

# SUBMISSION: CONSULTATION ON RURAL ALLIED HEALTH QUALITY, ACCESS AND DISTRIBUTION

20 August 2019

## BACKGROUND AND INTRODUCTION

The university sector is committed to educating our future health workforce as a fundamental component of Australia's health system. Universities offer multiple health courses and educate the majority of health professionals in Australia. Of this workforce, more than 200,000 - or over a quarter - are allied health professionals (AHPs)<sup>1</sup>. Allied health professionals play a major role in the prevention, treatment and management of ill-health across multiple sectors, both as individual, autonomous clinicians and as part of multidisciplinary health teams.

Through our national footprint, universities already undertake work to support greater distribution of all health professionals to rural areas. This includes a number of regionally located universities and the Rural Health Multidisciplinary Training (RHMT)<sup>1</sup> program's network of 19 Rural Clinical Schools (RCSs), 16 University Departments of Rural Health (UDRHs) and 26 Regional Training Hubs (RTHs). The network is funded by the Commonwealth Department of Health and is managed by 21 mostly urban-based universities. Both play a substantial combined role in supporting health workforce growth and distribution to rural Australia.

Universities Australia (UA) is the peak national body representing Australia's 39 comprehensive universities. UA's submission to this consultation is from a whole of university sector perspective and has been developed in consultation with UA's Health Professions Education Standing Group (HPESG). HPESG comprises senior leaders across all university health professional disciplines and jurisdictions. This includes representation from the Australian Council of Deans of Health Sciences (ACDHS), which acts as an umbrella body for university allied health education courses. UA refers the National Rural Health Commissioner to the [ACDHS submission](#) for more detailed allied health information and to individual university submissions for examples of education pathways that support effective workforce distribution.

UA welcomes the opportunity to respond to this consultation and to continue to work with the National Rural Health Commissioner to support closer policy development between higher education and health in this important area.

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<sup>1</sup> The RHMT Program is currently under review. The RHMT Program plays a critical role in supporting health workforce distribution to rural areas through quality education pathways.

## **POLICY AREA (PA) 1: RURAL ALLIED HEALTH POLICY LEADERSHIP, QUALITY AND SAFETY**

### **Consultation questions for PA 1:**

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

UA supports, in principle, the appointment of a Commonwealth Chief Allied Health Officer (CAHO) that oversees national allied health issues. The role should be similar to and aligned with the Commonwealth Chief Medical Officer (CMO) and Chief Nursing and Midwifery Officer (CNMO) positions.

It is important that a CAHO is more than just a figurehead. It needs to be a substantive role, adequately supported in the Department of Health (DOH) and with a clear strategy. The CAHO will need to have a good grasp of the diverse aspects of allied health service delivery. This includes:

- the allied health clinical education and workforce issues affecting different service domains, sectors and locations; and
- the importance of strong links between relevant stakeholders, portfolios and tiers of government in the development of allied health policy, funding and regulation.

Priorities for a CAHO position should include:

- Workforce development and distribution, including identified areas of allied health workforce need such as in rural locations, aged care, primary care and care under the NDIS.
- Clinical education including promoting effective links between health and education.
- Promotion of expanded allied health roles and their importance across various sectors in: health promotion; illness prevention/management; and maintaining/regaining functional independence.

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

Intersectoral and intergovernmental collaboration will both be important for the CAHO, given the divided responsibilities for health and education in Australia.

In the first instance, intersectoral collaboration could occur through engagement with an allied health workforce and education advisory group that connects these two important portfolios for the purposes of policy development and planning. Such a group would be similar to those that currently exist for Medicine and Nursing – the Medical Workforce Reform Advisory Committee (MWRAC) and the National Nursing and Midwifery Education Advisory Network (NNMEAN) respectively.

The Australian Allied Health Leadership Forum (AAHLF) already plays this role to an extent. UA suggests that this group be formalised and expanded where necessary (for example, with representatives from disability and aged care across both the public and private sectors) to constitute the allied health workforce advisory group. The group would be led by the CAHO who could connect as necessary with relevant representatives from the Commonwealth Departments of Education and Social Services.

Workforce developments in one discipline or sector can impact on workforce requirements in another. It is UA's strong view that representatives from all health professional workforces, sectors and education providers need to discuss workforce development and corresponding education requirements on a regular and frequent basis.

For this reason, UA continues to recommend that a long-term, enduring mechanism for health education and workforce planning is established that brings relevant sectors and players together across the whole health workforce.

As a first step, in addition to regular meetings between the CMO, CNMO and CAHO, UA recommends that an annual or biannual meeting of the combined allied health, medical and nursing and midwifery education and workforce committees be convened. Key topics could include:

- Interprofessional education
- Whole of workforce distribution – with a focus on rural areas
- Expanded and advanced scopes of practice and their role in areas of workforce shortage
- The impact of technology and AI on future health workforce development and care delivery

While a formalised role for an expanded AAHLF would already include jurisdictional representation, UA suggests that the CAHO also has strong links with the COAG Health Services Principle Committee (HSPC) and that AAHLF education and workforce recommendations feed into HSPC and COAG Health Council discussions as relevant.

***1.2.a: What would be the advantages and disadvantages of the abovementioned models for establishing a college?***

UA refers the Commissioner to the ACHDS submission in relation to this question.

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

UA refers the Commissioner to the ACHDS submission in relation to this question.

***1.2.c: What performance indicators would determine the effectiveness of a College?***

UA refers the Commissioner to the ACHDS submission in relation to this question.

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

UA does not see benefit in developing a dataset solely for rural allied health but does strongly support the Commonwealth developing a comprehensive national health workforce dataset within which rural and allied health workforce can be clearly identified and analysed. Ideally this data would be collected in a standardised way, publicly accessible and linked to data that also captures education, training and placement information (such as location, service domain and duration). The benefits of such a dataset include:

- workforce distribution comparisons across geographic areas;
- time series comparisons to examine change in workforce distribution to geographic locations and particular service domains/sectors;
- opportunities to monitor allied health workforce movement between rural and urban areas;
- impact of educational pathways and experience on workforce distribution; and
- impact assessment of policy/other interventions relevant to workforce distribution and training pipelines.

The challenges in collecting this data include:

- a. **Capturing workforce data from the self-regulating allied health professions:** National workforce data is currently captured only from those allied health professions regulated under the National Registration and Accreditation Scheme (NRAS) through registration with the

Australian Health Practitioner Regulation Agency (AHPRA). The self-regulating allied health professions are not required to register with AHPRA so the opportunity to capture workforce data linked to registration for these professions is limited. These professionals work in both the private and public sectors. Some workforce data about the self-regulating professions would exist through Local Hospital Network (LHN) and Primary Health Network (PHN) datasets however is likely to be quite variable.

UA recommends that workforce data consistent with that captured for the NRAS professions is also collected for the self-regulating allied health professions. This could either be through a departmental contract with the self-regulating professional bodies to undertake collection or potentially through resourcing/enabling consistent workforce data collection through PHNs and LHNs.

- b. **Capturing clinical education and placement data:** There are multiple factors which contribute to health professionals' decisions about where they practice; however, linking education and training data with workforce data would be useful in assessing the impact that particular education pathways/clinical training experiences have in workforce distribution. Universities previously completed an extensive annual clinical education survey through the former Health Workforce Australia (HWA). The survey was intensive and required significant university resources to complete – especially in those universities with a substantial number of health courses. However, universities were resourced to do this through HWA. This type of data is still critical for understanding and determining effective health workforce and training pipelines. UA recommends that universities are adequately resourced to capture this data in a nationally consistent way.

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

The following datasets could feed into a comprehensive workforce dataset:

- AHPRA registration data.
- Existing health workforce and labour force data from DOH, the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS). This could include data captured through the Health Demand and Supply Utilisation Patterns Planning (HeadS UPP) tool.
- The Independent Hospital Pricing Authority (IHPA)'s National Best Endeavours Data Set (NBEDS). This data set captures public hospital and health service data from entry-level trainees to new graduate health professionals. It is currently a voluntary data set so consistency and completeness varies however it is likely to grow over time and could be a useful data source.
- Local Hospital Network (LHN) and Primary Health Network (PHN) data sets captured as part of their population health planning processes
- Data from Rural Workforce Agencies (RWAs) - at both jurisdictional and national levels.
- Any existing private hospital and private practice data collections.
- Higher Education Information Management System (HEIMS) data.
- Data captured as part of the Boosting the Local Care Workforce (BLCW) initiative regarding workforce need under the NDIS.

HWA used to undertake a workforce census across the whole health workforce. UA recommends that this type of data collection be resumed. It could be filled in, where relevant, from existing data collections but added to through census or survey mechanisms where gaps exist.

***Any additional comments and feedback related to Policy Area 1.***

Capturing and linking data that enables tracking of health professionals longitudinally from entry-level university education and then onwards throughout their career is vital to better understanding effective pathways to rural workforce distribution. Longitudinal data tracking is also important in identifying factors that contribute to choosing to work rurally at different stages of career development. There can tend to be a focus on measuring the success or otherwise of a rural education program by whether or not a new graduate returns to a rural area soon after becoming qualified. However, longitudinal data is also required to capture the degree to which rural programs and other factors influence later career choices to work rurally.

## **PA 2: OPPORTUNITIES FOR RURAL ORIGIN AND INDIGENOUS STUDENTS**

### **Consultation questions for PA 2:**

#### ***2.1.a: What are appropriate target quotas for universities to select more rural origin students into allied health courses?***

While UA understands the intent behind this suggestion, the introduction of quotas is not supported. Both regionally and urban based universities already deliver effective programs that support allied health students to experience and choose rural practice. Programs range from a focus on attracting rural origin students to promoting and enabling urban based students to connect with and undertake clinical education and placements in rural communities. Introducing quotas would act as a perverse incentive by undermining and destabilising the range of models that are already working well in different areas.

Instead, UA recommends the introduction of incentives that promote institutional collaboration towards achieving rurally directed outcomes throughout an AHP's university education. This could include options such as inter-university collaboration and university-service provider collaboration.

All universities have an equity focus, one component of which is promoting increased enrolments amongst students from diverse situations, including rural areas. As outlined in the recent Department of Education (DOE) review into regional, rural and remote education, <sup>ii</sup> schools also play a key role in promoting pathways to higher education and various rural school-based programs exist to support this preparation. A further option is to incentivise universities and regional schools to collaborate to implement programs that promote allied health careers, such as running allied health summer schools and/or allied health career expos. This could be supported through joint policy and program development between DOH and DOE.

#### ***2.1.b: If quotas were to be set at different rates for different courses and university contexts, what should be considered in determining these quotas?***

See response to 2.1.a.

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

See response to 2.1.a.

#### ***2.2.a: Please describe alternate policy options within the Commonwealth's remit, which could achieve the same results in providing opportunities for rural and Aboriginal and Torres Strait Islander students to train as rural allied health professionals.***

To support increased participation of rural and Aboriginal and Torres Strait Islander students in allied health courses, UA recommends the following options:

- Maintain, and ideally increase, funding through the RHMT program for additional UDRHs and expansion of existing ones so that rural origin and Indigenous allied health students can undertake a greater proportion of their study in a UDRH, potentially closer to their home base.

An expanded RHMT program would also enable a greater number of urban students to spend longer in rural placements.

- Increase Austudy (or enable eligibility to New Start which provides greater funding support) for:
  - Rural-origin students to support relocation to metropolitan based universities to study allied health;
  - Urban-based students who undertake an agreed period of their allied health education and training in rural locations.

Relocation costs for both urban and rural students are frequently cited as obstacles to participating in education and training experiences that may assist in getting more health workforce to rural areas.

- Develop increased allied health education opportunities by policy and program collaboration between the Commonwealth Department of Health and:
  - the Department of Education (DOE), for example by:
    - » providing additional Higher Education Participation and Partnerships Program (HEPPP) funding to universities specifically targeted to allied health education. HEPPP supports higher education equity goals through a focus on low SES groups including those from rural Australia.
    - » Introducing a Bonded Allied Health Scheme, similar to the Bonded Medical Program whereby a number of additional Commonwealth Supported Places (CSPs) for allied health students are funded through the Department of Health with a return of service obligation to a rural area once the student is qualified.
  - the National Indigenous Australians Agency (NIAA) to explore options to further support Aboriginal and Torres Strait Islander students to undertake relevant education. For example, NIAA's Indigenous Student Success Program (ISSP) currently assists universities to offer support services that promote successful course completion, including in allied health.

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

UA refers the Commissioner to the ACHDS submission, to individual university submissions which highlight a range of local models and to the various examples of culturally safe and appropriate training and employment models available through Indigenous Allied Health Australia (IAHA).

***Any additional comments and feedback related to Policy Area 2.***

Evidence shows that rural origin is one of several factors that influence where students elect to work once qualified. The likelihood of returning to work in rural areas is increased when the following are all combined: rural origin of students; time spent in rural locations during training; and rural career pathways/sustainable rural jobs. However, it is not clear to what degree rural origin alone is a determinant of returning to work in rural areas. Although national data is lacking, data from some individual universities shows that urban-origin students who spend time in rural areas during their training also have an increased likelihood of returning to work in rural areas once qualified. There is also some evidence which shows that medical students of rural origin who have undertaken rural placements during medical school still choose metropolitan positions once qualified, especially if they have had to undertake internships and junior doctor rotations in urban locations and/or they choose a specialty where rural positions are limited.

The rural allied health strategy needs to focus on getting allied health professionals to the bush. While education pathways are an important component, the strategy needs to be careful not to rely solely on rural origin students and "home-grown" regionally-based solutions. While these are part of the solution, other

approaches also work and need to be included. A variety of other factors which lie outside of the control of education providers also influence work destination choice (including availability of rural positions, support for new graduates in rural areas, employer/employee incentives etc.) and need to be part of the mix – but are outside of UA’s remit.

Overall, UA recommends a consolidated multi-pronged strategy that draws on and extends approaches that are already driving allied health rural workforce outcomes in the right direction. This includes both rurally-based education approaches and approaches that acknowledge that urban-based students also choose to work rurally. Strategies also need to consider: incentivising collaborative approaches (as outlined in the response to 2.1.a); employer/employment incentives; and policy approaches that better support the current rural allied health workforce.

### **PA 3: STRUCTURED RURAL TRAINING AND CAREER PATHWAYS (MMM2 – 7)**

#### **Consultation questions for PA 3:**

##### ***3.1.a: What are the key strategies, considerations and feasible timeframes for provision of comprehensive allied health training in rural areas for:***

- i. full year training?*
- ii. full course training?*

See also the ACDHS submission for further detail.

It is not always viable or ideal to provide fully rurally-based programs. Barriers exist to the implementation of both one year and full course training in the regions that need to be taken into account in further allied health program development. For example:

- Considerations about full year and full course training for students must take into account the many different disciplines that lie within allied health. Not all are amenable to full course – or even full year – immersion training in rural areas. Identification of which allied health disciplines this type of approach may work for and the development of customised approaches is required. Serious consideration is also needed regarding effective funding models to support approaches where all or a significant duration of education and training occurs rurally. UA recommends further consultation with ACHDS regarding this.
- Regional universities and the RHMT program have already increased access to rural allied health education and is contributing to workforce distribution. Despite these activities and their associated education infrastructure, students from more distant rural, and especially remote, areas still have to move to study – often hundreds of kilometres – to other rural locations where relevant education infrastructure exists. Offering full course or full year allied health training will not address this issue.
- There are not always sufficient student numbers to make it feasible to run a whole university course for local students in a regional university or an associated facility. It may be possible to run more locally relevant, low number courses with top-up funding, subsidies and/or incentives from other sources. This could potentially be through blended funding from Commonwealth, state and local government as all arguably have a role in areas of thin markets/market failure. However, full local training still may not always be able to provide the breadth of clinical experience required to deliver the broad scope of practice mandated within allied health degrees as many rural areas lack a full suite of health services.

UA reiterates its recommendation that a multi-pronged approach to rural allied health workforce distribution and education pathways be implemented, drawing on the work that all universities are currently doing to support rural health workforce distribution.

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

UA supports expansion of the JFPP to include allied health students. Considerations in expanding this program to allied health include:

- identifying additional community hosts and more generalised capacity issues of rural communities to provide support and mentoring;
- funding for, and access to, accommodation in rural communities that may already be hosting medical JFPP scholars and/or where accommodation is limited;
- the capacity of allied health students to take on the three-year commitment and to fit in additional, non-clinical placements on top of full-time study loads; and
- the various coordination and collaboration requirements regarding placing an increased number of JFPP students in rural areas.

**3.1.c: Please describe other strategies within the Commonwealth's remit that could be implemented to:**

- i. increase the number of allied health courses and training available in rural locations?
- ii. increase the number of allied health student rural placement opportunities?

See previous responses in relation to point i).

UA strongly supports expansion of the RHMT Program as a mechanism for increasing rural allied health placements. In 2013, UDRH's delivered 23,840 student weeks of rural placements across a range of health disciplines<sup>iii</sup>. The RHMT program is currently under evaluation and UA will provide a written submission to this review in due course. However, current feedback suggests that there is potential to expand the program's focus on allied health. UA recommends that the National Rural Health Commissioner engages closely with the RHMT program evaluation in developing options for rural allied health distribution.

Another strategy to expand rural placements would be to extend the Health Workforce Scholarship Program (HWSP) to include entry-level students as well as already qualified professionals. Such scholarships could support urban-based students interested in "going rural". A number of such students are deterred from rural placements due to the costs which can include: double rental payments (urban-based rent must still be paid while on placement); transport costs of getting to and around their rural placement area; and loss of income from having to absent themselves from any part time work undertaken while studying.

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

See 3.1.c.

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

The role of universities within structured career pathways is to deliver and support quality education. Within the health professions, it is to prepare skilled and competent entry-level/beginning practitioners.

There is clear evidence that certain types of health professional educational experiences, particularly quality rural placements and exposure, increase the likelihood that students will return to these areas to work once qualified. However, many aspects of graduate work destination choice are outside of the remit of universities.

In health professional education, the compulsory clinical education component requires that universities are also actual or potential partners with local health services. There may be scope for universities to expand on this role to work with service partners to increase rural education opportunities, supervision and placement.

One option is through expanding the current DOH funded regional training hubs to include allied health. Through the current hubs, universities: “Identify [medical] students with an interest in practising rurally and facilitate access to networked rural training opportunities at an early stage in their careers”.

A further option is to fund university-health service partnerships. The focus here could be on building capacity in rurally based health services (including in aged, primary and disability care) that currently have limited or no engagement with universities. Universities could work to build supervision capacity and showcase the benefits of students to services. There is good evidence supporting the efficacy of this model in increasing supervision and placement capacity with benefits to clients, service providers and students<sup>iv</sup>.

***3.2.c: What is an appropriate governance model for rural generalist training which also supports skills extension for existing qualified rural allied health workers?***

UA refers the Commissioner to the ACHDS submission on this matter.

***Any additional comments and feedback related to Policy Area 3.***

UA has no further feedback on this area.

## **PA 4: SUSTAINABLE JOBS AND VIABLE RURAL MARKETS**

### **Consultation questions for PA 4:**

***4.1.a: What are the factors that would need to be considered to support the development of Integrated Allied Health Hubs (IAHs) which service regional catchments of Australia?***

Sufficient clinical supervision is a critical factor in the success and viability of the IAAs. UA refers the Commissioner to the ACHDS submission for further details.

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

See response to Q3.2.b. regarding the opportunity to adapt and scale up regional training hubs by expanding their scope to include allied health as well as medical students. Regional hubs already often include collaboration between a university/UDRH, RWA, PHN and LHN.

***4.1.c: How could Government structure funding arrangements to allow the flexibility necessary for regions to manage funding in the way that suits the specific needs of their communities?***

UA refers the Commissioner to the ACHDS submission on this matter.

***4.1.d: What kinds of Commonwealth support for allied health assistants could raise the capacity and effectiveness of rural allied health workforce?***

UA refers the Commissioner to the ACHDS submission on this matter.

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

UA supports expansion of the RHMT program to additional areas and supports the program including a greater focus on allied health and nursing.

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

UA refers the Commissioner to the ACHDS submission on this matter.

**Any additional comments and feedback related to Policy Area 4.**

UA recognises the importance of sustainable employment, adequate positions and career progression to the recruitment and retention of allied health in rural areas. However, many of the above questions lie outside of the remit of UA.

## **PA 5: TELEHEALTH ALLIED HEALTH SERVICES**

### **Consultation questions for PA 5:**

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

UA refers the Commissioner to the ACHDS submission on this matter.

**5b: The difficulties in making changes to the MBS are recognised. In relation to Policy Area 5, are there alternative arrangements not involving MBS that could achieve the same outcomes?**

**Please provide any additional comments and feedback related to this Policy Area.**

UA supports funding in telehealth and for virtual training, including associated equipment, across all universities. It has relevance across Australia – for the current and future health professionals based in urban centres providing the actual service as well as for the health professionals or assistants who will be with the rurally-based patient receiving the service. Universities need to be supported to offer this type of training independently as well as in partnership with health services.

It is important that telehealth is seen as part of, and not the whole solution to rural allied health service access. Excessive dependency on telehealth can actually detract from building up the local rural allied (and other) health workforce base that is required in situ to support and sustain key approaches to education and service delivery - such as supervision capacity, new graduate support, mentoring, research and the like. UA reiterates its support for a multifactorial approach to allied health workforce distribution and increased rural community access to health services and supports telehealth as part of this approach.

In relation to technology and eHealth software and systems: UA has become aware that there are actual or proposed charges levied on some universities for their health professional students to access patient electronic health records while on placement. This is detrimental to the principles of student placement. Using patient electronic health records is an integral and growing part of health care delivery and of the education and training that supports it.

Many of the other policy options suggested under policy area 5 are not directly relevant to universities. However, making allied health services more financially viable, for example through funding allied health telehealth consultations and case conferencing, assists in building capacity for practices to take on student teaching and supervision. Building this capacity is an important part of the workforce pipeline.

Although not directly relevant to telehealth, UA also recommends development of an allied health teaching and supervision Practice Incentive Payment (PIP). Such a payment exists in general practice to support medical student teaching. Expansion of a similar type of payment to allied health practices – about 70% of which are now in the private sector - could help build further supervision capacity.

UA also recommends changes to MBS charging for allied health services provided through Team Care Arrangements (TCAs) and any other eligible allied health MBS payments so that such services can still be

charged if a supervised student delivers part or all of the service. Patient consent for a student to deliver the service would need to be obtained. Currently, MBS arrangements for these services restrict student participation to observation only. This is a missed opportunity for a more comprehensive learning experience to occur and does not fully harness the capacity of practices that are already willing to take students.

### **General question re the overall intent of the discussion paper:**

***Please describe any other options or considerations for the Commonwealth which could affect distribution, quality and access for rural allied health services.***

This submission has offered a range of policy options that collectively assist in enhancing distribution of allied health workforce to rural areas through various education programs and pathways. It is important that whatever programs and policies are put into place include mechanisms for sustainability and recognise the need for ongoing support in areas that are typically thin markets. Investing in sustainability needs to be a key consideration in developing further advice.

## **REFERENCES**

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<sup>i</sup> Allied Health Professions Australia (AHPA) <https://ahpa.com.au/what-is-allied-health/>

<sup>ii</sup> Commonwealth Department of Education: Independent Review into Regional, Rural and Remote Education <https://www.education.gov.au/independent-review-regional-rural-and-remote-education>

<sup>iii</sup> Humphreys J, Lyle D, Barlow V. University Departments of Rural Health: is a national network of multidisciplinary academic departments in Australia making a difference? *Rural and Remote Health* 2018; 18: 4315. <https://doi.org/10.22605/RRH4315>

<sup>iv</sup> Commonwealth Department of Health: TRACS to the Future: Evaluation of Teaching and Research Aged Care Services (TRACS) models. Final Report: <https://agedcare.health.gov.au/tracs-to-the-future-national-evaluation-of-teaching-and-research-aged-care-services-tracs-models-final-report>