Geographical classifications and incentives for rural allied health workforce recruitment and retention

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Background: Government policy is used to enhance health workforce and to facilitate equity across regions as well as between rural and urban areas. For example, policy can create incentives for graduates to take up rural or remote positions by waiving HECS fees. For policies to be most effective they need be based on an unbiased classification system that recognises areas of greatest health workforce need.

Aim of the study: To use existing allied health workforce data to examine the validity of models of geographical classification employed for the allocation of workforce incentives in the context of the need for greater interprofessional collaborative practice.

Method: Census data from 2006 and 2011 were analysed in six steps to measure any possible changes in the allied health workforce over time, and to explain these change. Analysis was also performed of the Combined Allied Health Workforce (CAHW) data collected between 2008 and 2010 in New South Wales, South Australia, Tasmania and Northern Territory. It included rural as well as urban-based professionals from 25 disciplines. Survey data include demographic characteristics, employment, education, and recruitment and retention characteristics of 4921 respondents.

Relevance: In August 2012 the Senate Community Affairs References Committee (SCARC) noted that the Australian Standard Geographical Classification for Remoteness Areas (ASGC-RA) is unsustainable for the purpose of allocating workforce incentives. It has been suggested to replace it with a structure that considers more up-to-date geographical, population, workforce, professional and social data to identify locations for workforce recruitment and retention incentives. Although SCARC is supportive of the methodology and suggested outcomes of the Humphreys model, that model is based on medical workforce data. SCARC noted disparity in support provided between allied health professionals and medical practitioners to work outside the cities.

Results: The 2006–2011 Census data showed considerable allied health workforce increases for occupational and environmental health professionals (increase 128%), dietitians (48%), social workers (36%) and welfare workers (34%). Major decreases were recorded for medical imaging (down 14%), and speech pathology and audiology (down 11%). Many allied health professions decreased in numbers, including physiotherapy and occupational therapy. CAHW results for rural and remote allied health showed that feeling part of a multidisciplinary team was positively associated with job satisfaction and with intention to...
stay. Job satisfaction was also associated with ‘work makes a difference’ and ‘work valued by the community.’

**Conclusions:** Many of the remote allied health professions experienced decreases in numbers between 2006 and 2011, although the underlying mechanisms are not clear. In general, there is weak support for workforce recruitment schemes such as scholarships. Combining recruitment with targeted retention enhancement is likely to have a greater impact on remote allied health workforce numbers and associated health service capacity. As such, a revised workforce incentive scheme needs to align with allied health as well as medicine and nursing workforce data.