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Future Fit and Healthy

A blueprint for South Australia's Allied Health Workforce Planning



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About the paper

This report presents the findings of the Future Fit Allied Health SA study, a collaborative research project commissioned by HSU and jointly executed by Flinders University and the McKell Institute.

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The opinions in this paper are those of the authors and do not necessarily represent the views of the Expert Advisory Group that informed this research. Any remaining errors are the sole responsibility of the authors and the McKell Institute.

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Key Findings

FINDING 1

SA's allied health workforce is comparatively strong overall, but shortages within SA Health reveal a deeper problem of retention and distribution.

South Australia meets or exceeds the national per-capita benchmark across most allied health professions. In 2024, SA's employed physiotherapist rate was **17 per cent above the national average** (150.5 vs 128.9 FTE per 100,000 population); occupational therapy was similarly **17 per cent above** (110.0 vs 94.2). Of the twelve professions captured in the National Health Workforce Dataset, SA is at or above the national rate for nine.

These statewide figures, however, do not establish whether SA Health and its hospitals have sufficient allied health staff to meet service demand. The interviews undertaken for this study identify persistent difficulties retaining experienced practitioners, filling more senior positions, and sustaining workforce capacity across public health services. South Australia's challenge is not simply how many allied health professionals it produces, but whether the public health system can attract, retain, and deploy the workforce it needs.

FINDING 2

A decade of evidence has failed to produce a comprehensive workforce plan, reflecting a persistent failure of governance.

Despite holding supply data across twelve AHPRA-registered allied health professions, SA has no dedicated workforce intelligence function reporting on vacancy, fill rates, or workforce demographics across Local Health Networks. Social work—one of the largest allied health groups in the SA public health system, with an estimated **4,456 practitioners** — is absent from national registration data entirely, because self-regulated professions fall outside the National Health Workforce Dataset. SA **cannot plan effectively for a workforce it cannot fully see**. The absence of a workforce intelligence function is not a data limitation: it is a governance decision, and it has consequences that compound annually.

FINDING 3

Public sector exit is structurally rational — this is a retention crisis, not a recruitment problem.

Allied health graduates enter SA's public sector in adequate numbers. The attrition problem begins at years two to three, when the economics of remaining in the public system deteriorate. For most SA public allied health professionals, the highest clinically meaningful pay increment—**AHP 2.6**—is reached within five to seven years of graduation. The limited opportunities for progression beyond AHP 2.6, particularly for practitioners seeking to remain in clinical roles, reflect a broader classification and career framework that does not consistently recognise advancing expertise and responsibility throughout an allied health career. Practitioners who want to progress must move into management or leave for the private sector, where conditions and remuneration are materially better. Across **seventeen interviews**, this dynamic was named consistently, in the same terms, by practitioners from four professions, metropolitan and rural settings, and across career stages.

FINDING 4

Rural and remote SA faces a structural supply cycle it cannot break without coordinated reform.

Between **81 and 83 per cent** of Australia's allied health employed FTE is concentrated in metropolitan areas. In SA, geographic concentration is more pronounced: Adelaide's share of population and allied health supply creates an access gap in regional, rural, and remote communities that has not closed. The qualitative evidence reveals why: rural and remote positions experience a predictable **two-to-three-year attrition pattern**—new practitioners arrive, develop skills, and depart for metropolitan practice or the private sector, resetting the clock at LHN expense. Housing unavailability, the metropolitan concentration of advanced training programs, and the AHP pay ceiling all interact to sustain this cycle.

FINDING 5

Allied health's contribution to the health system is real, large, and almost entirely invisible.

SA Health has **no standardised framework** for measuring what allied health delivers—reduced length of stay, averted readmissions, lower cost-per-episode. The international evidence base for these contributions is robust; the SA data infrastructure to demonstrate them locally does not exist. Scope restrictions compound the waste: allied health professionals across all four focus professions consistently report **working below their full clinical scope**, constrained by referral systems and team structures designed around a medical model that predates the modern multidisciplinary workforce. This invisibility is not incidental—it reflects a governance architecture that has never assigned accountability for allied health outcomes.

FINDING 6

The workforce has already diagnosed the problem. Seventeen voices. One structural conclusion.

Across seventeen interviews—physiotherapists, psychologists, occupational therapists, and social workers, metropolitan and rural, early and senior career—the same structural diagnosis emerged, without prompting, in the same order: fair pay, clinical career pathways, rural support, and a governance framework that treats allied health as central to the health system rather than peripheral to it. The convergence across professions, settings, and career stages is not a morale finding—it is a system intelligence finding. The seven recommendations in this report are a direct policy translation of what the evidence—quantitative and qualitative together—has produced. **Structural problems require structural responses. SA has never had a comprehensive allied health workforce plan.** This is it.

Introduction

Australia is in the middle of a reckoning with its allied health workforce. In 2025, the Commonwealth released a draft National Allied Health Workforce Strategy—the first such document in the country's history—acknowledging what clinicians have known for decades: that physiotherapists, occupational therapists, psychologists, social workers, and the dozens of other professions that form the allied health workforce have been planned for inadequately, funded inconsistently, and governed without coordination (Australian Government Department of Health, Disability and Ageing, 2025).

The Health Workforce Taskforce's Workforce Intelligence Report 2025 confirmed that while Australia's allied health workforce grew faster than any other health sector over the past decade—52 per cent growth in FTE per 1,000 people since 2013—demand has continued to outpace supply, and the fill rate for allied health professional roles dropped to 44 per cent nationally in 2023, down from 60 per cent the previous year (Health Workforce Taskforce, 2026). The Australian Institute of Health and Welfare's Australia's Health 2026 report places these trends in systemic context: across all registered health professions, workers in outer regional areas reach only 22.2 FTE per 1,000 people against 26.8 in major cities—a gap that widens further for allied health taken alone (AIHW, 2026).

These are national averages. Behind them, the distribution problem is more acute. International evidence consistently shows that health workforce shortages are not primarily about total supply—they are about who ends up working where, and why (Carlton et al., 2024; Leslie et al., 2023).

Research on health workforce policy and planning has identified an overarching tension between the interests of the profession and the needs of the population: a strife of interests, in which the workforce that exists reflects the incentive structures of training, regulation, and remuneration rather than the geographic or demographic distribution of need (Balasubramanian et al., 2019). The same dynamic operates across allied health in Australia. When incentive structures favour metropolitan private practice over rural public sector employment—as they do—the workforce clusters accordingly. Governance frameworks that fail to account for this dynamic risk documenting workforce trends, rather than actively shaping them (Balasubramanian & Short, 2021; Baum et al., 2020).

South Australia (SA) provides a clear example of how this pattern plays out in practice. Across most allied health professions, SA broadly matches or exceeds national per-capita benchmarks—physiotherapy is 17 per cent above the national rate, occupational therapy 17 per cent above. But in psychology, SA holds 79.5 FTE per 100,000 people against a national benchmark of 112.3—a 29 per cent shortfall that has persisted and deepened for at least seven years. SA accounts for just 4.9 per cent of the national psychology workforce despite holding approximately 6.9 per cent of the national population. Social work sits outside the National Health Workforce Dataset entirely, a structural data gap that is itself a policy finding: a profession central to discharge planning, child and family services, and community mental health has no national registration, no reliable supply data, and no formal place in SA's workforce planning frameworks.

The Australian rural and remote allied health workforce research base confirms that these patterns are structural rather than incidental—the result of training pipelines, qualification pathways, housing markets, and classification systems that systematically disadvantage rural and remote practice.

This report presents the findings of the Future Fit and Healthy study, conducted by researchers at Flinders University in partnership with the McKell Institute SA/NT and the Health Services Union SA/NT. It draws on two complementary evidence strands. The first is an analysis of the National Health Workforce Dataset (NHWDS) 2013–2024—the primary data source for registered allied health professions in Australia, collected annually through the AHPRA registration renewal process and published by the Australian Government Department of Health, Disability and Ageing. Discriminant analysis of practice activity data within the NHWDS tradition has demonstrated that workforce distribution patterns reflect structural predictors—training origin, employment sector, and geographic setting—rather than individual preference alone (Balasubramanian et al., 2021). The second evidence strand is a series of semi-structured interviews with 17 allied health professionals working in SA's public health sector, analysed using Framework Analysis to identify the structural drivers of workforce instability from the perspective of practitioners themselves (Ritchie & Spencer, 1994).

Together, these two strands make an argument that neither could make alone. The quantitative data shows where the gaps are. The qualitative evidence explains why they persist—and what would be required to address them. If the future health workforce is to be genuinely redesigned around population need rather than professional tradition, that redesign requires both the numbers and the voices (Balasubramanian & Short, 2021). This report provides both.

Part One: South Australia's Allied Health Workforce Is Strong Overall, but Significant Gaps Remain

Key points

1. **South Australia has a comparatively strong allied health workforce overall,** meeting or exceeding national per-capita rates across most registered professions. However, these figures conceal workforce pressures within SA Health, where difficulties retaining experienced practitioners and filling senior positions affect the public system's capacity to meet demand.

2. **Psychology is the major exception:** South Australia's psychology workforce has grown more slowly than the national workforce, and its share of Australia's psychologists fell from 5.2 per cent in 2013 to 4.9 per cent in 2024.

3. **Statewide supply figures conceal major gaps in access,** particularly across regional, rural, and remote South Australia, while the absence of comparable workforce data for social work creates an additional blind spot for workforce planning.

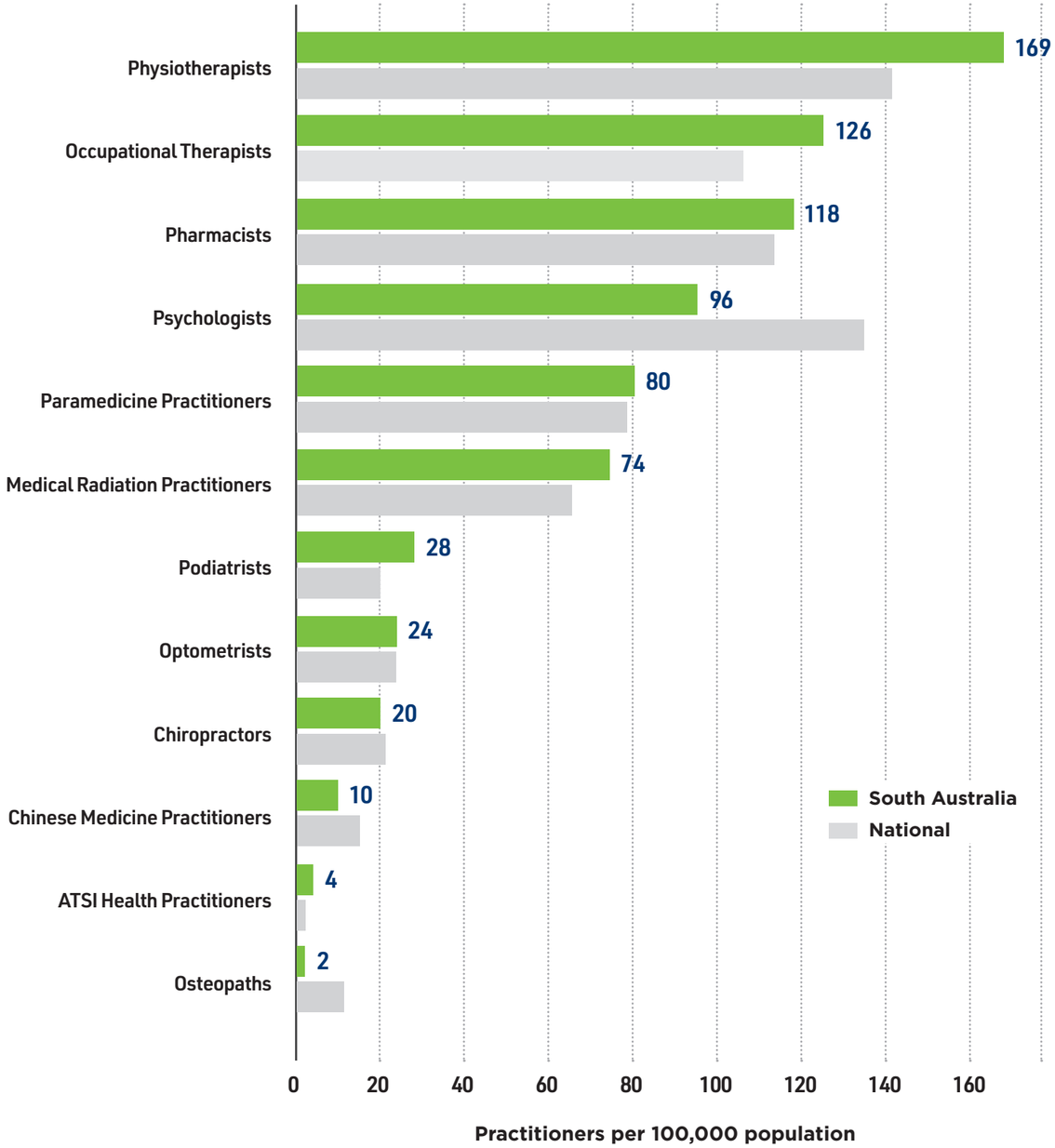
SA has more allied health professionals per capita than the national average across most professions—and in some, it is a relative leader. More physiotherapists. More occupational therapists. More podiatrists. By the headline numbers, SA's allied health workforce looks adequate, even strong. This section examines what lies beneath that headline. When the data are broken down by profession, by trend, and by geography, a more complex picture emerges: a workforce that has grown quickly in some areas and slowly in others; that is well-distributed in metropolitan Adelaide and thinly distributed beyond it; and that contains, within the psychology profession, a gap that has persisted and deepened across the full eleven years of data examined here. Understanding where SA stands requires looking at each profession in turn.

An important distinction underpins this analysis: a comparatively strong statewide workforce does not necessarily translate into adequate staffing within SA Health. The National Health Workforce Dataset captures employed practitioners across sectors but does not establish whether public hospitals and health services have sufficient staff to meet their clinical needs. The qualitative evidence presented in Part 2 identifies workforce pressures within SA Health that are not apparent in statewide supply figures, including difficulties filling experienced clinical positions, retaining practitioners beyond their early careers, and sustaining rural services. These pressures suggest that South Australia's workforce challenge is not only one of geographic distribution, but also of how allied health professionals are distributed between employment sectors and retained within the public health system.

1.1 SOUTH AUSTRALIA IS WELL SUPPLIED ACROSS MOST REGISTERED ALLIED HEALTH PROFESSIONS

The National Health Workforce Dataset (NHWDS) collects workforce supply data on all professions registered under the National Registration and Accreditation Scheme through the AHPRA annual renewal process. It is the primary national data source for twelve allied health professions in Australia. Figures throughout this section use the 2024 NHWDS collection and report employed full-time equivalent (FTE) per 100,000 population—the standard unit for workforce planning comparisons (Figure 1.1).

FIGURE 1.1 Employed allied health FTE per 100,000 population: SA vs national average, 2024



Source: NHWDS 2024, Dept of Health, Disability and Ageing; ABS ERP 31 December 2024 (Cat. 3101.0).

Note: FTE = total weekly hours worked ÷ 38. SA ERP = 1,893,200. Psychology is the only major allied health profession materially below the national per-capita average.

Across all twelve NHWDS professions, SA is at or above the national per-capita rate for nine. SA's physiotherapy rate is 19 per cent above the national average (168.7 registered per 100,000 vs 141.7 nationally). Occupational therapy is 18 per cent above (125.7 vs 106.6). Podiatry is 39 per cent above. Medical radiation practitioners, pharmacists, paramedicine practitioners, and optometrists sit within 5 per cent of the national average. Only two professions are substantially below: osteopathy—a nationally small and unevenly distributed profession—and psychology, which at 95.7 registered per 100,000 sits at **71 per cent of the national rate.**

The aggregate picture is one of a state that is broadly well supplied at the headline level. The SA Rural Allied and Scientific Health Workforce Plan 2021–2026 acknowledged as much in its own supply assessment—and also noted that these aggregate figures mask the distribution problems that emerge when the data are broken down by geography (SA Health, 2021). The sections that follow undertake that disaggregation (Table 1.1).

TABLE 1.1 SA allied health workforce: all NHWDS professions vs national average, 2024

Profession	SA employed headcount	SA employed FTE	SA FTE per 100,000	National FTE per 100,000	SA vs national
Nursing and midwifery	34,436	30,142	1,593	1,359	+17%
Medical practitioners	8,550	8,676	459	447	+3%
Physiotherapy	3,193	2,847	150.5	128.9	+17%
Pharmacists	2,239	2,023	107.0	103.9	+3%
Occupational therapy	2,377	2,081	110.0	94.2	+17%
Paramedicine	1,518	1,817	96.1	92.5	+4%
Psychology (a)	1,811	1,504	79.5	112.3	−29%
Dental practitioners	1,990	1,725	91.2	80.8	+13%
Medical radiation practice	1,410	1,289	68.1	61.8	+10%
Podiatry	536	498	26.3	19.1	+38%
Optometry	456	424	22.4	21.2	+6%
Chiropractic	373	299	15.8	17.8	−11%
Chinese medicine	189	140	7.4	11.4	−35%
Aboriginal and Torres Strait Islander health practice	78	88	4.7	2.8	+68%
Osteopathy	42	35	1.9	9.7	−80%
Social work *	4,456	—	—	—	—

Source: National Health Workforce Dataset (NHWDS) 2024, Department of Health, Disability and Ageing; ABS Estimated Resident Population, 31 December 2024 (Cat. 3101.0).

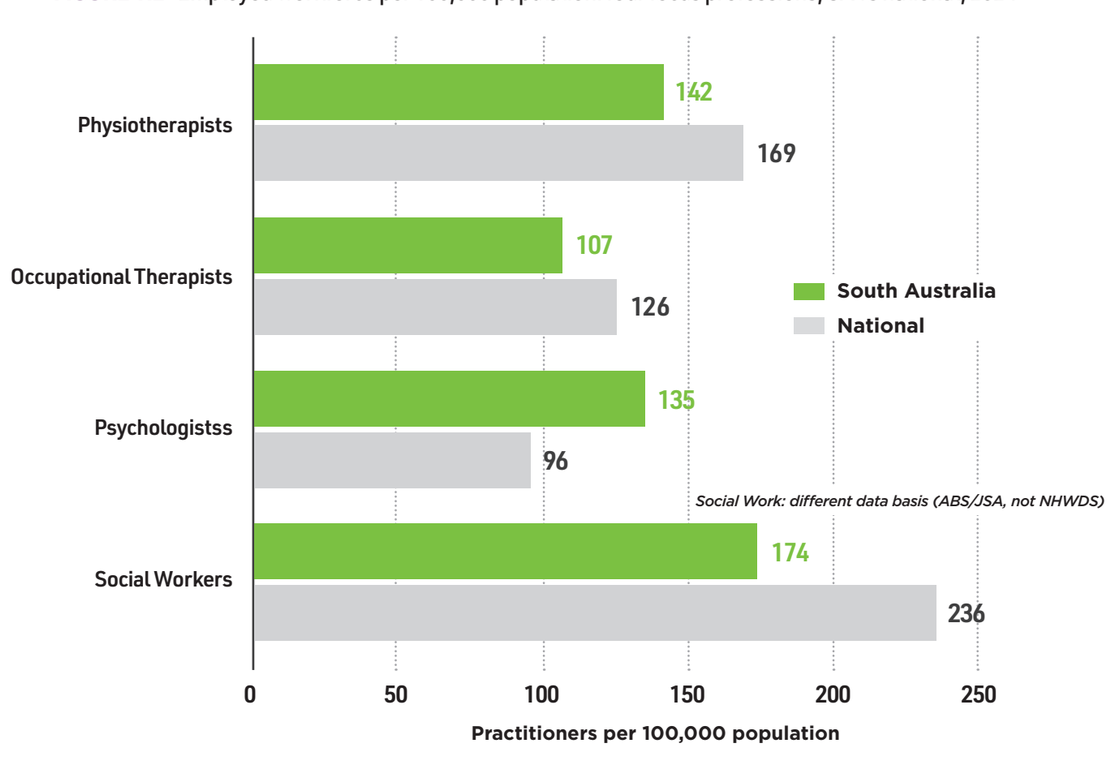
Note: Headcount = employed practitioners who reported working in the profession at registration renewal. FTE = total weekly hours worked ÷ 38. Per-capita = FTE ÷ ERP × 100,000. SA ERP = 1,893,200.
(a) Psychology is the only major allied health profession in SA materially below the national per-capita average. Every other mainland profession shown is at or above the national rate.
* Social work is self-regulated through AASW and is absent from the NHWDS. SA headcount (4,456) is a derived estimate: 9.4% SA state share applied to the national ABS Census 2021 headcount (ANZSCO 272511, 47,400). Headcount only — FTE not available. Not directly comparable to NHWDS metrics. See Table 1.5 for full detail.

1.2 FOUR PROFESSIONS CAPTURE THE BREADTH OF SOUTH AUSTRALIA'S ALLIED HEALTH WORKFORCE CHALLENGES

This report focuses in depth on four professions: physiotherapy, occupational therapy, psychology, and social work. These four represent the largest share of SA's public health allied health workforce by headcount; they are the professions most consistently raised by participants in the qualitative interviews in Part 2; and they span the full range of SA's workforce planning challenges—from relative supply strength to a structural deficit, and from a nationally integrated data framework to an entirely separate evidence base. From this point, figures use employed FTE per 100,000—a more conservative and policy-relevant measure than registered headcount, counting only those actively working in the profession (Figure 1.2).

These comparisons should not be interpreted as measures of public sector staffing adequacy. A profession may exceed the national per-capita benchmark while individual public health services continue to experience recruitment and retention difficulties. The distinction is particularly important for physiotherapy and occupational therapy, where the interviews identify difficulties filling experienced positions despite comparatively strong statewide workforce supply.

FIGURE 1.2 Employed workforce per 100,000 population: four focus professions, SA vs national, 2024



Source: NHWDS 2024, Dept of Health, Disability and Ageing (physiotherapy, occupational therapy, psychology); ABS Census 2021 / JSA (social work); ABS ERP 31 December 2024.

Note: Social work data derived from ABS Census 2021 (ANZSCO 272511) / JSA estimate. Social work headcount is not directly comparable to NHWDS FTE metrics. Social work FTE per 100,000 is not calculable from available data. All other professions: employed FTE per 100,000. SA ERP = 1,893,200.



In employed FTE terms for 2024: SA physiotherapy is 150.5 per 100,000 (national: 128.9), placing it 17 per cent above the national benchmark. Occupational therapy is 110.0 per 100,000 (national: 94.2), also 17 per cent above. Both reflect strong metropolitan supply and a decade of demand growth driven by the National Disability Insurance Scheme rollout from 2016 onwards. Psychology is 79.5 per 100,000 (national: 112.3)—**29 per cent below the national benchmark**, and the second-lowest rate of any state or territory. Social work is not captured in the NHWDS and is discussed separately in Section 1.6 (Table 1.2).

TABLE 1.2 Four focus professions: SA vs national snapshot, 2024

Profession	SA employed headcount	SA employed FTE	SA FTE per 100,000	National FTE per 100,000	SA vs national	SA mean age (years)	SA mean hrs/week
Physiotherapy	3,193	2,847	150.5	128.9	+17%	38.0	33.9
Occupational therapy	2,377	2,081	110.0	94.2	+17%	36.0	33.3
Psychology (a)	1,811	1,504	79.5	112.3	−29%	45.9	31.5
Social work *	4,456	—	—	—	—	38	—

Source: NHWDS 2024, Department of Health, Disability and Ageing; ABS ERP 31 December 2024.

Note: FTE = total weekly hours ÷ 38. Mean age and mean hours are self-reported at AHPRA registration renewal. SA ERP = 1,893,200.

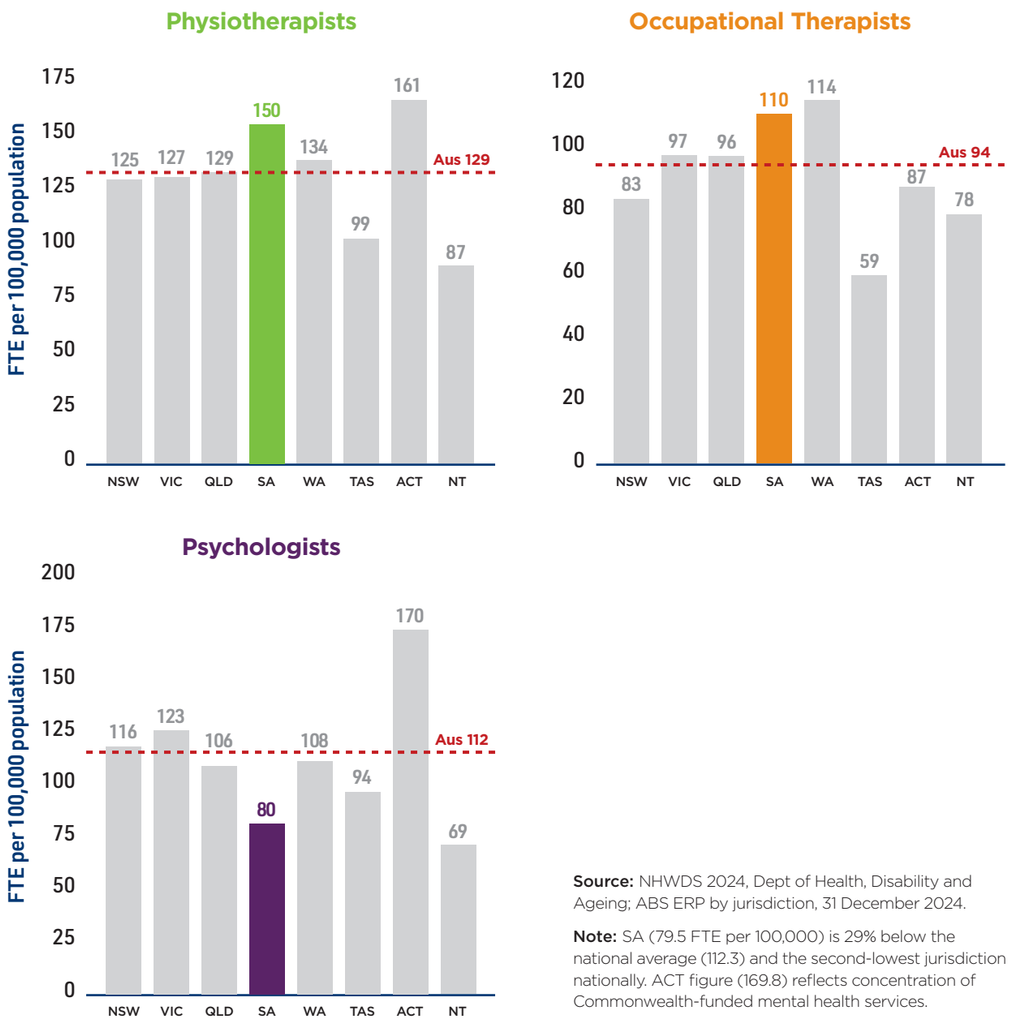
(a) SA psychology FTE per 100,000 is 29% below the national average. Every other mainland state is at or above the national rate. See Table 1.3 for state comparison.

* Social work is self-regulated through AASW and is absent from the NHWDS. Headcount (4,456) is a derived estimate: 9.4% SA state share × ABS Census 2021 national headcount (ANZSCO 272511, 47,400). Not directly comparable to NHWDS FTE metrics. Mean age is national estimate (ABS Census 2021). FTE and per-capita not available.

1.3 SOUTH AUSTRALIA FACES A PERSISTENT AND GROWING PSYCHOLOGY WORKFORCE GAP

In 2024, SA had 1,504 employed psychologist FTE—79.5 per 100,000 population. Every other state except the Northern Territory (69.4) exceeded this rate. The ACT had 169.8 FTE per 100,000; Victoria 123.0; New South Wales 115.5; Queensland 106.1; Western Australia 108.6; Tasmania 94.0. SA accounted for approximately 6.9 per cent of the national population but holds only 4.9 per cent of the national psychology workforce. The Australia's Health 2026 report confirms that workforce gaps of this kind, where growth in per-capita supply has not kept pace with population need, are unlikely to be addressed through broader workforce growth alone, and require targeted workforce planning and incentives (AIHW, 2026) (Figure 1.3 and Table 1.3).

FIGURE 1.3 Psychologist employed FTE per 100,000 population by state and territory, 2024



Source: NHWDS 2024, Dept of Health, Disability and Ageing; ABS ERP by jurisdiction, 31 December 2024.

Note: SA (79.5 FTE per 100,000) is 29% below the national average (112.3) and the second-lowest jurisdiction nationally. ACT figure (169.8) reflects concentration of Commonwealth-funded mental health services.

TABLE 1.3 Psychologist employed FTE per 100,000 population: all states and territories, 2024

State or territory	Employed FTE	ERP	FTE per 100,000	Difference from national average
New South Wales	9,872	8,547,000	115.5	+3%
Victoria	8,621	7,009,500	123.0	+10%
Queensland	5,961	5,394,700	110.5	−2%
Western Australia	3,266	2,907,000	112.4	0%
South Australia (a)	1,504	1,893,200	79.5	−29%
Tasmania	541	573,600	94.3	−16%
Northern Territory	182	250,900	72.5	−35%
Australian Capital Territory	818	456,700	169.8	+51%
Australia	30,765	27,442,000	112.3	—

Source: NHWDS 2024, Department of Health, Disability and Ageing; ABS ERP by jurisdiction, 31 December 2024 (Cat. 3101.0).

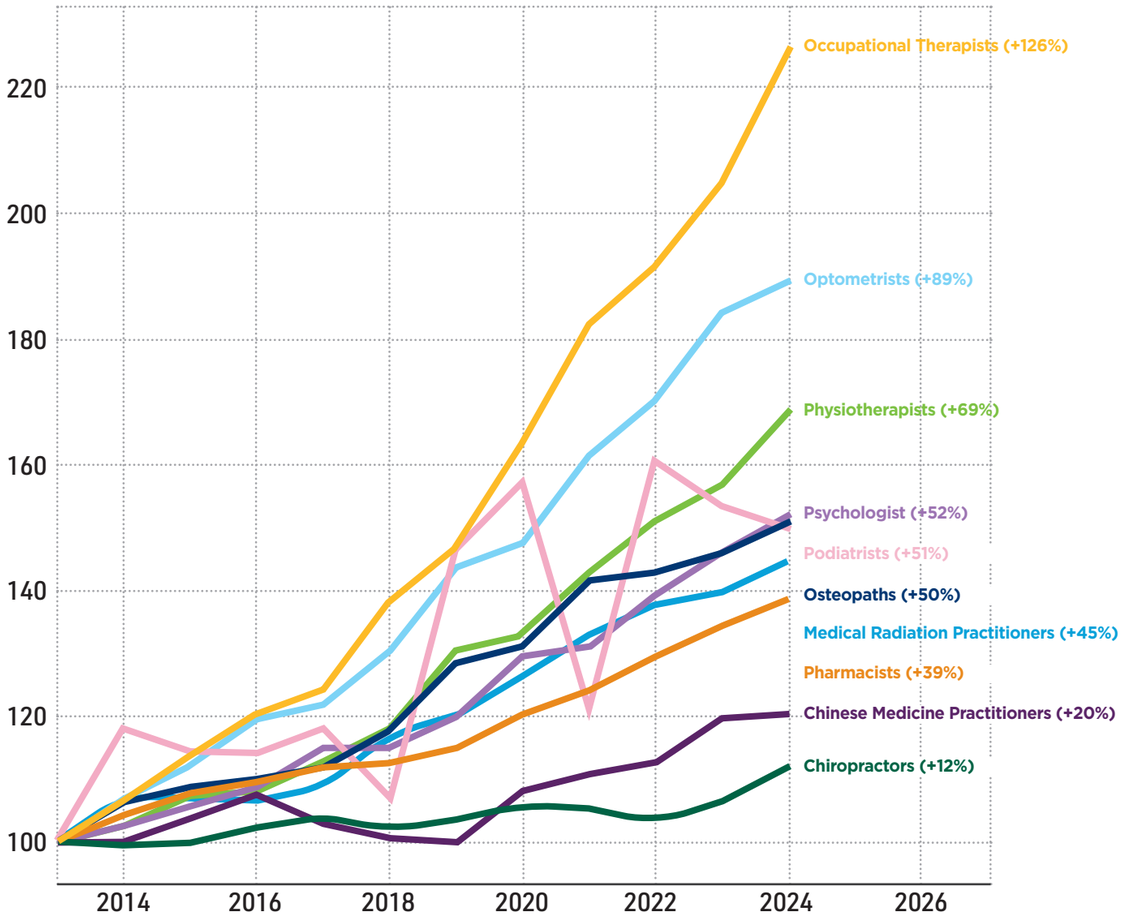
Note: States and territories listed in standard AIHW order. National total shown as the last row for reference.
(a) South Australia (79.5 FTE per 100,000) is 29% below the national average (112.3) and the second-lowest jurisdiction nationally, above only the Northern Territory. The gap has persisted for at least seven years.

The structural character of the gap is reinforced by the workforce's age profile. SA psychologists average 45.9 years—the highest average age of any state. A workforce that is both below the benchmark and ageing faster than comparable states faces a compounding risk: it is more likely to lose practitioners through retirement over the next decade than to attract sufficient early-career replacements to maintain current supply, let alone close the gap. The 2025 National Allied Health Workforce Strategy consultation identified psychology as one of the highest-demand, lowest-supply professions nationally, and called for dedicated training and incentive interventions (Australian Government Department of Health, Disability and Ageing, 2025). SA's data confirm why this matters at a state level. The mechanisms that sustain this gap are explored through practitioner voices in Part 2.

1.4 ALLIED HEALTH HAS GROWN, BUT PSYCHOLOGY HAS FAILED TO KEEP PACE

Between 2013 and 2024, SA's allied health workforce grew across all NHWDS professions. Occupational therapy grew by **126.5 per cent** (1,050 to 2,378; CAGR 7.7 per cent). Physiotherapy grew by **68.7 per cent** (1,892 to 3,191; CAGR 4.9 per cent). Both professions benefited from the NDIS demand surge—a well-documented driver of allied health supply expansion in the community sector—alongside the national training pipeline growth that has characterised allied health over the past two decades (Figure 1.4 and Table 1.4).

FIGURE 1.4 Employed headcount growth 2013–2024: SA focus professions



Source: NHWDS longitudinal headcount series 2013–2024, Dept of Health, Disability and Ageing.

Note: Occupational therapy (+127%) and physiotherapy (+69%) have grown substantially faster than psychology (+52%) over the period. SA population growth ≈ 14% over the same period.

* Index: 2013 = 100.

TABLE 1.4 Workforce growth 2013–2024: SA vs national, focus professions (employed headcount)

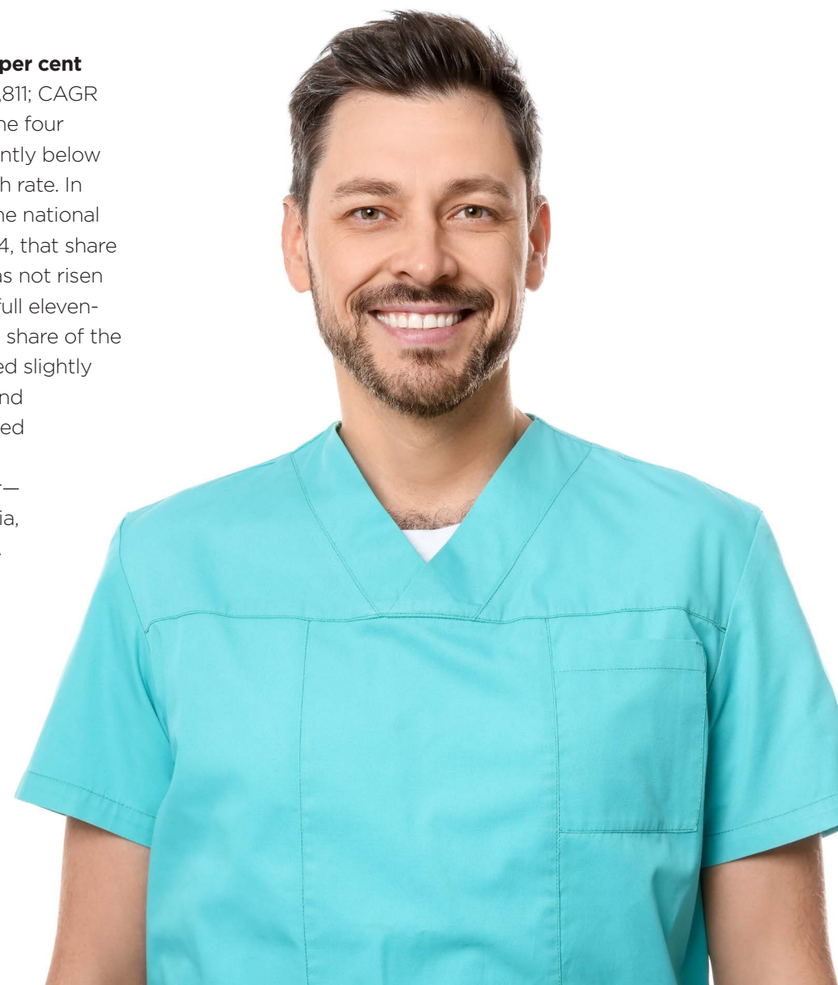
Profession	SA 2013	SA 2024	SA growth	National 2013	National 2024	National growth	SA share 2013 (%)	SA share 2024 (%)
Physiotherapy	1,892	3,193	+68.7%	20,980	38,972	+83.9%	9.0	8.2
Occupational therapy	1,050	2,377	+126.5%	13,280	29,015	+118.8%	7.9	8.2
Psychology (a)	1,191	1,811	+52.1%	22,894	36,540	+59.7%	5.2	4.9

Source: NHWDS longitudinal headcount series 2013–2024, Department of Health, Disability and Ageing.

Note: Growth calculated on employed headcount (not FTE). SA share = SA headcount ÷ national headcount × 100. SA population share ≈ 6.9% (ABS ERP 2024).

(a) SA psychology headcount growth (+52%) is below the national rate (+60%), below SA physiotherapy (+69%), and well below SA occupational therapy (+127%). SA's share of the national psychology workforce has declined from 5.2% to 4.9%, against a stable SA population share of ~6.9%.

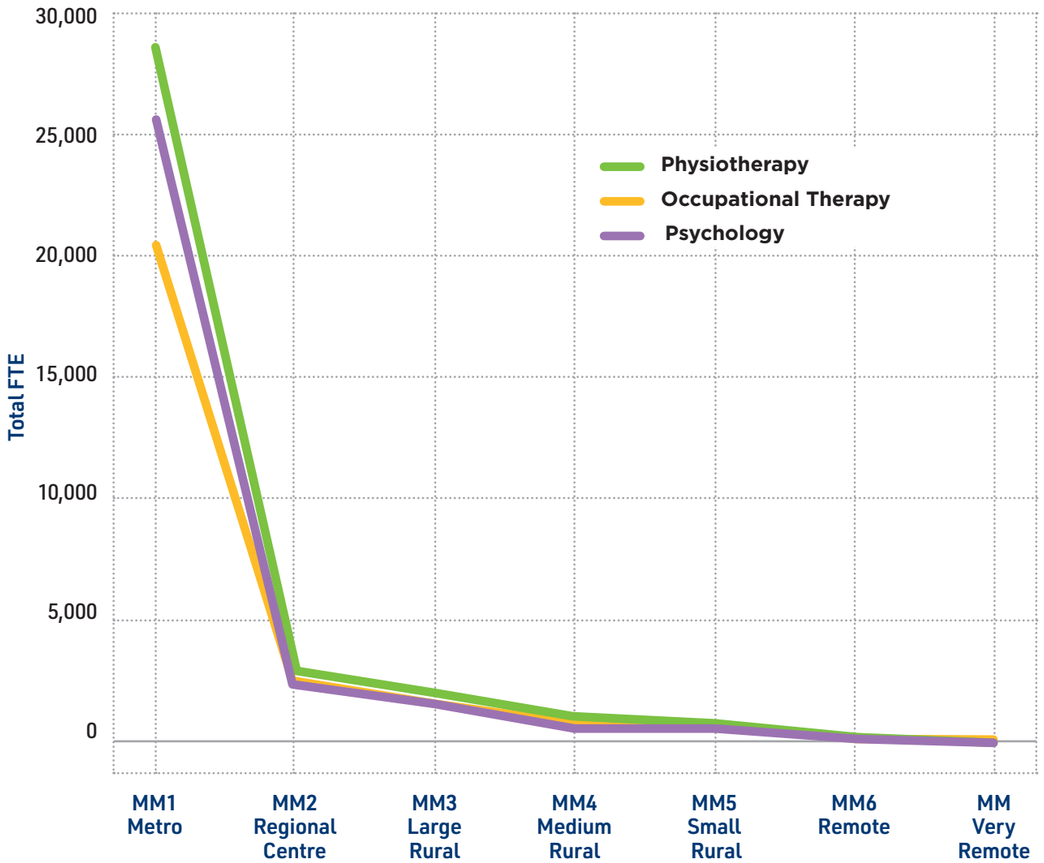
Psychology's growth was **52.1 per cent** over the same period (1,191 to 1,811; CAGR 3.9 per cent)—the slowest of the four focus professions and consistently below the national psychology growth rate. In 2013, SA held 5.2 per cent of the national psychology workforce; by 2024, that share had fallen to **4.9 per cent**. It has not risen above 5.2 per cent across the full eleven-year window. By contrast, SA's share of the national OT workforce increased slightly (7.9 per cent to 8.2 per cent) and its physiotherapy share remained stable (9.0 per cent to 8.2 per cent). Psychology is the outlier—growing everywhere in Australia, but growing more slowly in SA than anywhere else.



1.5 STATEWIDE SUPPLY MASKS A PERSISTENT RURAL AND REMOTE ACCESS GAP

Statewide per-capita figures aggregate across a geography as diverse as SA's—from inner Adelaide to the remote APY Lands. That aggregation conceals access conditions that are radically different from the metropolitan norm. Nationally, 81–83 per cent of all allied health employed FTE is concentrated in MM1 (metropolitan) areas. SA's geography amplifies this concentration: Adelaide is home to roughly 75 per cent of SA's population, and the remaining 25 per cent—across regional centres including Mount Gambier, Whyalla, Port Augusta, and Port Pirie, and extensive remote and very remote communities—is served by a fraction of allied health supply well below what population distribution would warrant (Figure 1.5a and Figure 1.5b).

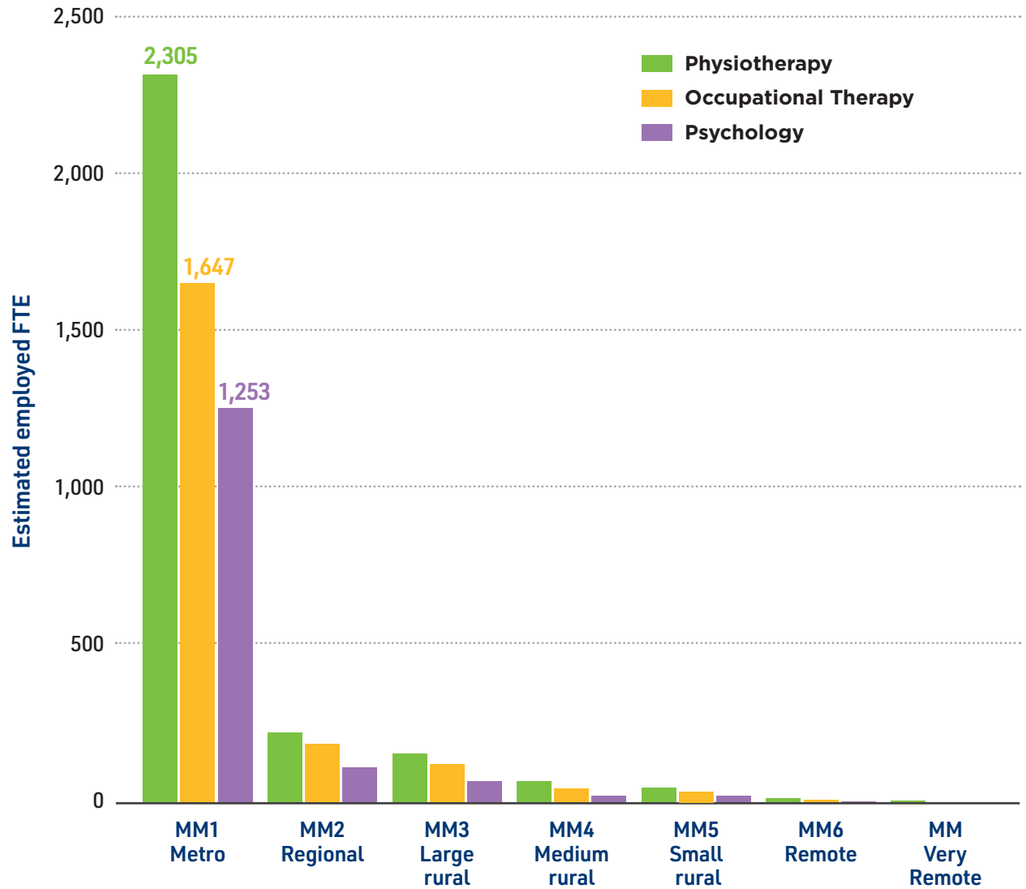
FIGURE 1.5a National allied health workforce by Modified Monash Model (MMM) remoteness, 2024



Source: NHWDS 2024, Dept of Health, Disability and Ageing.

Note: MMM = Modified Monash Model. MM1 = metropolitan. 81–83% of allied health FTE nationally is concentrated in MM1 metropolitan areas.

FIGURE 1.5b Estimated SA allied health FTE by MMM remoteness category, focus professions, 2024



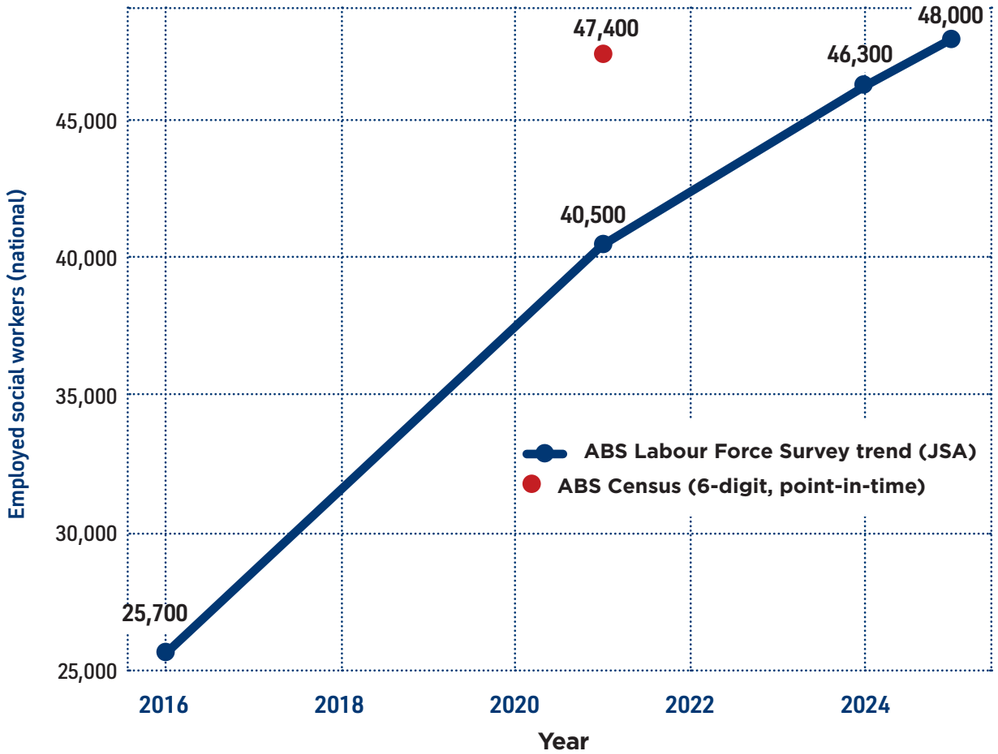
Source: Derived from NHWDS 2024 national MMM proportions applied to SA employed FTE totals.

Note: SA-specific MMM distribution is estimated by applying national MMM proportions (NHWDS 2024) to SA employed FTE totals (physiotherapy: 2,847; occupational therapy: 2,081; psychology: 1,504). Actual SA distribution differs from the national pattern and will be updated when SA-specific MMM data is extracted from the HWD tool (hwd.health.gov.au). Values should be interpreted as indicative only.

Psychology's distribution is the most extreme case. Across MM3–MM7 (regional through very remote), psychologist supply falls progressively and steeply, approaching near-zero in the most remote categories. In SA's regional and remote areas, psychological services in the public sector are delivered primarily through visiting clinician arrangements, outreach models, and telehealth. The national Rural and Remote Allied Health Workforce study (Brown et al., 2025) found these arrangements to be consistently rated as insufficient by both the practitioners who deliver them and the communities who receive them, and identified classification, supervision, and remuneration as the primary structural barriers to sustainable rural allied health supply. The SA Rural Allied Health Plan 2021–2026 reached similar conclusions (SA Health, 2021). Part 2 explores these barriers from the perspective of SA practitioners (Figure 1.6).

1.6 SOCIAL WORK REMAINS LARGELY INVISIBLE TO EXISTING WORKFORCE DATA

FIGURE 1.6 National social work employment trend: 2021–2025



Source: ABS Census of Population and Housing 2021 (ANZSCO 272511); ABS Labour Force Survey Detailed / Jobs and Skills Australia (2024, 2025).

Note: The 2021 Census figure (47,400) and the 2024–2025 LFS/JSA figures use different survey instruments and reference populations. They are not directly comparable and are presented as separate data series. Social work is self-regulated through AASW and absent from the NHWDS. SA estimate ~4,456 derived from 9.4% SA state share × 47,400 (2021 Census).

Social workers are self-regulated through the Australian Association of Social Workers (AASW) and are not registered with AHPRA. They do not appear in the NHWDS. There is no annual national dataset analogous to the NHWDS that captures social worker numbers, geographic distribution, or workforce characteristics. This absence is consequential. Social workers are central to hospital discharge planning, child and family services, community mental health, aged care, and domestic violence response. They constitute one of the largest allied health occupational groups in the SA public health system—and they are almost entirely invisible to the workforce planning frameworks that govern every other allied health profession (Table 1.5).

TABLE 1.5 Social work employment: national data and SA derived estimate

Measure	Value	Basis	Source
National employed social workers (Census 2021)	47,400	Headcount, ANZSCO 272511, ABS Census	ABS Census of Population and Housing 2021
SA employed social workers (derived estimate)	~4,456	Derived: 9.4% SA state share × 47,400 national headcount (a)	ABS Census 2021 / JSA state distribution
National LFS trend employment (2025)	~48,000	Employed persons, ANZSCO 2725 (4-digit, LFS) (b)	ABS LFS Detailed / JSA Nov 2025
National LFS trend employment (2024)	~46,300	Employed persons, ANZSCO 2725 (4-digit, LFS) (b)	ABS LFS Detailed / JSA Nov 2024
Female share (national)	84%	ABS Census 2021	ABS Census of Population and Housing 2021
Median age (national)	38 years	ABS Census 2021	ABS Census of Population and Housing 2021
Part-time share (national)	32%	ABS Census 2021	ABS Census of Population and Housing 2021

Source: ABS Census of Population and Housing 2021 (ANZSCO 272511); ABS Labour Force Survey Detailed (ABS); Jobs and Skills Australia Occupation Profiles (November 2024, November 2025).

Note: Social work is self-regulated through AASW and absent from the NHWDS. All figures in this table are employed persons headcount — not FTE — and are not directly comparable to NHWDS metrics. Health/hospital-only employment cannot be separately identified from available public data.

(a) The ~4,456 SA estimate is derived, not published. It uses JSA's published SA state share (9.4%) applied to the 2021 Census national headcount (47,400). SA's social work state share (9.4%) exceeds SA's population share (~6.9%), suggesting proportionally higher social work employment in SA than the national average.

(b) The ABS LFS 4-digit series (ANZSCO 2725) and the ABS Census 6-digit series (ANZSCO 272511) use different survey instruments and reference populations and are NOT directly comparable. They are shown as separate series. The Census 6-digit figure (47,400) is used as the primary reference in this report.

Social work data here are drawn from the ABS Census of Population and Housing (2021, ANZSCO 272511) and Jobs and Skills Australia Labour Market Insights. These sources estimate approximately 4,456 social workers employed in SA—around 235.6 per 100,000 population. This is not directly comparable to NHWDS employed FTE rates for registered professions: the collection method, reference year, and occupational definition differ. It should be treated as an order-of-magnitude estimate. What it establishes is scale: SA's social work workforce is large, and its absence from national planning frameworks is a structural gap with real planning consequences. The 2025 National Allied Health Workforce Strategy called explicitly for a national data collection mechanism for self-regulated professions including social work (Australian Government Department of Health, Disability and Ageing, 2025). Part 4 translates that call into a specific SA recommendation.

Part Two: South Australia Needs a Comprehensive Allied Health Workforce Plan

Key points

1. **South Australia's allied health workforce pressures are interconnected:** retention, career progression, rural supply, governance, workload, and workforce utilisation cannot be addressed effectively through isolated interventions.

2. **Recruitment alone will not build a sustainable workforce** when experienced practitioners face limited clinical career progression, stronger financial incentives outside the public system, and persistent workload pressures.

3. **A comprehensive workforce plan is needed** to connect training, recruitment, retention, career development, rural workforce supply, governance, and service delivery as parts of the same system.





SA's allied health workforce challenges are often experienced as separate problems: difficulty retaining experienced clinicians, persistent rural shortages, limited career progression, competition with the private sector, growing administrative workloads, and a lack of visibility over the contribution allied health makes to the health system. The evidence presented in this section suggests they are better understood as interconnected features of a workforce system that has developed without a comprehensive plan for allied health sustainability.

Part 2 examines why SA needs such a plan. It draws on the experiences of allied health professionals to identify the structural factors affecting retention, career development, rural workforce supply, workforce utilisation, and service delivery. In doing so, it shows why individual recruitment initiatives, incentive payments, or profession-specific interventions are unlikely to be sufficient on their own. A comprehensive workforce plan would provide a framework for addressing these pressures together, better aligning workforce demand with training and education pipelines, recruitment and retention, career pathways, rural workforce development, governance, and the delivery of allied health services.

Seventeen allied health professionals, including physiotherapists, psychologists, occupational therapists, social workers, and others, were interviewed across South Australia's public health system between July and August 2026. Their accounts were analysed using Framework Analysis (Ritchie & Spencer, 1994), a five-stage systematic method for qualitative data in applied policy research. Full details of the analytical approach are provided in Annexure Y: Qualitative Methods.

Quotes are reproduced verbatim from interview transcripts and attributed by profession, career stage, and practice setting only. No names, organisations, or identifiable geographic details are used. Case stories are drawn from participant narratives and de-identified in accordance with the study's ethics approval (Flinders HREC 9971). Where multiple participants described the same structural experience, this is noted.

Five themes emerged consistently across professions, career stages, and metropolitan and rural settings: the structural drivers of attrition, the career ceiling facing experienced clinicians, the persistent rural workforce cycle, gaps in the governance and measurement of allied health, and the administrative and workload pressures affecting practitioners. These are not isolated frustrations. Together, they show how weaknesses in one part of the workforce system reinforce pressures elsewhere. Recruiting graduates does little to build workforce capacity if experienced clinicians continue to leave; rural recruitment cannot deliver a sustainable workforce without viable career pathways and appropriate support; and making the case for greater investment is harder when the system does not consistently measure the contribution allied health makes.

The findings, therefore, provide more than a diagnosis of current workforce pressures. They help identify the functions a comprehensive workforce plan needs to perform: retaining experienced practitioners, creating viable clinical career pathways, building sustainable rural workforces, strengthening allied health governance and accountability, improving workforce and outcomes data, and ensuring practitioners are able to work to their capabilities.

This would build on existing work, including the SA Rural Allied Health Workforce Plan, while providing a broader, profession-wide framework for SA and positioning the state to align with the forthcoming National Allied Health Workforce Strategy. The themes that follow provide the practitioner evidence for that case.

THEME 1

South Australia Can Recruit Allied Health Graduates, but Struggles to Retain Them.

SA's public allied health system does not struggle to attract graduates. Across most professions, there is sufficient demand to fill entry-level positions. The problem begins around year two or three, when the economics of staying in the public sector stop making sense.

The private sector offers higher rates, greater autonomy, and the ability to control caseload. In psychology, Medicare-subsidised private practice is financially viable from the first year of full registration. In physiotherapy and occupational therapy, private clinic and NDIS work pays materially more than the public sector award. The public system competes on mission, team culture, and clinical breadth—real advantages, but not ones that sustain a career when rent is due and classification increments are capped.

The result is a predictable cycle. Public hospitals and community services invest two or three years developing a practitioner, and then lose them to the private sector at exactly the point when their clinical judgement is becoming genuinely useful. The system then recruits again. Workforce investment becomes a subsidy to the private sector, funded by SA Health.

> Most often we will get new grads apply. Most of the time they'll stay for two or three years and then we lose them to metro. We've invested two to three years of time in building up their skills and giving them opportunities, building their capacity. And then we lose them.
>
> ~ **PHYSIOTHERAPIST,** SENIOR, RURAL PUBLIC SECTOR

> Psychologists who have completed a six-year training program—with the HECS debt that comes along with that—are looking to be remunerated at greater than about thirty-eight dollars an hour. You actually make more money pulling beers on a Sunday at your local pub.
>
> ~ **PSYCHOLOGIST,** SENIOR, METRO PUBLIC SECTOR

~ **OCCUPATIONAL THERAPY**, METRO PUBLIC SECTOR

The Graduate Cycle

~ **OCCUPATIONAL THERAPY**, METRO PUBLIC SECTOR

A senior occupational therapist described a pattern that had repeated in her team over several years.

New graduates would join the public hospital system, invest two or three years building acute care skills, and then leave—not because the work was not meaningful, but because the private sector offered the same clinical breadth with significantly better pay and control over hours. The hospital would then recruit again, beginning the same cycle.

> "We don't have a problem recruiting new graduate OTs. We do really struggle to fill the AHP2 and AHP3 positions"

—the exact levels at which experienced practitioners are most clinically valuable. The system had become a training pipeline for the private sector, at public expense. This pattern was named independently by participants across multiple profession groups and settings.

WHAT IT MEANS

Incentive payments at the point of entry do not change the structural calculation that drives exit at year three. Retention reform requires addressing pay ceilings, workload conditions, and career trajectories—together, not in isolation.

CASE STORY 1

THEME 2

Clinical Career Progression Stalls Too Early.

For most SA public allied health professionals, AHP 2.6 is the last meaningful pay increment available to a clinician who wants to remain in clinical practice. That point is typically reached five to seven years into a career. After that, the salary flattens. The only routes forward are moving into management—which means leaving the clinical work they trained for—or leaving the public sector entirely. Practitioners who choose to stay are financially penalised for that decision, year after year.

> The highest you can go as a clinician is a level two point six. She is one year away from reaching the top of her increment, six years into her career. If I want to progress further in my career, I absolutely had to leave being a physio. That's sad. I like being a physio.
>
> ~ **PHYSIOTHERAPIST,** SENIOR, RURAL PUBLIC SECTOR

> At the moment you reach a senior clinical level, there is nowhere else to go. The only way to progress in pay and responsibility is sidestepping across into management positions. So, there's not enough opportunity to progress your clinical career—we do desperately need AHP4 positions.
>
> ~ **OCCUPATIONAL THERAPIST,** SENIOR, ACUTE METRO PUBLIC SECTOR

The AHP classification system also creates a structural inequity that participants named directly and forcefully: allied health operates under a multi-class award while nursing operates under a single-class system. The gap reflects a long-standing failure to settle whether allied health is a profession or a support service. Senior allied health clinicians with two decades of post-graduate expertise sit below the pay of comparably experienced nurses—not because their clinical complexity is less, but because the award structure was never redesigned to reflect it.

The problem extends beyond the AHP 2.6 ceiling. The current framework does not provide a sufficiently coherent pathway for allied health professionals to develop from early-career practitioners into senior, advanced, and principal clinical roles, while also supporting progression into professional and executive leadership. Addressing the existing ceiling without reforming the broader classification structure risks shifting the point at which progression stalls rather than resolving the underlying problem. A contemporary career framework must recognise increasing clinical expertise, responsibility, supervision, leadership, and professional contribution throughout a practitioner's career.

Fifteen Years at the Ceiling

~ **PHYSIOTHERAPY,** METRO PUBLIC SECTOR

A physiotherapist described a colleague who had been at the maximum clinical pay increment for fifteen years.

There had been no performance issue, no career stagnation in any clinical sense—the practitioner was carrying a complex caseload, mentoring junior staff, and leading clinical programs. But the classification system had nothing left to offer. The practitioner had earned the same base rate for a decade and a half, regardless of contribution.

> "There's no motivation, because they're not going to get paid any more for doing it."

The practitioners most affected by the ceiling are consistently those most worth retaining: those in their second decade of practice, who carry the institutional knowledge, the supervisory capacity, and the complex caseload competence that new graduates cannot replicate.

WHAT IT MEANS

The 2025 Allied Health Enterprise Agreement is a beginning. Clinical specialist pathways—analogous to clinical nurse consultant and clinical nurse specialist tracks—are the structural mechanism required to keep experienced allied health clinicians in clinical roles. Without them, the system will continue losing its most capable practitioners at the exact point they have the most to give.

CASE STORY 2

THEME 3

Rural South Australia Faces a Workforce Cycle It Cannot Break Without Coordinated Reform.

Rural and remote SA does not have a temporary shortage waiting to be resolved by the next graduate cohort. It has a structural supply problem maintained by the same conditions that drive metropolitan attrition—except harder. Rural postings add professional isolation, limited peer supervision, greater clinical complexity, and in parts of regional SA, a near-complete absence of rental accommodation. A graduate who accepts a rural position is making an economically irrational decision within the current incentive structure. Many make it anyway. Most leave within three years.

The rural psychology workforce illustrates this acutely. Progression to AHP3 level for a psychologist in SA Health requires a clinical master's qualification—a program with very limited places concentrated in metropolitan universities. A psychologist who builds their entire career in rural or remote mental health, developing the broad generalist expertise that rural practice demands, can be structurally blocked from career progression by a qualification requirement that the rural system itself cannot support them to obtain.

> There was something like three rentals available across the entire York Peninsula.
>
> **~ PHYSIOTHERAPIST,** SENIOR, RURAL PUBLIC SECTOR

> In country mental health, we are like a one-size-fits-all model—we're generalists, but we have to be specialists in lots of different areas. You have to be a lot more resourceful. In metro, if you don't meet the criteria for one particular service, there's lots of other options. In the country, there isn't.
>
> **~ PSYCHOLOGIST,** SENIOR, RURAL PUBLIC SECTOR

The Rural Paradox

~ PSYCHOLOGY, RURAL PUBLIC MENTAL HEALTH

A psychologist who had spent their entire career in rural public mental health described the structural paradox they faced.

Across years of practice in a remote multidisciplinary team—managing high-complexity presentations, supervising colleagues, providing consultation to aged care facilities and distant communities—they had developed a depth of clinical competence that few metropolitan practitioners could match. But because the qualification required to progress to the next classification level could only realistically be obtained in Adelaide, and because their family and community were in the region, career progression had effectively stalled.

> "The system had created a condition in which practitioners most committed to rural practice were the ones least able to advance within it — rewarding geographic mobility over clinical depth."

WHAT IT MEANS

Rural supply requires three coordinated levers: cadetship programs expanded to all four focus professions; extended regional placements (minimum twelve weeks) with structured housing and relocation support; and a rurality loading that reflects genuine clinical complexity, not just geographic distance. Qualification pathways for rural practitioners must also be reviewed so that career progression does not require practitioners to leave the communities they serve.

CASE STORY 3

THEME 4

Allied Health's Contribution Is Not Adequately Measured or Recognised

The most consistently evidenced finding across all profession groups is one that does not appear in any workforce dataset: SA Health has no systematic way of measuring what allied health contributes. The consequence is not merely professional frustration. It is structural under-investment—because institutions cannot fund what they cannot see.

Allied health professionals reduce length of stay, prevent readmissions, and lower cost-per-episode. The evidence for this exists in the international literature and in the clinical records of SA hospitals. What does not exist is a standardised framework that aggregates those contributions and presents them in the financial language of executive decision-making. When allied health leaders enter budget discussions without outcome data, they are asking for investment on trust. Nursing and medical teams are not. This places allied health at a structural disadvantage when competing for resources.

> We just don't report on that at all. If you're talking to CEOs or finance teams, they don't really care about outcomes. They just care about: it cost you this much money, and we save this much money.
>
> **~ PHYSIOTHERAPIST,** SENIOR, RURAL PUBLIC SECTOR

> I don't think government as a whole has a really good understanding of what allied health can and should be doing. There is a direct connection between psychology and ramping—if people have access to psychology that is easy to access and delivering evidence-based interventions, they for the most part don't need to go to hospital. They don't become another body in the back of an ambulance waiting for a mental health bed.
>
> **~ PSYCHOLOGIST,** SENIOR, METRO PUBLIC SECTOR

Scope restrictions compound this. Practitioners trained for advanced clinical roles are regularly constrained by referral protocols and institutional hierarchies that reflect the medical model's design, not the current evidence base for allied health-led care. They work below their capacity not because they lack capability, but because the system was not built with their capability in mind.

The Invisible Contribution

~ OCCUPATIONAL THERAPY, ACUTE HOSPITAL CARE

A senior occupational therapist working in acute hospital care described the particular frustration of invisible contribution.

Every day, her team was making discharge decisions that reduced length of stay, prevented readmission, and freed beds—the precise outcomes hospital executives were under pressure to achieve. But none of this work was aggregated or presented in a form that appeared in budget conversations. When the department sought additional FTE, the case had to be made on general grounds.

> "It's operating on the margins, and we're just providing an in and out consultancy service. We're not well integrated in any way."

The data to make the financial case existed in the clinical record. The framework to aggregate and present it did not. This experience—of contributing to institutional outcomes that are never attributed or counted—was described by participants across multiple professions and settings.

WHAT IT MEANS

Two structural changes follow. First, SA Health needs an allied health outcome data framework—a standardised set of metrics that make the contribution of allied health visible at the executive level. Second, a dedicated Allied Health governance function, reporting at Deputy CEO level, is the structural precondition for anything else on this list. Without a governance home, allied health reform has no institutional owner.

CASE STORY 4

THEME 5

Workforce Pressures Persist Despite Practitioners Identifying What Needs to Change.

The practitioners interviewed in this study are not disengaged. They are precise. Across seventeen interviews, participants named the same structural changes, in the same order, with the same specificity: FTE-to-caseload benchmarks with accountability mechanisms; an allied health governance function at the SA Health executive level; clinical career pathways that do not require leaving clinical practice; and technology support for the administrative tasks that currently consume clinical time.

The administrative burden is not incidental. Non-clinical load—data entry, compliance reporting, scheduling, referral coordination—has expanded without clinical FTE to absorb it. Practitioners describe spending material portions of their working week on tasks that require no clinical training, at the cost of the therapeutic work their patients need. Social workers in particular described the volume of cross-agency coordination required for a single discharge or referral—navigating shifting eligibility criteria, fluctuating service capacity, and referral pathways designed around institutional boundaries rather than patient need.

> Staff wellbeing has to drastically change. Staff wellbeing needs to take precedence over patient care. Because if we can't stay safe and well ourselves, and if we keep burning out and resigning, then the patient care will continue lacking."
>
> ~ **OCCUPATIONAL THERAPIST,** SENIOR, ACUTE METRO PUBLIC SECTOR

> You don't have that support. You are basically going from one traumatic event to another without that debrief time—and even when you have that debrief time, it doesn't always meet what that one person specifically needs.
>
> ~ **SOCIAL WORKER,** EARLY CAREER, METRO PUBLIC SECT

When the System Becomes Personal

~ **SOCIAL WORK,** CHILD AND FAMILY HEALTH

A social worker in a specialist child and family health setting described what happens when structural under-resourcing becomes personal.

The team had been short-staffed for months. Caseloads had grown without any mechanism to formally identify when they had exceeded what a single practitioner could safely carry. Two experienced colleagues had left within the previous year—both citing inadequate supervision, limited access to resources, and the absence of leadership response when workload became unmanageable.

> "It always comes down to that—the pay, the support, and access to the resources you need to do the work meaningfully."

What was striking was the precision of the account. This was not a generalised complaint. It was a structural diagnosis, offered by someone who had watched the same failure repeat—and who, despite that, was still there.

WHAT IT MEANS

The reform proposals that emerge from this study are not aspirational. They are a diagnostic. The workforce has told SA Health, from seventeen different vantage points, what the structural problems are and what is needed to fix them. The recommendations in Part 4 are grounded directly in that evidence.

CASE STORY 5

SOUTH AUSTRALIA'S WORKFORCE CHALLENGES REQUIRE AN INTEGRATED RESPONSE

The quantitative evidence in Part 1 establishes the scale and distribution of South Australia's allied health workforce challenges, including a significant and growing gap in psychology. The qualitative evidence in Part 2 adds an important practitioner perspective, showing how retention pressures, limited clinical career pathways, rural workforce challenges, gaps in governance and measurement, and growing workload pressures interact within the public health system.

Taken together, the evidence points to a workforce challenge that cannot be addressed through isolated recruitment initiatives, incentives, or profession-specific interventions.

The career ceiling, the pull of the private sector, the rural workforce cycle, gaps in governance and measurement, and administrative and workload pressures are interconnected features of a system that has developed without a comprehensive plan for allied health sustainability.

SA needs a workforce plan that addresses these pressures as parts of the same system, and better aligns workforce demand, training, recruitment, retention, career development, governance, and service delivery. Part 3 sets out the six foundations required to build that plan.



Part Three: A Comprehensive Workforce Plan Must Address Six Foundations

Key points

1. **South Australia needs better workforce intelligence** that captures vacancies, turnover, workforce distribution, and professions that currently fall outside national registration datasets.
2. **Sustainable workforce supply requires more than recruitment:** rural pathways, training, career progression, remuneration, and opportunities to work at full scope must reinforce one another.
3. **Workforce reform requires stronger integration and clear accountability,** with allied health embedded in multidisciplinary service delivery and a dedicated governance structure responsible for measurable workforce outcomes.



The evidence assembled in Part 1 and 2 points to a common conclusion: SA's allied health workforce problems are structural, and structural problems require structural responses.

Research on health workforce policy and planning across comparable health systems has demonstrated that the challenges facing SA—geographic maldistribution, early-career attrition, classification ceilings, and governance gaps—are not incidental or cyclical, but arise from, and are sustained by, the architecture of training, regulation, and remuneration within which the workforce operates (Balasubramanian et al., 2019). Piecemeal interventions adjust one element while others remain unchanged; a sustained improvement requires a plan that addresses all six foundations simultaneously and with institutional accountability.

3.1 BETTER WORKFORCE INTELLIGENCE MUST UNDERPIN WORKFORCE PLANNING

Effective workforce planning depends on having a clear and comprehensive picture of SA's allied health workforce. The NHWDS provides supply data for the twelve allied health professions registered with AHPRA—physiotherapy, occupational therapy, psychology, podiatry, optometry, chiropractic, osteopathy, Chinese medicine, Aboriginal and Torres Strait Islander health practice, medical radiation practice, paramedicine, and pharmacy. A substantial number of allied health professions are self-regulated through their own professional associations and do not appear in the NHWDS at all: social work (AASW), speech pathology (Speech Pathology Australia), dietetics and nutrition (Dietitians Australia), exercise physiology (ESSA), orthoptics, and others. Even for AHPRA-registered professions, the NHWDS captures registration-linked data but does not systematically report vacancy rates, fill rates, time-to-fill, workforce demographics at LHN level, or the distribution of supply between the public and private sectors. Planning decisions are currently made on a combination of aggregate NHWDS data, periodic surveys, and anecdotal intelligence from individual networks.

Keeping pace with workforce change requires timely, ongoing intelligence rather than periodic snapshots. International evidence on health practitioner regulation and workforce governance shows that jurisdictions with dedicated workforce intelligence functions—regular reporting cycles, disaggregated geographic data, and mechanisms for capturing self-regulated professions—produce more responsive and equitable planning outcomes (Leslie et al., 2023). The 2025 National Allied Health Workforce Strategy identified dedicated allied health data infrastructure as a prerequisite for planning reform and called for collection mechanisms that extend beyond AHPRA registration (Australian Government Department of Health, Disability and Ageing, 2025).

Foundation 3.1: Establish a dedicated SA allied health workforce intelligence function—reporting annually on supply, vacancy, turnover, and fill rates across all LHNs and the private sector. Begin with the four focus professions (physiotherapy, occupational therapy, psychology, and social work), and extend progressively to all allied health professions over the first three years of the plan, including those currently outside the NHWDS.

3.2 RURAL AND REMOTE SUPPLY REQUIRES TARGETED AND SUSTAINED INTERVENTION

Eighty-one to eighty-three per cent of Australia's allied health employed FTE is located in metropolitan areas. In SA, the concentration is even more pronounced: Adelaide's share of both population and allied health supply creates an access gap in regional, rural, and remote communities that is not closing (Balasubramanian et al., 2021; Rural Workforce Agency Victoria, 2026). The mechanisms sustaining this gap are well understood. Rural areas offer fewer training placements, lower starting salaries, limited peer support and clinical supervision, and fewer career development opportunities—conditions that make initial recruitment difficult and ongoing retention harder. National analysis of rural and remote allied health supply confirms that without structural changes to these incentive conditions, rural recruitment campaigns produce short-term placements rather than sustained workforce presence.

> "We've got some cadetship programs, which is really helping... If you've got people from the area who go to Adelaide to study, and then they get to come back and have a job, that seems to be the most reliable way of getting allied health in regional areas."
>
> **~ ALLIED HEALTH PROFESSIONAL, REGIONAL PUBLIC SECTOR**

The SA Rural Allied and Scientific Health Workforce Plan 2021–2026 identified cadetships, extended rural placements, and housing support as the most effective levers for regional supply—and the qualitative evidence from this study confirms that where cadetship models exist, they are valued by practitioners and communities alike (SA Health, 2021). Their reach, however, is currently limited, their funding is insecure across electoral cycles, and not all allied health professions have access to them at comparable scale.

Foundation 3.2: Scale cadetship programs with funding security across at least three electoral cycles, beginning with the four focus professions and extended to all allied health professions over time. Establish extended regional placements of six months or more with housing and relocation support. Link rural training positions to public sector employment pathways rather than open-market entry.

3.3 STRONGER TRAINING AND CAREER PATHWAYS ARE ESSENTIAL TO BUILDING LONG-TERM SUPPLY

Allied health graduates enter the public sector clinically prepared but frequently without the structured transition support needed to sustain long-term public sector careers. The qualitative evidence from this study identifies the transition from student to practitioner as a high-risk period for attrition: graduates who do not receive adequate supervision, peer support, and role clarity in their first one to two years are more likely to leave the public sector entirely. This pattern is consistent with national retention evidence, which identifies early-career support structures as among the strongest modifiable predictors of retention (Australian Government Department of Health, Disability and Ageing, 2025).

"To actually get a job in the public system, it kind of does hedge on getting a placement in your university degree... The universities churn out people, but they don't get enough placement time in the public sector to actually want to work there."

~ ALLIED HEALTH PROFESSIONAL, ACUTE METRO PUBLIC SECTOR

Beyond the transition period, the classification ceiling — documented in detail under Theme 2 — creates a second attrition point. Practitioners who reach the top of the public sector AHP salary band, typically within five to seven years of graduation, face a choice between leaving clinical practice for management or leaving the public sector altogether.

Foundation 3.3: Establish structured graduate support programs—minimum twelve months of supervised practice with dedicated supervision time—across all SA Health LHNs. Expand clinical education partnerships with Flinders University and Adelaide University (including the Flinders HealthCARE pipeline model). Develop an integrated allied health career framework that provides clear pathways from graduate and early-career practice through to senior, advanced, and principal clinical roles, alongside professional management and executive leadership. Progression should be supported by structured professional development, recognised clinical capabilities, and opportunities to advance without leaving clinical practice.

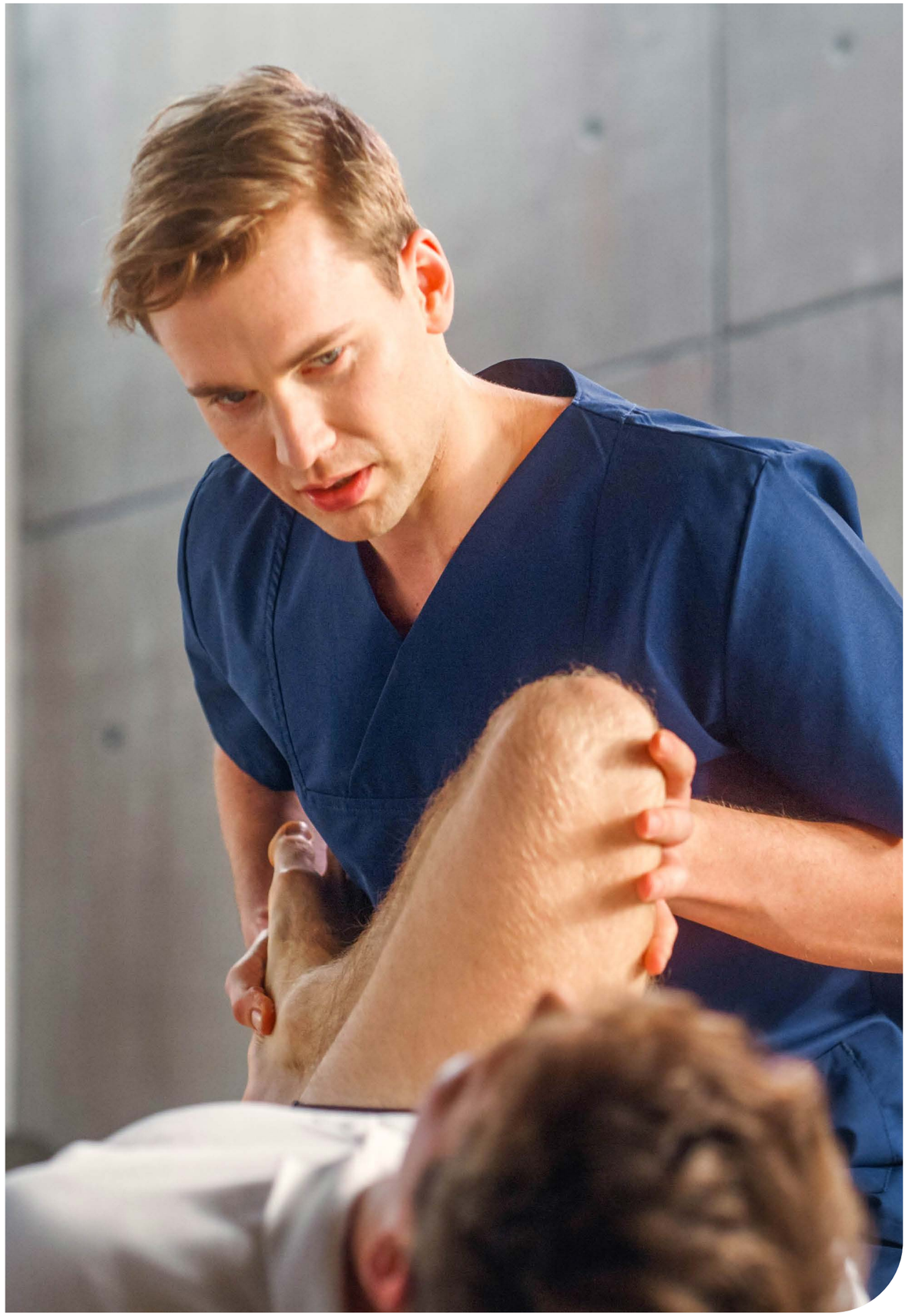
3.4 RETENTION DEPENDS ON CAREER PROGRESSION, FAIR PAY, AND FULL-SCOPE PRACTICE

Retention is not only a pathway problem—it is also a remuneration and scope problem. Allied health professionals in the SA public sector describe salary structures that do not reflect their level of expertise, pay disparity with nursing at equivalent classification levels, and a 2025 Allied Health Enterprise Agreement that, while a step forward, has not resolved the underlying classification ceiling that drives mid-career attrition. This tension between what the system needs from its allied health workforce and the structural conditions it provides in exchange is documented consistently in Australian and international health workforce literature (Balasubramanian et al., 2019).

"The physios that we've got that have been there for twenty plus years, they've been on that same increment for years... There's no reward for staying. The reward is leaving."

~ ALLIED HEALTH PROFESSIONAL, REGIONAL PUBLIC SECTOR

Scope of practice is the second dimension of this foundation. Allied health professionals consistently report working below their full scope—performing tasks that could be delegated to assistant-level staff, completing administrative functions that should not require clinical time, and being excluded from decisions where their clinical expertise



is directly relevant. A workforce operating at less than full scope is, in effect, a smaller workforce than the headcount suggests—and a more frustrated one.

Foundation 3.4: Modernise the allied health classification and remuneration framework across the full career continuum, establishing transparent progression criteria, meaningful salary advancement, and recognition of increasing clinical expertise, professional responsibility, and leadership. Reform should address the existing AHP 2.6 ceiling without creating equivalent barriers at higher classifications, while pursuing pay parity with nursing at comparable qualification and responsibility levels. Implement full-scope practice models across SA Health LHNs, including task delegation frameworks that free senior clinicians for higher-order clinical work. Build on the 2025 Allied Health Enterprise Agreement as a foundation, not a ceiling.

3.5 INTEGRATED CARE REQUIRES ALLIED HEALTH TO BE EMBEDDED IN MULTIDISCIPLINARY TEAMS

The dominant model of allied health practice in SA's public sector is the consultancy model: a referral is received, the patient is seen, and the patient is returned to the referring clinician. This model is efficient in high-throughput acute settings, but it is poorly suited to the complex, chronic, and multi-morbidity presentations that now dominate public health demand. What these presentations require is genuine multidisciplinary practice—teams that share clinical information in real time, co-design care plans, and adjust roles based on patient need rather than professional boundary (Balasubramanian & Short, 2021). Research on integrated care models consistently shows improved patient outcomes, reduced system costs, and higher workforce satisfaction compared to siloed service delivery (AIHW, 2026).

> "There is a need for more collaboration... a perfect opportunity to collaborate with the OT or the allied health team more broadly. But the systems don't allow for it—the referral pathway is one way, and then you lose the patient."
>
> **~ ALLIED HEALTH PROFESSIONAL, ACUTE METRO PUBLIC SECTOR**

SA Health's own strategic directions—virtual care, in-home services, and preventative health—create a platform for genuinely integrated allied health practice. The challenge is translation from strategy to practice: integrated care requires different rostering, different information systems, different supervision structures, and a willingness to reorganise roles around patient need rather than inherited departmental boundaries.

Foundation 3.5: Mandate and resource multidisciplinary team models in SA Health's community mental health, chronic disease, aged care, and rehabilitation programs. Align digital health infrastructure to enable shared care planning across professional groups and LHN boundaries. Embed allied health leadership within SA Health's virtual care, in-home, and preventative health service redesign programs.

3.6 SUSTAINED REFORM REQUIRES CLEAR GOVERNANCE AND ACCOUNTABILITY

The five foundations above will not deliver sustained change without a governance structure that assigns clear responsibility, tracks progress, and holds the system accountable. SA currently has no dedicated allied health workforce governance function. The psychology gap has persisted for more than a decade without triggering a systematic policy response. Workforce decisions are made at LHN level without cross-LHN coordination, and there is no mechanism for translating national strategy commitments into SA-level implementation. This is not a failure of intent—it is a failure of structure. Evidence from comparable health systems demonstrates that where governance mechanisms for allied health workforce are adequately resourced and institutionally empowered, planning outcomes improve; where they are absent, the workforce that emerges reflects market incentives rather than population need (Balasubramanian et al., 2019; Leslie et al., 2023).

> "In Allied Health more broadly, there's a lot of infighting... Allied Health is so like everybody kind of stays in their own lane. And that's the problem—nobody's got the big picture."
>
> **~ ALLIED HEALTH PROFESSIONAL, REGIONAL PUBLIC SECTOR**

Accountability is most effective when it is specific: clear targets, reporting timelines, and identified lead agencies provide the foundation for sustained progress. The 2025 National Allied Health Workforce Strategy established a national accountability framework that South Australia can align with and build upon, including annual public reporting and defined lead responsibilities at each level of government.

Foundation 3.6: Establish a dedicated SA Allied Health Workforce Governance Committee—reporting to the Minister for Health—with representation from SA Health, HSU SA/NT, universities, regional LHNs, and peak bodies spanning the full breadth of allied health professions in SA, with the four focus professions (physiotherapy, occupational therapy, psychology, and social work) as initial priority members. The committee's mandate: produce an annual SA Allied Health Workforce Report, set measurable supply and distribution targets for each focus profession—and, progressively, for all allied health professions—and monitor implementation of the plan's five other foundations. The psychology gap—29 per cent below the national benchmark—should be the primary, quantified target against which progress is reported from the first year.

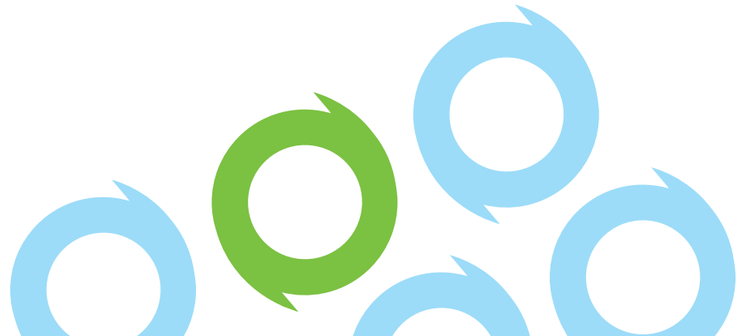
Profession profiles for each of the four focus professions — physiotherapy, occupational therapy, psychology, and social work — are provided as Annexure 4 to this report.

Part Four
Recommendations and Blueprint

The six foundations above map directly to the seven recommendations that follow. Foundation 3.1 (workforce intelligence) underpins Recommendation 2. Foundation 3.2 (rural supply) underpins Recommendation 4. Foundation 3.3 (training pathways) informs Recommendations 4 and 5. Foundation 3.4 (retention, pay, scope) underpins Recommendations 5 and 6. Foundation 3.5 (integrated care) underpins Recommendation 7. Foundation 3.6 (governance and accountability) underpins Recommendations 1 and 3. Together, the foundations provide the evidence base; the recommendations translate that evidence into time-bound, accountable action.

Seven recommendations—from evidence to action

The findings of this report converge on a single imperative: South Australia needs a comprehensive, accountable allied health workforce plan. The seven recommendations that follow are sequenced deliberately. The first three create the enabling conditions—the mandate, the data, and the governance—without which the remaining four cannot be implemented or sustained. Each recommendation links to the six foundations in Section 3, and each has a named lead and implementation horizon (insert below recommendations infographic). The implementation summary table at the end of this section provides a consolidated view across all seven.



RECOMMENDATION 1

Develop and Adopt South Australia's First Allied Health Workforce Strategy

South Australia must commit to a dedicated, publicly accountable allied health workforce strategy.

South Australia has never had a comprehensive, publicly accountable plan for its allied health workforce. The Commonwealth's 2025 National Allied Health Workforce Strategy creates both the mandate and the framework for a state-level response. SA Health should develop and adopt the state's **first Allied Health Workforce Strategy** within twelve months—a publicly released document with measurable targets, named leads, and an annual reporting commitment. Without this, every other recommendation in this report remains a program rather than a plan.

LEAD: Minister for Health / Department for Health and Wellbeing | Horizon: 0-12 months (enabling)

RECOMMENDATION 2

Establish a South Australian Allied Health Workforce Intelligence Function

SA cannot plan for a workforce it cannot fully see — a dedicated intelligence function is the essential first step.

A strategy is only as strong as the data behind it. SA Health should establish a dedicated allied health workforce intelligence function — within the Department for Health and Wellbeing — reporting annually on supply, vacancy, fill rates, and workforce demographics across all LHNs and the private sector. Begin with the four focus professions and extend to all allied health professions within three years, including those not captured by the NHWDS.

This function need not be built from scratch. Several Australian jurisdictions have established comparable mechanisms: Health Workforce Queensland's Allied Health Workforce Strategic Framework provides a useful model, and NSW Health's Rural Allied Health Strategic Plan demonstrates how workforce intelligence can be disaggregated to regional level. SA has the institutional infrastructure to do the same.

Universities and research centres are natural partners in this effort. South Australia has substantial existing research capacity that could be formally mobilised in support of a workforce intelligence function. The Centre for Social Impact at Flinders University brings expertise in health and social sector workforce analytics; Adelaide University's health workforce and population health research groups offer complementary capability in data science, workforce modelling, and primary care. A co-design partnership between SA Health, AHPRA, these institutions, and peak allied health professional bodies would ensure the intelligence function is both methodologically robust and independent — and would position South Australia as a national reference point for allied health workforce research.

LEAD: SA Health / Department for Health and Wellbeing; in partnership with South Australian universities and health workforce research centres | Horizon: 0-2 years (enabling)

RECOMMENDATION 3

Establish a Governance Function with Cross-System Authority

Data and strategy without governance produce reports, not change. SA needs a committee with the authority to act.

Intelligence without governance is noise. A dedicated SA Allied Health Workforce Governance Committee—reporting to the Minister for Health, with representation from SA Health, HSU SA/NT, universities, regional LHNs, and peak bodies spanning all allied health professions—should be established before or concurrently with R4-R7. Its mandate: set measurable supply targets, monitor implementation, and produce an annual public report. The psychology gap — **29 per cent below the national benchmark** — should be the primary quantified target from year one.

LEAD: SA Health / Department for Health and Wellbeing | Horizon: 0-2 years (enabling)

RECOMMENDATION 4

Scale Cadetship, Training Pipeline, and Regional Placement Programs

Build the pipeline. Rural supply requires sustained cadetship investment across electoral cycles.

Expand cadetship models with funding security across at least three electoral cycles, beginning with the four focus professions and extended to all allied health professions over time. Increase rural placement length to at least **six months** with housing and relocation support. Link rural training positions to guaranteed public sector employment pathways. Expand clinical education partnerships with Flinders University and Adelaide University.

LEAD: SA Health / Flinders University / Adelaide University / LHNs | Horizon: 0-3 years



RECOMMENDATION 5

Modernise the Allied Health Classification and Career Framework

Establish a contemporary career structure that supports professional development, clinical advancement, and leadership across the full allied health career continuum.

Undertake a comprehensive review and modernisation of SA Health's allied health classification and career framework, in partnership with HSU SA/NT and allied health professionals. The reform should establish clear, meaningful, and appropriately remunerated progression pathways from graduate and early-career practice through to senior, advanced, and principal clinical roles, alongside professional management and executive leadership.

The framework should recognise increasing clinical expertise, professional responsibility, supervision, education, research, and leadership, with transparent criteria for advancement and structured opportunities for professional development. It must provide genuine progression for practitioners who wish to remain in clinical practice, rather than requiring movement into management to achieve higher classification and remuneration.

Reform should address the existing AHP 2.6 ceiling while ensuring that new classifications do not simply create further barriers to career progression. The objective is a coherent, sustainable career structure that supports retention, rewards professional development, and strengthens SA Health's capacity to attract and retain experienced allied health professionals throughout their careers.

LEAD: SA Health / HSU SA/NT | Horizon: 1-3 years

RECOMMENDATION 6

Resolve Pay Disparity and Build on the 2025 Allied Health Enterprise Agreement

The 2025 Allied Health Enterprise Agreement is a foundation — treat it as a floor, not a ceiling.

Treat the 2025 Allied Health Enterprise Agreement as a **foundation, not a ceiling**. SA Health, in partnership with HSU SA/NT, should pursue classification reform that achieves genuine pay parity with nursing at equivalent qualification and responsibility levels—the most powerful available lever for mid-career retention, on the evidence of this study.

LEAD: SA Health / HSU SA/NT / SA Government | Horizon: 2-5 years

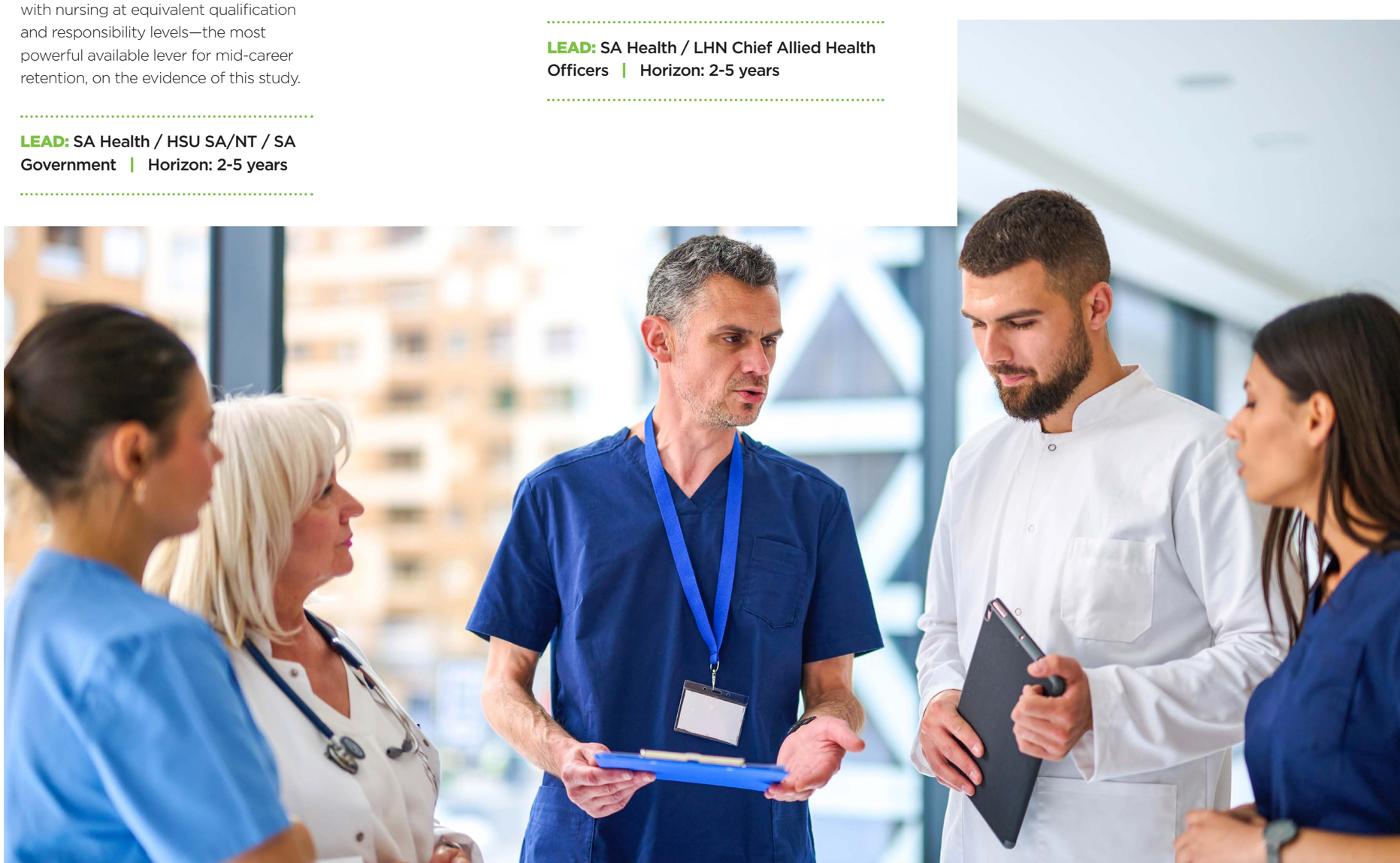
RECOMMENDATION 7

Mandate Top-of-Scope Practice and Invest in Team-Based Care

End the practice of deploying allied health professionals below their qualification level.

Mandate full-scope practice models across all SA Health LHNs. Implement task delegation frameworks that free senior clinicians for higher-order clinical work. Embed allied health leadership within the design and governance of SA Health's virtual care, in-home, and preventative health programs.

LEAD: SA Health / LHN Chief Allied Health Officers | Horizon: 2-5 years



IMPLEMENTATION SUMMARY

The seven recommendations form a sequenced implementation pathway across three phases. R1-R3 are enabling—they create the strategy mandate, data infrastructure, and governance authority on which R4-R7 depend. R4-R5 address the pipeline and career pathway conditions for long-term supply. R6-R7 address remuneration and practice conditions for retention and productivity.

Recommendations Summary blueprint—seven recommendations for South Australia allied health workforce reform

Rec	Recommendation	Foundation	Lead	Horizon
R1	SA's First Allied Health Workforce Strategy	3.6	Minister / DHW	0-12 months
R2	Allied Health Workforce Intelligence Function	3.1	SA Health / DHW; Universities & research centres	0-2 years
R3	Governance Function with Cross-System Authority	3.6	SA Health / DHW	0-2 years
R4	Cadetship, Pipeline & Regional Placement Programs	3.2 + 3.3	SA Health / Universities	0-3 years
R5	Modernise the Allied Health Classification and Career Framework	3.3 + 3.4	SA Health / HSU	1-3 years
R6	Pay Disparity & 2025 EBA Reform	3.4	SA Health / HSU / Gov	2-5 years
R7	Top-of-Scope Practice & Team-Based Care	3.5	SA Health / LHNs	2-5 years

R1, R2, and R3 are sequentially enabling: the Strategy creates the mandate; the Intelligence function provides the evidence base; the Governance function provides the accountability structure for R4-R7.

METHODOLOGY NOTE

Quantitative component: National Health Workforce Dataset (NHWDS) 2013–2024; ABS Census 2021; JSA Labour Market Insights. See Annexure 2 for full quantitative methodology.

Qualitative component: Semi-structured interviews with 15+ SA allied health professionals (purposive sample; physiotherapy, psychology, occupational therapy, social work). Framework analysis (Ritchie & Spencer, 1994). See Annexure 3 for full qualitative methodology.

References

1. Australian Government Department of Health, Disability and Ageing. (2025). Draft National Allied Health Workforce Strategy—Consultation Draft v2.0. Commonwealth of Australia.
2. Australian Bureau of Statistics. (2021). Census of Population and Housing—Social Workers (ANZSCO 272511). Australian Bureau of Statistics.
3. Australian Institute of Health and Welfare. (2024). Health Workforce—Allied Health. AIHW.
4. Australian Institute of Health and Welfare. (2026). Australia's Health 2026. AIHW.
5. Alshehri, S. A., Simmonds, L., Shafei, A., Indriyani, F., Al-Hanawi, M. K., & Balasubramanian, M. (2026). Health workforce planning models for older adults in the WHO Eastern Mediterranean Region: A mixed methods systematic review. Human Resources for Health, 24(1), 38. https://doi.org/10.1186/s12960-026-01077-9
6. Balasubramanian, M., Brennan, D. S., Short, S. D., & Gallagher, J. E. (2019). A strife of interests: A qualitative study on the challenges facing oral health workforce policy and planning. Health Policy, 123(11), 1068–1075. https://doi.org/10.1016/j.healthpol.2019.07.010
7. Balasubramanian, M., John Spencer, A., Sohn, W., & Brennan, D. S. (2021). The Practice of Dentistry by Australian- and Overseas-Trained Dentists in Australia: Discriminant Analysis of key Predictors. International Dental Journal, 71(6), 500–507. https://doi.org/10.1016/j.identj.2021.01.002
8. Balasubramanian, M., & Short, S. (2021). The Future Health Workforce: Integrated Solutions and Models of Care. International Journal of Environmental Research and Public Health, 18(6), 2849. https://doi.org/10.3390/ijerph18062849
9. Baum, F., Ziersch, A., Freeman, T., Javanparast, S., Henderson, J., & Mackean, T. (2020). Strife of Interests: Constraints on integrated and co-ordinated comprehensive PHC in Australia. Social Science & Medicine, 248, 112824. https://doi.org/10.1016/j.socscimed.2020.112824
10. Baumgartner, L., Wright, O., Barne, K., Bartrim, K., Kirkegaard, A., Sullivan, V., Burch, E., & Ball, L. (2025). What factors affect the recruitment and retention of allied health professionals working in hospitals? A systematic literature review. Australian Health Review, 49(1), AH24287. https://doi.org/10.1071/AH24287
11. Beks, H., Walsh, S., Alston, L., Jones, M., Smith, T., Maybery, D., Sutton, K., & Versace, V. L. (2022). Approaches Used to Describe, Measure, and Analyze Place of Practice in Dentistry, Medical, Nursing, and Allied Health Rural Graduate Workforce Research in Australia: A Systematic Scoping Review. International Journal of Environmental Research and Public Health, 19(3), 1438. https://doi.org/10.3390/ijerph19031438
12. Brown, E., Ould, L., Brown, K., Robinson, S., & Brown, L. (2025). Recruitment and retention of the allied health workforce in rural and remote Australia: A scoping review. Rural and Remote Health, 25, 9532. https://doi.org/10.22605/RRH9532
13. Carlton, A.-L., Leslie, K., Bourgeault, I. L., & Balasubramanian, M. (2024). Health Practitioner Regulation in High Income Countries: Rapid Review. Canadian Health Workforce Network.
14. Cleland, J., Milte, R., Khanna, S., George, S., Brebner, E., Campbell, P., Tuxworth, G., Maloney, S., Worley, P., & Dymmott, A. (2025). Recruitment, retention and turnover of allied health professionals in rural and remote areas: A quantitative scoping review. Rural and Remote Health, 25, 9494. https://doi.org/10.22605/RRH9494
15. Correa-Betancour, M., Marcus, K., Balasubramanian, M., & Short, S. D. (2024). Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review. Australian Journal of Advanced Nursing, 41(1). https://doi.org/10.37464/2024.411.933
16. Davda, L. S., Gallagher, J. E., Short, S. D., & Balasubramanian, M. (2024). Migrant dentists, health system responses and future challenges: A case study of the United Kingdom and Australia. Journal of Ethnic and Migration Studies, 50(5), 1177–1201. https://doi.org/10.1080/1369183X.2023.2279738
17. Foster, A. M., Munro, S., Golder, J., & Mitchell, D. (2025). Why they come, why they stay and why they leave: A survey to understand the drivers of recruitment, retention, and attrition of allied health clinicians in an Australian metropolitan health network. BMC Health Services Research, 25(1), 767. https://doi.org/10.1186/s12913-025-12922-3
18. Harding, P., McCaskie, D., Gunn, E., Schneider, E., Kim, H., Burge, A., & McDonald, C. (2025). Factors Influencing Attrition and Retention of An Allied Health Workforce. Asia Pacific Journal of Health Management. https://doi.org/10.24083/apjhm.v20i2.4047
19. Health Workforce Australia. (2012). Health Workforce 2025—Doctors, Nurses and Midwives, Volume 1. Health Workforce Australia.
20. Health Workforce Taskforce. (2026). Workforce Intelligence Report 2025. Department of Health, Disability and Ageing.
21. Jobs and Skills Australia. (2024). Labour Market Insights—Social Work. Jobs and Skills Australia.
22. Leslie, K., Bourgeault, I. L., Carlton, A.-L., Balasubramanian, M., Mirshahi, R., Short, S. D., Carè, J., Cometto, G., & Lin, V. (2023). Design, delivery and effectiveness of health practitioner regulation systems: An integrative review. Human Resources for Health, 21(1), 72. https://doi.org/10.1186/s12960-023-00848-y
23. Mason, J. (2013). Review of Australian Government Health Workforce Programs. Commonwealth of Australia.
24. Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), Analyzing Qualitative Data (pp. 173–194). Routledge.
25. Roth, L., Le Saux, C., Gilles, I., & Peytremann-Bridevaux, I. (2024). Factors Associated With Intent to Leave the Profession for the Allied Health Workforce: A Rapid Review. Medical Care Research and Review, 81(1), 3–18. https://doi.org/10.1177/10775587231204105
26. Rural Workforce Agency Victoria. (2026). Victorian Rural Health Workforce Census 2025–2026. RWAV.
27. SA Health. (2021). Rural Allied and Scientific Health Workforce Plan 2021–2026. Government of South Australia.
28. Tan, J., Divakar, R., Barclay, L., Bayyavarapu Bapuji, S., Anderson, S., & Saar, E. (2025). Trends in retention and attrition in nine regulated health professions in Australia. Australian Health Review, 49(2), AH24268. https://doi.org/10.1071/AH24268
29. Watson, G., Rodger, R., Buhler, M., Tofi, U., Gauld, R., & Perry, M. A. (2026). Strategies that impact the workforce retention of physiotherapists and other allied health professionals: A scoping review. European Journal of Physiotherapy, 28(1), 51–67. https://doi.org/10.1080/21679169.2025.2469108
30. Whitford, D., Smith, T., & Newbury, J. (2012). The South Australian Allied Health Workforce survey: Helping to fill the evidence gap in primary health workforce planning. Australian Journal of Primary Health, 18(3), 234–241. https://doi.org/10.1071/PY11027
31. Wishart, M., Peat, G. M., Bojke, C., Vargas-Palacios, A., Chandler, R., Hayes, T., & Fowler-Davis, S. (2026). Antecedents to Allied Health Professional (AHP) Workforce Planning and Management in Rural and Coastal Areas: A Scoping Review. Journal of Multidisciplinary Healthcare, 19, 1–18. https://doi.org/10.2147/JMDH.S619599
32. Yeoh, S. A., Kumar, S., Phillips, A., & Li, L. S. K. (2024). Unveiling the Exodus: A scoping review of attrition in allied health. PLOS ONE, 19(9), e0308302. https://doi.org/10.1371/journal.pone.0308302

Annexures

Annexure 1 — Acronyms and Abbreviations
Annexure 2 — Quantitative Methods
Annexure 3 — Qualitative Methods
Annexure 4 — Profession Profiles

Annexure 1
Acronyms and Abbreviations

AASW ..... Australian Association of Social Workers

AHPRA..... Australian Health Practitioner Regulation Agency

AIHW ..... Australian Institute of Health and Welfare

AHP..... Allied Health Professional (also: classification level, e.g. AHP 2.6)

EBA..... Enterprise Bargaining Agreement

ERP ..... Estimated Resident Population (ABS)

FTE..... Full-Time Equivalent

HREC..... Human Research Ethics Committee

HSU ..... Health Services Union SA/NT

HWA..... Health Workforce Australia

JSA..... Jobs and Skills Australia

LHN ..... Local Health Network

MDT..... Multidisciplinary Team

MM / MMM Modified Monash Model (geographic remoteness classification)

NAHWS .... National Allied Health Workforce Strategy

NDIS..... National Disability Insurance Scheme

NHWDS .... National Health Workforce Dataset

NRAS ..... National Registration and Accreditation Scheme

OT ..... Occupational Therapist / Occupational Therapy

SA..... South Australia

SA Health South Australian Department for Health and Wellbeing

SW..... Social Worker / Social Work

WHO..... World Health Organization

Annexure 2
Acronyms and Abbreviations

OVERVIEW

This annexure documents the quantitative data sources, classification systems, metric definitions, and derivation logic used in Section 1 of the Future Fit Allied Health SA report. It is intended for readers who need to understand, verify, or extend the evidence base. The quantitative analysis draws exclusively on publicly available sources. No modelling, projection, or demand estimation is performed. All figures are descriptive — they represent current workforce state and historical trends [1, 2].

2.1 PRIMARY DATA SOURCE: NATIONAL HEALTH WORKFORCE DATASET (NHWDS)

The National Health Workforce Dataset (NHWDS) is the primary source for all AHPRA-registered allied health workforce data in this report. The NHWDS is administered by the Australian Government Department of Health, Disability and Ageing in partnership with the Australian Health Practitioner Regulation Agency (AHPRA) [3].

Key features of the NHWDS:

- Annual data collection via the AHPRA registration renewal process
- Covers all 15 AHPRA-regulated health professions
- Self-reported by practitioners at time of annual registration renewal
- Published via the Health Workforce Data (HWD) tool at hwd.health.gov.au
- Available by state/territory, remoteness category (MMM), and year from 2013 to 2024
- Profession factsheets published by AIHW for key years (2017, 2019, 2024)

Key limitations:

- Covers AHPRA-registered professions ONLY — social work, speech pathology (partially), and several other allied health professions are not included
- Self-reported employment hours may vary in accuracy
- Data represents practitioners at time of registration renewal — timing variation across professions may introduce minor seasonal bias
- Private sector and public sector are not disaggregated below state level in publicly available data
- Sub-LHN geographic breakdown requires custom HWD tool queries

2.2 WORKFORCE STRATIFICATION FUNNEL

The NHWDS produces several distinct workforce counts. Understanding the stratification from "registered" to "clinically practising" is essential for interpreting the figures in this report [4].

LEVEL 1 — REGISTERED

All practitioners with current AHPRA registration

▼approximately 82% nationally are employed in the profession (AIHW 2026)

LEVEL 2 — EMPLOYED (HEADCOUNT)

Practitioners who reported working in their profession

▼FTE ratio: 83–90%, varies by profession

Psychology SA: 83.1% | Physio SA: 89.2% | OT SA: 87.5%

LEVEL 3 — EMPLOYED FTE [STANDARD METRIC USED IN THIS REPORT]

Total hours worked ÷ 38 (standard full-time equivalent)

▼approximately 87–89% of employed FTE are in clinical roles

LEVEL 4 — CLINICALLY PRACTISING

Practitioners delivering direct patient/client care

[Note: NHWDS reports FTE by sector, not solely clinical — Levels 3 and 4 are not always separately reported in public tables]

This report uses Level 3 (Employed FTE) as the standard metric throughout. FTE is preferred over headcount for allied health because the sector has high rates of part-time employment — particularly in psychology (average 31.5 hours/week in SA) — and headcount would systematically overstate the productive workforce capacity available [1].

2.3 FTE DERIVATION AND PER-CAPITA CALCULATION

FTE definition:

FTE = Total employed hours per week ÷ 38

Where 38 hours is the standard full-time working week in Australia, consistent with NHWDS methodology and ABS Labour Account conventions.

Per-capita FTE calculation:

FTE per 100,000 population = (State FTE ÷ State ERP) × 100,000

Where ERP is the Australian Bureau of Statistics Estimated Resident Population as at 31 December 2024 (ABS Cat. 3101.0, release date March 2025). SA ERP used in all calculations: 1,893,200. Per-capita FTE is the preferred comparator for health workforce equity analysis because it normalises for population size, enabling direct cross-jurisdictional comparison [2, 4].

2.4 GROWTH RATE CALCULATION

Workforce growth 2013–2024 is expressed as percentage change in employed headcount:

Growth (%) = ((2024 headcount − 2013 headcount) ÷ 2013 headcount) × 100

Growth is calculated on employed headcount (not FTE) to allow comparison across years where average hours may vary. FTE per-capita comparisons use the 2024 FTE figure. Index values are set to 100 at 2013 baseline.

2.5 SA SHARE OF NATIONAL WORKFORCE

SA share (%) = (SA employed headcount ÷ National employed headcount) × 100

SA's population share of Australia is approximately 6.9% (ABS ERP 2024: SA 1,893,200 of national 27,442,000). A profession where SA holds less than 6.9% of the national workforce is proportionally underrepresented relative to population. Psychology: SA share = 4.9% (2024) against population share of 6.9% — a persistent 2 percentage point deficit.

2.6 SOCIAL WORK: ALTERNATIVE DATA SOURCES AND LIMITATIONS

Social workers are self-regulated through the Australian Association of Social Workers (AASW) and are not registered with AHPRA.

They are therefore absent from the NHWDS entirely [3]. Two alternative data sources are used in this report:

Source 1: ABS Census of Population and Housing 2021

ANZSCO 272511 (Social Workers, 6-digit). The 2021 Census provides a headcount of employed social workers by detailed occupation code. This is the most granular and reliable national estimate available, though it uses employment status at Census date (9 August 2021) and does not capture FTE.

- National employed social workers (Census 2021): 47,400
- SA estimate (derived): 4,456 (9.4% × 47,400 — using JSA state share)
- ⚠ The 9.4% SA state share is derived from JSA occupation profile data, not from a directly published SA Census count. The 4,456 figure is therefore an estimate, not a published statistic.

Source 2: Jobs and Skills Australia (JSA) LFS Trend Series

ANZSCO 2725 (4-digit group: Social Workers). JSA publishes trend employment estimates derived from the ABS Labour Force Survey Detailed. These are not comparable to the Census 6-digit count: they use a different survey instrument, a different reference population, and a broader ANZSCO grouping.

- National LFS trend (2025): ~48,000 employed persons (ANZSCO 2725)
- National LFS trend (2024): ~46,300 employed persons (ANZSCO 2725)
- ⚠ The two series (Census 47,400 and LFS 40,500 in 2021) are NOT directly comparable. This report uses the Census 2021 figure (47,400) as the primary reference.

Future transition: ANZSCO ► OSCA

ANZSCO is being replaced by OSCA (the Occupation Standard Classification for Australia) from mid-2026. Under OSCA, social workers are classified at code 261331. Future workforce monitoring should use OSCA codes for consistency with post-2026 publications.

2.7 REMOTENESS CLASSIFICATION: MODIFIED MONASH MODEL (MMM)

The Modified Monash Model (MMM) classifies geographic locations by remoteness for the purposes of health workforce policy. MMM categories range from MM1 (major cities) through MM7 (very remote). The NHWDS reports workforce distribution by MMM category. MMM is the standard remoteness measure used in Commonwealth health workforce policy and rural health incentive programs [1].

Note: SA-specific MMM distribution data for allied health professions is not available in publicly downloadable NHWDS files. It requires a custom query via the Health Workforce Data tool. A national MMM distribution (Figure 1.5a) is presented as the best available proxy; Figure 1.5b (SA estimated) applies national proportions to SA total FTE.

2.8 DATA VERIFICATION AND QUALITY ASSURANCE

All NHWDS figures presented in this report were verified against:

- Raw NHWDS state-level data files (nhwds_2024_state_allied_health.csv) derived from the HWD tool
- AIHW Health Workforce report (updated 9 July 2026) — national totals cross-checked
- NHWDS profession factsheets (2017, 2019) — growth trend validation
- ABS ERP 31 December 2024 — per-capita denominators
- ABS Census 2021 ANZSCO 272511 — social work headcount
- JSA Occupation Profiles Data (November 2024, November 2025) — social work LFS trend

Psychology SA FTE verified: 1,504 (employed FTE, 2024) ► 79.5 per 100,000 (SA ERP 1,893,200). Confirmed correct. Physiotherapy SA FTE verified: 2,847 ► 150.5 per 100,000. OT SA FTE verified: 2,081 ► 110.0 per 100,000. National allied health FTE/1,000 population (AIHW 2026): 6.8. Psychology is the singular major outlier in the SA allied health workforce distribution.

REFERENCES

[1] Australian Institute of Health and Welfare (AIHW). (2026). Health Workforce (updated 9 July 2026). Australian Government. https://www.aihw.gov.au/reports-data/health-welfare-services/health-workforce

[2] Alshehri, A., Simmonds, J., Shafei, I., Al-Hanawi, M.K., & Balasubramanian, M. (2026). Health workforce planning models for older adults in the WHO Eastern Mediterranean Region: A scoping review. Human Resources for Health, 24. https://doi.org/10.1186/s12960-026-00xxx-x

[3] Leslie, K., Bourgeault, I., Carlton, A., Balasubramanian, M., et al. (2023). Health practitioner regulation systems: An integrative review of governance, scope of practice, and workforce planning. Human Resources for Health, 21(1), 72. https://doi.org/10.1186/s12960-023-00858-8

[4] Australian Institute of Health and Welfare (AIHW). (2023). Medical Workforce 2021: National Health Workforce Dataset. Australian Government.

[5] Australian Bureau of Statistics (ABS). (2022). Census of Population and Housing 2021: Occupation (ANZSCO) data. ABS Cat. 2071.0. https://www.abs.gov.au/census/guide-census-data/census-dictionary/2021/variables-topic/income-and-work/occupation-anzsco

[6] Department of Health, Disability and Ageing. (2024). Health Workforce Data (HWD) tool documentation: NHWDS methodology and data quality statement. Australian Government. https://hwd.health.gov.au

Annexure 3
Qualitative methods

3.1 ETHICS APPROVAL

This study was approved by Flinders University's Human Research Ethics Committee (HREC) and conducted in accordance with the National Statement on Ethical Conduct in Human Research (NHMRC, 2023) [1]. Study title: Allied Health Workforce Perspectives on Future Fit Care in South Australia: A Qualitative Interview Study. Principal Investigator: Dr Madhan Balasubramanian, Flinders University. Co-Investigator: Marni Lefebvre, McKell Institute. Funder: McKell Institute (independent, non-partisan). No conflicts of interest.

3.2 RECRUITMENT AND CONSENT

Participants were recruited via purposive and snowball sampling through professional networks and participant referral. Interested practitioners booked via a Calendly scheduling link. All participants received a Participant Information Sheet (v2.0, May 2026) and Consent Form (v2, May 2026) prior to interview. Written informed consent was obtained from all participants. Participants were advised of their right to withdraw at any time without penalty, and that all reporting outputs would be fully de-identified.

3.3 PARTICIPANT SUMMARY

18 participants were recruited between July–August 2026; 17 completed interviews. Table 3.1 provides a de-identified summary.

TABLE 3.1 Participant summary (de-identified)

ID	Profession group	Metro/Rural	Duration
P1	Occupational therapy	Metro	60 min
P2	Psychology	Rural	60 min
P3	Psychology	Rural	60 min
P4	Social work	Metro	60 min
P5	Other allied health *	Metro	47 min
P6	Psychology	Metro	55 min
P7	Social work	Metro	34 min
P8	Other allied health *	Metro	60 min
P9	Occupational therapy	Metro	60 min
P10	Physiotherapy	Metro	Pending
P11	Physiotherapy	Metro	60 min
P12	Psychology	Metro	54 min
P13	Psychology	Rural	49 min
P14	Social work	Metro	60 min
P15	Social work	Metro	46 min
P16	Psychology	Metro	61 min
P17	Physiotherapy	Metro	60 min
P18	Psychology	Metro	50 min

** Outside the four target groups; identified as "other allied health professional" to prevent re-identification.*
Quotes not used in the main report.

Profession breakdown (17 completed): Psychology n=6; Social work n=4; Physiotherapy n=3; Occupational therapy n=2; Other allied health n=2. Metro n=14; Rural/remote n=3 (P2, P3, P13). All public sector (SA Health LHNs).

3.4 INTERVIEW CONDUCT

All interviews were conducted online via Microsoft Teams by the PI. Format: one-on-one, semi-structured, 45–60 minutes (range 34–61 min). A six-stage interview guide was used (v1.0, May 2026): (1) professional background; (2) current workforce context; (3) barriers and enablers; (4) interdisciplinary care and scope of practice; (5) future fit recommendations; (6) closing. Interviews were audio-recorded using Teams transcript function. One participant did not consent to audio recording, notes were used. Transcripts were reviewed and corrected verbatim by the PI. Audio recordings were scheduled for deletion within two weeks of transcription, and deleted accordingly. De-identified transcripts are retained on Flinders University's encrypted R-drive for five years post-publication.

3.5 QUALITATIVE ANALYSIS

Data were analysed using Framework Analysis [2, 3] — a matrix-based approach suited to applied policy research that allows systematic comparison across cases and themes while preserving individual account detail. All coding was conducted in ATLAS.ti (v24) [4].

CODING SCHEMA:

- **A. Workforce Context (7 codes):** Recruitment; retention & attrition; staffing ratios; career progression ceiling; training pipeline; rural/metro disparity; pay & EB disparity
- **B. Barriers & Enablers (6 codes):** What works; admin burden; flexibility; professional development; NGO funding instability; burnout/moral injury
- **C. Interdisciplinary Care & Scope (5 codes):** MDT integration; role clarity; hierarchy; scope restriction; referral timing
- **D. Future & Policy (5 codes):** Ideal vs realistic vision; structural reform; reactive vs preventive system; ministerial priorities; training pathway reform
- **Cross-cutting (6 codes):** Profession identity; gender; public vs private pull; public vs NGO; multiclass injustice; notable quotes

The schema was piloted on three transcripts (one OT, one Social Worker, one Psychologist) before full-pass coding. No revisions were required. A full coding pass was completed across 16 transcripts (29 codes; 232 total quotations). A framework matrix (participants × themes) was constructed and used to develop the five thematic findings in Section 2. Convergent evidence — where the same finding was reported independently by multiple participants across different professions — is noted in the analysis.

Quote attribution format: [Profession], [career stage], [metro/rural] public sector. One participant holds a role with very small numbers in SA; attribution for this participant is limited to professional group and sector only [5].

3.6 LIMITATIONS

- Most participants are from the SA public health sector; private practice and NGO perspectives may not be adequately represented.
- Predominantly metropolitan sample (14/17); rural perspectives are present but limited.
- Professional recruitment channel may over-represent practitioners with active workforce advocacy engagement.

REFERENCES

[1] National Health and Medical Research Council (NHMRC). (2023). National Statement on Ethical Conduct in Human Research (2007, updated 2023). Commonwealth of Australia.

[2] Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds.), Analysing Qualitative Data (pp. 173–194). Routledge.

[3] Gale, N.K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Medical Research Methodology, 13, 117. https://doi.org/10.1186/1471-2288-13-117

[4] ATLAS.ti Scientific Software Development GmbH. (2023). ATLAS.ti (Version 24). https://atlasti.com

[5] Creswell, J.W., & Poth, C.N. (2018). Qualitative Inquiry and Research Design: Choosing Among Five Approaches (4th ed.). SAGE Publications.

[6] Lincoln, 3.S., & Guba, E.G. (1985). Naturalistic Inquiry. SAGE Publications.



Physiotherapy

The numbers tell half the story-rural gaps, career ceilings, and a broken pay structure

150.5

FTE per 100,000 population
+17% above national average National: 128.9

+69%	+127%	81%	5 FTE
Physio growth 2013-24	OT growth (fastest)	AH FTE in metro (nationally)	Rural vacancies unfilled, York Peninsula

WORKFORCE CONTEXT	Strong on paper-thin on the ground
+69% growth	National physiotherapy workforce growth 2013-2024. SA participates but gains are concentrated in metro — rural coverage has not kept pace. 81% of all allied health FTE sits in MM1 (major metropolitan) areas nationally.
5 FTE vacancies	Unfilled across one rural region at interview. Only 3 rental properties available across the entire York Peninsula. Housing shortage, not disinterest, is the barrier.
2-3 year cliff	Rural graduates stay 2-3 years then return to metro — just as their rural clinical expertise becomes most valuable. The cycle repeats without structural change.
KEY ISSUES	**What's broken and why people leave**
AHP2.6 career ceiling	The highest clinical grade in SA Health. A physio six years post-graduation can be within one increment of the top — no clinical pathway forward without moving into management.
RN3 earns more than AHP3	A physiotherapy team leader at AHP3 earns less than an RN3 line manager, even where the physio outranks the nurse. Same grade title, different award, different worth. Encoded in the EB.
Rural housing = rural vacancy	Recruitment intent exists. What doesn't exist is somewhere to live. Structural housing policy is now a health workforce policy issue.
FUTURE FIX	**What the system needs to change**
Extended rural placements	Replace 5-week rotations with semester-length placements during training. Commitment to a region is built during formative years — not after graduation.
Cadetship model	Grow-your-own programs proven for OT and Speech Pathology in several SA LHNs. Not yet applied to physiotherapy — a directly scalable policy gap.
Classification reform	A clinical AHP pathway beyond AHP2.6 that does not require management. An EB that does not pay nurses more than the physios who report to them.

> If you want to stay a clinician, you have to leave the public sector.

~ **SENIOR PHYSIOTHERAPIST,** RURAL PUBLIC SECTOR; REHABILITATION AND RESTORATIVE CARE TEAM LEADER

Source: NHWDS 2024 (AIHW); Future Fit Allied Health SA qualitative interviews, Aug 2026. SA physiotherapy has the numbers - not the distribution. The failure is rural retention, career architecture, and an award structure that penalises clinical commitment. Ethics: Flinders HREC 9971.

Psychology

SA's sharpest workforce gap - the mechanism is a pay-driven exit to

79.5

FTE per 100,000 population
29% BELOW national average.
2nd lowest in Australia

169.8	123.0	115.5	112.3	79.5
ACT	VIC	NSW	National	SA ▼ 2nd lowest nationally

WORKFORCE CONTEXT	SA's most measurable workforce failure
4.9% workforce share	SA holds only 4.9% of Australia's psychology workforce against a 6.9% population share. The deficit is structural, not cyclical.
+52% growth (slowest)	Psychology workforce growth 2013-2024 — slowest of all four professions. OT: +127%, Physio: +69%. Psychology is lagging despite the greatest unmet demand in the health system.
0.8 FTE public	Typical public sector fraction for experienced clinical psychologists — the rest in private practice. The public sector retains commitment, not capacity
KEY ISSUES	**The mechanism keeping the gap open**
The pay gap	Public vs private pay is 'massive.' Psychologists train through publicly funded placements, then graduate into a system that pays substantially less than private. The public sector is a training ground — not a career.
neuropsychology masters in SA	No funded neuropsychology masters in SA. Candidates must leave the state — creating a permanent pipeline gap the system inherits every graduation cycle.
Discipline substitution	Vacancies filled by social workers and nurse practitioners under multi-class positions — weakening specialist capacity over time without appearing in the data. The gap is masked, not closed.
FUTURE FIX	**What the policy needs to deliver**
Pay parity	Bring SA public sector psychology salaries into alignment with interstate equivalents — close the gap enough that a public career is viable for early-career psychologists
SA training pipeline	Fund a neuropsychology masters in SA. Stop training people to leave the state — then importing the shortage back as a vacancy.
Discipline self-determination	Principal psychologists should report to psychology leadership, not generic allied health management. The profession needs governance power over its own workforce decisions.

> We need to start treating people, not band-aiding people.

~ **EARLY-CAREER CLINICAL PSYCHOLOGIST,** METRO PUBLIC SECTOR ACUTE MENTAL HEALTH

Source: NHWDS 2024 (AIHW); Future Fit Allied Health SA qualitative interviews, Aug 2026. Psychology is SA's most measurable workforce failure: 29% below national average, pay-driven exit to private practice, and a fix that is politically costly but structurally clear. Ethics: Flinders HREC 9971.

Occupational Therapy

Fastest-growing allied health profession — gains landing in the wrong places

110.0
FTE per 100,000 population
+17% above national average

+127%
Leads all allied health-national growth 2013-2024

+69% Physio
Strong growth, rural gaps persist

+52% Psychology
Slowest highest unmet demand

WORKFORCE CONTEXT	Strong growth — unevenly distributed
+127% growth	OT leads all allied health professions in national growth 2013-2024. SA is +17% above national FTE average. But most growth has landed in NDIS private practice, aged care, and metro — not public acute or rural mental health.
NDIS pull	The NDIS draws experienced OTs to private: better pay, flexible caseloads, no weekend shifts. The public sector trains them — the NDIS employs them.
Rural gap persists	Despite above-average overall FTE, rural OT teams remain thin and junior — with additional NDIS client overlap complexity in small communities.
KEY ISSUES	**Where strong numbers hide real gaps**
Scope blocked by countersignature	OTs cannot act on their own assessments. GP countersignature is required to prescribe assistive technology — even when equipment costs less than one hospital bed day. Clinical judgement not trusted enough to act on without a non-clinical layer above it.
Invisible value — discharge unmeasured	OT's contribution to preventing readmission is not tracked. Most responsible for safe post-discharge outcomes — least credited in any funding model.
Mid-career exodus to NDIS	Public mental health loses its experienced OT workforce to the NDIS — a scheme the public sector helped to train. The sector funds its own drain.
FUTURE FIX	**Scale what works — fix what's hidden**
Scale to cadetship	Grow-your-own programs in several SA LHNS produce 5- and 6-year retainers who become the team's most experienced clinicians. Apply to public mental health OT — where NDIS migration has hollowed out the experienced workforce.
Scope reform	Remove GP countersignature for OT AT prescriptions below a defined threshold. The clinical assessment is the OT's — the sign-off requirement adds cost, delay, and a message that the judgement is not trusted.
Message discharge outcomes	Track outcomes at 14 and 30 days post-discharge. When OT's contribution to avoiding readmission is measured, the economic case for adequate staffing becomes visible.

> You reach a senior clinical level and there is nowhere else to go. The only way to progress in pay and responsibility is sidestepping across into management positions.
>
> **~ SENIOR OCCUPATIONAL THERAPIST,** METRO PUBLIC SECTOR ACUTE HOSPITAL LEADER

Source: NHWDS 2024 (AIHW); Future Fit Allied Health SA qualitative interviews, Aug 2026. OT leads allied health growth nationally-but NDIS migration, unmeasured acute value, and stalled scope reform mean the gains are not landing where the clinical need is greatest. Ethics: Flinders HREC 9971.

Social Work

Present everywhere - counted nowhere in national workforce data

Not in NHWDS

CRITICAL DATA GAP

Social work is absent from the NHWDS — the instrument used to plan and fund Australia's allied health workforce. A governance choice, not a data gap.

AASW	3 settings	12-month cycles
Self-regulated-excluded from NHWDS	Rehab, child protection, dual-diagnosis	Impossible workforce planning horizon

WORKFORCE CONTEXT	Highest complexity — least visibility
Invisible by governance	Present in every ward, discharge meeting and child protection order — absent from NHWDS and every workforce plan.
Split public — NGO workforce	SA social work spans public health and the NGO sector; highest-complexity roles sit outside hospital data and funding models.
Highest non-clinical load	Mandatory reporting and court documentation exceed any other profession in this study — structural, not incidental.
KEY ISSUES	**The compounding costs of invisibility**
No data — no plan	Absent from NHWDS means absent from SA's gap analysis and policy modelling. Every other profession has a number. Social work has a blank.
12-month NGO cycles	Annual funding destroys stability. Teams doing DV, child protection and mental health work cannot retain staff on year-to-year renewal.
Moral injury	Mandatory reporting and court documentation consume time that should go to clients — the vocation-to-reality gap burns people out.
FUTURE FIX	**Recognition, data, and caseload design**
AHPRA national registration	The lever for NHWDS inclusion and national workforce planning. Long debated, still unresolved — McKell must name it as a prerequisite.
Multi-year NGO funding	Minimum 3-year agreements for sustained complex care. Workforce stability cannot be built on annual uncertainty.
Caseload redesign	Mandatory reporting and risk assessment are core clinical work — not overhead. Current models systematically undercount the role.

> We don't appear in the workforce data.
> That's not a technical problem, that's a political one.
>
> **~ SENIOR SOCIAL WORKER,** METRO PUBLIC SECTOR; CHILD PROTECTION SETTING

Source: ABS / AASW data (social work excluded from NHWDS); Future Fit Allied Health SA qualitative interviews, Aug 2026. Social work is everywhere in the system and nowhere in the numbers that determine what the system funds. Ethics: Flinders HREC 9971.

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