



**Submission on the
*Health Workforce 2040 Strategy &
Our Healthcare Future – Immediate Actions
Consultation Paper***

TASMANIAN GOVERNMENT

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1.0 About Exercise & Sports Science Australia

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports professionals in Australia, representing more than 7,000 members, including university qualified Accredited Exercise Physiologists (AEPs), Accredited Sports Scientists (ASpSs), Accredited High-Performance Managers (AHPMs) and Accredited Exercise Scientists (AESs).

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

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

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

The ESSA National Office and the Tasmanian State Chapter collectively welcome the opportunity to respond to the Tasmanian Government's draft *Health Workforce 2040 Strategy (Workforce Strategy)*, *Our Healthcare Future – Immediate Actions and Consultation Paper* and the draft *Health Workforce 2040: Allied health* document.

2.0 Introduction

As of February 2021, there are 112 AEPsⁱ working in Tasmania's private and community healthcare as part of Australia's allied health workforce, making exercise physiology one of Tasmania's larger allied health professions. Tasmanian AEPs lead the prevention and treatment of prevalent chronic diseases including heart and lung disease, cancer, diabetes, obesity and mental health; and provide a vital conduit between community and hospital healthcare.

AEPs are equipped with the qualifications and expertise to improve healthcare by actively preventing chronic disease, reducing the financial burden of healthcare, and improving access, equity, and health outcomes for Tasmanians. Furthermore, with an average of ten new exercise physiology studentsⁱⁱ graduating from the University of Tasmania (UTAS) each year, future workforce capacity exists to address both the short, medium and long-term health needs of Tasmanians and the healthcare system.

Despite the substantial number of AEPs in Tasmania, the exercise physiology profession has been overlooked in Tasmania's *Health Workforce 2040 Strategy* and consultations to date. Specifically, AEPs have not been included in the *Health Workforce 2040: Allied health (draft)* document.

ESSA commends the Tasmanian Government for taking a long-term strategic perspective on healthcare. However, ESSA is deeply concerned that exercise physiology, a recognised allied health profession with a strong local heritage and clinical reputation has been overlooked, risking positive health outcomes for Tasmanians. ESSA also has concerns that Tasmania is the only state apart from the Northern Territory that does not directly employ any Accredited Exercise Physiologists with public hospitals. Therefore, this submission is three-fold.

Firstly, it profiles Tasmania's exercise physiology profession. Secondly, it demonstrates that AEPs are highly valued within private, community and hospital healthcare environments as integral members of effective multidisciplinary teams in preventing and treating chronic disease and in supporting Tasmanians with long-term behavioural and lifestyle changes. Thirdly, the submission highlights the untapped opportunity to include AEPs in Tasmania's public health system to foster operational efficiencies and patient experiences and long-term health outcomes.

In addition, this submission answers multiple consultation questions as posed in the *Our Healthcare Future – Immediate Actions Consultation Paper*. Specifically, the submission addresses relevant questions under Reform Initiative 1 and Reform Initiatives 3b and 3c as being most relevant to the exercise physiology profession. ESSA has collaborated closely with the ESSA Tasmanian Chapter as well as key AEP opinion leaders practising in Tasmania's private and community health to develop responses to these questions.

3.0 Summary of Recommendations

Recommendation 1: That the DoH and the THS continue to explore models of care operating in other Australian states that successfully incorporate AEPs into multidisciplinary teams spanning public hospital, community and private healthcare.

Recommendation 2: That the Tasmanian Government redirects investment into prevention to achieve a target of five percent of its health expenditure by 2031.

Recommendation 3: That the DoH supports the employment of AEPs in the private sector to facilitate the continuing equitable access of the population to Medicare exercise physiology services, other compensable schemes and private health insurance.

Recommendation 4: That the DoH includes the exercise physiology profession in the consultation for Tasmania's *Health Workforce Strategy 2040* and added to the next iteration of the Government's *Allied Health Workforce Strategy 2040* and beyond.

Recommendation 5: That the DoH collaborates with UTAS, ESSA and other allied health professional bodies on an immediate consumer education campaign on the roles and value of all allied health professions.

Recommendation 6: That the DoH and the THS facilitate an increase in the number of employment opportunities for allied health practitioners (including AEPs) within community and health service centres.

Recommendation 7: That the DoH provides funding to enable each of Tasmania's four main hospitals to employ at least one AEP, either by providing block funding or supporting the establishment of an AEP funding code via the Independent Hospital Pricing Authority (IHPA).

Recommendation 8: That the DoH and the THS assist Tasmanians with, or at risk of, prevalent chronic diseases to become more physically active and support sustainable behavioural change by establishing cancer, diabetes, mental health and obesity clinics across Tasmania.

Recommendation 9: That the DoH and the THS seek out, acknowledge and foster innovative new models of service delivery (including public-private partnership models).

Recommendation 10: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support a review of restrictions on access to MBS items and encourage the Australian Government to develop agreed clinical governance telehealth standards and move to using blended payments and block funding to support greater access to telehealth by rural, regional and remote patients.

Recommendation 11: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support the retention of temporary MBS telehealth items.

Recommendation 12: That the Tasmanian Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.

Recommendation 13: That the Tasmanian Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) considers additional funding for technology literacy initiatives, especially for those living in rural and remote areas.

Recommendation 14: That the DoH and the THS consider a system to facilitate automated referrals.

Recommendation 15: That the Tasmanian Government through the Health National Cabinet Reform Committee considers the integration of My Aged Care and My Health Records and/or the sharing of data across both platforms.

Recommendation 16: That the Tasmanian Department of Health explores the possibility of establishing a web-based platform which enables patients' public hospital information be shared with private health care providers.

Recommendation 17: That the Tasmanian Minister for Health and the DoH support the coordination of funding mechanisms which facilitate person-centred holistic care and minimise unintended consequences.

Recommendation 18: That DoH works with peak GP groups (i.e. The Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine) to facilitate a greater take up of *My Health Record*.

Recommendation 19: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support the development of consistent definitions of terms to support the collection of data across all parts of our health system and its key interfaces.

Recommendation 20: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee examine the gaps in standards across electronic health records and consider options for regulating electronic health records.

Recommendation 21: That the THS considers the need for community health liaisons in hospitals to help older Tasmanians navigate their way into relevant community health services.

Recommendation 22: That the THS establishes a formal communication channel that enables two-way communication with the local exercise physiology profession and other allied health professions to collaborate on solutions to facilitate better patient experience for older Tasmanians.

Recommendation 23: That the DoH and the THS implement the Exercise is Medicine© program for Tasmania's primary healthcare providers to reinforce healthcare sector knowledge and health literacy on exercise prescription and behavioural change.

Recommendation 24: That the Tasmanian Government via the Council on Federal Financial Relations support the removal of GST on exercise physiology services.

Recommendation 25: That the DoH supports Tasmanians to modify their lifestyles by integrating [Exercise Right](#) into Tasmanian Government public health education activities.

Recommendation 26: That the DoH and the THS support Tasmanians to make positive lifestyle changes by funding and providing access to Healthy Eating Activity and Lifestyle (HEAL™).

Recommendation 27: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support the re-activation of work on development of the national physical activity strategy.

Recommendation 28: That all allied health professions delivering services under compensable schemes be included in the *Workforce Strategy* including exercise physiologists and that these allied health professions be involved in the development of chronic disease management strategies, referral pathways and service delivery options.

Recommendation 29: That the DoH groups clinical physiologists with a cardiac focus together with exercise physiologists in a new category of exercise and clinical physiologists and that echocardiographers be grouped together in a separate category with sonographers.

Recommendation 30: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support initiatives to

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

Recommendation 31: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support initiatives to increase the amount of funding available for allied health research and extend funding for the provision of allied health services through Medicare and/or for the commissioning of allied health services via the Primary Health Networks.

Recommendation 32: That THS explores the development of referral pathways and programs in accordance with Tasmania's future health needs through a series of round tables with health professions.

Recommendation 33: That the DoH and the THS map the scope of practice for allied health professions to enable contingency planning and the ability to deploy the allied health workforce to better support primary and public healthcare systems.

Recommendation 34: That the DoH and the THS engage with Ahpra Boards/Councils for Ahpra regulated allied health professions and professional associations for self-regulated and independently regulated allied health professions on scope of practice issues regarding scope of practice issues.

Recommendation 35: That the DoH provides more opportunities for allied health professionals, especially from newer and emerging professions like exercise physiology to be involved in service planning.

Recommendation 36: That the DoH and the THS engage with education providers to extend the range of allied health professions offered under the Allied Health Rural Generalist Pathway.

Recommendation 37: That the DoH works with UTAS to ensure that appropriate rural student practicum placements are available.

Recommendation 38: That the DoH works with peak professional allied health bodies to support professional development for allied health professionals, especially for newly graduated sole practitioners working in private practice.

Recommendation 39: That the DoH liaises with UTAS on potential initiatives for medical, nursing and allied health schools; and host annual multidisciplinary conferences to develop a strong, collaborative and sustainable healthcare workforce.

Recommendation 40: That the composition of the recommended State-wide Clinical Senate be inclusive and weighted between medical, nursing and allied health professions and include proportional representation of newer and emerging healthcare professions.

Recommendation 41: That the DoH and the THS collaborate with UTAS, ESSA and other allied health professional bodies to research the inspirations and aspirations of current allied health students to help inform future leader initiatives and implement a range of initiatives once this research is completed.

4.0 Snapshot of the AEP workforce in Tasmania

4.1 Description

AEPs work across many sectors and in many settings. Pathology domains covered by AEP services include cardiovascular, metabolic, neurological, musculoskeletal, cancers, kidney, respiratory / pulmonary and mental health, and other conditions for which there is evidence that exercise can improve a client's clinical status. AEPs specialise in clinical exercise interventions for a broad range of pathological populations. These persons may be at risk of developing, or have existing medical conditions and injuries. The aims of AEP interventions are to prevent or manage acute, sub-acute or chronic disease or injury, and assist in restoring one's optimal physical function, health or wellness.

4.2 Training

AEPs must meet the training provisions below:

- Graduate from a minimum four years of study in an ESSA accredited course meeting the AQF requirements for Level 7 that leads to bachelor degree qualifications.
- Meet the professional standards for exercise science, leading to accreditation as an Accredited Exercise Scientist (AES), including 140 hours of practical experience for the purpose of undertaking an exercise intervention to improve health and fitness, wellbeing or performance, or focus on prevention of chronic conditions.
- Meet the professional standards for exercise physiology, including 360 hours of practical experience with clients with clinical conditions (e.g. cardiovascular, pulmonary, metabolic, musculoskeletal, neurological).

UTAS offers a course which is accredited by ESSA: a Bachelor of Exercise and Sport Science with Clinical Honours in Exercise Physiology. Graduates of this course are eligible for accreditation as an AEP.

4.3 Regulation

Exercise physiology is a self-regulated health profession. ESSA meets the benchmark standards set by the [National Alliance of Self Regulating Health Professions](#) (NASRHP) for the regulation and accreditation of practitioners within that profession. Other recognised health professions like audiology, dietetics and speech pathology are also self-regulated health professions meeting NASRHP standards. Exercise physiology is not regulated under the Health Practitioner Regulation National Law.

4.4 Numbers

Using the same Australian Bureau of Statistics (ABS) estimated resident population estimatesⁱⁱⁱ underpinning the *National Health Workforce Dataset* used in the draft *Health Workforce 2040: Allied health* document, ESSA has calculated an approximate Occupied AEP FTE per 100,000 Population. The figure below is approximate because ESSA cannot confirm whether the ABS data used was for the 2017-2018 financial year (FY). The other factor impacting on the validity of this calculation is that ESSA's accreditation year is a calendar year not a financial year.

Total population 2018: 528,298 as of 30 June 2018 (2017-18 financial year)

Total Accredited AEPs as 31 December 2018: 75

AEP Occupied FTE per 100,000 population 14.2

Table 1 below outlines the sectors in which AEPs were employed in the 2020 calendar year:

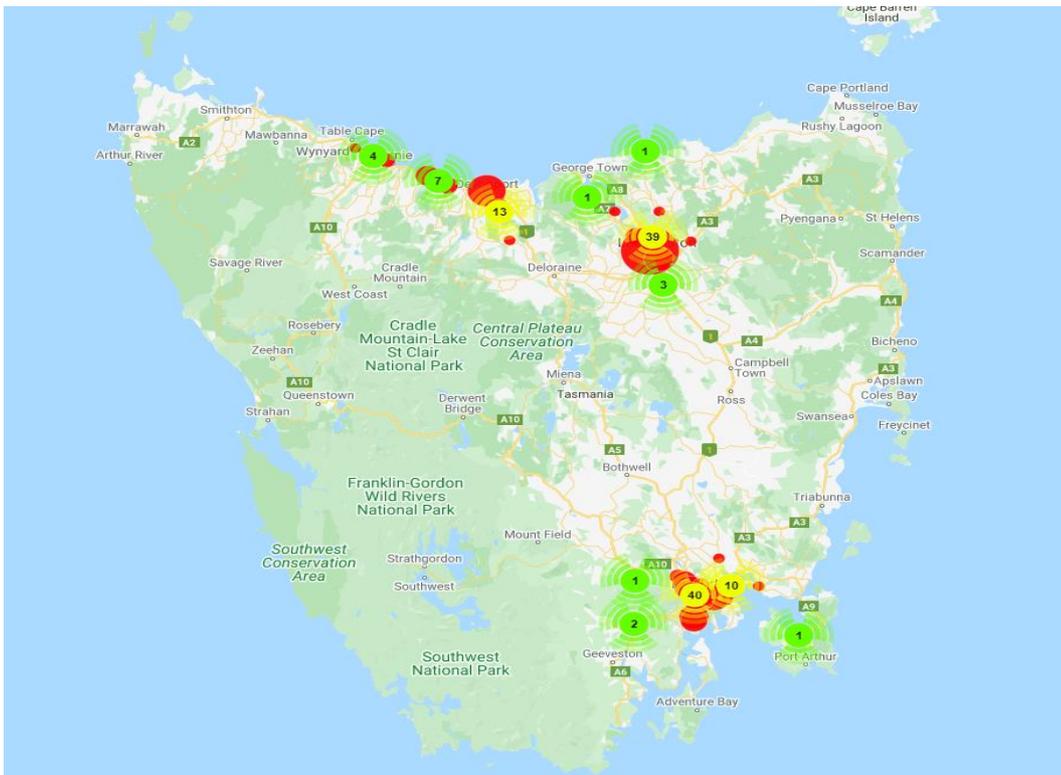
Table 1: Tasmanian AEP Numbers per Sector of 31 December 2020*

*Number of AEPs	Percentage	Primary Work for AEPs in TAS
34	47.9	Private company
17	23.9	Health care organisation
7	9.9	Fitness club or institution
5	7.0	Research or education institution
3	4.2	Workers' compensation agency
2	2.8	State government organisation
1	1.4	Federal government organisation
1	1.4	Mining
1	1.4	Student
71	100.0	

*Figures based on the 71 out of 114 current accredited AEPs who disclosed information to ESSA during the 2020 calendar year.

Figure 1 outlines the distribution of AEPs across Tasmania in accordance with ESSA's 2020 data collection:

Figure 1: Tasmanian AEP Numbers by geographic location December 2020*



*Figures based on the 71 out of 114 current accredited AEPs who disclosed information to ESSA during the 2020 calendar year.

5.0 Efficacy & cost/benefits of AEP services

This section highlights a sample of the contemporary research which evidences the efficacy and cost/benefits of exercise physiology interventions in both the prevention and treatment of chronic disease. Various studies have demonstrated the cost benefits of allied health interventions in ESSA's 2015 Deloitte commissioned report on [Value of Accredited Exercise Physiologists in Australia^{iv}](#). This report evidences the high return on investment for exercise physiology services in treating people with chronic conditions, namely pre-diabetes, type II diabetes, mental illness, cardiovascular and other chronic diseases.

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

ESSA and its Tasmanian State Chapter would be delighted to work more closely with the Tasmanian Government and its Department of Health to continue to provide additional evidence. At this stage, the provision of exhaustive evidence on all prevalent chronic diseases is beyond this submission.

6.0 Immediate actions required

The final section of this submission addresses the consultation questions posed within the *Our Healthcare Future – Immediate Actions Consultation Paper* that are most relevant to Tasmania's exercise physiology profession. These relate to Reform Initiative 1, Reform Initiative 3b and Reform Initiative 3c. ESSA is committed to collaborating with Tasmanian Health and other professions to build on this dialogue to ensure the best possible health outcomes for Tasmanians today and in future.

Reform Initiative 1

Q1. How can we target better our current investment as well as future investments in health to ensure a sustainable and balanced mix of services is delivered across the whole of the health system to provide right care in the right place at the right time?

Rates of potentially preventable hospital separations are 15–35 per cent more likely for residents of regional areas, and more than twice as likely for residents of remote areas^{vi} so the role of allied health practitioners including AEPs who work in the primary and secondary care interface working to improve potentially preventable hospital admissions are vital.

Consideration needs to be given to investing in services that assist the Department of Health (DoH) and the Tasmanian Health Service (THS) to be more sustainable and address the health needs of Tasmanians in a more timely and person-centred approach. Greater priority needs to be given to funding community health services to ease the pressure within Tasmania's hospital system and promote early intervention and prevention of chronic diseases.

AEPs work within public and private hospitals, within community health centres and as private practitioners across Australia. Existing clinical governance models include in-patient prehabilitation and acute care rehabilitation clinics to expedite patient recovery (resulting in shorter hospital stays) and support a patient's transition to community-based care services. AEPs provide ongoing treatment where needed and support the uptake of positive lifestyle modifications, long-term behavioural change and mitigate re-hospitalisation.

Furthermore, there are strong models of clinics across Australia operating specifically to prevent, support and manage specific chronic diseases, for example cancer, diabetes, pulmonary and cardiac rehabilitation. AEPs and other allied health providers are vital for optimal patient care in these settings.

ESSA participated in positive discussions with the Director of Allied Health, Southern Region Services in 2020 about alternative clinical governance structures and various models of care operating in other states. ESSA remains committed to assisting the DoH and THS in exploring and scoping such alternatives.

Recommendation 1: That the DoH and the THS continue to explore models of care operating in other Australian states that successfully incorporate AEPs into multidisciplinary teams spanning public hospital, community and private healthcare.

The WA Government recently adopted recommendations from a landmark *Sustainable Health Review*^{vii} on what is needed to transform health spending and services to provide high quality healthcare while aiming to build a more sustainable future. **A key recommendation was to increase and support investment in public health, with spending on prevention to be increased to at least 5 per cent of total health expenditure in WA by 2029** to more than \$440 million per year, noting in 2018 that only 1.6 per cent of the total health budget was spent on prevention.

\$70 million per annum was spent on public health measures in Tasmania in addition to \$8.6 million for the *Healthy Tasmania Strategic Plan* which is focused on improving the state's health^{viii}, which equates to 1.8 per cent of the 2018-2019 health budget^{ix}.

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

Recommendation 2: That the Tasmanian Government redirects investment into prevention to achieve a target of five percent of its health expenditure by 2031.

The uptake of exercise physiology Medicare items by Tasmanians is shown in Table 2 below:

Table 2: Uptake of Exercise Physiology MBS Items by Tasmanians compared to other Australians (2017-2018 and 2018-2019) per 100,000 population

		State								Australia
		NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Estimated Resident Population (ERP) as at 30 June 2018	7,867,936	6,321,606	4,927,629	1,736,527	2,574,193	522,410	412,025	247,517	24,601,860
	Estimated Resident Population (ERP) as at 30 June 2019	7,980,168	6,462,019	5,009,424	1,751,963	2,594,181	528,298	420,379	247,058	24,982,688
Item 10953 Exercise physiology- Individual service CDM	2017/2018 Services	100,523	48,365	96,564	27,371	28,217	7,644	4,717	1,489	314,890
	Take up Rate of Services per 100,000	1,278	765	1,960	1,576	1,096	1,463	1,145	602	1,280
	2018/2019 Services	106,587	53,477	111,165	30,641	30,642	7,913	4,865	1,935	347,225
	Take up Rate of Services per 100,000	1,336	828	2,219	1,749	1,181	1,498	1,157	783	1,390
Item 81110 Exercise Physiology - Assessment for group services Type 2 diabetes	2017/2018 Services	2,975	1,951	2,217	3,334	821	256	17	33	11,604
	Take up Rate of Services per 100,000	38	31	45	192	32	49	4	13	47
	2018/2019 Services	3,040	1,829	2,230	3,484	935	258	35	39	11,850
	Take up Rate of Services per 100,000	38	28	45	199	36	49	8	16	47
Item 81115 Exercise Physiology - Group services Type 2 diabetes	2017/2018 Services	16,383	10,171	11,137	17,129	3,896	1,175	109	168	60,168
	Take up Rate of Services per 100,000	208	161	226	986	151	225	26	68	245
	2018/2019 Services	16,196	10,896	12,489	18,633	4,545	1,411	227	164	64,561
	Take up Rate of Services per 100,000	203	169	249	1,064	175	267	54	66	258
Item 81315 Exercise physiology health service - Aboriginal Health Services	2017/2018 Services	1,288	220	1,768	93	211	142	10	48	3,780
	Take up Rate of Services per 100,000	16	3	36	5	8	27	2	19	15
	2018/2019 Services	1,127	39	1,854	255	195	127	12	25	3,634
	Take up Rate of Services per 100,000	14	1	37	15	8	24	3	10	15

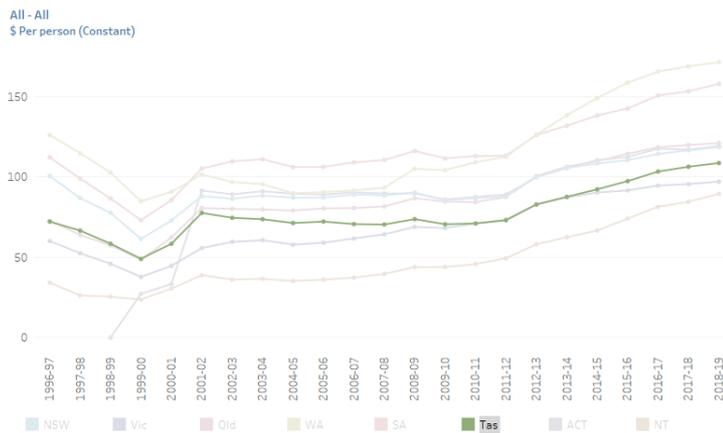
This table confirms that Tasmanian AEPs have assisted Tasmanians to access exercise physiology MBS items in an equitable manner.

In respect to private health insurance, as of 49 per cent of Tasmanians have some form of private health insurance (PHI) hospital cover compared to 53.2 per cent of all Australians^{xii}. Figure 2 shows that per person figure for PHI expenditure for Tasmania is the third lowest in the country.

Figure 2: Per person figure for PHI – Tasmania vs other states and territories^{xiii}

Total Health Expenditure

Select level of analysis: <input type="radio"/> Whole nation <input checked="" type="radio"/> Compare states/territories	Select jurisdiction: All	Select total or per person: <input type="radio"/> Total <input checked="" type="radio"/> Per person	Select pricing view: <input type="radio"/> Current <input checked="" type="radio"/> Constant
Select government or non-government source: Non-government	Broad area of expenditure: Primary health care		
Select source of funds: Health Insurance Funds	Detailed area of expenditure: All		



Note: The ACT per person figure includes large expenditures for NSW residents, due to cross-border service consumption.
Source: AIHW Health Expenditure Database.
<http://www.aihw.gov.au>

Recommendation 3: That the DoH supports the employment of AEPs in the private sector to facilitate the continuing equitable access of the population to Medicare exercise physiology services, other compensable schemes and private health insurance.

Q2. How can we shift the focus from hospital-based care to better community care in the community?

The Tasmanian Government needs to prioritise care within community and health services centres and investment in community programs. Stakeholder collaboration facilitated by the DoH to review and refine referral pathways to community care, to develop alternative models of care and to increase health literacy is required to shift the focus from hospital-based care to community care.

ESSA advocates for a collective approach requiring collaboration from government agencies, community health services, public hospitals, private hospitals, professional associations, educational institutions, and health consumers. No one institution, organisation or profession can generate systemic change for Tasmanian’s healthcare system, though leadership from the DoH is critical in facilitating and supporting change.

The recognition of the value of all allied health professions (including self-regulated allied health professions) is vital to immediate, mid-term and long-term healthcare and workforce discussions. Equal consideration must be given to including those self-regulating and independently regulated health professions alongside those professions which are regulated under the National Registration and Accreditation Scheme (NRAS) administered by Australian Health Practitioner Regulation Agency (Ahpra).

The 2018 COAG Health Council Communique^{xiv} confirms the purpose of the National Registration and Accreditation Scheme:

“It (NRAS) is not intended as a means to protect the interests of health professions or to confer standing or credibility on individual professions. **Inclusion of a profession in the NRAS is not indicative of that profession’s value or its contribution to health service delivery.**”

The Communique acknowledges that NRAS is not the only form of health practitioner regulation as below:

“**The NRAS is one of a number of forms of health practitioner regulation.** Other forms of regulation include: professional codes and standards; membership of professional organisations and associations; consumer protection legislation; and statutory codes of conduct administered by governments (including the National Code of Conduct for health care workers).”

While Tasmania’s exercise physiology profession was not included in the Tasmanian Government’s draft *Health Workforce 2040 Strategy*, nor the draft *Allied Health Workforce 2040* document, AEPs currently fulfil an important role as a conduit between the hospital and community healthcare systems and assist Tasmanians access Medicare and other compensable schemes.

As homegrown exercise professionals graduating from UTAS with undergraduate and post-graduate studies in clinical exercise physiology, Tasmania’s AEPs are highly regarded clinicians. This is evidenced by the numerous letters of support submitted by local healthcare services, not-for-profits, businesses and other key stakeholders, as part of the consultation process to develop this submission.

ESSA has received support from the following organisations which endorse the role of AEPs and support the exercise physiology profession being included in Tasmania’s ongoing consultations on healthcare strategy and future workforce planning.

ESSA understands that several of these organisations provided written letters of support as part of the consultation process.

- Allied Health Professions Australia
- Australian Society of Lifestyle Medicine
- Cancer Council Tasmania
- Care Assessment Consultants
- Coastal Physiotherapy
- Diabetes Tasmania
- Heart Foundation
- In2Change Consultancy
- Primary Health Tasmania
- Royal Flying Doctor Service
- The Link Youth Health Service
- THS North Podiatry.

Recommendation 4: That the DoH includes the exercise physiology profession in the consultation for Tasmania’s Health Workforce Strategy 2040 and added to the next iteration of the Government’s Allied Health Workforce Strategy 2040 and beyond.

As outlined previously, Tasmania’s 112-strong AEP workforce^{xv} is one of the larger allied health professions in the state. ESSA suggests that this AEP workforce is currently underutilised and has additional professional capacity to fulfil its scope of practice.

ESSA is supportive of increasing the number of allied health professionals in Tasmania. ESSA shares a mutually beneficial working relationship with UTAS and is supportive of the university's plans to expand its existing suite of allied health courses (comprising exercise physiology, psychology and pharmacology) to include occupational therapy, speech pathology and physiotherapy in 2022.

ESSA is committed to working collaboratively with UTAS to promote Tasmania's allied health workforce to encourage greater community uptake of local allied health services. In addition, ESSA would welcome a more inclusive approach to public health awareness campaigns from the Tasmanian Government to genuinely profile the state's existing allied health professionals as an immediate priority.

Recommendation 5: That the DoH collaborates with UTAS, ESSA and other allied health professional bodies on an immediate consumer education campaign on the roles and value of all allied health professions.

ESSA calls on the Tasmanian Government to show a genuine commitment to prioritise and allocate funding to support an increase in the number of allied health positions available for AEPs within the public health system, both in public hospitals and in community and health services centres.

There are no AEPs currently employed in Tasmania's public health system. This is a barrier to efficiently transitioning in-patients to community-based care options which can leave patients vulnerable to rehospitalisation and unable to build their health literacy on positive lifestyle changes and sustain long-term behavioural change. AEPs advocate for clinical follow-up following hospital discharge to optimise and expedite recovery, with one Tasmanian AEP reporting^{xvi} that:

"I frequently see clients who have had quality care in hospital, but once discharged have no idea how to navigate what's next, what to do, where to go or who to see. Our system is failing patients because it does not support their healthcare with follow-up services in community health. When patients do find their way, too often their health has gone downhill and the time-lapse that could have been avoided is to the patient's detriment."

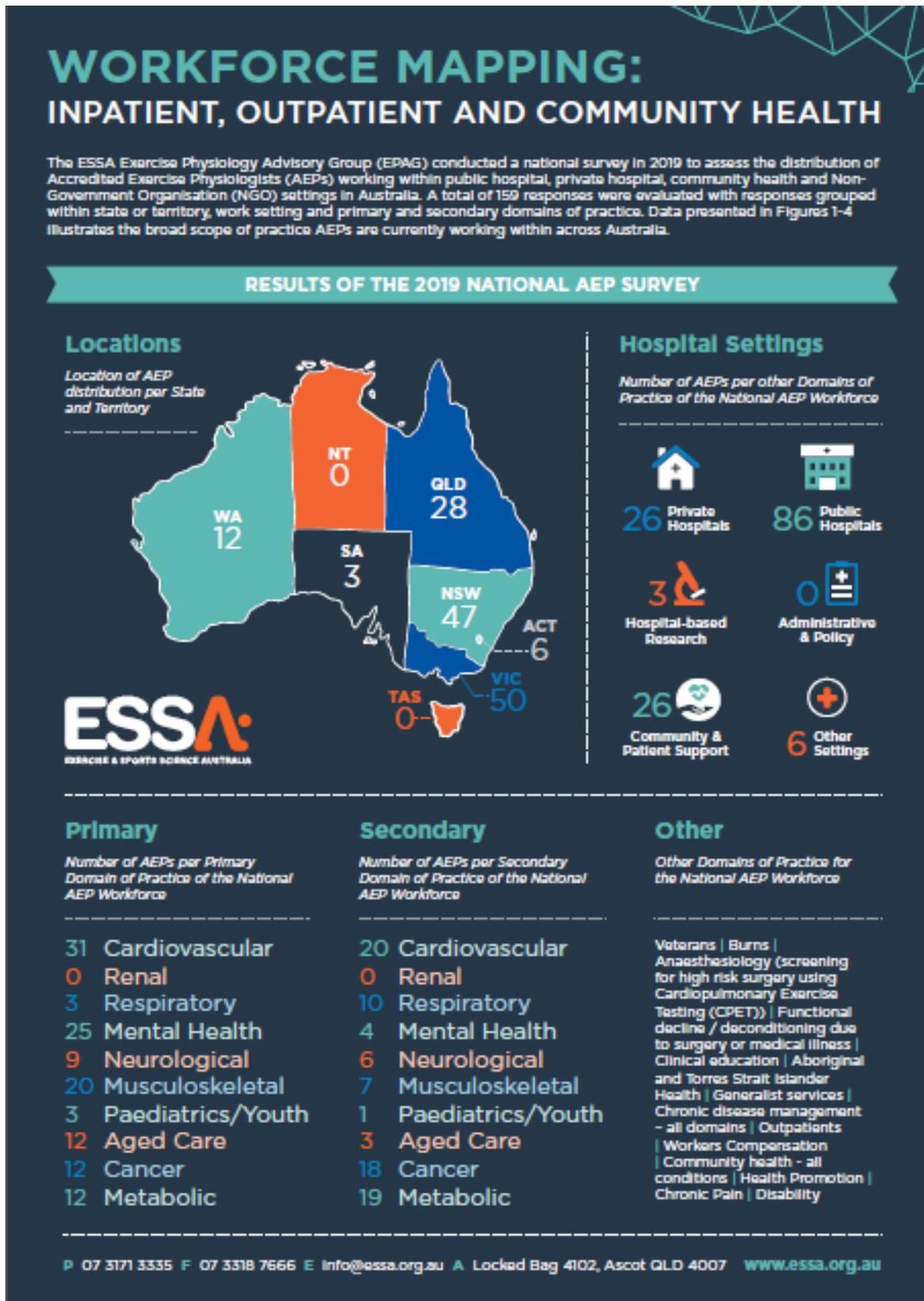
Therefore, expanding employment opportunities for AEPs in public hospitals and in community health will reduce existing barriers to better health outcomes and long-term behaviour change and lifestyle improvements for Tasmanians.

Other integral requirements to enable a shift of focus from hospital-based care to community care include:

- facilitating an increase in the number of allied health professionals in professions that are under-represented compared to national averages and
- creating viable career pathways including graduate placement programs and senior clinical positions in both public hospitals and community health centres.

Figure 3 below outlines where AEPs are employed in hospital settings.

Figure 3: Location of AEPs employed in hospital settings per State and Territory, 2019^{xvii}



As noted earlier, Tasmania is the only state apart from the Northern Territory that does not directly employ any Accredited Exercise Physiologists with public hospitals. Even the Australian Capital Territory with over 100,000 fewer residents (426,794) than Tasmania (534,457^{xviii}) employs six AEPs.

Recommendation 6: That the DoH and the THS facilitate an increase in the number of employment opportunities for allied health practitioners (including AEPs) within community and health service centres.

Recommendation :7 That the DoH provides funding to enable each of Tasmania’s four main hospitals to employ at least one AEP, either by providing block funding or supporting the establishment of an AEP funding code via the Independent Hospital Pricing Authority (IHPA).

Recommendation 8: That the DoH and the THS assist Tasmanians with, or at risk of, prevalent chronic diseases to become more physically active and support sustainable behavioural change by establishing cancer, diabetes, mental health and obesity clinics across Tasmania.

The implementation of Tasmanian Government incentives to support the delivery of innovative community-based care via different models would grow the workforce by potentially attracting additional allied health practitioners to Tasmania to augment available resources to enable better community care.

By way of example, one New South Wales region facilitates an innovative public–private partnership (PPP) model of service delivery^{xix} in four outer regional towns to provide allied health care to inpatients, aged care facility residents and outpatients. It has found that the PPP model has the potential to address service gaps in hospitals, residential aged care and primary care in rural areas.

Recommendation 9: That the DoH and the THS seek out, acknowledge and foster innovative new models of service delivery (including public–private partnership models).

Q5. How can we make better use of telehealth so people can receive care closer to home, and what are the barriers preventing utilisation of telehealth?

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

Figure 4: Allied Health MBS Telehealth Consultations Nov 2019 to October 2020 (does not include any activity claimed using codes that are specifically for mental health interventions)

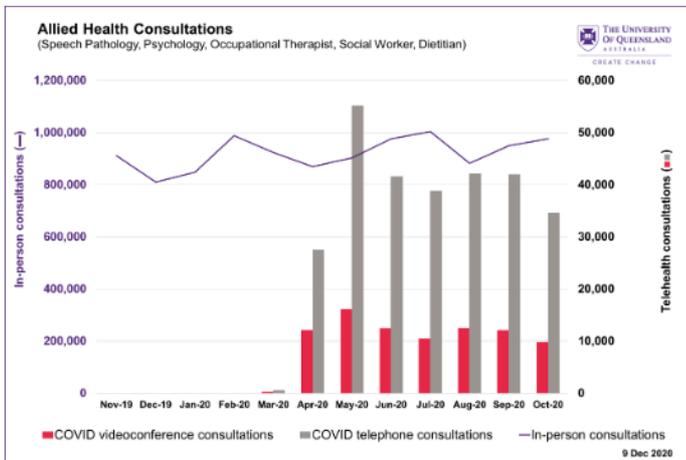


Figure 5: General Practitioner MBS Telehealth Consultations Nov 2019 to October 2020

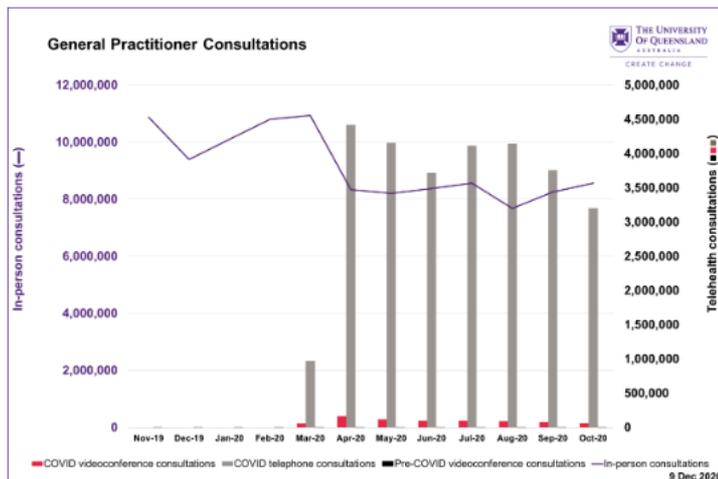
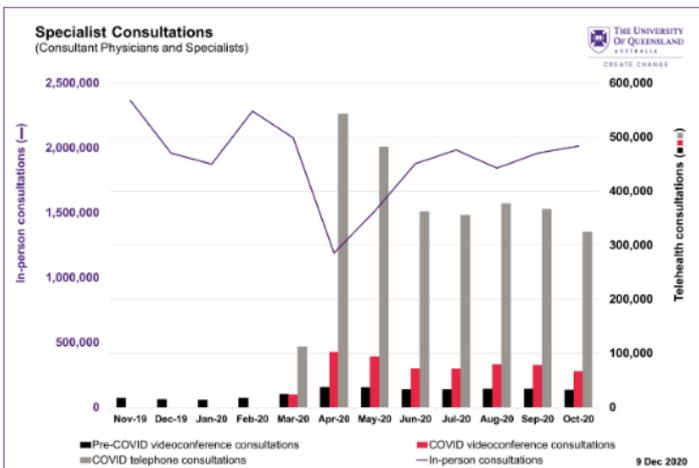


Figure 6: Specialist Consultations MBS Telehealth Consultations Nov 2019 to October 2020



The allied health usage patterns coincide with the anecdotal evidence that ESSA has collected that AEPs spent considerable time and effort during lockdown stages of the COVID-19 pandemic to assist their patients transition to video conferencing by providing access to loaned devices and/or providing them with intensive support to install software and learn how to operate required platforms.

Along with other peak professional allied health bodies, ESSA has contributed to an Australian wide survey of telehealth usage by allied health practitioners and their clients (including Tasmanian AEPs and their clients) during the COVID-19 pandemic. This as yet unpublished research^{xxi} by the University of Melbourne found:

“One-in-two clients reported that video and telephone consults were very effective, and clinicians rated video consults an average 8/10 and telephone consults 7/10 for effectiveness (ranging from 0 (not at all effective) to 10 (extremely effective)). This aligns with systematic review findings suggesting that rehabilitation delivered via telehealth results in equivalent or better outcomes on average, than in-person care.”

The paper also indicated that:

“Some clients appear to be better suited to telehealth and were very satisfied with these services. This included clients in remote areas, those who needed to travel long distances or to make complex arrangements to attend in-person consults, people with very busy schedules and those who needed to take time off work or arrange childcare to access in-person care, and clients who benefit from or prefer to stay at home (e.g. clients with fatigue, mobility issues, social anxiety issues, immuno-compromised). These findings align with a recent systematic review identifying facilitators of satisfaction with telehealth services including ease of use, the potential for improved outcomes and communication, decreased travel time, increased access to care, increased self-awareness and self-management of conditions, a reduction in missed appointments and decreased wait times”

Not long after the introduction of temporary telehealth item numbers in March 2020 in response to the COVID-19 pandemic, changes were made to **requiring general practitioner (GP) providers to have an existing and continuous relationship with a patient in order to provide telehealth services. This is a critical barrier to telehealth** for some Tasmanian rural, regional and remote patients, especially itinerant workers and others who do not meet the current criteria.

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

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

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

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

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

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

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

Recommendation 10: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support a review of restrictions on access to MBS items and encourage the Australian Government to develop agreed clinical governance telehealth standards and move to using blended payments and block funding to support greater access to telehealth by rural, regional and remote patients.

Recommendation 11: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support the retention of temporary MBS telehealth items.

A second key barrier to accessing telehealth which is critical in rural and remote areas is the technology. Technology barriers include digital literacy, internet speed, bandwidth and access to devices/software platforms.

In April 2020, the Royal Australian College of General Practitioners in a [media release^{xxiv}](#) acknowledged that some people were not willing to access telehealth without onboarding support:

“some patients are avoiding consultations because they don’t feel comfortable using new technology such as video conferencing”.

A [Consumer Health Forum survey, What Australia’s Health Panel said about Telehealth - March/April 2020^{xxv}](#), of 95 members of its Australia’s Health Panel found:

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

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

Many rural, regional and remote Tasmanian patients struggled with bandwidths and internet speeds and transitioning to using telehealth platforms (including allied health providers) during the early stages of COVID-19.

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

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

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

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

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

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

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

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

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

Recommendation 12: That the Tasmanian Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) reviews Australia's overall broadband network strategy to invest in better technology i.e. fibre to the premises (FTTP) to homes and businesses; and fibre to the basement (FTTB) for apartment blocks and other large buildings.

Recommendation 13: That the Tasmanian Government through the National Cabinet Reform Committees (Rural and Regional Australia and Infrastructure and Transport) considers additional funding for technology literacy initiatives, especially for those living in rural and remote areas.

Q7. How can we improve integration across all parts of our health system and its key interfaces (e.g. primary health, mental health, disability services, aged care and acute care)? What should be our priorities for integration?

The four key priorities to integrate all parts of the health system are inclusion, innovation, education and empowerment, simplified referral processes, and technology.

Inclusion

As noted earlier, government agencies, peak bodies, not-for-profit and healthcare professionals need to take a more inclusive approach to enable systems change both within the public system and the interfaces with other sectors and levels of care. Inclusion must span the acknowledgment of other professions and their scopes of practice for the benefit of patients. Inclusion also requires more open communication, coordination and knowledge sharing. Greater coordination and integration of services across the different care sectors will ensure better service delivery, improved efficiency, better health outcomes and improved quality of life. The intersection between current initiatives and reforms across care sectors must be clearly understood and coordinated to prevent any unintended consequences.

Innovation

Innovating new models of service delivery and displaying a shared commitment to multidisciplinary care across professions and key interfaces are essential to enable integration. ESSA advocates for solutions both within and outside of the current healthcare system to better meet the specific needs of individuals and vulnerable populations.

Education & empowerment

A higher priority should be given to health education and the empowerment of Tasmanian health consumers/patients. Empowering health consumers and allowing them to take more ownership of their own health will prevent hospital admissions and enhance their experiences outside of hospital. Education, motivational coaching and long-term behavioural change are key elements of AEP service provision. Therefore, ensuring the exercise physiology profession is embedded across the key interfaces of the health care system will facilitate greater self-empowerment and lifestyle changes for Tasmanians.

Simplified referral processes

The referral processes from hospital to community and private healthcare, and from community to hospital needs to be made easy. ESSA advocates for a simplified referral process for better continuity of care, resource efficiency gains and for an improved experience for both health consumers and healthcare providers. Referral pathways support the integration of services and the coordination of multidisciplinary team care.

Current processes create a disproportionate burden on GPs when adopting technology could facilitate automation in alignment with the patient journey. For example, referral systems for patients who present with certain scenarios could be automated, rather than relying on individual health professionals. The current process creates complexity, whereas simplicity will aid in the integration of health services and support patients to navigate the system and ensure they see the right health professional at the right time. For example, referrals could be scheduled for all patients post-hospital stay, and automated for prehabilitation and rehabilitation respectively, in the lead-up to and in follow-up to surgical procedures.

Recommendation 14: That the DoH and the THS consider a system to facilitate automated referrals.

Technology

Technology is a key enabler for integration and therefore a high priority.

Allied Health Professions Australia's recent *Digital Health Adoption Study* indicates that exercise physiologists are one of the allied health professions most ready for increased digital health adoption, with a majority (86 per cent) using an electronic record system to record patient notes, and two thirds indicating that the technology used by their practices is up to date. The report highlights that:

“Exercise physiologists also report the highest number of benefits from digital health, and the fewest number of barriers. Efficiency is overwhelmingly the main driver of value, with 72 per cent indicating that digital health technologies improve efficiencies in their practices and provide faster access to information. Improved collaboration with other healthcare providers is also perceived as a major benefit amongst exercise physiologists.”

Consideration needs to be given in respect to the infrastructure needed to support the integration of data being generated through medical and technological advances (e.g. genomics, wearables, biosensors, remote monitoring systems and data sources outside the health system) and the sharing of information for team-based models of care. ESSA members also report patient frustration about having to repeat themselves multiple times about health issues which is a source of health consumer frustration.

Information is also duplicated about health conditions for My Aged Care so a system that linked both sets of information would be advantageous for patients.

Recommendation 15: That the Tasmanian Government through the Health National Cabinet Reform Committee considers the integration of My Aged Care and My Health Records and/or the sharing of data across both platforms.

Greater coordination and integration of services across the different care sectors will ensure better service delivery, improved efficiency, better health outcomes and improved quality of life. The intersection between current initiatives and reforms across care sectors must be clearly understood and coordinated to prevent any unintended consequences.

As one example, the *Counsel Assisting's Final Submissions*^{xxxii} to the Royal Commission into Aged Care Quality and Safety flagged the issue of consistent definitions of terms to support the collection of data:

“Ensuring the quality and consistency of data in the aged care national minimum dataset will require consistent definitions of terms. In the future, **an important task for aged care data management is establishing a ‘common language’ for aged care data. Attention should be paid to the intersection between aged care and health care and the importance of common terms to enable the systems to communicate. This will require the standardisation of data throughout the aged care system while ensuring compatibility with the health care sector.** The Australian Government announced the ‘Aged Care Data Compare’ project in June 2020 which is looking at this issue. The Australian Aged Care Commission should work with the Department of Health on the management of this project in the future.”

Funding mechanisms need to be coordinated so alternative models of care can be matched with complementary payment models, as the traditional payment mechanisms such as fee-for-service under Medicare and other compensation schemes can create perverse incentives and constrain person centred holistic care. There should be mechanisms to support innovation where traditional funding frameworks can be challenged, and flexibility for different approaches to be trialled.

The issue of sharing patients’ hospital data with private providers should be addressed. To provide a seamless transition for older Tasmanians once discharged from hospital, private healthcare providers should be given access to a patient’s public hospital information. The example set by Queensland which became the first jurisdiction in 2016, and remains the only jurisdiction, allows general practitioners (external to the public system), to see a patient’s public hospital information, such as pathology and radiology test reports.

Public hospital information is shared through [The Viewer](#), a Queensland Health database where information about patients is stored on a read-only, web-based platform. Access to [The Viewer](#) has:

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

In 2020, Queensland Health released a consultation paper asking for feedback on facilitating access of Apha registered allied health practitioners to [The Viewer](#).

Recommendation 16: That the Tasmanian Department of Health explores the possibility of establishing a web-based platform which enables patients' public hospital information be shared with private health care providers.

Another issue is that general practitioners are not all using the Australian Government's [My Health Record](#), according to anecdotal information provided to ESSA. Instead, they use a variety of diagnostic imaging platforms which creates an extra burden for allied health professionals to access vital patient information.

In addition, electronic health records are currently unregulated^{xxxiii}. There are inconsistent structures, data elements and use of clinical terminologies and classifications. Addressing the lack of standards across electronic health records will facilitate transfer of clinical data between electronic health records for clinical purposes; linking individual health data for integration of care across different sectors of the healthcare system; and reliable extraction of patient data for practice improvement and research purposes.

Recommendation 17: That the Tasmanian Minister for Health and the DoH support the coordination of funding mechanisms which facilitate person-centred holistic care and minimise unintended consequences.

Recommendation 18: That DoH works with peak GP groups (i.e. The Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine) to facilitate a greater take up of [My Health Record](#).

Recommendation 19: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support the development of consistent definitions of terms to support the collection of data across all parts of our health system and its key interfaces.

Recommendation 20: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee examine the gaps in standards across electronic health records and consider options for regulating electronic health records.

Q8. How can we strengthen the interface between hospital services and aged care to improve community healthcare for older Tasmanians?

Tasmanian AEPs work in the aged care sector. ESSA members report that older patients frequently leave hospital without a clear pathway on what care and services the patient needs following their hospital stay. Therefore, it is usual for patients to visit their GPs for further advice and for referrals. Given the pressure on Tasmania's primary healthcare system, and GPs in particular, employing allied health practitioners in the public hospital system to provide community health liaison services would strengthen the interface between hospitals and community aged care. This matter also highlights that there is no formal communication channel between THS and AEPs.

Furthermore, as already recommended, another way to circumvent this issue is via automated referrals for older Tasmanians post-hospital stay, to ensure health practitioners are helping patients navigate their next steps, and can ensure patients understand what is next, why specific services are needed and where to find those services.

Recommendation 21: That the THS considers the need for community health liaisons in hospitals to help older Tasmanians navigate their way into relevant community health services.

Recommendation 22: That the THS establishes a formal communication channel that enables two-way communication with the local exercise physiology profession and other allied health professions to collaborate on solutions to facilitate better patient experience for older Tasmanians.

Q10. How can we build health literacy, self-management and preventative health approaches into the day-to-day practices of our health services across the whole health system?

Reinforcing healthcare sector knowledge about the benefits of physical activity in preventing and managing chronic disease is needed. ESSA manages [Exercise is Medicine[®] \(EIM[®]\) Australia](#), which is a bespoke education program designed to support primary healthcare practitioners including general practitioners, nurses, primary healthcare Networks and medical interns in training hospitals. EIM[®] aims to increase literacy on the role that physical activity plays in the prevention, management and treatment of chronic disease. EIM provides insight as to how exercise is medicine, who to refer to for particular exercise interventions and when to refer for best possible patient outcomes. As GPs and nurses are already well-known and trusted pillars in community health, reinforcing knowledge and generating additional referral pathways to AEPs will increase access to physical activity to help reduce the burden on the health system, reduce hospitalisations and improve the health and wellbeing of Tasmanians.

EIM[®] Australia workshops are endorsed by The Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and Australian Primary Health Care Nurses Association. The workshops are facilitated by AEPs or physiotherapists and can be delivered throughout Tasmania in a combination of face-to-face and online sessions by local AEPs.

Recommendation 23: That the DoH and the THS implement the Exercise is Medicine[®] program for Tasmania's primary healthcare providers to reinforce healthcare sector knowledge and health literacy on exercise prescription and behavioural change.

Q11. How can we better incorporate preventative health and health literacy initiatives into current and future care, across the range of settings, including acute community, primary and private?

Initiatives should focus on both improving the literacy of consumers as well as health care professionals about modifiable risk factors (e.g. diet and exercise) and promoting existing evidenced based community programs and resources supporting healthy living. A focus on improving consumer access to exercise interventions delivered by AEPs will also support preventative health and a previous section has addressed improving access to Medicare through telehealth and funding for additional AEP services. A long standing policy anomaly and key priority for ESSA which needs to be rectified is the payment of goods and services tax (GST) on exercise physiology services.

Tasmanians with private health insurance and those who are paying privately are paying GST on exercise physiology at a time when

- the Australian Minister for Health, The Hon. Greg Hunt MP is focusing on insurance reforms to ensure the affordability of private health insurance^{xxxiv}
- out-of-pocket payments for private health insurance general treatment ancillary services increased by 3.2 per cent in 2020 compared to the same quarter in 2019^{xxxv}
- around half (49 per cent) of Tasmanians have some form of private health insurance general treatment cover (hospital cover) compared to 53.2 per cent of all Australians as at 30 September 2020^{xxxvi}
- the average out-of-pocket fee to see a specialist reached a record high of \$83.77 and the average out-of-pocket fee to see a general practitioner (GP) reached a nominal high of \$38.46 in 2018-19^{xxxvii}.

Exercise physiology is the only standalone profession in the [MBS Group M3 \(allied health chronic disease management plan individual services - items 10951–10970\)](#) that is not exempt from GST.

The Tasmanian Government is paying GST on exercise physiology for all exercise physiology services delivered through WorkCoverTasmania.

The following Australian Health Practitioner Regulation Agency regulated ‘non-medical’ health professions are exempt from GST:

- occupational therapy
- physiotherapy and
- podiatry.

There are also several self-regulating ‘non-medical’ health professions with a GST exemption:

- audiologists
- dietitians
- social workers and
- speech pathologists.

Recommendation 24: That the Tasmanian Government via the Council on Federal Financial Relations support the removal of GST on exercise physiology services.

One evidence-based resource is [Exercise Right](#), which offers easily accessible information and education on improving an individual’s health and wellbeing, paramount to generating meaningful change. It is one of Australia’s largest evidence-based resource hubs providing public health information in an array of easy to understand formats including videos, blogs, factsheets, case studies, infographics and articles. Funded, developed and promoted by ESSA to support a more active nation, Exercise Right resources are tailored to specific population groups. Each resource has been prepared by AEPs, is based on contemporaneous evidence and practice, and has been designed specifically to promote the lifestyle benefits of physical activity and a healthy diet.

Exercise Right is recognised as an official partner of Healthdirect Australia, a national, government-owned, not-for-profit organisation which supports Australians to manage their own health and wellbeing through a range of multichannel health information and advice services. The Healthdirect website continues to be the number one Australian online source of health information, with more than 34 million visits in 2018-2019.

Information from Exercise Right has supported more than 500,000 users to date in 2020 and the content is being used by other state governments and peak health promotion charities including:

- This Girl Can (Victorian Government)
- Western Australian Government
- Queensland Government
- National Heart Foundation
- Cancer Council.

ESSA would welcome the opportunity to partner with the Tasmanian Government to leverage the Exercise Right resources to support the health literacy of Tasmanians.

Partnerships should recognise the need for GPs in all communities (metropolitan and rural) to be aware of and connected to local healthy lifestyle initiatives themselves or alternatively, have access to a social prescribing program which integrates health and social care. Supporting a national social prescribing program would ensure that patients are referred to relevant evidenced based programs and resources.

Public health messaging about modifiable risk factors would be more effective and less confusing for the general public if it could be co-ordinated. A suite of consistent messages could be developed with for use by government, health promotion charities and other peak health bodies including professional associations.

A target for prevention research needs to be set and funded from existing health and medical research funds. The establishment of a national clearinghouse for prevention would also assist with the dissemination of research.

Monitoring and surveillance needs to include a focus on new in-home and wearable technologies (sensors and wearables) which offer an effective and cost-efficient approach to health management or encourage preventative behaviours. mHealth (mobile health, using mobile phones and other wireless technology in medical care and self-monitoring devices) also needs to be factored in.

Physical activity and exercise is still not routinely prescribed in primary care. For example, research shows that only 18 per cent of patients who visit their GPs receive physical activity advice, and that prescription of physical activity by GPs is predominately provided as part chronic disease management as opposed to as prevention^{xxxviii}. As noted above, the implementation of the Exercise is Medicine© program would support health practitioners to prescribe physical activity.

From a national perspective, formally recognising AEPs within the Australian healthcare system has gone some way to incorporate preventative health and health literacy initiatives into healthcare. Evidence indicates a statistically significant difference in effect between supervised exercise and unsupervised exercise, partly due to the attention and support of exercise physiologists delivering the interventions^{xxxix}. AEPs use their expertise in motivational coaching, assessment and exercise prescription as well as their knowledge of the potential risks and likelihood of the presence of comorbidities in populations with chronic disease to support patients.

Recommendation 25: That the DoH supports Tasmanians to modify their lifestyles by integrating [Exercise Right](#) into Tasmanian Government public health education activities.

Prevention strategies via consumer education about food, exercise, self-care and mental health will also facilitate preventative health and health literacy.

ESSA delivers an education program titled, [Healthy Eating Active Lifestyle](#) (HEAL™), which involves eight-weeks of lifestyle modification that enable participants to develop lifelong healthy eating and physical activity behaviours. HEAL™ is focused towards early-intervention and treatment of current chronic disease.

The program includes pre and post individual consultations, with follow-up health consultations at five and 12 months. The program accepts GP referrals through Medicare and focuses on recruiting participants in local communities through local service providers. HEAL™ is delivered by AEPs and is currently incorporated into the [NSW Healthy Eating and Active Living Strategy](#)^{xi} and [NSW State Health Plan: Towards 2021](#)^{xli} as a method for improving the health and wellbeing of New South Wales people.

A 2015 study^{xliii} assessing the efficacy of the HEAL™ program indicated that participation achieved improvements in pre-diabetes and type 2 diabetes mellitus risk factors. Specific outcomes included increased level and frequency of physical activity; reduced daily sitting time; increased daily serves of fruit and vegetables consumed; reductions in body mass, BMI, waist circumference and blood pressure; and improved measures of functional capacity. At baseline, 60 per cent of participants were not meeting recommended physical activity levels while at post-program testing this had dropped to 45 per cent.

HEAL™ could be easily incorporated into Tasmania’s community health services. Providing funding to assist in program management, implementation and local resource development would increase public awareness and participation rates.

Recommendation 26: That the DoH and the THS support Tasmanians to make positive lifestyle changes by funding and providing access to Healthy Eating Activity and Lifestyle (HEAL™).

ESSA understands the development of the national physical activity strategy has ceased due to the review and rationalisation of the former COAG Councils and Ministerial Forums. Work on the national physical activity was being done by the Meeting of Sport and Recreation Ministers (MSRM) Committee. The review of the COAG Councils and Ministerial Forums recommended that MSRM be disbanded. ESSA is hoping that an alternative mechanism can be found to re-activate this work.

Recommendation 27: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support the re-activation of work on development of the national physical activity strategy.

Reform Initiative 3b

Q1. How should the Health Workforce 2040 strategy be further refined to guide and inform the development of a strong and sustainable professional workforce that is aligned to meeting the future health needs of Tasmanians?

Consideration should be given to providing additional support to those allied health professionals living in rural and remote areas. In 2020, the former National Rural Health Commissioner, Emeritus Professor Paul Worley, highlighted the important role of allied health in rural, regional and remote Australia in his final *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*^{xliiii}:

“Allied health professionals are essential to the physical, social and psychological wellbeing of people living in rural and remote Australia. They are integral to the care of rural and remote communities, whose capacity to achieve optimal health outcomes is limited by inequitable access to appropriate health services. They are also integral to the economic development of rural and remote populations particularly in relation to workforce participation and educational outcomes.

There is both an undersupply and a maldistribution of allied health services in rural and remote towns of less than 30,000 people that can be addressed by an integrated service and learning pathway linked to more and better structured jobs, greater participation of Indigenous Australians, improved access to workforce data and through national allied health leadership.”

Further in the report, Emeritus Professor Worley notes:

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

To address the undersupply and maldistribution of allied health services in rural and remote areas (and more broadly across all of Tasmania), the *Workforce Strategy* needs to be refined to include all private sector allied health professionals who deliver services under compensable schemes like Medicare Benefits Schedule (MBS), the NDIS and aged care as a priority. This would ensure that Tasmanians can continue to access those services on an equitable basis compared to other Australians. The fact that some types of allied health professionals are not currently employed in the public system should not be a criterion for their exclusion from the *Workforce Strategy*.

Specifically, it is imperative that at a minimum, allied health professions delivering services under compensable schemes be included in the development of chronic care strategies, referral pathways and service delivery options. Specifically, the *Workforce Strategy* should include the exercise physiology profession.

An examination of the allied health professions with MBS items highlights some glaring omissions in the full list of allied health professions analysed in preparing the *Health Workforce 2040: Allied health (draft)* document:

- a. [Chronic Disease Management - Individual Allied Health Services under Medicare](#)
Diabetes Educators - item 10951 and Exercise Physiologists - item 10953
- b. [Group Allied Health Services under Medicare for people with Type 2 diabetes](#)
Assessment for group services (Diabetes Educators item 81100 and Exercise Physiologists item 81110)
Group services (Diabetes Educators item 81105 and Exercise Physiologists item 81115)

Another reason to include diabetes educators and exercise physiologists in the *Workforce Strategy* is based on a comparison of numbers of excluded allied health professionals as of 8 February, 2021 compared to other allied health professions included in the *Strategy*:

- 112 AEPs (excluded)
- 17 Credentialed Diabetes Educators® as evidenced by a search of the [Australian Diabetes Educators Association website](#) (excluded)
- 7 audiologists as evidenced by a search of the [Audiology Australia website](#) (included)
- 2 clinics as evidenced by a search of the [Human Genetics Society of Australasia website](#) with 5 counsellors working in the public health sector (included).

Recommendation 28: That all allied health professions delivering services under compensable schemes be included in the *Workforce Strategy* including exercise physiologists and that these allied health professions be involved in the development of chronic disease management strategies, referral pathways and service delivery options.

Consideration should also be given to how some allied health professions are grouped when there are overlaps with scopes of practice and registration/accrediting bodies. One such example is the profession of cardiac

physiology where a search of the [Australian Council for Clinical Physiologists](#) for Tasmania to obtain the public record reveals **only one Accredited Clinical Physiologist with a cardiac focus** as per Figure 7:

Figure 7: Results of a search of Accredited Clinical Physiologists in Tasmania

State: is "TAS"

[Edit search](#) [Clear search](#)

Search: Found: 5

Name	Profession	State	ACCP ID
Bridges, Kim	Respiratory Level 2	TAS	56843857
JOHNSON, Christopher	Respiratory Level 2, Sleep Level 2	TAS	55261256
NORMAN, Miriam	Cardiac Level 2	TAS	55401228
Salter, Patrick	Respiratory Level 2	TAS	56792908
YOUNG, Sally	Respiratory Level 2	TAS	55604681

It is ESSA’s view that clinical physiologists with a cardiac focus could be grouped together with exercise physiologists in a new category of exercise and clinical physiologists because the scope of practice for these professionals overlaps with the scope of practice for Accredited Exercise Physiologists. The key difference is that ultrasound and echocardiography is not within the scope of AEPs.

Given that echocardiographers need to be registered with the Australian Sonographer Accreditation Registry as do sonographers, it seems logical that echocardiographers could be re-categorised with sonographers who also need to be registered with the Australian Sonographer Accreditation Registry.

Recommendation 29: That the DoH groups clinical physiologists with a cardiac focus together with exercise physiologists in a new category of exercise and clinical physiologists and that echocardiographers be grouped together in a separate category with sonographers.

Tasmania has consistently lower average numbers of Australian Health Practitioner Regulation Agency regulated allied health professionals (AHPs) per 100,000 population than the national average and consistently lower than average Ahpra regulated AHPs than any other Australian State or territory as per Table 4 below. Similarly, there are lower than average numbers of AEPs in Tasmania compared to Ahpra regulated AHPs in Tasmania and Australia.

It should be noted that the aggregated figures should not be looked at isolation as there are considerable variations between allied health professions and ESSA’s accreditation year is a calendar year not a financial year.

Table 4: Employed AEPs allied health practitioners# per 100,000 population 2013-2019 Fys 2013-2019 Tasmania vs. Australia^{xliv}

Year	AEPs* Tasmania	AHPs Tasmania	AHPs Australia
2018-2019 FY 113 AEPs accredited in the 2019 calendar year	21.4	509.2	572.5
2017-2018 FY 75 AEPs accredited in the 2018 calendar year	14.2	410.1	480.0
2016-2017 FY		397.5	465.8
2015-2016 FY		393.6	455.6
2014-2015 FY		391.8	447.2
2013-2014 FY		379.9	436.3
2012-2013 FY		360.8	426.1

Allied health professionals only include Ahpra regulated professions the following professions: occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health practitioners, chiropractors, chinese medicine practitioners, medical radiation practitioners. 2019 includes paramedics. No self – regulated or independently regulated allied professionals are included within these figures. FTE is calculated using total hours and based on a 38 hour week.

* These figures are calculated using the same estimated resident population figures as used for the Apha professions. These figures represent an over-estimation of the number of Accredited AEPs in Tasmania per 100,000 population as the calculations are based on the total number of accredited AEPs, some of whom work less than FTE hours.

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

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

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

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

“Recommendation 3 – Expanding Distribution

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

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

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

Exercise physiology is a self-regulated health profession so much of the AIHW data excludes workforce data on exercise physiologists, dietitians, speech pathologists, audiologists and other health professionals not regulated by the Ahpra.

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

In a similar vein, exercise physiology services are not specifically listed in the Australian and New Zealand Standard Industrial Classification (ANZSIC) framework. Currently, the class that best fits exercise physiology services is within the 91110 Health and Fitness Centres and Gymnasias Operation class. This class consists of units mainly engaged in operating health clubs, fitness centres and gymnasias. Units in this class provide a range of fitness and exercise services. The 91110 class is inappropriate for exercise physiology services as they should sit within Group 853 ALLIED HEALTH SERVICES: Class 8539 Other Allied Health Services alongside other allied health professional services. ESSA has previously made a submission to the ABS *Review of 2021 Census Topics* in 2018 asking for this change but no change has been accepted by the ABS to date.

Recommendation 30: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support initiatives to

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

Q2. How do we work with the private sector, as well as other levels of government to ensure our combined workforce serves the future needs of our community?

Further investment is needed by the Australian Government to expand Tasmanians' access to Medicare. The recent completed review process by the [MBS Review Taskforce](#) has not recommended any new allied health items be established nor existing items be extended. The Taskforce supported the rationale for many recommendations for new items but advised more research is needed to develop an appropriate evidence base to support the proposed new items. The lack of research is a result of an underinvestment in research into the benefits of allied health so it would appear a stalemate has been reached for the time being.

Recommendation 31: That the Tasmanian Minister for Health and the DoH through the Health National Cabinet Reform Committee support initiatives to increase the amount of funding available for allied health research and extend funding for the provision of allied health services through Medicare and/or for the commissioning of allied health services via the Primary Health Networks.

Q4. What innovations or changes are needed for our health workforce to more closely align our professional health teams with the future needs of Tasmanians?

As outlined earlier, ESSA advocates for the DoH and the THS to take a more inclusive approach to better align health teams with the future needs of Tasmanians. This includes the acknowledgement and integration of emerging professions like AEPs and allied health professions more broadly into care teams. This also requires greater collaboration between professions to enable better understanding of their respective scopes of practice, where the overlaps and gaps exist, to foster effective multidisciplinary team care.

In addition, clear pathways and programs are needed to support acute to long-term care for Tasmanians, in particular vulnerable populations such as older Tasmanians and those with disability.

Recommendation 32: That THS explores the development of referral pathways and programs in accordance with Tasmania's future health needs through a series of round tables with health professions.

A significant issue for staffing in hospitals is the difficulty in sourcing surge staff in the case of an infectious disease outbreak or a natural disaster. ESSA suggests that a mapping of hospital activities against the scopes of practice of allied health professionals (both Apha and self-regulated professions) may assist with planning for the efficient redeployment of public hospital staff during future events. This mapping may also look at circumstances where general practitioners and specialists are re-deployed and allied health professionals can assist in managing patients' chronic conditions until GPs and specialists return to their regular roles. It would also ensure that there would be no underutilisation of allied health professionals' scopes of practice.

ESSA further suggests that a surge workforce register be established. ESSA was approached by NSW Health in August 2020 to assist in developing an exercise physiology surge COVID-19 testing workforce as COVID-19 testing was identified as within scope for AEPs. In an ideal pre-COVID-19 world, mapping would have already been completed on the scopes of practice of allied health professionals. This mapping would have identified the pre-requisite skills necessary for COVID-19 testing enabling recruitment of a surge workforce to be completed much earlier.

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

Recommendation 33: That the DoH and the THS map the scope of practice for allied health professions to enable contingency planning and the ability to deploy the allied health workforce to better support primary and public healthcare systems.

Q5. How do we support health professionals to work to their full scope of practice?

Whilst allied health roles are generally not substitutable and cannot be substituted like medical and nursing positions, a better understanding of the scopes of practice by service leaders would assist in supporting allied health professionals to work to their full scopes of practice.

ESSA recommends that the DoH and the THS extend their understanding of the scopes of practice of all allied health professions by contacting the Ahpra Boards/Councils for Ahpra regulated allied health professions and

professional associations for self-regulated and independently regulated allied health professions. Consideration could then be given to developing resources and providing opportunities for service leaders to better understand the scopes of practice of allied health professionals.

Another simple solution to expand the pool of allied health professionals available to undertake work in the public system is to consider job titles, job descriptions and selection criteria to allow any allied health professional with the appropriate scope of practice who can perform a role to deliver the services required to apply for allied health jobs.

Examples of roles where either an exercise physiologist, an occupational therapist or a physiotherapist could perform the same kind of work within their scopes of practices are in prehabilitation or post-surgery rehabilitation, cardiac rehabilitation rehab and pulmonary rehabilitation. Occupational therapy and physiotherapy are closely aligned allied health therapies to exercise physiology as evidenced by all three professions being recognised as 'physical therapies' under the new [COVID-19 Temporary MBS Allied Health Services for Residents of Aged Care Facilities](#).

Additional short courses or onsite training could be made available to extend the scopes of practice to allow existing allied health professionals to operate independently without the need for another type of allied health professional (sometimes at another site) to sign off on certain approvals. An example from other states is in the prescription of gait aids (such as a wheeled walker) where an exercise physiologist with a small amount of training could prescribe these aids without the need for an offsite OT or a physio to approve the prescription.

Consideration could be given to expanding the number of professions available in the [Allied Health Rural Generalist Pathway](#). At that moment, the pathway is not available for all allied health professions. The two-level, university delivered program, encompassing rural generalist practice development is only available for seven professions: medical imaging, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, podiatry, and speech pathology.

Increased consumer literacy about allied health and its role in the healthcare system has been flagged previously as has the need for more collaboration and a better shared understanding between medical, nursing professionals and allied health professionals.

Supporting allied health professionals in the public system to use telehealth allows them to provide continuity of care when patients are discharged from hospital. When distance is too great or the ability to travel for other reasons to access out-patient services is difficult, the delivery of allied health services by telehealth can provide a suitable alternative.

Health professionals should be supported to work in multidisciplinary teams to deliver collaborative care to ensure the best possible patient outcomes. Consideration could be given to funding multidisciplinary case conferences to enable info sharing and relationship building between medical and allied health professions and help shape referral and treatment pathways which can then be included in the various Primary Health Networks' HealthPathways.

Micro-credentialling can also extend the scopes of practice for allied health professionals. Again, dialogue with Ahpra Boards/Councils and professional associations would assist in determining the most appropriate micro-credentialling opportunities.

Opportunities for student practicum placements within Tasmania should be maximised so that more 'grow your own' health professionals can be supported.

Recommendation 34: That the DoH and the THS engage with Ahpra Boards/Councils for Ahpra regulated allied health professions and professional associations for self-regulated and independently regulated allied health professions on scope of practice issues regarding scope of practice issues.

Recommendation 35: That the DoH provides more opportunities for allied health professionals, especially from newer and emerging professions like exercise physiology to be involved in service planning.

Recommendation 36: That the DoH and the THS engage with education providers to extend the range of allied health professions offered under the Allied Health Rural Generalist Pathway.

Q6. How do we support Tasmanians to access the education and training they need to be part of the State's future workforce?

The provision of defined and integrated career pathways, best practice frameworks and clear scopes of practice are integral to support Tasmanians to access the education and training they need to be part of the state's future workforce.

ESSA requires that AEPs must meet the [AEP Professional Standards](#) to be eligible for accreditation and then they must meet recency of practice and continuing professional development (CPD) requirements to ensure currency and to grow scope. ESSA has also developed the [Scope of Practice Framework Policy](#) which supports exercise professionals to understand scope and how to effectively advance and extend scope.

There are specific training issues relating to the recruitment and retention of health practitioners in rural areas. Emeritus Professor Paul Worley in his *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*^{xlvii} notes:

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

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

“Recommendation 1 – Improving Access

To improve access to allied health services, **it is recommended that the Commonwealth progressively establish, initially through a series of demonstration trial sites, Service and Learning Consortia** across rural and remote Australia. With the support of new and existing program funding, Service and Learning Consortia will **integrate rural and remote ‘grow your own’ health training systems with networked rural and remote health service systems.**

Service and Learning Consortia will consist of local private, public, and not for profit service providers, training providers, and community representatives collaborating across multi-town and multi-sector networks, according to community need. Once established, Service and Learning Consortia will improve

recruitment and retention of allied health professionals by making rural and remote allied health practice and training more attractive and better supported.”

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

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

Recommendation 37: That the DoH works with UTAS to ensure that appropriate rural student practicum placements are available.

Recommendation 38: That the DoH works with peak professional allied health bodies to support professional development for allied health professionals, especially for newly graduated sole practitioners working in private practice.

In addition, creating and hosting events, inter-profession learning and networking opportunities would also help inform the development of a strong and sustainable health workforce in Tasmania. Such initiatives would generate collaboration, increase awareness, enable knowledge sharing and increase understanding of the skills and qualifications needed for effective multidisciplinary teams. Targeted at health professions through University studies through practicum or work experience programs, and reinforced via annual multidisciplinary conferences, initiatives like these could have immediate impacts and over time strengthen Tasmania’s healthcare system.

Recommendation 39: That the DoH liaises with UTAS on potential initiatives for medical, nursing and allied health schools; and host annual multidisciplinary conferences to develop a strong, collaborative and sustainable healthcare workforce.

Reform Initiative 3c

Q1. How could a State-wide Clinical Senate assist in providing advice to guide health planning in Tasmania?

A State-wide Clinical Senate could assist in providing advice to guide health planning in Tasmania by enabling greater access for a range of healthcare professionals, health consumers and government to collaborate and communicate about issues and solutions and focus on system innovation and reform.

ESSA advocates for representation on the Clinical Senate to be reflective of Tasmania’s current and future healthcare workforce. Careful composition will be required to ensure that the composition of the Clinical Senate

mirrors the composition of the entire workforce, that is, not just those professions currently working in the public system. It should also have a balance of medical, nursing and allied health representation.

Recommendation 40: That the composition of the recommended State-wide Clinical Senate be inclusive and weighted between medical, nursing and allied health professions and include proportional representation of newer and emerging healthcare professions.

Q7. What format would be best to engage our future health leaders?

ESSA does not believe that a future Health Leaders Forum is the only way to support and develop emerging health leaders.

Initiatives that could generate deep levels of engagement for future health leaders include vocational work experience programs for school students, student bursaries, university scholarships, professional recognition and bespoke awards for excellence across the private and public health systems. Such initiatives would foster a pipeline for future homegrown health leaders and attract those seeking a challenge because the very challenges that health leaders experience by living and working in a remote state with a relatively small, diverse and dispersed population also offers vast learning and genuine career development opportunities.

Recommendation 41: That the DoH and the THS collaborate with UTAS, ESSA and other allied health professional bodies to research the inspirations and aspirations of current allied health students to help inform future leader initiatives and implement a range of initiatives once this research is completed.

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