Briefing Paper

Topic: Strengthening the Allied Health Assistant workforce through occupational co-regulation

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OVERVIEW

Allied Health Assistants (AHAs) have the potential to increase healthcare accessibility by both directly and indirectly performing allied health tasks, under the guidance and delegation of allied health professionals.

Despite their significant contribution, AHAs remain underemployed and underutilised, primarily due to employers' uncertainty regarding the risks associated with delegation by allied health professionals, what tasks to delegate and how to incorporate AHAs into their business model. Furthermore, the absence of formal recognition within healthcare funding models presents a challenge in establishing a robust business case for the employment of AHAs. The under-utilisation of AHAs impairs the ability of allied health service providers to meet increasing demand for services in the most efficient way and burdens the health system with the cost of an allied health professional's time, when an AHA may be able to safely provide the service.

The Allied Health Assistants' National Association Ltd (AHANA) seeks to address these challenges by proposing the development of a co-regulation framework for AHAs, co-designed with its industry partners (AHANA organisation members). This framework aims to provide a mechanism for officially recognising and increasing the incorporation of AHAs into healthcare delivery and funding structures, thereby maximising their potential and ensuring their skills are used more effectively.

Key to this proposal is government endorsement, through co-regulation of the self-certification system managed by AHANA. This system not only validates the qualifications (where held) and competencies of AHAs and in doing so, facilitates their eligibility for government funding— either directly (such as through provision of a provider number) or indirectly, through designated care models.

The introduction of such a framework will provide a way for employers to guarantee that their AHAs meet certain standards, while providing funding to ensure a sustainable business model to employ AHAs to deliver components of their work under delegation, thereby encouraging greater employment and utilisation within the healthcare sector.

This paper outlines the need for co-regulation of the AHA workforce in guiding AHANA's development of an industry-aligned proposal for the Federal Government's consideration.

BACKGROUND

AHAs play a vital role in supporting allied health professionals, delivering essential services to diverse patient populations, including older adults, individuals with disabilities, and those transitioning from hospital care.

AHANA, the peak body for this workforce, defines an AHA as *a healthcare worker who has demonstrated competencies to provide person-centred, evidence-informed therapy and support to individuals and groups, to help protect, restore and maintain optimal function, and promote independence and well-being. An AHA works:*

a) *within a defined scope of practice and in a variety of settings, where they actively foster a safe and inclusive environment; and*

b) *under the delegation and supervision of an allied health professional.*

The level of supervision may be direct, indirect or remote and is dependent on the AHA's demonstrated competencies, capabilities and experience.

Despite their importance, AHAs operate under disparate state and territory frameworks, lacking standardised training/qualification requirements and work under multiple Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes which has hampered workforce utilisation, visibility and policy development.

To address these issues, AHANA has established standards for Practicing AHAs which verify the qualifications and experience of those practitioners, as well as a range of other quality measures. AHANA has also been instrumental in lobbying the Australian Bureau of Statistics to assign a distinct ANZSCO code to AHAs through the ANZSCO comprehensive review *Updating ANZSCO: Reflecting a modern Australian labour market*, leading to inclusion of a proposed code for AHAs in the ABS' Preliminary Proposed Changes – Consultation Round 2[1] (currently under consultation).

The value of the AHA workforce

AHAs, when employed effectively, have the potential to increase access to allied health services, decrease waiting times, and deliver care closer to the patient by directly delivering a range of services to individuals and groups, as well as through the delivery of non-clinical roles[2][3] . Some examples of the roles of AHAs include:

- Provision of group and individual speech therapy in schools and communities[4]
- Provision of speech therapy in inpatient rehabilitation[5]
- Functional retraining of hospital inpatients following a stroke[6] [7][8]
- Provision of training for Activities of Daily Living for individuals and groups in an aged care inpatient rehabilitation unit

[1] https://consult.abs.gov.au/standards-and-classifications/anzsco-comprehensive-review-round-2/results/final_consultationround2_preliminaryproposedchanges.pdf

[2] Snowdon, D. A., King, O. A., Dennett, A., Pinson, J. A., Shannon, M. M., Collyer, T. A., ... & Williams, C. M. (2022). Delegation of patient related tasks to allied health assistants: a time motion study. *BMC Health Services Research*, *22*(1), 1280.

[3] Snowdon, D.A., Storr, B., Davis, A. *et al.* The effect of delegation of therapy to allied health assistants on patient and organisational outcomes: a systematic review and meta-analysis. *BMC Health Serv Res* **20**, 491 (2020).

[4] Boyle J, McCartney E, Forbes J, O'Hare A. A randomised controlled trial and economic evaluation of direct versus indirect and individual versus group modes of speech and language therapy for children with primary language impairment. Health Technol Assess. 2007;11(25):iii–v.

[5] Wenke R, Lawrie M, Hobson T, Comben W, Romano M, Ward E, et al. Feasibility and cost analysis of implementing high intensity aphasia clinics within a sub-acute setting. Int J Speech Lang Pathol. 2014;16:250–9.

[6] Cannell J, Jovic E, Rathjen A, Lane K, Tyson AM, Callisaya ML, et al. The efficacy of interactive, motion capture-based rehabilitation on functional outcomes in an inpatient stroke population: a randomized controlled trial. Clin Rehabil. 2018;32:191–200.

[7] Lincoln NB, Parry RH, Vass CD. Randomized, controlled trial to evaluate increased intensity of physiotherapy treatment of arm function after stroke. Stroke. 1999;30:573–9.

[8] Parry RH, Lincoln NB, Vass CB. Effect of severity of arm impairment on response to additional physiotherapy early after stroke. Clin Rehab. 1999;13:187–98.

- Delivery of community based exercise programs to improve mobility Lord 2008[9]
- Provide basic footcare, administrative support, assist in the manufacture of orthotics[10]
- Health promotion and education around foot care[9]

What do we mean by 'occupational co-regulation'?

Occupational regulation is the *legally defined requirements or rules that govern entry into occupations and subsequent conduct within them*. **Co-regulation** is one of four types of occupational regulation (see Attachment 1). In this paper we are use the term co-regulation to be *a certification scheme operated by a profession peak body (e.g., AHANA), where some of the peak body's regulatory functions are delegated from, and/or recognised by, government.* This creates a partnership between government and the peak body, where the latter is carrying out functions on behalf of government.

Co-regulation is generally conditional on the peak body meeting mandated standards in relation to governance and the certification process. Co-regulation can generate significant incentives for members of the occupation to:

- seek and maintain peak body certification; and
- comply with the peak body's standards for ethical conduct and practice.

The purpose of the delegation/recognition could be for allocating funding, provider rebate status, or granting visas.

Examples of Allied Health co-regulation in Australia:

Medicare, NDIS, DVA and the Commonwealth Home Support Program

Currently, many allied health professionals who hold certain classes of peak body certification can access rebates under government funding programs. For example, they may be allocated a provider number which gives them access to funding from certain bodies, such as NDIS, My Aged Care, Medicare, private health insurance, and state-based insurance services. Practising members of Speech Pathology Australia, Dietitians Australia are eligible to become registered providers under Medicare, NDIS and Department of Veterans Affairs. This means the practitioner, or their patients, qualify for funding or rebates. Furthermore, services provided by Certified Practising Speech Pathologists are eligible for Commonwealth Home Support Program funding. However AHAs do not have access to these funding models; thereby limiting the utility of AHA and the optimisation of healthcare services.

Assessing Authorities for immigration purposes

There are peak bodies which been appointed as assessing authorities by the Australian Government Department of Home Affairs (Immigration and Citizenship). Assessing authorities are tasked with the assessment of the skills, qualifications and/or work experience of prospective migrants who believe they are qualified in an occupation on the Skilled occupations list. For example, the Australian Society of Medical Imaging and Radiation Therapy, the Australian Orthotic

[9] Lord S, McPherson KM, McNaughton HK, Weatherall M. How feasible is the attainment of community ambulation after stroke? A pilot randomized controlled trial to evaluate community-based physiotherapy in subacute stroke. Clin Rehabil. 2008;22:215–25.

[10] Farndon, L., & Nancarrow, S. (2003). Employment and career development opportunities for podiatrists and foot care assistants in the NHS. *British Journal of Podiatry, 6*(4), 103-108.

Prosthetic Association, Dietitians Australia, and Speech Pathology Australia are assessing authorities.

It is in the interests of governments to support profession peak body certification schemes where they have the capacity to improve the safety, quality and competence of the health workforce. Governments also have an interest in ensuring the most cost-effective use of limited health funding and can use these certification schemes to promote the most efficient and effective division of labour in healthcare. For instance, AHAs working under the supervision of an allied health practitioner may be able to deliver a range of low risk, or routine, clinical services which enables allied health professionals to see expand their services, and/or provide more complex services. However, this relies on the availability a skilled and competent AHA and allied health professional workforces.

What is the role of AHANA in occupational co-regulation of allied health assistants?

Co-regulation for the AHA workforce is essential. Using co-regulatory partnerships with government agencies to recognise, formalise and finance the important role of AHAs within an allied health delegated model of care has the potential, not only to strengthen the quality of the services provided by AHAs but also to:

- support allied health professionals to delegate more work to AHAs within a formal framework that optimises the expertise of the allied health professional, while increasing their capacity to provide services, and
- increase the capacity of resource-constrained allied health services, to better meet the health needs of the population.

There are multiple options for AHA co-regulation:

1. Recognition of AHAs as a service provider with a specific, funded service item number. For example if a podiatrist wants to employ a podiatry assistant to deliver some aspects of client care, they would be able to receive funding from an insurer (Medicare, DVA, Private Health Insurance) to support those costs in the form of a specific “AHA” item number that reimburses the clinician (either the podiatrist or the AHA) for delivery of care using an AHA in a fee-for-service funding model.
2. Recognition of AHAs as a service provider within the model of care. For example, a podiatrist employing a podiatry assistant to deliver some aspects of client care would receive funding from an insurer (Medicare, DVA, Private Health Insurance), when the AHA is recognised as part of the model of care.
3. Restricting reimbursement for AHA services to credentialed Practising AHAs only.
4. Provision of a tiered funding model that recognises different levels of credentials for AHAs; with higher level credentials attracting higher funding levels. For example, AHANA require a Certificate IV qualification (i.e., Australian Qualifications Framework Level 4) for *Certified* Practising AHAs; whereas, *Provisional* or *General* Practising AHAs require a Certificate III qualification (i.e., Australian Qualifications Framework Level 4).

AHANA's certification scheme ensures quality care, public safety, professional ethics, and continuous professional development among AHAs. Recognition by government programs would bolster public confidence in AHAs and increase their employability and funding opportunities. AHANA carries out important quality assurance functions that aim to:

1. **Enhance quality of care:** The primary goal is to help ensure AHAs deliver high-quality care. Standards set by AHANA define what good AHA practice looks like and provide a benchmark that all practising AHAs are expected to meet.
2. **Protect public safety:** Certification by AHANA helps to ensure that AHAs have the appropriate skills and knowledge to carry out their roles safely. This is particularly important as AHAs often work with vulnerable populations, including people with disabilities, the elderly, and those recovering from illness or surgery.
3. **Maintain professional ethics:** AHANA aims to uphold professional ethics, helping to ensure that AHAs conduct themselves in a manner that is respectful, responsible, and in the best interests of their patients/clients.
4. **Promote continuing professional development:** AHANA membership provides a structured way to support ongoing learning and development, which is critical in a fast-evolving field like healthcare. By setting requirements for mandatory continuous professional development, AHANA membership (and certification of non-member AHAs who meet the same standards) helps ensure that AHAs keep their skills and knowledge up-to-date.
5. **Ensure accountability:** AHANA membership and certification of non-members ensures professional accountability by providing mechanisms for handling complaints and carrying out disciplinary actions when necessary. It can protect both the public and the occupation by dealing with individuals who fail to meet the established standards.
6. **Instil public confidence:** Certification of members and non-members should enhance public confidence in AHAs. Knowing that the occupation is governed by a set of clear standards and is under the oversight by external body representing the occupation can increase trust in the services provided by AHAs.

Attachment 2 provides details of AHANA's AHA certification program.

By strengthening co-regulatory partnerships with government agencies, AHANA's certification program can enhance the quality and quantity of allied health services. AHANA's Practising AHAs, recognised under government programs, would facilitate more efficient division of labour within healthcare, allowing allied health professionals to focus on assessment and complex cases while AHAs are delegated routine tasks. AHA co-regulation will help address unmet needs in the community, improving patient access to healthcare by providing cost effective and efficient services.

Next steps

Government co-regulation of AHAs is essential for standardising the profession, enhancing workforce visibility, and ensuring equitable access to funding and employment opportunities. By recognising AHANA's certification program, governments can promote quality healthcare delivery, optimise resource utilisation, and meet the evolving needs of the population.

To achieve co-regulation, dialogue between AHAs, their employers, allied health professionals, government stakeholders, and funders is crucial. Proposed models include recognising AHAs as service providers with specific funding item numbers and restricting reimbursement to AHANA's Practising AHAs. However, considerations such as award structures, funding mechanisms, and healthcare financing reforms must be addressed.

Attachment 1: Typology for defining types of occupational regulation for the health workforce

Certification (non-statutory)

Under a certification scheme, there is no underpinning statute enacted by government that confers powers on a regulator to license members of the profession or occupation. Rather, practitioners join together to establish an association with a constitution, bylaws and rules for its members. The association may be registered as a body corporate under the relevant law of a country.

On joining the association, a practitioner member agrees to abide by the rules of the association and its code of ethics, and their name and other details will generally appear on a web-based register maintained by the association. The association may also operate a consumer complaints mechanism and the rules may provide for members to be expelled for serious breaches of the code of ethics. However, the system is voluntary – practitioners can choose not to join the association and still practice, and they can continue to practise if expelled from the association for reasons of misconduct.

A variation on this model is where the entity that maintains the practitioner register may be initiated by the professional association but established as a separate legal entity, with a specific mandate to carry out regulatory functions on behalf of the profession. While there is organisational separation of the regulatory functions from the membership representation and advocacy functions, the arrangements continue to be entirely voluntary. Consumers, insurers and health service providers may rely on information provided by the register of practitioner members for trusted advice about who is qualified to practise the profession, but there is no direct involvement or recognition from government.

Co-regulation (various models)

Co-regulation is like certification. The key difference is that some of the functions of the self-regulating professional association may be either delegated from or recognised by government. This government recognition or delegation may be conditional on the certification body meeting specified standards in relation to governance and its certification standards and processes. This recognition process establishes, in effect, a partnership between government and the certifying body and the benefits that flow to practitioners from certification create incentives for practitioners to comply with the professional association's standards.

Negative licensing

Under a negative licensing scheme, there is no legal barrier to entry to an unregistered profession – anyone can practice, no matter what their level of training or skill. However, a law is enacted that provides a mechanism for a statutory regulator to receive and investigate complaints that a practitioner has engaged in 'prohibited conduct' or breached minimum standards of practice enacted under a statutory 'code of conduct'. The regulator may issue a prohibition or banning order to remove a practitioner from practice when the regulator finds the practitioner has committed an offence, breached the code or engaged in prohibited conduct and their continued practice presents a serious risk to the public. There may be offences for breach of a prohibition order and an online searchable public register of prohibition orders issued.

Statutory registration or occupational licensing

Under a statutory registration or occupational licensing system, the purpose and functions of the system are not determined by the profession alone (as in the case of non-statutory certification schemes) but are generally set out in legislation or another instrument of authority and are subject to public scrutiny (through the responsible parliament and minister). The legislation establishes a regulatory body with powers to register or license and regulate practitioners. Entry to a regulated profession is limited only to those the regulatory body considers to be properly qualified and of good character. This gate-keeping role is underpinned by statute, with powers for the regulatory body to prosecute unregistered persons who pretend to be qualified to practise in the profession when they are not. The statute provides an effective mechanism for restricting entry to the profession and disciplinary powers to deal with practitioners whose practice falls below an acceptable standard.

There are two distinct regulatory mechanisms found in statutory registration schemes: *reservation of title* and *reservation of practice*. While many registration laws contain provisions that prohibit an unregistered person from using a reserved professional title or pretending to be qualified and registered when they are not (reservation of title), some laws go further – they prohibit an unregistered person from providing certain types of clinical services (reservation of practice). Reservation of practice provisions can create an exclusive scope of practice, in effect a monopoly, for the profession or occupation concerned.

Source: Lin et al., WHO Global Guidance on Health Practitioner Regulation: A large scale rapid review of the design, operation and strengthening of health practitioner regulation systems (2022) (in print)

Attachment 2: AHANA membership – Structure and Standards

AHANA membership classes

AHANA has developed well-defined standards for its membership structure:

- Practising Members
- Student Members
- Associate Members
- Organisation Members
- Non-Practising Members
- Life Members

AHANA recognition of credentials

AHANA recognises credentials of AHAs:

- through Membership (see Section 1 below); and
- non-members who meet recognised standards (see Section 2 below)

Section 1:

The entry requirements for each membership class, based on qualifications and/or experience, are as follows (from AHANA Membership Rule 1):

Membership	Credentials / qualifications	Practise requirements	Insurance Cover available	Competency determination required Y/N	Conditions
Practising Member (Provisional)	Currently practising as an AHA, endorsed by AHP supervisor	Nil	Yes	No	Nil
Practising Member (General)	Certificate III/IV/Diploma in AHA	Nil	Yes	No	Nil
	Evidence of equivalent qualifications provided (Clause 5.2)	Determination by Board	Yes	Yes	Nil
	Recency of practice evidence provided.	3 years FTE	Yes	No	1. Available for 3 years ONLY from date approved by Board.
Practising Member (Certified)	Certificate IV in AHA	3 years FTE	Yes	Yes	Nil
	Diploma or above in AHA	1 year FTE	Yes	Yes	Nil
	Evidence of equivalent qualifications provided (Clause 6.2)	Determination by Board	Yes	Yes	Nil
Non-Practising Member	Previously held Practising (General or Certified) membership	No	No	No	1. If practising, must apply for Practising Membership

Student Member	Enrolled in Certificate III/IV/Diploma in AHA \	No	No	No	1. Membership can only be held for duration of study 2. If practising, must apply for Practising Membership instead
Associate Member	Not required	NO	NO	NO	1. If practising, must apply for Practising Membership.
Life member	Board determination of outstanding service to the AHA profession over an extended period	NO	NO	NO	1. If practising, must apply for Practising Membership.
Organisation Member	Meets the requirements of Clause 11.2 of By-Law 2022-01	NO	NO	NO	Nil

Section 2:

The following is clause 13 from the AHANA Membership by-law:

13. Recognition of the credentials of non-members

13.1 A person may apply under this Clause 13 for assessment of their credentials against the requirements for Practising Member (General) or Practising Member (Certified) classes of membership approved and published by the Board under Clause 3 of this By-law.

13.2 A person who applies for recognition of their credentials under this Clause 13 is not required to apply for or hold membership of the Association.

13.3 On payment of the required Fee, the Board may assess and determine an application under this Clause 13 and issue written advice on whether the person's credentials meet the requirements for membership as a Practising Member (General) or Practising Member (Certified).

13.4 A person who applies under this Clause 13 and meets the credential and other Practising Member (General) requirements from Clause 5 of this By-law is eligible for membership of the Association under Clause 5 of this By-law, on payment of the required Fee.

13.5 A person who applies under this Clause 13 and meets the credential and other Practising Member (Certified) requirements from Clause 6 of this By-law is eligible for membership of the Association under Clause 6 of this By-law, on payment of the required Fee.

Compliance requirements

To retain membership, AHANA members must comply with the AHANA:

- Code of Conduct
- Continuing Competence Requirements

The AHANA Continuing Competence Requirements incorporates CPD requirements, recency of practice requirements, and standards for those who are resuming practise:

CPD requirements:

4.1 Subject to Clause 8 of this By-law, all Practising Members must complete **at least 20 hours** of CPD each membership year. The CPD undertaken should:

a) be focussed on improving patient outcomes and experiences;
b) draw on the best available evidence, including well-established and accepted knowledge that is supported by research where possible, to inform good practice and decision-making;
c) contribute directly to improving competence (performance and behaviour) and keeping up to date in the AHA's scope and setting of practice;
d) build on existing knowledge;
e) include a **minimum of five hours'** CPD in an interactive setting with other AHAs and/or AHPs;
f) include a **minimum of four hours'** CPD focussed on responding to and supporting Diversity through practise, with no less than **two hours'** CPD focussed on Indigenous cultural responsiveness; and
g) include **at least four** of the CPD hours related to professional issues.

Recency of practice

5.1 Subject to Clause 8 of this By-law, to maintain recency of practice, all Practising Members must complete a minimum of:

a) 450 hours of practice in the previous three years, or
b) 150 hours of practice in the previous 12 months.

5.2 This requirement applies to all AHAs who hold practising membership, except for newly graduated AHAs who are applying for membership for the first time.

5.3 When applying to renew a practising membership, each member must make a declaration about whether they have met the recency of practice requirements under this By-law, during the previous membership year.

Resuming practice

5.4 Where a member is resuming practice after a break of more than three years, they must satisfy Board that a supervision plan is in place that is sufficient to ensure the member's successful return to safe and competent practice.

Certification requirements

Every application for an AHANA membership contains a mandatory declaration, with the contents of the declaration dependent on the type of application submitted.
The certification process requires the applicant to declare any issues that may affect their suitability to practise, including (for example) serious criminal charges and criminal history.