Chapter 6

The factors affecting the supply of speech pathologists in Australia and some options to address shortages

6.1 This report has focused on the inability of people with a range of speech and language disorders, at all stages of life, to access adequate speech pathology services when they most need these treatments. This chapter considers various options to address this issue commencing with discussion of the factors that determine access to speech pathology services in Australia:

- the level of funding for public speech pathology positions;
    - public funding that is flexible, able to be accessed early in a person's condition, and able to facilitate developmental outcomes;
- the level of funding for individuals to access private speech pathology services;
- funding for initiatives that promote community awareness and support for speech pathology services;
- the number and quality of speech pathology graduates from Australian universities;
- the system in place to train speech pathologists, including options for clinical placements;
- the ability of graduates to find work and secure meaningful professional development opportunities, particularly in the community health sector;
- the deployment of new graduates (where they find work; public or private, geographic location)
- the level of funding for clinical research to support the case for, and method of intervention and the standing of the profession; and
- the way in which speech pathologists are employed within the education, health, the aged care system and the correctional services system.

6.2 Submitters and witnesses to this inquiry put views and recommendations to the committee on all these issues. There was general consensus that greater funding is needed, particularly for public speech pathology services. The central argument is that this funding is important not only to meet the growing demand for these services in a fair and equitable way; it is also crucial to provide training opportunities for students and a career structure and professional development opportunities for graduates.

Publicly funded speech pathology positions

6.3 Several submitters identified the supply problem—and its solution—in terms of the shortfall in the number of publicly funded speech pathology positions. As the President of Speech Pathology Australia, Professor Deborah Theodoros, told the committee:

> There is really no delicate way to say it: there are just not enough public funded speech pathology positions. We do have an established private speech pathology sector but this should not be the only option for the Australian people, and most of the time it is. For those who cannot pay for private services they go without or they languish on long public waiting lists, to find that by the time their name comes up their condition has worsened or their child no longer meets the age eligibility.[1]

6.4 Several witnesses drew attention to the consequences of the current shortfall in funding public speech pathology positions. Professor Elizabeth Cardell is the Director of a new speech pathology program at Griffith University's Gold Coast Campus. She expressed support in her submission for the increase in Commonwealth-supported places in university programs and Health Workforce Australia funding to support growth in clinical placements. However, she noted that there had been no commensurate increase in publicly-funded speech pathology positions or services. As a result, Professor Cardell argued, sourcing clinical placements for student training has been increasingly challenging and competitive, and the employment opportunities for graduates are becoming more limited. She cited a survey by the Queensland Speech Pathology Clinical Education Collaborative which indicated that the market place for clinical placements in Queensland will be saturated by 2016.[2]

6.5 Associate Professor Patricia McCabe, Associate Professor Kirrie Ballard and Dr Natalie Munro wrote of the 2010–2011 national survey of parents of children with speech and language disorders:

> …paediatric services are inadequate in many areas of Australia, primarily due to lack of funding. It appears limited funding is being rationed by service providers so that school aged children and adolescents are not receiving services and all children receive less service than their parents believe they need and far less than the research suggests they require.[3]

6.6 Ms Elizabeth Forsyth of the not-for-profit organisation, Northcott, told the committee that the model for funding speech pathology services currently appears to be the driver for accessing services, rather than an assessment of need. She added:

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1 *Committee Hansard*, 11 June 2014, p. 2.

2 *Submission 213*, p. 2.

3 *Submission 85*, p. 2.

> We also see that there is an ongoing, and will be an increasing, unmet need for speech pathology services and that the demand for services will continue across the board. We actually see that there are particular cohorts of people who currently have really limited access to funding or no access to funding. Of particular concern to us are children who have lower level communication needs and who do not necessarily have a disability diagnosis and therefore access to funding to get some assessment or some support.[4]

6.7 SPA recommended that the Commonwealth Department of Health provide access to specialist speech pathology support via the Medicare Benefits Schedule, across the lifespan, for individuals with communication and swallowing disorders (see below).[5]

6.8 In its submission to the inquiry, Carers NSW made several recommendations aimed at increasing access to speech pathology services. These included proposals:

- to increase the Medicare subsidy of speech therapy services for children with disability;
- that public speech therapy services be increased to meet demand and that a priority system be introduced for children close to school age; and
- that additional financial support be provided to remote families facing high travel costs to access speech pathology services.[6]

6.9 Many submitters to this inquiry emphasised the need for better funding of speech pathology services within the public education system. Chapter 5 of this report has highlighted the fact that in New South Wales, Western Australia, the ACT and the Northern Territory, there are no speech pathologists attached to schools. But even in states where there are, submitters expressed strong concern with the growing number of children who require speech pathology but are unable to get timely access to these services. SPA noted that:

> In Victoria some schools purchase private speech pathology input, as Department of Education and Early Childhood Development speech pathologists are often unable to give direct therapy support to the majority of students who need it. The involvement of specialist therapists may even be limited where there is a significant and obvious need for their involvement.[7]

4 *Committee Hansard*, 11 June 2014, p. 1.

5 *Submission 224*, p. 13.

6 *Submission 87*, p. 1.

7 *Submission 224*, p. 36.

The frequency and flexibility of public funding

6.10 An accompanying argument, put by several submitters, is that there needs to be funding for public speech pathology services to ensure access early in a person's condition, and at key times throughout their condition. SPA, notably, made several recommendations that emphasised the importance not only of what could be accessed and by whom, but when and how this access needed to occur. In this vein, it made the following recommendations:

> The Commonwealth Department of Health provide access to specialist speech pathology support via the Medicare Benefits Schedule, across the lifespan, for individuals with communication and swallowing disorders, allowing that:
>
> (a) the number of sessions provided be based on evidence with respect to intervention effectiveness
>
> (b) services be flexibly delivered, such as via direct (in clinic), out of clinic (e.g., home based), indirect (e.g. training of a parent or carer) or telehealth services;
>
> (c) the range of conditions not be limited to only specific disability groups (e.g. Autism or conditions under the Better Start for Children with Disability), but include recognised specific communication impairments, such as, but not limited to, severe language disorder, childhood apraxia of speech, cleft palate, stuttering, voice, aphasia.
>
> (d) medical specialists (ie paediatricians, ENT) be accorded direct referral to speech pathology rights (for all Medicare items applicable to speech pathology)
>
> (e) general practitioners be accorded referral rights to speech pathology as a single discipline under the Chronic Disease Management items, without the person requiring the services of another health professional, as currently is required.[8]
>
> The Commonwealth Department of Health provide flexible and sustained funding options which will provide support to maintain and optimise a person's functioning including communication during episodic events of heightened need at different stages, as well as providing life-long support through to end stage care.[9]
>
> The Australian Government should mandate use of a revised aged care funding tool that adequately identifies communication and/or swallowing disorders and provides funding for comprehensive assessment and management by a speech pathologist if indicated. This must ensure provision of funding for periodic review or follow-up as required.[10]

8 *Submission 224*, p. 78.

9 *Submission 224*, p. 60.

10 *Submission 224*, p. 69.

> The Department of Health provide funding based on episodes of care for evidence-based intervention programs for adults with persistent communication disorders e.g. stuttering; and adults with progressive communication disorders, eg Parkinson's disease.[11]
>
> Individuals with head and neck cancer have access to publicly funded speech pathology services at all stages of the cancer pathway.[12]

6.11 Other submitters emphasised the need for more publicly funded consultations. Speech Pathology Tasmania, for example, recommended that:

> Medicare's Chronic Disease Management Plan must be extended to 10 visits per year. Communication problems that are part of a 'chronic disease' are always more complex than can be addressed in just five sessions annually.[13]

Direct funding to support private speech pathology options

6.12 Another avenue to increase access to speech pathologists in Australia is to provide financial assistance for people with speech and language disorders to visit private speech pathologists. One example of this type of assistance is the New South Wales Government's *Better Start for Children with Disability* initiative (Better Start). Introduced on 1 July 2011, Better Start is funded by the Commonwealth Department of Social Services. It provides the families of eligible children with disability with up to $12 000 to purchase early intervention services, treatments and resources delivered and recommended by registered service providers. To be eligible for Better Start, a child must have a diagnosis of a limited range of disabilities and be registered before six years of age. Families have until the child turns seven to access the funding, and a maximum of $6,000 can be spent per financial year.[14]

6.13 Carers NSW recommended in its submission that registration for Better Start should be simplified and streamlined and more broadly promoted in the speech pathology community to increase the range and diversity of providers. It argued that:

> …given the high cost and necessary frequency of speech therapy sessions, as well as the higher fees applied to Better Start participants, the annual cap of $6 000 and total cap of $12 000 may limit the benefits that this intervention could provide to children and their families. For example, at $150 per session, a child's entire yearly allocation could be used up on weekly speech therapy services, and their total funding exhausted after two years.[15]

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11 *Submission 224*, p. 79.

12 *Submission 224*, p. 51.

13 *Submission 259*, p. 7.

14 *Submission 87*, p. 1.

15 *Submission 87*, p. 2.

6.14 Ms Rosie Martin, Senior Speech Pathologist at Speech Pathology Tasmania, expressed her support for both the Better Start and the *Helping Children with Autism* (HCWA)[16] initiatives. She argued that both these Commonwealth programs have 'greatly and respectfully improved parent-choice-driven therapy options for those children who qualify'. Indeed, Ms Martin put the case for extending the funding available through these programs:

> From a communication growth point of view, many children are just reaching the 'acceleration' phase of their intervention programme when the funding expires. These schemes need to be extended, and/or coordinated with the NDIS so that they continue for another two to three years. This would bring children through, with ongoing support, to the point at which they tend, in any case, to make their own choice to have a break from therapy in the pre-adolescent and early adolescent years. This extension of financial support to families would greatly improve the options for treatment of children with social communication problems who are having trouble making friends at school. These troubles begin to surface most painfully at about the age that the [DSS]funding currently expires.[17]

6.15 Similarly, Early Childhood Intervention Australia (ECIA) argued the need to broaden access to children's speech pathology services, such as those funded through Better Start and HCWA, prior to the introduction of the NDIS. It stated:

> The shortage of speech pathology services for very young children across the country has been clearly demonstrated through the implementation of the new funding initiatives introduced by the Australian Government five years ago. These initiatives are based on diagnosis and only a small number of disability groups are eligible. Children with other types of disabilities are excluded from this funding known as Helping Children with Autism and Better Start. It is critical that this shortage is addressed prior to the full introduction of the National Disability Insurance Scheme, which will supercede these [DSS] funded services. A significant increase in demand is expected when the diagnostic criteria will be expanded so that all children with any type of disability or developmental delay will be eligible for early childhood intervention services based on the principle of reasonable and necessary supports.[18]

6.16 Northcott's submission emphasised that funding should be based on an individual's need rather than setting funding amounts based on diagnoses within programs. It was critical of the HCWA program for failing to identify the individual's need. In contrast, Northcott strongly supports the roll-out of the National Disability

16 The HCWA program provides all children with Autism under 7 years of age access to $12 000 funding for allied health therapy services, regardless of their level of need.

17 *Submission 259*, p. 8.

18 *Submission 256*, p. 2.

Insurance Scheme (NDIS) given that the scheme will provide access to speech pathology services based on actual need.[19]

6.17 The NDIS is expected to be fully rolled out by 2018–19. As chapters 4 and 5 noted, the scheme has an individualised funding model. It will give funds to an eligible person with disability to spend on services and equipment according to their needs and life goals.

6.18 The NDIS will provide a significant injection of funding for speech pathology services. As Dr Ken Baker, the Chief Executive of National Disability Services, noted:

> Although it is difficult to predict how many additional speech pathologists will be required as a result of the NDIS, the investment in early invention services for young children with disability will certainly increase (as the scheme seeks to reduce its future liabilities). Early intervention services will be available to many more children than currently receive them and these services will be available at a higher intensity…
>
> Increased demand for speech pathology will also arise from the NDIS improving the access that adults with disability have to therapy services. In the case of speech pathology, it is expected that some adults with long-term disability will have improved access to communication services and equipment, and to services such as the treatment of swallowing disorders (dysphagia). Assessing and treating communication disorders improves a person's quality of life and improves their ability to participate in the community and to work; diagnosing and treating dysphagia reduces the incidence of chest infections and pneumonia. Appropriate access to speech pathology services will, therefore, improve people's lives and reduce acute health care costs.[20]

6.19 However, the individualised funding model of the NDIS, and the planned departure of state governments from their current disability service obligations, has raised some concerns. SPA noted:

> As states such as NSW wind up their state-based disability support systems, we are very concerned about gaps that will not be filled by NDIS, leading to further disadvantage for people with a disability. Our members have reported that there are likely to be gaps in availability of speech pathology support, particularly in rural and remote areas. There is a high administrative burden associated with coordinating supports that do not fit the direct one-to-one service approach for which the NDIS is mostly suited. For example, models of service that have been successfully implemented in the past (such as fly in-fly out services providing to a number of people in the same town) will be more difficult to implement because each participant under the NDIS has a separately developed, individual plan. Thus a

19 *Submission 190*, pp 5–6.

20 *Submission 180*, pp 1–2.

> therapist who would like to offer a satellite service to several NDIS participants in the same town would need to coordinate travel time allowances being split across each individual plan equally, in order to provide the service. This can place an administrative burden on the therapist which may compromise the provision of the service.[21]

6.20 SPA recommended that the Department of Social Services undertake a review of NDIS and state based disability services now; in 12 months; and then 24 months, to consider if people with specific communication or swallowing disabilities who are not deemed eligible for NDIS support have 'fallen between the gaps'.[22]

6.21 SPA told the committee that the advent of the NDIS will increase demand for speech pathology services in Australia. However, it argued that there are adequate numbers of speech pathologists to meet this demand. It did qualify this confidence by noting its concern with the risks to retention and recruitment to the sector as a consequence of the transition to the NDIS:

> State funding withdrawal, focus on individualised funding, shift to NGO and private provider service provision paradigms, loss of career structure, loss of clinical supervision, loss of training and professional development opportunities, erosion of clinical governance structures, loss of communication access and community capacity building programs and services. SPA believes addressing these risks to retention and recruitment of speech pathologists as providers to participants of the NDIS is of particular importance in speech pathology because health, education and the private sector are all competing employers.[23]

Recommendation 5

6.22 The committee recommends that the federal Department of Health work with the National Disability Insurance Agency to develop a position paper on the likely impact of the National Disability Insurance Scheme (NDIS) on speech pathology services in Australia. The paper should consider:

- **the possible impact of the NDIS on the demand for speech pathology services in Australia, and the likely drivers of this demand;**
- **the need for greater numbers of trained speech pathologists as a result of increased demand for speech pathologist services arising from the introduction of the NDIS;**

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21 *Submission 224*, p. 74. See also the comments of Mrs Robyn Stephen, Speech Pathology Australia, *Committee Hansard*, 11 June 2014, p. 7.

22 *Submission 224*, pp 13, 75.

23 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 5.

- **the need for the speech pathology profession to develop telehealth practices to cater for NDIS participants requiring speech pathology services; and**
- **concerns that the withdrawal of State funding for speech pathology services in anticipation of the NDIS may leave some people worse off if they are ineligible to become an NDIS participant.**

The position paper should be circulated to key stakeholders for consideration and comment and to assist in decision making.

Community capacity building

6.23 A third avenue through which to facilitate greater access to speech pathology services is to fund initiatives that promote community awareness and support of these services. This is known as 'community capacity building'. SPA, for example, recommended in its submission that:

> The Department of Social Services and the National Disability Insurance Agency (NDIA) extend funding beyond individual support for persons with disability, to include sustaining services that reduce barriers to participation and promote community awareness and support. This should include training in communication disorders for NDIS staff and those employed as NDIS Planners.[24]

6.24 Ms Forsyth of Northcott argued that while the NDIS may resolve some of the issues around equity and access to funding, there also needs to be funding for 'a community capacity building approach' for speech pathology services. As she explained:

> While there will always be a need for individuals to have access to funding to support their individual needs, we think there is a big need for adequate funding and resourcing so that there can be an approach that targets the community and community members, particularly in school and education settings. The focus of the speech pathology intervention or service would be around building the skills and the capacity of those teachers, the staff or those key community members to identify communication needs and respond on a holistic level, building a much more inclusive environment for kids, particularly for those kids with lower level communication skills who would benefit from early intervention or some assistance at the early stages in order to decrease their need for more formal or costly supports later in life.
>
> That is a gap that we see in the system. We operate some and in our submission we point to an example of our SPOT in Schools program. That is one example of a program in this space that has been effective. But we really do not see an ongoing funding source or an identified area of need

24 *Submission 224*, p. 75.

> that says speech pathology is not just going to be about an individual funding, assessment and intervention approach but should look at a skills development and community capacity building approach to provide some broader scale supports in the community.[25]

The challenge of training speech pathologists

6.25 As this chapter has discussed, a key challenge facing the speech pathology profession is to attract public funding that will ease the pressure on waiting lists and meet the significant backlog of demand for public speech pathology services. While meeting this demand is imperative, funding for public speech pathology positions is also important to provide clinical placements for students and employment and professional development opportunities for graduates. The following section looks at the number of speech pathology students in Australian universities over the past decade and the numbers graduating.

Box 6.1: Training speech pathologists

Speech pathologists complete a degree at university covering all aspects of communication including speech, writing, reading, signs, symbols and gestures. Currently, there are 15 universities offering 24 speech pathology programs.

Courses are either a **four year undergraduate bachelor's degree** or a **two year entry level Masters' degree** (where there is a bachelor's degree requirement in a related discipline). **Charles Sturt University**, for example, offers both a Bachelor of Speech and Language Pathology and a Master of Speech Pathology. Students graduating from both courses must meet the same competency standards. **Griffith University** has recently introduced a Master of Speech Pathology at its Gold Coast Campus. Pre-requisite degrees for this course include health science, linguistics, medical science, psychology, public health, education, and nursing.

There are **clinical placements** in the third and fourth years for undergraduate students and in both years for students in the two year Master's course. Speech Pathology Australia is the peak professional body that represents speech pathologists in Australia and has a role in accrediting university programs that train speech pathologists.

Source: http://www.speechpathologyaustralia.org.au/information-for-the-public/frequently-asked-questions

25 *Committee Hansard*, 12 June 2014, p. 1. See also Northcott, *Submission 190*, p. 6.

Commencements, enrolments and completions for 2005–2012

6.26 The committee requested data from the federal Department of Education on the number of students commencing, enrolled in, and actually having completed an undergraduate or postgraduate qualification in speech pathology at an Australian university between 2005 and 2012.[26] These data are shown in Tables 6.1–6.3 (below).

6.27 Table 6.1 relates to new enrolments in speech pathology courses offered in Australian universities. This is the first year intake. Table 6.2 shows enrolments—the number of students in the system in all years (including commencements). Table 6.3 shows the number of students who have completed the requirements of a speech pathology course in a given year.

6.28 The tables show that there has been a significant increase in the number of commencements (1st year students) and enrolments (students in the system) for both undergraduate and postgraduate courses in speech pathology over the period. There was a 71.6 per cent increase in commencements for bachelor courses in speech pathology from 2005 and 2012 (Table 6.1), and a 62.6 per cent increase in the number of undergraduate enrolments in these courses over the period (Table 6.2).

6.29 The bachelor's degree in speech pathology is a four year degree. With rising commencement and enrolment numbers, one would expect that the numbers graduating from undergraduate speech pathology courses would also be increasing. However, as Table 6.3 shows, the numbers graduating with a bachelor's degree in speech pathology at Australian universities has been stagnant over the period. In 2005, 401 students completed a bachelor's degree in speech pathology; in 2012, 402 students completed a bachelor's in speech pathology. The calendar year with the highest number of completions over the period was 2009, when (only) 408 students graduated.

6.30 Table 6.1 shows that in 2006, there were 523 commencements in undergraduate speech pathology courses in Australia. Assuming these students studied full time, passed their exams and progressed to the next year, one would expect that a similar number would graduate in 2010. However, Table 6.3 shows that only 380 students completed their bachelor's degree in 2010. Certainly, given the significant number of additional enrolments since 2005, and the introduction of several new undergraduate speech pathology courses since 2012, the expectation must be that completion numbers will increase sharply in coming years.

26 The committee thanks the federal Department of Education for its assistance in providing this information and permitting the publication of this data in this report.

Table 6.1: Commencements in Speech Pathology, 2005-2012*
Source: Selected Higher Education Statistics - Department of Education

			2005	2006	2007	2008	2009	2010	2011	2012	% change 2005-2012
Postgraduate	**61707**	**Speech Pathology**	120	145	123	120	161	170	218	308	156.7%
Bachelor	**61707**	**Speech Pathology**	497	523	555	548	638	684	769	853	71.6%
Total			617	668	678	668	799	854	987	1,161	88.2%

Table 6.2: Enrolments in Speech Pathology, 2005-2012*
Source: Selected Higher Education Statistics - Department of Education

			2005	2006	2007	2008	2009	2010	2011	2012	% change 2005-2012
Postgraduate	**61707**	**Speech Pathology**	321	370	401	343	383	429	510	650	102.5%
Bachelor	**61707**	**Speech Pathology**	1,631	1,721	1,814	1,830	1,977	2,106	2,355	2,652	62.6%
Total			1,952	2,091	2,215	2,173	2,360	2,535	2,865	3,302	69.2%

Table 6.3: Completions in Speech Pathology, 2005-2012
Source: Selected Higher Education Statistics - Department of Education

			2005	2006	2007	2008	2009	2010	2011	2012	% change 2005-2012
Postgraduate	**61707**	**Speech Pathology**	101	80	131	114	127	114	159	182	80.2%
Bachelor	**61707**	**Speech Pathology**	401	371	362	347	408	380	392	402	0.2%
Total			502	451	493	461	535	494	551	584	16.3%

* Commencements refer to first year students. Enrolments refer to first year and continuing students.

Commencements, enrolments and completions for 2013–2014

6.31 SPA provided the committee with data showing commencements and expected completions in 2013 and 2014 from the 15 Australian universities that offer speech pathology courses. Table 6.4 summarises these data. The number of commencements continues to grow. The number of students enrolled increased strongly from 2013 to 2014, and the number of students expected to complete and graduate in both years was significantly higher than the numbers shown for the 2005–2012 period (see Table 6.3). In 2014, five Australian university courses expected more than 50 speech pathology students to graduate: the bachelor's programs at Curtin University of Technology, Flinders University, La Trobe University, the University of Queensland and the University of Sydney.[27]

Table 6.4: Commencements and expected graduations in 2013 and 2014 [28]

	Number of students commencing	Number of students enrolled	Number of students expected to complete/graduate
2013	1,181	3,171	720
2014	1,312	3,581	719

Source: Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 7, Attachment 1.

6.32 The committee asked SPAa for its comment on the number of speech pathology courses and graduates in Australia in recent years. Ms Gail Mulcair, the Chief Executive Officer of SPA responded:

> There are 15 universities that offer 24 speech pathology programs. Some of the universities offer a bachelor's program, some offer graduate entry master's program, which is two years, as against the bachelor's being four years; and some universities offer both.[29]

6.33 Professor Deborah Theodorus, the President of SPA, told the committee that the number of Masters' programs is small compared with the number of bachelor's programs. She noted that 'the vast majority of graduates will be coming through bachelor programs'.[30] Ms Mulcair added:

> And the number of students going into those programs are larger than the intake for the graduate master's as well. We know that there were roughly 1 300 new students commencing speech pathology programs this year…across all of those programs—both bachelor's and graduate entry

27 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 7, Attachment 1.

28 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, pp 6–7, Attachment 1.

29 *Committee Hansard*, 11 June 2014, p. 5.

30 *Committee Hansard*, 11 June 2014, p. 5.

> master's—and that is more than double the figure if you go back 10 years. It has been a significant increase. Of all of those programs that I mentioned, 10 of the programs are new in the last five years. There has been a significant recent increase in terms of the number of training programs. Because of the four-year pipeline for graduates to be completing their course we are now seeing, particularly of this year and I think future years, a significant increase in the number of graduates entering the workforce. We are estimating around 730 new graduates at the end of this year. That is a 45 per cent increase since the figures in 2005.
>
> …Both [Professor] Corinne [Williams] and Deb [Thoedoros], heads of speech pathology programs, can confirm that the attrition rate for speech pathology is certainly comparable if not less than other health professions. It is around the sort of 10 per cent to 15 per cent.[31]

Clinical placements

6.34 Speech pathology students undertaking a Bachelors or Masters degree are required to undertake a clinical placement as a requisite for the completion of their university course. For students to meet the Competency-based Occupational Standards (CBOS) and graduate, they must have access to sufficient clinical experience to allow them to meet the standards.[32]

6.35 However, with the 'significant increase in the number of students training' and the funding pressures on the public system, there has been pressure on clinical placements. As Ms Mulcair told the committee:

> We are seeing that it is increasingly difficult for some of the public sector facilities—hospitals, community health, rehab facilities—to take students to the same level that they did previously, largely because of their workforce pressures and their competing demands in terms of how they are having to prioritise their services.[33]

6.36 Professor Theodoros noted that the nature of clinical placements was also changing as the types of care have changed. She gave the example of the significantly shorter period of time that a person would now stay in rehabilitation, which means there is less time for students to gain the experience and the competencies that SPA requires them to have.[34]

6.37 Associate Professor Steven Cumming, Head of Discipline in Speech Pathology at the University of Sydney, identified the lack of clinical placements for students as one of two significant 'chokepoints' in training the profession. He noted that Health Workforce Australia had addressed this issue in its 'Placement Capacity

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31 *Committee Hansard*, 11 June 2014, p. 5.

32 *Submission 224*, p. 88.

33 *Committee Hansard*, 11 June 2014, p. 5.

34 *Committee Hansard*, 11 June 2014, pp 5–6.

Growth projects', which are aimed at better managing the allocation and distribution of placements between institutions. However, he cautioned that:

> …it is not clear that this model is sustainable in the medium to long-term, and indeed it may have given universities a false sense of ongoing growth in availability of placements. The work of Health Workforce Australia, Speech Pathology Australia and the universities in exploring and developing alternate experiences on such as simulations and virtual clients may represent a more viable and sustainable approach to the increasing number of students competing for practical clinical experience.[35]

6.38 The limited number of opportunities for students to undertake a clinical placement in the public system is reflected in various trends. One of these is for health services and other organisations to require payment to have students on placement.[36] SPA informed the committee that the:

> [C]apacity to meet these costs varies between universities which results in inequities in the universities' ability to provide clinical placements opportunities. In addition this also results in inequity between clinical placement providers. The unintentional flow on effect has been an erosion of the willingness of non-paid organisations to take students.[37]

6.39 Another reflection of the limited number of clinical placements available in the public system is private speech pathologists reporting an increase in requests from universities to provide clinical placements. However, SPA notes that placements with sole practitioners provide limited exposure to or experience with:

> …how to provide clinical placements, time pressures, insurance considerations, client perceptions, potential financial burden and access to private health fund or Medicare rebates.[38]

6.40 SPA told the committee that the profession is currently looking at broader options for clinical training including simulated learning activities.[39] Professor Theodoros reflected that universities are having to be 'very innovative' to ensure that their students can gain clinical experience.[40]

6.41 In its submission, SPA argued that robust data is needed regarding the ability of the profession to meet the demand for clinical placements. It recommended that:

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35 *Submission 261*, p. 2.

36 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 3.

37 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', June 2014, p. 4.

38 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 4.

39 Ms Gail Mulcair, *Committee Hansard*, 11 June 2014, p. 5.

40 Professor Deborah Theodoros, *Committee Hansard*, 11 June 2014, p. 6.

> Health Workforce Australia continue its support to enhance access to clinical placement opportunities for speech pathologists in Australia, including Simulated Learning Environment projects and models for increasing clinical education within private practice, as part of a broader review of speech pathology workforce availability and projected need.[41]

6.42 In August 2014, Health Workforce Australia (HWA) was abolished and its functions were subsumed within the federal Department of Health. The committee supports SPA's recommendation that the work of HWA should be continued.

Recommendation 6

6.43 The committee recommends that the federal Department of Health develop a strategy aimed at broadening the opportunities for speech pathology students to undertake clinical placements that satisfy the profession's Competency-based Occupational Standards. The strategy should be developed in consultation with:

- **the relevant heads of Department from each of the 15 Australian universities offering speech pathology courses; and**
- **Speech Pathology Australia and a broad cross-section of its membership.**

The ability of graduates to find work

6.44 The committee received some submissions from speech pathologists expressing their frustration at the difficulty in finding secure, full-time work in the public system. The short-term contracts that some graduates have been forced to accept has impacted on their job satisfaction and their capacity to make major financial decisions.

6.45 SPA told the committee that new graduates are reporting difficulties finding full time positions in the public sector. It noted that in 2016 the number of graduates will peak: 'in the absence of increased growth in positions, it is likely that these new graduates will need to find employment in other sectors of the workforce'.[42] SPA also observed that many new graduates:

> …are entering the workforce as sole private practitioners potentially leading to a higher attrition rate than usual. Others are being contracted by private practitioners, or NGOs and potentially have little job security and fewer professional supports than would traditionally be offered to new graduates and early career speech pathologists.[43]

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41 *Submission 224*, p. 89.

42 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 4.

43 Speech Pathology Australia, 'Speech pathology training and workforce in Australia—an overview', 24 June 2014, p. 4.

6.46 The committee recognises that a possible reason for long waiting lists in the public system is the shift of both new graduates and qualified practitioners to the private system. In terms of new graduates, the problem is the lack of full-time positions in the public sector. Qualified and experienced speech pathologists leave the public system to seek the financial rewards of the private practice. The committee agrees with SPA that it is important that funding for public speech pathology positions is increased to attract and retain talented and committed staff in the public system and real options for people with speech and language disorders who are unable to afford private services.

Where graduates find work

6.47 One factor that also affects the supply of speech pathology services is the placement of new graduates in the workforce. This was not an issue that was raised with the committee in any detail, but it is clearly an important one. Associate Professor Cumming expressed his concern that graduates were gravitating to private practice in areas where the need for services may not be greatest:

> While the number of graduates entering the workforce will increase significantly over the next decade, there is also evidence of increasing geographical and demographic clustering of speech pathology services in Australia. For example, the *University of Sydney Graduate Destinations Survey* suggests that there has simultaneously been a slight drop in the employment of recent graduates, coupled with a proportional increase in the number of new graduates moving directly into private practice. At the same time, changing eligibility criteria for publicly funded rehabilitation and disability services are obliging more consumers to seek out private speech pathology services. This tendency towards increased private provision will impact upon the ability of the public health care system to ensure adequate and equitable speech pathology service delivery to geographically, demographically or financially disadvantaged populations. I note that other submissions have outlined the difficulties that currently exist in providing stable, high-quality speech pathology services to non-metropolitan communities and I will not reiterate those difficulties here. Suffice it to say that there are considerable challenges in ensuring equity, quality and access of speech pathology services throughout the country, and these challenges require a national solution together with careful consideration of the present and future speech pathology workforce.[44]

6.48 The Queensland Government noted in its submission to the inquiry that its agencies have reported some challenges in recruiting and retaining speech pathologists:

> For example, DETE [Queensland Government Department of Education, Training and Employment] reports an ongoing challenge of managing episodic vacancies, particularly in rural and remote areas of Queensland. Current DCCSDS [Queensland Government Department of Communities,

44 *Submission 261*, p. 2.

> Child Safety and Disability Services] speech–language pathology services are limited in rural and remote communities where sole speech–language pathologists may have to travel very long distances to see one client. In addition, local Hospital and Health Services have reported shortages in some rural areas related to difficulties in recruitment.[45]

6.49 The committee notes that a range of incentives have been put in place to attract medical graduates to regional and remote areas of Australia where their services are most needed. Under the Rural Health Workforce Strategy:

- doctors who relocate to regional and remote areas for the first time may be eligible for payments of up to $120 000;
- doctors already working in regional and remote locations may be able to access retention payments of up to $47 000;
- medical graduates can have a portion of their medical studies Higher Education Contribution Scheme (HECS) fees reimbursed for every year of training undertaken or service provided in rural, regional or remote Australia;
- the Bonded Medical Places (BMP) Scheme which provides funding to universities to offer 600 additional medical school places each year for students willing to commit to training and/or working in a district of workforce shortage; and
- the Medical Rural Bonded Scholarships (MRBS) is an annual scholarship payment from the Commonwealth Government paid to students who in return commit to working in a rural o remote area of Australia for 6 continuous years after completing their training as a specialist.[46]

6.50 The committee is not convinced that incentives along these lines would necessarily be appropriate for the speech pathology profession. However, it believes that there is a need for further work to be done to identify the extent of the shortage of speech pathologists in rural and remote areas of Australia, and the merit of different options and incentives to attract and retain professionals to these areas.

Recommendation 7

6.51 The committee recommends that the federal Department of Health investigate the evidence of geographical and demographic clustering of speech pathology services in Australia. This investigation should look at:

- **the number of new graduates in speech pathology moving directly into the public health care system;**

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45 *Submission 268*, p. 4.

46 Department of Health, *Rural Health Workforce Strategy Incentive Programs*, http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/RHWS_incentive_programs (accessed 16 August 2014).

- **the proportion of new graduates moving into regional and remote areas of Australia;**
- **the proportion of new graduates from regional universities (such as Charles Sturt) opting to remain in a regional area to practice; and**
- **the attitudes of those graduates who work in a regional or remote area of Australia following the completion of their studies, including:**
    - **the reason why they opted to work in a regional or remote location; and**
    - **whether they intend to remain working in that location; and**
- **the attitudes of those graduates who work in metropolitan areas following the completion of their studies as to:**
    - **the reason why they opted to work in a metropolitan location; and**
    - **the attractiveness of various financial incentives to encourage them to relocate to a regional or remote area.**

6.52 The committee recommends that this investigation should be considered in the context of:

- **the findings of the project to map language support services across Australia against the Australian Early Development Index (recommendation 3); and**
- **the findings of the proposed audit of the adequacy, strengths and limitations of existing speech and language services for children in Australia (recommendation 4).**

Funding for clinical research

6.53 A submission from Dr Adam Vogel of the University of Melbourne argued that research funding for communication and swallowing impairment is 'dramatically under-represented in Australia's two key funding bodies', the Australian Research Council (ARC) and the National Health and Medical Research Council (NHMRC). He explained:

> A recent audit of funding allocated by NHMRC and ARC over a 10 year period (2004–2013) for projects focussing on pathological communication and swallowing showed a discrepancy between research funding and disease burden and prevalence in Australia. The paper, to be published in the Medical Journal of Australia, describes a review of all funding (including people support, project, program, linkage and discovery grants) allocated to projects with a specific focus on communication or swallowing disorders. Only 154 of the 12 000 grants awarded by the NHMRC and ARC during this 10 year period met criteria. The monetary value of these grants totalled approximately AU$61 million (1.1% of all funding awarded). Funding for hearing impairment (42%) represented the bulk of grants (not including AU$32.6 million awarded to the HEARing Cooperative Research Centre since 2007), followed by stuttering (17%), language (16%), speech

> (7%), literacy (3%), swallowing (3%) and mixed focus (12%). 20% of the value of the 154 grants awarded were for people support (i.e., salaries for researchers).[47]

6.54 A similar point was made by the Centre for Research Excellence in Child Language. In its submission, the Centre noted that language impairment receives around one-fifth of the funding that the NHMRC allocates to obesity 'despite similar rates and significant, enduring consequences'.[48] It added:

> In the 2011-12 financial year alone, obesity research was awarded more than seven times the amount allocated to speech and language disorders research ($37 million compared to $5 million).[49]

The Centre for Research Excellence in Child Language recommended that language impairment should be a new National Health Priority area.[50]

6.55 The committee has not had the opportunity to examine the issue of funding for clinical research in any detail. It does note that there has been some significant funding given to understanding the science of how language develops, what goes wrong and the best way to intervene. The Murdoch Children's Research Institute, for example, was recently awarded $2.5 million to establish the Centre for Research Excellence in Child Language.[51]

Service delivery models

6.56 Chapter 4 of this report noted that an important determinant of the future demand for speech pathology services in Australia is the model of service delivery. The committee received several recommendations from submitters and witnesses aimed at improving the process through which people with speech and language disorders at different stages of life can access these services. These recommendations emphasise the need for more streamlined and targeted models of service delivery

Streamlining access to, and administration of, early intervention services

6.57 Associate Professor Michael McDowell from the Neurodevelopment and Behavioural Paediatric Society of Australasia recommended developing a single integrated government strategy for Early Intervention. He argued that this strategy would combine the NDIS, the HWCA and subsequent early intervention initiatives, and publicly funded services. Further, he put the case for a single government

47 *Submission 97,* pp 2–3.

48 *Submission 161*, p. 1.

49 *Submission 161*, p. 1.

50 *Submission 161*, p. 1.

51 *Submission 161*, p. 15.

department as the lead agency in Early Intervention (0 to school age) with all publicly funded therapy for early intervention to be provided by that department.[52]

6.58 In addition to a more efficient governance framework for early intervention, Associate Professor McDowell proposed a single point of entry for assessment and treatment services for speech pathology. He also advocated a portfolio of intervention models such as training parents to deliver services, group programs and working with early childhood educators so that they can deliver services.[53]

6.59 The Centre of Research Excellence in Child Language has argued that despite the efforts of professionals in health and education, the needs of children and families are not being met. It claimed that the current model, which consists largely of 'targeted specialist interventions' delivered by speech pathologists, is neither sustainable nor equitable. The Centre argued that:

> A shift is needed in emphasis, analogous to that in other areas of healthcare, from a specialist clinical focus to one grounded in public health principles. Testing alternative service models would ensure the use of the most equitable, efficient and effective approaches to language promotion and early intervention.
>
> In the first instance, such an approach could involve harnessing the increasing interest from Medicare Locals as place-based advocates of child health and development. The Australian Early Development Index could also be used to identify geographic areas with higher rates of developmental vulnerability in which to test alternative service approaches and programs. This would enable the generation of new evidence about what works in areas of high need and would complement the Federal Government's already considerable investment through Communities for Children. Our Centre is developing an accessible, short form method for detecting children at higher risk for Language Impairment, which may prove useful in identifying specific children that could participate in this different service paradigm.[54]

6.60 The committee believes that there is merit to this idea of using Primary Health Networks to target speech pathology services to those children most in need of these services (see recommendation 9).

The education system: a tiered approach?

6.61 The committee received proposals to streamline access to speech pathologists within the education system. SPA, notably, suggested the following model:

- Speech pathologists are trained to work within schools, alongside teachers and other educational team members and with parents to improve educational

52 *Submission 118*, p. 2.

53 *Submission 118*, p. 2.

54 *Submission 161*, p. 12

outcomes for children. A best practice model for the provision of speech pathology services in schools is the 'Response to Intervention' model which invokes multiple tiers of service provision:

- Tier 1 (all students in the school): Provision of high-quality, evidence-based teaching and learning that supports oral language development across the school;
- Tier 2 (extra support): Provision of focussed support for children or groups of children who are struggling in Tier 1;
- Tier 3 (individual support): Individual intervention and support to target skill deficits and prevent further problems; individualised classroom strategies to support access to the curriculum.[55]

6.62 The Western Australian Primary Principals Association also argued the merit of a three tiered model. It claimed that this model would align 'the instructional needs of students with increasingly intensive interventions in the context of the best evidenced based, universal curriculum and teaching and learning practices'. The Association explained the three tiers as follows:

- Tier 1 is the universal level that is preventative and proactive where data informs the design of intervention. At this level all students receive research-based high quality, engaging, general education that incorporates on going universal screening, progress monitoring, and prescriptive assessment that supports the design and implementation of instruction;
- some students require more intense focus, more time and some degree of specialisation and differentiation over the short or slightly longer term. This is tier 2. At tier 2, interventions are rapid response, targeted group interventions provided to students identified as at-risk of academic and/or social challenges and/or students identified as underachieving who require more targeted approaches. The expectation is to accelerate learning and to minimise impact of difficulties; and
- a few students may require more specialised intervention and significant intensity and time, often for the longer term. This is tier 3. This level targets students with intensive/chronic academic and/or behavioural or social needs based on ongoing progress monitoring and or diagnostic assessment.[56]

Engaging speech pathologists with aged-care residential homes

6.63 The committee noted in chapter 5 the SPA's concerns with the current model of service provision in residential aged care homes. The committee has recommended that the federal, state and territory governments inquire into the current service delivery model for speech pathology services in aged care residential homes in

55 *Submission 224*, p. 38.

56 *Submission 228*, pp 9–10.

Australia. It is particularly concerned that nursing staff have the skills to screen residents in aged care facilities for communication and swallowing disorders. The broader goal should be for residential aged-care centres to engage routinely and systematically with speech pathologists, whether employing them directly or contracting out their services.

6.64 The committee also agrees with SPA that in terms of the involvement of speech pathologists in aged-care homes, they have an important role in creating a communication-friendly environment. This means that those who work in the aged care setting are educated about how to communicate with people with speech and language disorders and how to facilitate that communication.[57]

Speech pathologists within the youth justice system

6.65 Associate Professor Pamela Snow has argued that speech pathologists need to be employed in both community-based and custodial settings within the youth justice system. She writes that:

> Young offenders represent the extreme end of developmental vulnerability. There are many young people whose circumstances do not result in youth justice involvement but who never-the-less are educationally and socially marginalised and developmentally vulnerable as a result of undiagnosed or mis-attributed communication impairments. Such young people fail to achieve their potential and will make disproportionate demands on government-funded services, such as housing, mental health, substance abuse, and vocational training programs. Although prevention and early intervention are optimal, intensive and specialist services must be made available to vulnerable young people in their still formative adolescent and early adult years. Speech Pathology has a hitherto largely overlooked, but strongly research-informed role to play in the lives of young people who are developmentally vulnerable for a range of reasons, whether as a consequence of neurodisabilities such as autism spectrum disorders, or as a consequence of socio-economic adversity in early life.[58]

6.66 The organisation, Mental Health for the Young and their Families (Victoria), argued the benefits of programs that target improved communication skills among juvenile offenders. It argued:

> Research indicates that appropriate programs can make a difference to communication skills. Improved communication skills can make a difference to social competence, emotional well-being and executive functioning. This improves the outcome for the young person in terms of quality of life and for the Juvenile Justice system in terms of reduced recidivism. This has been recognized by the Juvenile Justice authorities in Victoria through participation of all young offenders in schooling programs enhanced by specialist assessments and interventions with language

57 *Committee Hansard*, 11 June 2014, p. 8.

58 *Submission 32*, p. 4.

> development programs. This is aimed at helping the young people become more productive members of society and less likely to engage in recidivist offending. Ongoing evaluative research is being undertaken to clarify the effectiveness of various interventions. The cost of implementing such programs is believed to be small compared to the benefits of greater productivity and reduced costs of recidivist delinquent behaviour and necessary ongoing social support programs, possibly even to subsequent generations. The verification of the estimated cost effectiveness of these interventions will take some years of follow-up research. Even a cost-neutral outcome would be a program success, but the benefits are likely to be shown to be much greater. An interesting question is whether the programs can be effective with young adult offenders who have developmental language delays, which could warrant consideration of implementation in the adult forensic system.[59]

6.67 SPA proposed engaging speech pathologists more directly to treat juvenile offenders within the justice system. It recommended that:

> Appropriate screening, specialist assessment and intervention be available to children and young people who are already in the criminal justice pathway, including that:
>
> (f) speech pathology service provision in secondary schools also be extended to 'special behavioural schools' to provide targeted support to students with communication and literacy difficulties, and to provide teachers with whole of classroom strategies;
>
> (g) education centres within youth justice services involve speech pathologists in the education team to contribute to the curriculum, consult with educators and other justice staff, and provide targeted support to young offenders, to improve their language, literacy and social interaction skills, with the aim of reducing recidivism.[60]

Recommendation 8

6.68 The committee recommends that the federal Department of Health, in collaboration with state and territory governments, Speech Pathology Australia, and other key stakeholders, prepare a position paper on the most appropriate model of service provision for speech pathologists working in:

- **early childhood intervention services;**
- **the education system;**
- **the justice system;**
- **the health system; and**
- **the residential aged-care environment.**

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59 *Submission 110*, p. 1.

60 *Submission 224*, p. 13 & p. 47.

Committee view

6.69 This chapter has discussed various options to address the shortage of speech pathologists in Australia. These options relate to both the level and the type of funding to support the profession, as well as the professional opportunities for students and the placement of graduates. All these issues must be considered in the context of where resources are needed and for what purpose. As chapter 5 discussed, important preliminary work is needed to map language support services against the Australian Early Development Index, and audit the adequacy, strengths and limitations of existing speech and language services for children (see chapter 5).

6.70 The committee considers that there is a strong case for greater funding of public speech pathology positions in Australia. However, this should be better substantiated and articulated. In its submission, SPA argued the need for a 'robust cost-benefit analysis of speech pathology intervention', which could be conducted by the Productivity Commission or a consultancy such as Deloitte Access Economics.[61]

6.71 The committee believes that there has been sufficient evidence gathered during the course of this inquiry to warrant an analysis of the benefits and costs of speech pathology intervention. This inquiry should consider the costs of doing nothing (retaining current funding levels) in terms of:

- the effect of long waiting lists on the individual in need of the service;
- the difficulty of retaining high quality staff in an over-stretched public system;
- the lack of clinical placements and employment opportunities for graduates; and
- the impact on those who miss out on services altogether.

6.72 It should then consider the costs and benefits of speech pathology intervention based on the Department of Health's position paper on the most appropriate models of service provision for speech pathologists working in various settings (see recommendation 9).

Recommendation 9

6.73 The committee recommends that the federal government commission a cost-benefit analysis of:

- **the current level of funding for public speech pathology positions. This should include:**
  - **the impact on individuals of existing waiting lists;**
  - **the limited provision of speech pathologists in the education, aged care and youth justice settings;**

61 *Submission 224*, p. 13 and p. 47.

- **the impact on individuals where services are not available;**
- **the impact of limited clinical placements and job opportunities for the speech pathology profession; and**
- **the impact on the Australian community of underfunding these services.**

- **the various service delivery models proposed by the federal Department of Health (see recommendation 8).**