Response from *Council of Deans of Nutrition and Dietetics, Australia and New Zealand* (CDND ANZ) to:

Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution. Options for Commonwealth Government Policy Reform and Investment. From the Office of the National Rural Health Commissioner

Due Date for Submission:7 August 2019 – extension 12 August 2019

Background to Council of Deans of Nutrition and Dietetics, Australia and New Zealand (CDND, ANZ)

CDND ANZ was established in 2015 with representation from all Universities currently offering qualifications in Nutrition and Dietetics across Australia and New Zealand that are recognised for dietetics practice by the Dietitians Association of Australia or the Dietitians Board New Zealand. The CDND ANZ aims to provide a forum for discussion, feedback, consultation and advocacy on issues relevant to nutrition and dietetics in Australia and New Zealand, independent of the Dietitians Association of Australia, Universities Australia, Dietitians Board New Zealand, Dietitians New Zealand and Universities New Zealand. The Terms of Reference of the CDND ANZ include providing advice and advocacy on standards required for the teaching, research and practice of Nutrition and Dietetics in Australia and New Zealand.

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Response

Following is the response from the CDND ANZ to the '*Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution Options for Commonwealth Government Policy Reform and Investment from the Office of the National Rural Health Commissioner*.'

1.1.a: 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 Council of Deans of Nutrition and Dietetics (CDND) supports the appointment of a Chief Allied Health Officer/Advisor.

In relation to the education and training of allied health students the CDND advise the following top priorities for improving rural allied health distribution, access and quality in the next five years:

- Ensuring equitable access to Allied Health services in rural and regional areas, through:
    - Providing leadership on cultural safety, ensuring culturally safe allied health services are provided
    - Developing a vision for the evaluation and potential re-structuring of Allied Health evidence-based care and service-delivery models.
    - Suitable policy and appropriate systems/structures to support Allied Health staff and students on placements in rural and regional areas. This may include: securing adequate funding commensurate to that provided for medical and nursing students training in rural and regional areas; funding for travel, accommodation, and basic training salary.
    - Increasing employment opportunities
    - Increasing capacity for rural and regional placements for Allied Health students.
    - Improving career structures to retain staff.
    - Increasing access to quality continuing professional development, micro-credentialing, and supervision for rural allied health.
      Evaluation of health funding models (including funding of Allied health, Medicine, Nursing and other services) to enable health services in a given geographical area to work collaboratively, rather than in a segmented fashion across disciplines, sectors (acute, primary care, prevention) or geographical areas.

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

To improve intersectoral collaboration the CAHO/A position would need to have a governance structure that allowed input and accountability via a number of sources. These sources should include:

-Aboriginal and Torres Strait Islander leaders as well as continuing and deep consultation with Indigenous Allied Health Australia, the National Aboriginal and Torres Strait Islander Health Worker Association and National Aboriginal Community Controlled Health Organization.

-a Citizen Advisory Council –representing citizens living in rural, regional and remote areas and are users of healthcare services

-Allied Health Professional Associations

-Councils of Deans

Any governance structure would need to ensure strong input from Aboriginal and Torres Strait Island leaders.

Question 1.2.a: What would be the advantages and disadvantages of the above mentioned models for establishing a College?

The Council of Deans of Nutrition and Dietetics does not currently believe that a college as proposed along the lines of the medical profession is feasible with a diversity of allied health profession and their accrediting bodies.

The advantages include:

- Consistent strategic approaches to the development and delivery of allied health services in rural and regional areas.
- Strategic use of funding to improve service delivery. For example offering funding for professional organisations like the Dietitians Association of Australia (DAA) or to Universities to provide professional development; micro-credentialing; practical training; site visits face to face and onsite in rural areas.
- Co-ordination of education training and placement opportunities.

The disadvantages of a college

- There is a diversity of allied health training and placement needs that would require coordination. A single entity may not be able to meet all needs.
- Duplication of roles already performed by multiple other organisations. With increased resourcing these organisations would be able to perform the functions of a “college”
- Without adequate resourcing the college would not be able to meet its strategic vision
- A centralised approach in a major capital city may not be able to meet the needs of a rural and regional remit

Question 1.2.b: Which model or approach do you support for adopting a College? Please provide the details of the model and the reasons why.

The model which includes “evolution of an existing organisation or association” so that existing networks, programs and infrastructure are used.

Question 1.2.c: What performance indicators would determine the effectiveness of a College?
The following are important performance indicators

- culturally safe service provision
- number of training opportunities and staff
- student and staff satisfaction with training and employment supervision available in health services
- retention / attraction of staff to rural and regional areas
- evidence-based and better service delivery models
- service delivery models which are: responsive; limit patient travel; minimise patient costs; allow for some allied health specialisation roles in rural and regional areas.

In relation to student dietetic placements, education and training, the following are suggested performance indicators:

- Establishment of recognised and valued rural practice training pathways which could provide accredited advanced professional development in rural skills (including specialist and generalist approaches).
- Increased student interest, value and participation in rural placement
- Meeting student needs for accommodation, travel, financial and education support

Question 1.3.a: What are the benefits and challenges of investing in a unique national rural allied health workforce dataset?
Currently Accredited Practising Dietitians are self-regulated and outside APRA there is limited government data and under-recognised in workforce planning, especially with respect to the prevention and disability workforce. We strongly recommend that dietitians need to be a registered profession.
The benefits of investing include that it could:

- inform the development and delivery of micro-credentials and continuing professional development (CPD).
- further and more specifically inform training, education and competency needs to prepare students for the rural allied health workforce
- matching workforce numbers with health outcomes/needs in geographical areas
- Informing Allied Health workforce needs for both the disease **prevention** and the health **management** workforces and then the trajectory workforce.

The challenges of investing include:

- lack of registration and lack of clarity regarding how the titles “dietitian” and “nutritionist” are used. Specifically the current problems with the questions that the ABS uses in the census, to capture data on this workforce, need to be improved and informed by recognised professional credentialing bodies such as through the Dietitians Association of Australia.
- how to capture practitioners in dual roles and across multiple-sectors
- Keeping data updated given mobility of workforce and shifts in funding

Question 1.3.b: What existing rural allied health workforce datasets/structures could be used already as the basis for this national dataset?
We are unaware of any existing dataset that is comprehensive enough to form the basis of decision-making in this area. We would encourage a process of scoping the available data on the dietetics and nutrition workforce –that would potentially involve a number of key stakeholders.

Question 2.1.a: What are appropriate target quotas for universities to select more rural origin students into allied health courses?
There is inadequate data on workforce needs to be able to effectively establish a quota – which will be different for each profession – and should be informed by workforce needs in prevention and management and a commitment for job creation. Any quota established would still require students to meet the minimum entry requirements.

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.
Employment structures or area-wide health service structures in rural and regional areas which support: student supervision; allied health professional employment commensurate with needs and experience ie not leaving new graduates in sole private or public positions; and career advancement options which enable allied health professionals to continue working in rural areas are all important policy factors to consider. IAHHs seem to offer promise in this area.

Question 2.2.a: Please describe alternate policy options within the Commonwealth's remit, which could achieve the same results in providing opportunities for rural and Aboriginal and Torres Strait Islander students to train as rural allied health professionals.
In relation to Nutrition and Dietetics, these factors may be important:

- Promotion of opportunities in allied health
- Scholarships to support Aboriginal and Torres Strait Islander candidates for undergraduate feeder and masters qualification for professional qualifications.
- Education policy which supports Aboriginal and Torres Strait Islanders to access Science subjects at secondary school or bridging programs to enter University Science disciplines. Specifically, addressing barriers related to Aboriginal and Torres Strait Islander student access to taking science at secondary school is important, as secondary school science is needed to enter courses in dietetics and nutrition. For example, ensuring schools in rural communities have science laboratories or have access to a secondary school science program to train in laboratories.

Question 2.2.b: Please describe any regional, culturally safe and appropriate training and employment models, that could be scaled up and/or adapted to increase the Aboriginal and Torres Strait Islander allied health workforce.

We are aware of a range of programs in this space but evaluation of effectiveness of these approaches is unclear. We would encourage a scoping study to identify and provide recommendations of the most appropriate programs.

Factors which are important include:

- Consulting with Aboriginal and Torres Strait Islander controlled health services.
- Conceptualisation of career structure for generalists as well as specialists
- Opportunities for advancement and leadership in an appropriate education framework.
- Recognised qualifications in nutrition for Aboriginal and Torres Strait Islander health workers.
- Career structure in rural and regional health services, in particular the CDND sees a place for building Aboriginal and Torres Strait Islander career pathways through nesting of qualification from Cert III through to higher degrees.

Question 3.1.a: What are the key strategies, considerations and feasible timeframes for provision of comprehensive allied health training in rural areas for:
i) full year training?
ii) full course training?

- No comment

Question 3.1.b: What are the factors that would need to be considered to ensure the successful expansion of the John Flynn Program to include placement scholarships for rural allied health students?

The John Flynn Program should be extended to allied health.

- To ensure that, like Doctors, Allied Health students also receive two weeks pay per year and are provided with accommodation or accommodation support. Placements to some regions of higher need, may require additional support or funding. For example, in Far North Queensland funding students to fly with practitioners to Cape and Torres Strait communities .
- Funding support for NGOs and Aboriginal controlled health agencies to offset their additional costs associated with taking students.
- For Nutrition and Dietetics an immersion approach may be more feasible that 2 weeks per year across the course of the degree. This would take into account that Dietetic student placements are undertaken in blocks ranging from 2 to 10 weeks across different practice contexts.

Question 3.1.c: Please describe other strategies within the remit of the Commonwealth that could be implemented to:
i) increase the number of allied health courses and training available in rural locations?
ii) increase the number of allied health student rural placement opportunities?

The Council of Deans of Nutrition and Dietetics is not supportive of increasing the number of programs to train nutrition and dietetic professionals Programs in rural areas struggle to attract appropriate staff and have difficulties sustaining quality.
The Council of Deans of Nutrition and Dietetics is supportive of providing micro-credentialing and CPD. This needs to be a mix of face to face and technology delivery. Grant funds to provide these include flying in experts in specialist areas.
Other strategies and points for consideration:

- Articulating a vision for how existing University Departments of Rural Health could be used to best support training allied health students for rural areas.
- An accreditation system for current post-qualification (rural and regional) allied health profession training programs could be created under the remit of the "college" or alternatively with appropriately structured and resourced UDRHs.
- Potential for all allied health professional training courses include rural health content.
- Integrating indigenous knowledge into university training courses

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?
Unable to comment

Question 3.2.b: Please describe other policy options, within the Commonwealth's remit, which could achieve the same result in clearly articulating and promoting structured career opportunities.
See previous responses

Question 3.2.c: What is an appropriate governance model for rural generalist training which also supports skills extension for existing qualified rural allied health workers?
The Allied Health Rural Generalist Program serves as an appropriate example and potentially also as a governance model.
An accreditation system for courses run by Universities to ensure quality and standard training may also have value.
Similarly, as noted above, strategies and points for consideration include:

- Articulating a vision for how existing University Departments of Rural Health (UDRHs) could be used to best support training allied health students for rural areas. This would require reviewing the structure (away from a primarily biomedical model) and resourcing of the UDRHs.
- Competencies for dietetic professionals already adequately cover competencies for working in rural and regional contexts. However, there is scope for articulating advanced competencies and practice in this space. Integrating indigenous knowledge into university training courses
- Consider creating roles for Allied Health Professional clinical educators in UDRHs that are funded at the Commonwealth level.

Question 4.1.a: What are the factors that would need to be considered to support the development of IAHHs which service regional catchments of Australia?
Integrated Allied Health Hubs (IAHHs) offer a lot of potential for the Allied Health workforce, student placements and citizen healthcare needs.
There is a role for University Departments of Rural Health to support IAHHs and co-locate with them either physically or virtually. This could help focus the funding already available in rural areas through UDRHs. It could also help focus research priorities; research outcomes; and the workforce, including professional development for allied health staff.
Linking IAHHs with existing networks such as Primary Health Networks will also be valuable.

Question 4.1.b: Please describe any examples of integrated and collaborative service models that could be scaled up and or adapted under the proposed IAHHs principles in this options paper.
Unable to comment

Question 4.1.c: How could Government structure funding arrangements to allow the flexibility necessary for regions to manage funding in the way that suits the specific needs of their communities?
Funding structures should be equitable and meet allied health training needs in rural areas and also meet disease prevention and health management needs.

Question 4.1.d: What kinds of Commonwealth support for allied health assistants could raise the capacity and effectiveness of rural allied health workforce?
In prevention and in the management of chronic conditions we would encourage the development of Aboriginal Health workers to undertake nutrition-related activities. This however requires the development of nutrition specific qualifications, a career structure and ongoing support and mentoring.

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?
Unable to comment

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

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.
Funding for technology and to improve accessibility to technology should be a key concern.
Evaluation of whether health insurance and MBS funding needs to be extended to cover more dietetic services via telehealth - beyond the funding currently only available for MBS Eating Disorder items, is needed.

Question 5b: The difficulties in making changes to the MBS are recognised. In relation to Policy Area 5, are there alternative arrangements not involving MBS that could achieve the same outcomes?
Both MBS and private health insurance funding arrangements should be evaluated here. However, consideration also needs to be given to ensure equity for rural, regional and remote patients to improve access to care.

The Council of Deans of Nutrition and Dietetics would welcome participation in ongoing consultations as the model becomes clearer.