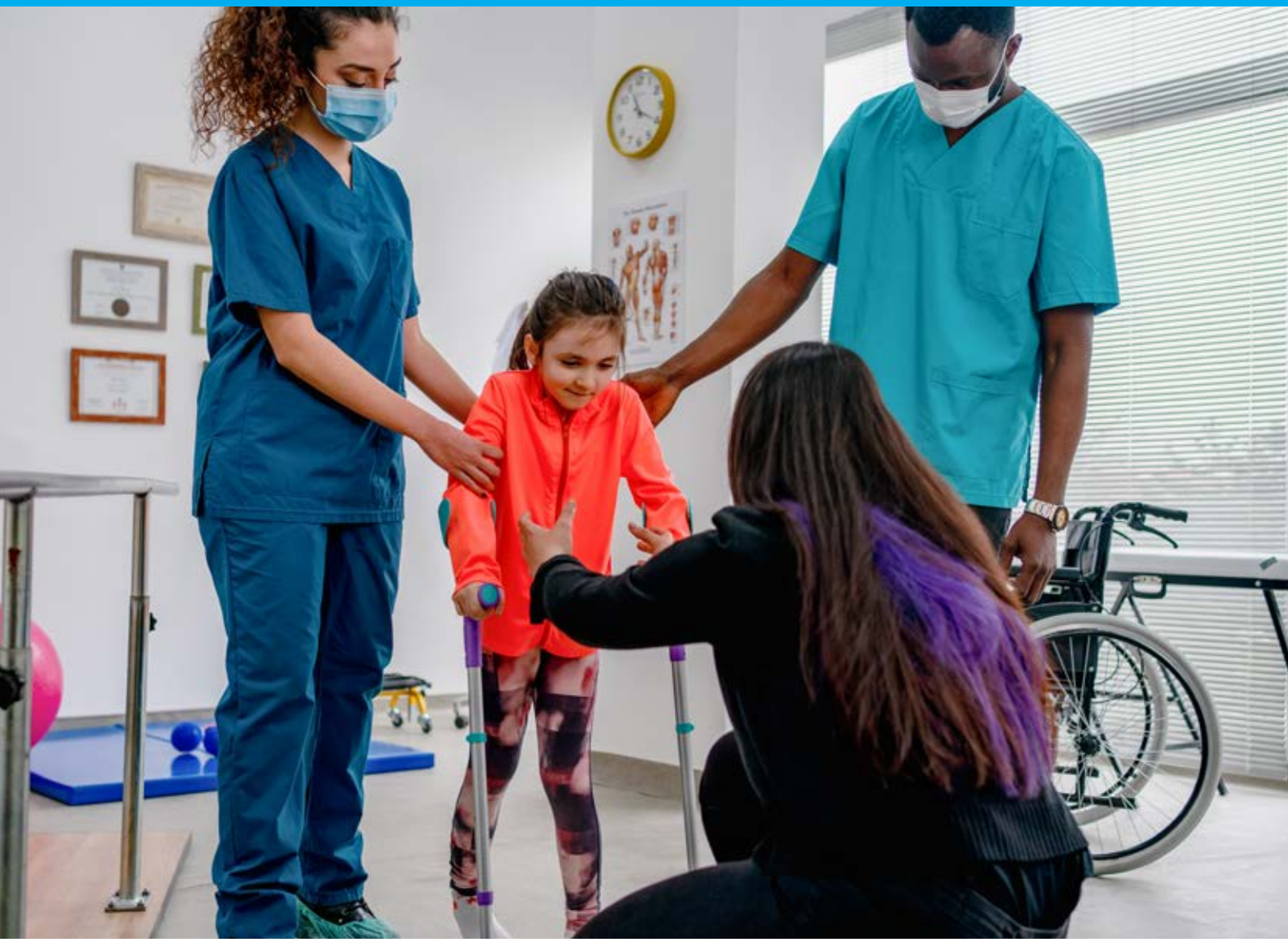
AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Statement from the Australian Physiotherapy Association on Unregulated Allied Health Assistants



APA Position

The Australian Physiotherapy Association (APA) believes that all Australians deserve equal access to safe, high-quality, evidence-based care.

The APA supports Unregulated Allied Health Assistants (UAHA) and acknowledges the key role the care workforce plays when supporting the delivery of a high-quality allied health service to maximise patient outcomes. We acknowledge the importance of developing the UAHA workforce nationally for both the aged care and disability sectors. However, to promote the safe and effective use of this workforce, and in setting role parameters, it is important to note that the UAHA workforce can only complement a therapy program. Unregulated Allied Health Assistants must work under the supervision and delegation of an Allied Health Professional (AHP) to assist with therapeutic and program related activities.

Preamble

Health workforce solutions should aim to build service capacity including in supporting the physiotherapy workforce to strengthen care for all Australians. In reconfiguring the health system, we acknowledge that the health care workforce has diversified, including through the formalised roles for health care assistants as well as the introduction of UAHAs. However, there remains ongoing barriers to their effective use and while the UAHA workforce was introduced over a decade ago a lack of leadership at the national level has led to the unplanned development of specific sectors of the workforce. As a consequence, there are now considerable policy gaps to establishing the role formally within a national health workforce context.

As a key priority, it is important to highlight that in addition to new role development, stronger national policy action is required to strengthen the existing health workforce, including increased access to physiotherapy. Therefore, in gaining a deeper understanding of demand and supply factors for the care and support workforce, there is a need to focus on the development of a national workforce strategy across all professional groups. A lack of allied health national data presents a significant evidence-to-policy gap and this remains a key barrier to workforce planning in establishing workforce supply, distribution and estimation of future workforce needs.

In new role development, professional jurisdiction is key. In protecting discipline scope, it is important to state that the APA will strongly resist any attempts to encroach on discipline-level boundaries by UAHAs or any other discipline. Therefore, in planning and setting role delineation, as these relate to the UAHA workforce specifically, the APA would like to see more emphasis on setting relevant discipline-level boundaries and in defining governance and structure of the role. In the first place, there is a need to define the role to assist in clarifying full definition and scope in the context of the relationship to the AHP. Further, in addition to a defined scope of practice linked to service need, there is a need to clearly define professional and clinical UAHA supervision structures, the delegation framework, and broader skill requirements of the role.

Recommendations

The APA calls on the Commonwealth and state and territory governments to:

1. Develop a national workforce strategy for the physiotherapy workforce, factoring disability and aged care workforce needs.
2. Ensure the introduction of UAHAs into allied health teams protect broader discipline scope and never a substitution for registered physiotherapists.
3. Pursue options to regulate the UAHA workforce through participation in the National Registration and Accreditation Scheme (NRAS).

   Ahpra-level regulation of the UAHA would help to:

   3.1 Define the UAHA role nationally to assist in clarifying full definition and scope in the context of the relationship to the AHP.

   3.2 Clearly define nationally professional and clinical UAHA supervision structures and the delegation framework.

   3.3 Clarify nationally the qualifications, career pathway and levels, and broader skill requirements of the role.

   Key interim measures would need to include:

   3.4 Formal controls so that the scheme that the UAHA is funded by has a registration process.
4. Address the considerable burden of compliance on the AHP due to differing jurisdictional arrangements.

   4.1 Provisions to support the AHP in maintaining Professional Indemnity Insurance coverage.

   For UAHAs in the National Disability Insurance Scheme (NDIS), addressing compliance supports would include:

   4.2 An evidence-based framework that considers AHP registration requirements and any relevant state or territory requirement.

   4.3 Controls to ensure that decisions about delegation remain the responsibility of the AHP.

   4.4 Detailed descriptions of required qualifications and eligible activities for each level.
5. Develop workforce and training policy that include incentivised supports, including for AHP supervision, to support sector growth.

   5.1 Fund a range of training, supervision and support structures with focus on supported learning from entry-level and early career phase to proficient competency levels.
6. Ensure a continued focus on national campaigns to prioritise the diversity of roles within the care workforce.

   In valuing the UAHA workforce:

   6.1 Explore the potential for this workforce to offer an early career entry point to physiotherapy and the allied health professions particularly in rural Australia.

   6.2 Fund a formal national training pathway that includes a scholarship program to both offer an early career entry point via UAHA pathway to build the Aboriginal and Torres Strait Islander physiotherapy workforce.

Background

Policy context
Unregulated Allied Health Assistants are an emerging group in allied health practice with potential to make a valuable contribution to allied health care but there remain ongoing barriers to their effective use.

The APA defines the UAHA as a health care worker who supports the delivery of allied health care by assisting people with personal care and activities of daily living. The provision of such care is delegated and directly supervised by a registered physiotherapist or AHP. While the UAHA is accountable for accepting and carrying out the care delegated to them, it is the registered physiotherapist or AHP who retains the overall responsibility for all delegated activities.

Regulatory controls
The lack of a compliance and enforcement framework with the UAHA sitting outside of the NRAS presents a significant ongoing risk to safety and quality.

It is the absence of the required controls that significantly increases the risk of task substitution and unsafe practice particularly in the disability space. It is not sufficient for UAHAs to be bound by a National Code of Conduct for health workers and/or to fall under the NDIS Quality and Safeguarding Framework when delivering services to NDIS participants. There is a need to pursue options from within Ahpra-level regulation. As an interim measure, controls are needed so that the scheme that the UAHA is funded by has a registration process, similar to the working of the State Insurance Regulatory Authority (SIRA) in New South Wales.

A key issue lies in the ad hoc way health workforce design and planning is approached at both the national and state and territory level. This has led to the need for development of separate frameworks to support UAHA workforce development, and within these separate clinical supervision guidelines have been developed. The APA acknowledges the Commonwealth Government's recent commitment in the $12.3 million care and support workforce package in the 2021-22 budget. This being the first stage of investments to support regulatory alignment reforms across the aged care, disability and veteran-care sectors to create a single care and support workforce.

Task delegation
For the safe and effective use of the UAHA workforce there is a need to formalise principles of delegation at a national level to ensure adequate controls and to direct the required AHP oversight.

It is important to recognise tasks delegated to an UAHA have legal implications and carry indemnity risk with the AHP professionally accountable for the outcome. This is particularly important in the context of profit-driven strategies that see large corporate practices preference care by UAHAs over AHPs. The delegation of tasks to an UAHA is determined by the physiotherapist and depends on the knowledge, skills and prior training of the UAHA, the patient's goals and the level of supervision available to support the UAHA. A further key concern lies in compensable bodies and (differing) allowances within those schemes for UAHAs. It is these differing jurisdictional arrangements that add to the existing considerable burden of compliance on the sector.

Factoring costs
A funding structure is needed to recognise the physiotherapist's non-face-to-face investment in patient therapy program whereby components may be completed by an UAHA.

Physiotherapists already spend a large amount of time on management and administration. The ongoing supervision and training role a physiotherapist has when supporting an UAHA to deliver high-quality services is one of the many non-face-to-face services physiotherapists provide. In addition to this, red tape is further increased when working across multiple compensation schemes with changing complexities and time burden. To address this, the APA calls on the Federal Government to explicitly document and fully fund the formal partnership between physiotherapists and UAHAs to improve patient, stakeholder and provider understanding at a national level.

Valuing care work
More policy attention is required to valuing the care work and care and support workers as the key factor affecting the supply in both the near and longer term.

Formal career pathway development is key to growing the care and support workforce. Multiple training pathways will be important. For the UAHA workforce there is a need to address the gap between the current state and the requirements for the future workforce. The development of a career pathway and framework is required to clarify the available entry points and opportunity for movement within and between the various occupational groups by recognition of prior learning and current competence.

Further untapped opportunities include supportive funding models to fully realise the opportunities presented by the UAHA workforce. This extends to training and opportunities to explore this model as an early career entry point for physiotherapy. In meeting the health needs of Aboriginal and Torres Strait Islander peoples, the care and support workforce needs to be culturally safe and responsive to the needs of the community. Increasing the number of Aboriginal and Torres Strait Islander health workers is key to achieving this. For this to occur initiatives need to be put in place to make careers in health both attractive and accessible. A scholarship program would help to both offer an early career entry point via UAHA pathway and build an Aboriginal and Torres Strait Islander physiotherapy workforce.

Conclusion

The APA plays a leading role in shaping the future of physiotherapy through workforce policy solutions to drive contemporary care models and clinical excellence. Inadequate staffing levels, skill mix and training are the key causes of substandard care in the current care system. At this critical point in the policy cycle, we welcome national focused efforts to tackle the ongoing care workforce shortages impacting on quality care for our most vulnerable Australians. If these measures are to support the safe and effective use of the UAHA workforce, more focus is required on national policy setting that can direct regulatory controls to ensure role clarity and the required skill mix to support safely delegated care with appropriate levels of supervision.

Acknowledgements
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