modelling for professions and sectors

2.4 Undertake coordinated evidence-based workforce planning at both a regional and national level

2.5 Implement supports for workforce mobility across sectors

Why change is required

2.1 Develop and implement a national allied health workforce data set to have consistent collection across self-regulated and Ahpra-registered professions and allied health assistants

An allied health workforce data gap analysis, commissioned by the Department of Health and Aged Care, reported that allied health workforce data is fragmented and incomplete (DoHAC 2022a). Enhanced data is needed to better understand allied health activity, supply and demand in public and private settings, and across sectors and jurisdictions.

The collection, sharing and use of allied health data across governments and organisations is highly variable between nationally regulated and self-regulated allied health professions. Allied Health Assistant workforce data is also limited and of variable quality.
Workforce data linkages need to extend beyond Australian Government data and should include data collected through universities, vocational education providers, allied health peak bodies with regulatory roles, state and territory activities, private health insurers and other sources.

2.2 Improve visibility and understanding of training and workforce supply, distribution and activity across the allied health workforce professions and the sectors they

Allied health is diverse, encompassing a range of professions, delivered in different sectors and settings, and under various governance arrangements and funding models. Allied health professionals work in more than 30 unique workplace settings including private practices; medical centres; Aboriginal health services; community pharmacies; hospitals; schools, aged care facilities; and disability, justice, and non-hospital paramedic settings (DoHAC 2024f).
Allied health professionals are also maldistributed across Australia (NRHC 2020).

Different factors give rise to sector and setting-specific challenges that can be better considered with collaborative, data-driven workforce planning, including trends observed in the allied health workforce and training pipeline, such as maldistribution, enrolment patterns and consumer access to allied health services, particularly in regional, rural and remote areas.

2.3 Complete supply and needs-based demand modelling for professions and sectors

Nationally consistent allied health workforce supply and demand data will build a strong evidence base to ensure policy measures and programs appropriately target key workforce solutions. Robust data could support targeted funding of workforce attraction and retention measures such as scholarships and relocation allowances. Modelling could also direct funding for profession-specific training, training incentives, improved staffing profiles and immigration supports and strategies to ensure it is targeted to areas of greatest need. While existing datasets may reflect allied health activities across some workplace settings, the data is not integrated and does not capture allied health services delivered in all settings or through other funding models such as private health insurance or private billing (DoHAC 2022a).

2.4 Undertake coordinated evidence-based workforce planning at both a regional and national level

Overcoming these data limitations will assist policymakers to take an evidence-based, coordinated, national approach to workforce planning whilst considering regional variations. Ultimately, this will support better forward planning and decision making so that the supply of the allied health workforce ~~professionals~~ better meets the demand for allied health services.

2.5 Implement supports for workforce mobility across sectors

Some allied health services are co-funded by the Australian Government and state and territory governments, such as those provided through public hospitals and the National Disability Insurance Scheme (NDIS). Other allied health services are funded by state, territory and local governments, such as some community and mental health services. Allied health services can also be funded through not-for-profit organisations. Many private sector businesses have different income streams, including from patients accessing services through workers' compensation, private health insurance, the Medicare Benefits Scheme (MBS), Home Care Package Program, Commonwealth Home Support Programme or Department of Veterans' Affairs health care arrangements.

The disparate requirements associated with these programs, such as regulatory, accreditation and reporting requirements, can hinder allied health professionals' ability to work across multiple employers or settings. Progressing digital health, data sharing and data linkage projects will help to provide sources of allied health activity data across settings and sectors, which can also assist with workforce planning. Stakeholder intelligence can also provide insights regarding sector-specific workforce shortages and help to identify barriers and enablers to workforce mobility across sectors. National collaboration will support capturing this additional intelligence through appropriate forums.

Priority Two: What success will look like

Addressing the actions in Priority Two will allow workforce planning and modelling to be undertaken for ~~all~~ allied health ~~professions~~, at a national and cross-sectoral level. This will drive policy decisions that enable the workforce to be more adaptable and mobile across a range of work settings and sectors in response to service demand.

Priority Three: Build a sustainable allied health workforce

Objective

Improve training and career pathways to facilitate a sustainable allied health workforce that is flexible and empowered to meet the needs of diverse communities accessing allied health care in different sectors.

Actions

The Partners to the Strategy will collaborate to:

3.1 Develop clear and responsive education and training pathways that embrace, cater

for and grow a diverse allied health workforce. This includes strengthening ~~creating~~ pathways for progression from the vocational education and training (VET) sector to higher education for allied health professions

3.2 Enhance student supports, supervision incentives and clinical placement opportunities to develop capabilities and support work readiness

3.3 Create pathways for lateral and vertical career progression, and incentives to increase allied health professionals in generalist, specialised, research, clinical education and leadership roles

3.4 Address regulatory and legislative barriers that are known to contribute to workforce attrition

3.5 Design and implement strategies to support and retain future and current allied health professionals, at all stages of their careers, including those from diverse backgrounds[4].

Why change is required

3.1 Develop clear and responsive education and training pathways that embrace, cater for and grow a diverse allied health workforce. This includes creating pathways for progression from the vocational education and training (VET) sector to higher education for allied health professions.

High-quality education and training, underpinned by robust support during training and practice, is essential in securing the sustainability of the allied health workforce. This starts with attracting and retaining allied health students and ***developing alternative pathways to tertiary allied health degrees.***

AHAs play an important role in facilitating allied health professionals to work to their full scope of practice, supporting access to~~delivery of~~ allied health services and delivering innovative models of care. They also ~~could also~~ play a vital role in the future allied health training pipeline. The VET system, which provides nationally accredited training for ~~h supports skills development fo~~r AHAs, ~~is a useful tool for~~ attract~~sing~~ school leavers and people from diverse backgrounds to the sector and can represent an entry point to further study in an Australian Qualifications Framework level 7 qualification (AQF 2013). This highlights a potential opportunity ***to promote and strengthen ~~develop clearer~~ pathways between VET and allied health university qualifications***. Similar pipelines exist in other workforces such as the transition of assistants in nursing to enrolled and registered nurses.

[4] *For the purposes of this document, we have used the definition of 'diversity' and 'diverse' from the Diversity Council of Australia 22. DCA (2017). What is Diversity & Inclusion? https://www.dca.org.au/resources/di-planning/what-is-diversity-inclusion-intersectionality, accessed 12 November 2024. - differences between people in how they identify in relation to their social identities; this may be culture or faith, age, gender, caring responsibilities, and LGBTIQ+ status. The definition also includes people of Aboriginal and Torres Strait Islander background. In addition, Priority Four specifically focuses on this population.*

3.2 Enhance student supports, supervision incentives and clinical placement opportunities to develop capabilities and support work readiness

Stakeholder consultations have highlighted many challenges regarding allied health training, particularly in relation to student clinical placements and supervision. Effectively supervised clinical experiences are crucial to developing the skills and confidence required to deliver high-quality and safe care. Balancing demand for – and availability of – clinical placements is a key challenge. ***Enhancing placement opportunities and supervision incentives*** will strengthen the training pipeline, build allied health capability, and ensure a strong supply of allied health professionals.

Clinical placements are a mandatory requirement for allied health students to qualify for a degree. Mandatory work placements are also required for nationally accredited allied health assistant qualifications. Many students must forego paid work to undertake unpaid placements and relocate, leading to 'placement poverty'. This may dissuade students from entering an allied health course and can result in negative perceptions of employment in the relevant industry (DoE 2024). Increased costs of living can also adversely impact allied health students' capacity to undertake study and participate in clinical placements.

A study from 2024 (Lambert et al. 2024) indicated that the inability to maintain employment due to placement requirements has far reaching consequences for attracting and retaining health students in university courses. The study confirmed that mandatory professional placements have significant financial and emotional implications for students and their families. For instance, health students reported the median cost for their most recent placement was $1,500 compared to a median of $547.50 for a similar length placement for nursing of 5 weeks. Food insecurity was also highly prevalent. This widespread financial difficulty adversely impacts personal wellbeing, with students indicating they are experiencing burnout prior to graduation.

One of the authors concluded that financial burden of unpaid, mandatory placements was a driving force of inequity among students, and if not addressed, would ultimately lead to a lack of diversity in the health and teaching professions. The research demonstrated that single parents, students with children, people living with a disability or from lower socioeconomic background are less likely to begin and finish degrees that require mandatory professional placements (Dragon 2025).

A recent review into Australia's higher education system, the Australian Universities Accord, confirmed that students require further financial supports while studying (DoE 2024).

> *"To ensure 'placement poverty' does not deter tertiary participation and successful completion, the [Australian Universities Accord] recommends that the Australian Government work with higher education providers and employers to introduce payment for unpaid placements, including government financial support for placements in the areas of nursing, care and teaching"* (p. 6, DoE 2024).

In the 2024-25 Budget, the Australian Government announced it would establish a Commonwealth Prac Payment to support students studying to be a teacher, nurse, midwife or social worker, when they are undertaking mandatory placements. This new payment will be available for eligible students from 1 July 2025 (MotEP 2024). While Commonwealth Prac Payments will be available for eligible students studying to become social workers, the payments is not available for students in other allied health disciplines.

University study may be an economic decision for prospective students. The Higher Education Loan Program (HELP) enables many students to complete tertiary education by being able to repay HELP costs once working. However, stakeholders reported that the salaries of allied health professionals do not always align with the costs of allied health tertiary studies.

Stakeholders noted that high ATAR[5] scores are often required to enter allied health courses at universities. As such, allied health students may expect higher-paying salaries that may be available in other professions requiring high ATAR scores. Accordingly, stakeholders have suggested that the cost of allied health degrees should be reduced to align more closely with prospective future earnings (DoE 2024).

Stakeholders have also identified there is an opportunity to promote and enhance financial supports for allied health students, noting there are typically limited scholarships available at a national level for students pursuing allied health studies.

3.3 Create pathways for lateral and vertical career progression, and incentives to increase allied health professionals in generalist, specialised, research, clinical education and leadership roles.

Stakeholders raised significant concerns about allied health attrition, which has been linked to a lack of early career support and mentorship, scope of practice limitations, and lack of defined allied health career pathways.

Burnout is a significant workforce issue facing allied health professionals (Yeoh et al. 2024).

> *"Professionals experiencing burnout find themselves overwhelmed by prolonged and intense workplace stress, resulting in a reduced sense of personal accomplishment, diminished interest in their professional roles, and ultimately the desire to leave their profession"* (p. 18, Yeoh et al. 2024).

[5] The Australian Tertiary Admission Rank (ATAR) is a numerical rank that measures a student's overall academic compared to their peers. Universities use the ATAR to select students for admission to specific courses.

Predictors of burnout include working in private practice, working longer hours and across multiple workplaces, shorter consultation times, increased client complexity, expectations of the profession, lack of support and having less access to paid sick leave (Burri et al. 2022, Bonanno et al. 2024, Evans et al. 2024). Burnout has been noted in many allied health professionals including podiatrists (Bonanno et al. 2024), radiographers, speech pathologists (Yeoh et al. 2024) and musculoskeletal allied health professionals (M Clarke et al. 2024).

Similarly, stakeholders raised concerns about burnout and its association with attrition. As well as reducing the workforce size, burnout and premature exit from a profession may reduce the pool of senior allied health professionals who would otherwise be able to take on mentorship and support roles for new graduates. Likewise, junior allied health professionals may be forced to take up more advanced and complex roles without sufficient workplace support and experience.

Professional support for allied health professionals contributes to improved clinical practice, client outcomes and enhanced workplace satisfaction. Despite this, formal professional support is low and could be improved through the introduction of workforce policies (Bell et al. 2014, Saxby et al. 2015). Identifying options for career variety, including lateral and vertical progression, through specialised roles and skill acquisition can lead to improved job satisfaction and retention. This includes supporting extended and advanced scopes of practice, undertaking research, and transitions into clinical education, leadership and management roles.

3.4 Address regulatory and legislative barriers to access and supports that are known to contribute to attrition.

In Australia, allied health professionals are either regulated through the NRAS or are self-regulated. The NRAS is administered by Ahpra and ensures that health professionals are suitably trained, qualified and safe to practise. For self-regulated professions, professional associations or certifying entities provide similar functions to Ahpra, including certifying qualifications, setting and maintaining standards, and overseeing professional development.

Feedback from consultations indicates there are regulatory barriers contributing to workforce attrition. For example, during the COVID-19 pandemic, Ahpra-registered professionals had priority access to personal protective equipment (PPE) and vaccinations, ensuring their safety and ability to continue providing essential services. Other feedback suggests that processes of self-regulation are not considered robust, making it more difficult to derive an income from government funding streams or being subject to higher auditing requirements (SPA 2024). As outlined in the final report of the Unleashing the Potential of our Health Workforce (Scope of Practice) Review (DoHAC 2024a), Commonwealth, state and territory government legislation and regulatory instruments (unrelated to the NRAS) are prescriptive in naming professions that are authorised to perform particular activities, and/or the settings or employers under which there is authority to perform those activities. This has the impact of

prohibiting professions that are not named from carrying out the relevant activities, even when activities otherwise fall within the scope of practice for that profession.

Self-regulated professions experience barriers to working to their full scope of practice due to their self-regulated status, which automatically excludes them from the wide range of legislation or regulations that refer to the National Law.

3.5 Design and implement strategies to attract, support and retain future and current allied health professionals, at all stages of their careers, including those from diverse backgrounds[6]

Retention of allied health professionals in the workforce is key to ensuring a strong workforce which is capable of meeting the needs of the community. Attrition rates vary significantly amongst the allied health professions, underscoring the unique challenges faced by the different professions (Yeoh et al. 2024). As highlighted earlier, many factors are associated with allied health workforce attrition such as lack of defined career pathways, job satisfaction, insufficient workforce support and opportunities for professional development, high patient workloads, barriers to high quality service delivery and full scope of practice, burnout and a lack of professional recognition (Yeoh et al. 2024). There are also generational changes; younger allied health professionals want flexible work conditions and opportunities to achieve work-life balance (Yeoh et al. 2024). Examination of retention supporting factors will enable consideration, design and implementation of strategies supporting allied health professionals to stay in the workforce. In turn, a mature and experienced workforce will be better placed to support new graduates in developing skills and working to their full scope of practice.

Australia's population is diverse. In terms of cultural and linguistic diversity[7], almost 30% of the population were born overseas (AIHW 2024), 23% speak a language other than English at home and 3.4% do not speak English well (AIHW 2023). Up to 11% of the population may have diverse sexual orientation, sex or gender identity (AHRC 2014), and approximately 21% of people living in Australia have a disability (ABS 2024). An allied health workforce that is representative of the diversity of the Australian population can uplift access to culturally safe care for all consumers (Stanford 2020).
Universities and VET providers are well placed to ensure the allied health training pipeline promotes diversity and inclusion (DoE 2024). Allied health employers also have a responsibility to provide inclusive workplaces; this may have the ancillary benefit of supporting allied health retention. A diverse pool of leaders and policymakers can also positively influence foundational changes

[6] *For the purposes of this document, we have used the definition of 'diversity' and 'diverse' from the Diversity Council of Australia 22. DCA (2017). What is Diversity & Inclusion? https://www.dca.org.au/resources/di-planning/what-is-diversity-inclusion-intersectionality, accessed 12 November 2024. - differences between people in how they identify in relation to their social identities; this may be culture or faith, age, gender, caring responsibilities, and LGBTIQ+ status. The definition also includes people of Aboriginal and Torres Strait Islander background. In addition, Priority Four specifically focuses on this population.*

[7] First Nations peoples are culturally and linguistically diverse. See Priority Five for information specific to the First Nations allied health workforce.

required to support a diverse workforce. All stakeholders can contribute to inclusive learning and work environments through an organisational commitment to diversity; such a commitment will pay dividends for building and sustaining a culturally diverse allied health workforce.

Priority Three: What success will look like

Progressing the actions for Priority Three will lay the foundations for a sustainable allied health workforce. The workforce is better retained due to career opportunities and satisfaction, as well as supports to facilitate ongoing education, training and supervision. Training pathways will exist from school, early career through to advanced practice roles.

Priority Four: Grow, support and retain the Aboriginal and Torres Strait Islander allied health workforce

Objective

1) Attract, retain, grow and value the Aboriginal and Torres Strait Islander allied health workforce
2) Ensure a culturally responsive environment for allied health students, allied health assistants, allied health professionals and consumers.

Actions

The Partners to the Strategy will collaborate to:

4.1 Implement strategies to attract, retain and support the Aboriginal and Torres Strait Islander allied health workforce in alignment with the Framework

4.2 Ensure culturally responsive environments for Aboriginal and Torres Strait Islander allied health students, allied health assistants, allied health professionals and consumers including supporting expansion of cultural mentoring programs and cultural responsiveness training for the broader workforce

4.3 Create and support pathways for progression from the VET sector to higher education for Aboriginal and Torres Strait Islander allied health students

4.4 Build on financial supports for Aboriginal and Torres Strait Islander allied health students

4.5 Advance professional development opportunities for Aboriginal and Torres Strait Islander allied health professionals to enable lateral and vertical career progression. This includes improving pathways for Aboriginal and Torres Strait Islander allied health professionals to take up leadership roles and drive system-level change.

Why change is required

4.1 Implement strategies to attract, retain and support the Aboriginal and Torres Strait Islander allied health workforce in alignment with the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation

Aboriginal and Torres Strait Islander peoples are underrepresented in the allied health

workforce (DoHAC 2021a). Recruitment and retention of Aboriginal and Torres Strait Islander allied health professionals are influenced by several unique factors including social determinants, geographical isolation, funding complexities and cultural challenges (McCalman et al. 2019). Innovative strategies are required to support ***full workforce participation*** within all allied health professions, roles, levels, locations and sectors.

Stakeholder consultations emphasised the necessity for funding mechanisms to be sustainable and to accommodate the unique needs of organisations delivering care to Aboriginal and Torres Strait Islander people. To achieve this, allied health workforce models need to be co-designed with communities.

Additionally, consultations highlighted inequities in incentives for Aboriginal and Torres Strait Islander graduates to return to their own communities to start or build their careers.

The benefits of Aboriginal and Torres Strait Islander peoples' participation in the health workforce include increased access to culturally safe care, improved health outcomes and economic prosperity for Aboriginal and Torres Strait Islander peoples (DoHAC 2021a). All governments are committed to growing the Aboriginal and Torres Strait Islander health workforce to population parity (3.43%) by 2031 (DoHAC 2021a).

Prioritising the attraction and growth of the Aboriginal and Torres Strait Islander allied health workforce aligns with the objectives of the Framework, and directly supports reforms including the National Agreement on Closing the Gap (National Agreement on Closing the Gap 2020), National Aboriginal and Torres Strait Islander Health Plan 2021–2031 (DoHAC 2021b) and the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016 – 2026 (AHMAC 2016). Partnering with Aboriginal and Torres Strait Islander peak bodies and organisations to develop community-led solutions are essential to advance the actions in the finalised Strategy.

4.2 Ensure culturally responsive environments for Aboriginal and Torres Strait Islander allied health students, allied health professionals and consumers, including supporting expansion of cultural mentoring programs and cultural responsiveness training for the broader workforce

Cultural responsiveness is pivotal to the success of these policies, reforms and initiatives. However, further work is required to ensure that all learning, employment and service delivery environments are culturally responsive for Aboriginal and Torres Strait Islander peoples. This includes supporting changes at a system, organisational and individual level to ensure culturally informed service provision.

Aboriginal and Torres Strait Islander allied health stakeholders have reported inconsistencies in workplace cultural safety. Cultural responsiveness may be lacking in workplaces where health professionals and managers have not participated in cultural safety training and/or are not aware of trauma-informed care or the multiple forms of discrimination that Aboriginal and Torres Strait Islander peoples experience. A lack of cultural responsiveness is also likely to

be evident at an organisational level where clinical governance needs improvement.

Expansion of cultural mentoring programs and meaningful cultural responsiveness training for all professionals is likely to ensure that cultural safety and responsiveness is embedded in all work and service delivery environments. This may be enhanced by the introduction of cultural safety standards and supports in both prevocational and employer onboarding for all allied health students and professionals. It also includes allowing non-Aboriginal and Torres Strait Islander health professionals or students the opportunity to work or have training placements in ACCHOs.

Promotion of cultural leadership and active collaboration with Aboriginal and Torres Strait Islander peoples in training and workplace codesign is likely to improve cultural safety experiences and support the retention of Aboriginal and Torres Strait Islander students and allied health professionals.

4.3 Create and support pathways for progression from the vocational education and training (VET) sector to higher education for Aboriginal and Torres Strait Islander allied health students

There are existing programs and initiatives that seek to grow the Aboriginal and Torres Strait Islander allied health workforce through accessible and culturally safe educational pathways and training (DoHAC 2024g). Work is also underway to support Aboriginal and Torres Strait Islander people to access training and gainful employment in the health sector (NIAA 2021, DoHAC 2021a). Consultations with stakeholders emphasised the importance of expanding programs to support transitions for Aboriginal and Torres Strait Islander people into allied health careers, including place-based training models.

Evidence shows that the development of wraparound supports for Aboriginal and Torres Strait Islander students results in significantly better tertiary completion rates (Gwynne et al. 2020). Historically, Aboriginal and Torres Strait Islander peoples' university enrolment and completion rates have been low (UA 2017). Although rates have been tracking upwards over the last decade, further work is required to increase Aboriginal and Torres Strait Islander peoples' representation in tertiary education. Universities Australia members have committed to developing culturally safe learning environments and building collaborative relationships with Aboriginal and Torres Strait Islander peoples to support equal completion rates by field of study by 2028 compared with the broader student population.

4.4 Build on financial supports for Aboriginal and Torres Strait Islander allied health

Allied health scholarships (IAHA(a), DoHAC 2023c, DoHAC 2023d, DoHAC 2024h) are available to facilitate access to university, and several government-funded programs support Aboriginal and Torres Strait Islander students to connect, thrive and succeed in tertiary studies (NIAA(a), NIAA(b)). From 2024, all eligible First Nations peoples are guaranteed a Commonwealth supported place for bachelor level courses (excluding medicine) when accepted into their

chosen course of study at a public university. Despite these scholarships and programs, there are still barriers for Aboriginal and Torres Strait Islander students to be able to access and complete tertiary education. ***Further development of supports and training pathways*** will help to build the Aboriginal and Torres Strait Islander allied health workforce.

4.5	Advance professional development opportunities for Aboriginal and Torres Strait Islander allied health professionals to enable lateral and vertical career progression. This includes improving pathways for Aboriginal and Torres

High-quality clinical supervision and mentoring is important for all allied health professionals, including the Aboriginal and Torres Strait Islander workforce (Yeoh et al. 2024). Effective strategies include mentoring that is delivered by an Aboriginal or Torres Strait Islander person, specific case consultation with clinical experts, two-way mentoring between Aboriginal and Torres Strait Islander and non-Indigenous allied health professionals and digitally facilitated mentoring and communities of practice (McCalman et al. 2019). Although some formal programs are available (IAHA(b), PPA 2022a), enhancement and expansion of mentorship programs may support retention of Aboriginal and Torres Strait Islander peoples in the allied health sector (McCalman et al. 2019).

Likewise, enhancement of professional development opportunities targeting job specific capabilities (CRANAplus, DoHAC 2024i) can improve job satisfaction and help to build the Aboriginal and Torres Strait Islander allied health workforce (McCalman et al. 2019, Islam et al. 2022). Building leadership capabilities and opportunities (Harfield et al. 2021) for Aboriginal and Torres Strait Islander peoples will also provide positive workforce and health outcomes (McCalman et al. 2019).

Priority Four: What success will look like

Progressing actions from Priority Four will increase the ~~the number of~~ Aboriginal and Torres Strait Islander allied health workforce ~~allied health professionals~~ through education and career pathways that support transition into culturally safe and responsive work environments, early career development, and opportunities for leadership roles.

Improved cultural capability within the broader allied health workforce and services will also ensure that Aboriginal and Torres Strait Islander allied health students, allied health assistants and ~~and~~ professionals feel culturally safe and supported and can provide allied health models of care that better meet the needs of Aboriginal and Torres Strait Islander communities.

Priority Five: Grow, support and retain regional, rural, and remote allied health workforces

Objective

Grow, support and retain regional, rural, and remote allied health workforces with the skills required to serve their communities.

Actions

The Partners to the Strategy will collaborate to:

- **5.1** Implement strategies to target university access for individuals of rural and remote origin
- **5.2** Implement strategies that facilitate place-based learning and development of rural and/or remote clinical placement opportunities for allied health students
- **5.3** Promote ~~Foster~~ and strengthen ~~enhance~~ pathways for progression from the vocational education and training (VET) sector to higher education for regional, rural, and remote secondary school~~allied health~~ students
- **5.4** Tailor incentives and structured supports to address maldistribution of the allied health workforce in regional, rural and remote areas.
- **5.5** Implement professional development and mentoring programs for allied health professionals living and/or working in regional, rural or remote areas to support lateral and vertical career progression and retention. This includes opportunities for generalist training, supporting allied health professionals to meet the needs of the community.

Why change is required

5.1 Implement strategies to target university access for individuals of rural and remote

The allied health workforce is maldistributed across Australia resulting in service access inequities. Allied health professionals tend to be concentrated in metropolitan areas, regional centres and large rural towns, while smaller rural towns, remote and very remote communities have low rates per capita (DoHAC 2024f). The reasons for workforce maldistribution are complex and – depending on the location – may include market failure, low socioeconomic status of a region, and lack of positions funded through public or not-for-profit health services (Cortie et al. 2024).

Research suggests that gains can be made via strategies targeting ***university access*** for individuals of rural and remote origin, ***place-based learning***, and development of ***rural and remote placement opportunities*** for allied health students.

Allied health students from non-metropolitan areas are more likely to take up rural and remote work opportunities following graduation than metropolitan counterparts (Couch et al. 2021, Puah et al. 2023, Fisher et al. 2024). However, non-metropolitan students are underrepresented in tertiary health courses (Jessup et al. 2023). In general, regional and

remote students are 4.7% less likely to attend university and 5.8% less likely to graduate (Cardak et al. 2017). Costs of living and relocation are major barriers for rural and remote students (UA 2017). While some scholarships and programs are available to support tertiary access for rural and remote individuals (Services Australia 2022, PEF 2024, Services Australia 2024, PPA 2024b), there may be opportunities to enhance supports for degree study, clinical placements and professional development, including support in the acquisition of generalist skills.

5.2 Implement strategies that facilitate place-based learning and development of rural and/or remote clinical placement opportunities for allied health students

The availability of place-based learning opportunities provides benefits to rural and remote students and communities. Historically, most allied health courses have been delivered in metropolitan areas and there are still relatively few allied health courses offered in MM4-MM7 areas (McKinstry et al. 2024). A number of factors can influence non-metropolitan allied health course offerings including program accreditation requirements, high profession specific course costs and difficulty attracting educators and supervisors. Rural and remote students are also more likely to be mature students with family and work commitments (DoE 2020). While flexible and online learning pathways may be more attractive and accessible for this cohort, allied health courses may struggle to accommodate such options (McKinstry et al. 2024). Other challenges include the availability of clinical placement supervisors, limitations in placement settings (i.e., acute care versus primary care), and curricula and placement requirement constraints (KBC Australia 2020). Metropolitan students may also face economic challenges when undertaking rural and remote placements. Innovative approaches facilitating regional and rural training opportunities may address access inequities and uplift rural and remote allied health workforce numbers.

5.3 Promote and strengthen ~~Foster and enhance~~ pathways for progression from vocational education and training (VET) sector to higher education for regional,

The National Rural Health Commissioner's report Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia (NRHC 2020) highlights that formalising pathways between VET training and tertiary training for rural origin students is a means of developing a sustainable rural workforce and viable healthy communities. It also recommends rural end-to-end allied health undergraduate training and increased opportunities for longer-term placements in rural settings as mechanisms for attracting students to remain in a rural area after graduation.

5.4 Tailor incentives and structured supports to address maldistribution of the allied health workforce in regional, rural and remote areas.

The World Health Organization (WHO) has identified a broad range of strategies to enhance recruitment and retention of health professionals in regional, rural and remote areas (WHO 2010). This includes employing people of rural background, ensuring curriculums reflects rural issues, providing financial incentives, and ensuring professional or personal support can be offered.

Stakeholder consultations have highlighted the need to target incentives and supports to areas of greatest shortage, in order to rebalance the distribution of the allied health workforce. Whilst governments fund a range of incentives that aim to encourage allied health professionals to work in regional, rural, and remote areas, increasing the value to be commensurate with incentives for nursing or medical professionals may have a positive downstream effect.

5.5 Implement professional development and mentoring programs for allied health professionals living and/or working in regional, rural or remote areas to support lateral and vertical career progression and retention. This includes opportunities for generalist training, supporting allied health professionals to meet the needs of the community.

Facilitating access to continuing professional development is a key factor for supporting retention of rural and remote allied health professionals (Cosgrave et al. 2018, Wakerman et al. 2019). Enhancing professional development supports may also improve job satisfaction (Pang et al. 2024, Yeoh et al. 2024). Likewise, effective mentorships can help retain rural and remote allied health professionals by providing guidance, support and identification of further learning needs (Rohatinsky et al. 2020).

To be able to provide safe and high-quality health care in rural or remote Australia, health professionals need to have a broad set of skills that better reflect the health needs of local communities. Development of ***sustainable rural generalist training*** for the allied health workforce and service delivery models that improve access to allied health services for rural and remote communities are becoming increasingly important.

Priority Five: What success will look like

Addressing the actions in Priority Five will ensure that the allied health workforce is distributed more proportionally across Australia and that those working in regional, rural or remote areas have the appropriate skills and professional supports to sustainably provide care to their communities.

Next steps

Strategy finalisation

The draft Strategy outlines complex and interdependent priorities, objectives and actions. Following further consultation activities, the draft Strategy will undergo revisions, in collaboration with the Steering Group and the Advisory Group (membership at Attachment A). Once developed, the finalised Strategy will be provided to Australian, state and territory Health Ministers for endorsement, after which the Strategy will be made publicly available.

Strategy implementation

Once the draft Strategy is finalised and endorsed, significant collaboration will be required to ensure its objectives are realised. An implementation plan will underpin the finalised Strategy to support its delivery and ensure that the actions achieve intended objectives.

Relationships and partnerships

To support implementation of the finalised Strategy, building strong relationships among all allied health stakeholders, including governments, the allied health workforce and education providers, is essential. Successful implementation is dependent upon continued collaboration and contribution.

Implementation partners include agencies and organisations with a stake in allied health workforce planning. These are likely to include the Australian Government, state/territory and local governments, universities, vocational education providers, allied health peak bodies and professional associations, relevant Aboriginal and Torres Strait Islander organisations, primary health networks, and other organisations that represent the allied health industry. Together, these partners will need to prioritise actions and investments that support profession, setting and sector-specific workforce needs.

Governance

Governance is critical in ensuring the objectives of a workforce Strategy are achieved. Following the release of the finalised Strategy, it is recommended that an Allied Health Workforce Advisory Collaborative is set up to oversee its implementation. An Aboriginal and Torres Strait Islander Allied Health Workforce Advisory Committee is also recommended to support the co-design of relevant allied health workforce initiatives. Partnerships with the education sector, professional associations, regulating bodies, industry and governments will also mean that workforce planning can draw on the knowledge and expertise of stakeholders.

Monitoring and evaluation

A monitoring and evaluation framework with agreed measures of success for the Strategy will support evaluation activities and enable reporting on progress towards achieving the Strategy's vision. The framework will outline the time periods at which data will be collected and analysed and may consider methods of data collection. A monitoring and evaluation framework will also promote accountability across agencies and organisations and can inform remedial strategies if the actions in the finalised Strategy are not being realised as expected.