NATIONAL RURAL HEALTH ALLIANCE INC.

Under pressure and under-valued: allied health professionals in rural and remote areas

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Under pressure and under-valued: allied health professionals in rural and remote areas

EXECUTIVE SUMMARY

For the purposes of this Paper, rural and remote allied health professionals are audiologists, dietitians, hospital pharmacists, occupational therapists, optometrists, orthoptists, physiotherapists, podiatrists, prosthetists/orthotists, psychologists, radiographers, social workers and speech pathologists who work in areas classified under the Australian Standard Geographical Classification Remoteness structure as 'Inner and Outer Regional Australia' or 'Remote and Very Remote Australia'.

There is a low level of community awareness of the wide range of services provided by allied health professionals. In rural and remote areas they practise either independently or in multi-professional teams. They provide specialised, comprehensive and integrated care. They work in assessment, health promotion, palliative care, care planning, chronic disease management, treatment and rehabilitation, and in improving health outcomes by maximising individuals' function and independence and limiting hospitalisation. Allied health professionals provide services in many sectors and service settings, including education, aged care, public health, industry, disability and welfare.

The lack of services means people are not aware of what should be available and what is possible through allied health. The allied health professional needs to be considered an integral member of rural and remote multidisciplinary health care teams. The new allied health initiative in Medicare provides an opportunity to ensure that this is progressed.

The current systems for training and preparation, recruitment and retention, and professional support of rural and remote allied health professionals are unsatisfactory. There are insufficient resources for undergraduate and postgraduate placement programs, contributing to problems in education and rural recruitment. Across rural and remote areas as a whole there are insufficient numbers of allied health professionals, and many of them are inadequately prepared and/or supported for rural and remote practice, stressed and overworked.

Inadequate priority is given by health services and their managers to allied health positions and practitioners, resulting in delays in recruitment, and poor orientation and induction. Added to this is non-systematised professional development and postgraduate training, contributing to high turnover and delays in recruitment.

The Commonwealth's university funding for allied health is at a lower unit level than for nursing and medicine students. Universities and health facilities (hospitals) are unable to fund a sufficient number of appropriate clinical placements.[i]

Australia needs an integrated service model for rural and remote allied health professionals that includes well-resourced undergraduate placements[ii], adequate numbers of positions in the public sector in rural and remote areas, and strong professional development and postgraduate education support.

Action on the recommendations in this Position Paper will help increase the number, profile and effectiveness of allied health professionals in rural and remote areas, and through this make a major contribution to improved health for people in those areas.

INTRODUCTION

The poorer health of people living in rural and remote areas has been well documented[iii]. People in rural and remote regions have higher levels of risk factors, such as physical inactivity, obesity, smoking, harmful alcohol consumption, high blood pressure and poor nutrition. Compared with their city peers they experience more accidents and exposure to violence, have poorer mental health and a higher rate of suicide. There are higher mortality rates in the non-Indigenous population in more remote areas than in the major cities.[iv] The proportional size of the Indigenous population also contributes to higher death rates in regional areas by 5–10% - and by 50% in remote areas. This health and welfare profile results in higher rates of morbidity and mortality, and means there is a significant capacity for the preventative and rehabilitative work of allied health professionals to contribute to better health[v].

This paper proposes a range of integrated educational and training initiatives, service development models and support programs to promote recruitment, retention and effective service delivery by allied health professionals in rural and remote areas.

Definition

There are three major groups in Australia's clinical health professional workforce - medicine, nursing and allied health.

The term 'allied health professions' has a variety of definitions, and different professions are included depending on the definition selected and the purposes for which it is used.

The National Rural and Remote Allied Health Advisory Service (NRRAHAS) prepared a discussion paper on a possible classification of clinical allied health professions, which has been further developed by Services for Australian Rural and Remote Allied Health Inc (SARRAH)[vi]. That paper suggests that, to be part of *the clinical and diagnostic allied health professional workforce*, a health professional must:

- be involved in direct client contact, providing direct treatment or assistance, assessment, patient management and education, in primary and/or secondary care;
- be tertiary-trained through recognised university degrees;
- be required to obtain specific qualifications to obtain State or Territory registration, and/or a license or accreditation to practise, and/or to join a professional association;
- work directly with others in the same category and with medical and nursing professionals as part of a multidisciplinary team to achieve best practice outcomes for the client;
- be potential members of a multidisciplinary Primary Health Care Team; and
- be currently able to provide services directly to the public sector[vii].

Using this approach the NRRAHAS/SARRAH discussion paper lists people in a number of disciplines as 'rural and remote allied health professionals'. They are audiologists, dietitians, hospital pharmacists, occupational therapists, optometrists, orthoptists, physiotherapists, podiatrists, prosthetists/orthotists, psychologists, radiographers, social workers and speech pathologists, working in areas classified under the Australian Standard Geographical Classification Remoteness structure as 'Inner and Outer Regional Australia' or 'Remote and Very Remote Australia'.[1] NRRAHAS proposed this list for its own work, not as a definitive or final definition.

Despite the continuing definitional difficulties of the term 'allied health', it is recommended that the term be retained, given the relatively clear understanding of the disciplines which have traditionally been regarded as being included under it.

Role

Allied health professionals play essential and cost-effective roles in healthcare in both the public and private sectors[viii]. For example, a study by Hay et al. (2002) on the cost-effectiveness of preventive occupational therapy for older adults living independently showed that a nine-month program of occupational therapy intervention costing $548 per subject saved $2,593 per subject in post-intervention costs, compared to a control group. Quality adjusted life years improved 4.5% in the intervention group[ix].

While allied health professionals may practise independently, they frequently work in multi-professional teams to provide specialised, comprehensive and integrated care. In rural and remote communities they play an important role in assessment, health promotion, care planning, chronic disease management, treatment and rehabilitation, and in improving health outcomes by maximising individuals' function and independence, and limiting hospitalisation. They also provide a range of services in sectors other than health, including education, aged care, public health, industry, disability and welfare. Despite this, there is a general lack of awareness by consumers and other health professionals of the wide range of services provided by allied health professionals.

There is a need to raise the awareness of people in rural and remote communities, and of other health practitioners, about the roles of allied health professionals and their skills in acute care, aged care, health promotion, mental health, palliative care and rehabilitation. Where people have no experience of a particular type of service, they will often be unaware of its potential benefits and may not express demand for it. As well, improved understanding would increase the esteem in which allied health professionals are held, increase school students' aspirations to those professions and positively influence Governments to provide additional support for allied health programs. Improving consumers' awareness of the valuable roles of allied health professionals will only be effective if there are sufficient services available for consumers to access.

[1] Some practitioners work in one ASGC category and work in another.

WORKFORCE ISSUES

A collaborative, multidisciplinary approach is needed to effectively tackle health workforce issues[x]. To date in Australia there has been a strong emphasis on nursing and medical workforce issues but relatively little attention has been paid to allied health skills shortages, resulting in the poor development of studies of allied health recruitment and retention. The absence for many years of an accepted role in allied health for the Australian Government contributed to this.

Overall knowledge of the allied health workforce has been hampered by the lack of a standard definition, the absence of a national planning strategy and the unavailability of nationally consistent data, all of which impact on future planning and policy development for the sector. There is an urgent need to understand in detail the extent, causes and impact of allied health workforce shortages, and to project and plan for future needs in the light of the changing health services environment.

Demographic information

While many reports have been published about aspects of the allied health workforce in Australia (for example, by State and Territory Health Departments, the Australian Institute of Health and Welfare and the Department of Employment and Workplace Relations) none provide a comprehensive national workforce profile based on the degree of rurality or remoteness. The first national snapshot across the metropolitan, rural and remote allied health workforce in Australia was undertaken by NRRAHAS, based on data obtained from the Australian Bureau of Statistics 2001 Census and covering the thirteen professions listed above[xi].

The project had a number of key findings in relation to the allied health workforce.

- There is a large diversity in the size of the various professional disciplines that comprise the allied health professional workforce in Australia. Based on their size, the workforce can be divided into four broad groups:
  - physiotherapy, social work, psychology and radiography, with a workforce in 2001 of between 8,000-11,000 each[xii];
  - occupational therapy and speech pathology, with workforces of between 3,000-6,000;
  - dietetics and podiatry with 1,500-2,000; and
  - orthoptics, audiology and prosthetics, with workforces of less than 1,000 professionals.

- Allied health professionals are employed in many different settings and by a large number of employers.

  - At the Commonwealth Government level, allied health services are provided to specific target groups such as war veterans, people with a disability, pensioners, rural and remote residents and Aboriginal and Torres Strait Islander residents through specific, nationally-funded programs and agencies, as well as through specific allied health programs.

- At State and Territory government levels, allied health professionals are employed through Departments of Health (in hospitals, community health services, paediatric units, rehabilitation services, outpatient units, mental health services), Departments of Education (student services, pre-school services), Disability Services, Child Welfare and Justice Departments.

- Allied health professionals are employed by non-government agencies such as disability services, aged care services, health promotion services and Aboriginal Community Controlled Health Organisations.

- Allied health professionals work in private practice – including in their own small businesses and in the insurance and compensation sectors.

- Generalisations about the allied health workforce can be overly simplistic, as there are significant variations across disciplines. However, on average, it is mostly female with less than a quarter of the workforce male (23%), although this varies among disciplines, with orthotics being strongly male-dominated. In contrast to the nursing and medical profession it is also relatively young, with 61% aged between 25–44 years, and 10% under 25 years. Less than half (45%) are employed in the public sector. Overall, over 20% of the total workforce is working more than 40 hours a week.

- There are very few Aboriginal and Torres Strait Islander people in the allied health professions, with the Indigenous population significantly under-represented across the range of disciplines and across all States and Territories.

- There are considerably more people with allied health qualifications than identify as a currently practising allied health professional on the census form. This indicates that a significant proportion of the qualified allied health professional workforce is not employed within their profession. These people are either employed in other health professional jobs (such as management or community health), enrolled in Graduate Health Programs, or are not in the workforce. This represents a substantial level of workforce under-utilisation.

There were a number of specific findings from the project concerning rural and remote allied health professionals.

- Just 24% of allied health professionals service the 32% of Australia's population living in the rural and remote regions of Australia. Not one allied health discipline had a third of its workforce in these regions: just over half of the disciplines had a quarter of their workforces in these regions, averaging 24–28%, and four disciplines had between 10–20% of their workforce in them. The smaller professions of orthoptics, audiology and orthotics had the lowest representation in proportional terms. Furthermore, as for other professions, access to allied health professional services decreases with increasing remoteness.

Table 1: Number and percentage of allied health professions in capital cities and rural and remote regions

Allied Health Profession	Number	Major Capital	Rural and remote (% of number)
Audiologist	797	639	158 (19.8)
Dietitian	1996	1508	488 (24.4)
Hospital pharmacist	1713	1367	346 (20.2)
Medical Imaging	8322	6321	2001(24)
Occupational therapist	5339	3989	1350 (25.3)
Orthoptist	434	382	52(12)
Orthotists /prosthetist	356	288	68 (19.1)
Physiotherapist	10249	7679	2570 (25.1)
Podiatrist	1750	1323	427 (24.4)
Psychologist	9318	7406	1912 (20.5)
Social worker	9108	6823	2285 (25.1)
Speech Pathologist	3006	2166	840 (27.9)
Total:	**52388**	**39882**	**12497 (23.9)**

Source: Lowe, S and O'Kane A (2003), National Allied Health Workforce Report, June, Canberra.

Occupational therapy, speech pathology, social work and dietetics had a higher proportion of their public sector workforces in rural regions than of their private sector workforces. Radiography, physiotherapy, podiatry and psychology had a higher proportion in the private sector in rural and remote regions.

- There were no audiologists, orthoptists, orthotists or podiatrists located in the very remote regions of Australia. Overall, the Northern Territory had the lowest ratios for both public and private sector allied health professionals, and consequently poor access to these professions, particularly in more remote areas. For example, there were just three podiatrists and two clinical psychologists in the Northern Territory.

- In rural and remote regions audiology, medical imaging, orthotics and speech pathology all had a greater percentage of the public and private workforce working over 40 hours. Orthotics had almost half of its available private sector workforce in rural and remote regions working over 40 hours.

- The youngest (and hence least experienced) members of most disciplines work in the more remote areas.

These findings indicate a number of general issues:

- As with other health professions, there is a national shortage of allied health professionals, particularly in rural and remote areas where the shortages are critical. Inadequate numbers of allied health professionals to meet community needs lead to a high level of professional stress and burnout, resulting in high job turnover (and low retention). This national shortage is highlighted in the National Health Workforce Strategic Framework (April 2004).

- People with the highest need have access to the lowest levels of service delivery. Compared to their metropolitan counterparts, rural and remote communities have significantly lower levels of access to allied health professionals. Despite high levels of morbidity, Indigenous Australians - who make up a high proportion of the remote population - still lack effective access to a wide range of health care services. Health services for Indigenous Australians remain medically-focussed and deal with the reactive treatment of disease rather than promotion of health and independence. More health professionals and better-funded services could make significant inroads into Indigenous health problems such as obesity, diabetes, cardio-vascular disease, speech and hearing difficulties and mental health.

- There is a greater reliance on the public sector for the provision of allied health services in the rural and remote regions of Australia, with limited development of private services. This is largely a result of limited financial resources and incentives to practise in lower socio-economic areas, and time-related difficulties of having clients dispersed over large geographic areas with poor road and transport systems.

- Some allied health specialties are absent completely in some communities, adversely affecting those needing aged and disability care, rehabilitation or care under the National Health Priority Areas.

- The small number of Indigenous allied health professionals presents difficulties for developing culturally appropriate allied health services.

- Lack of access to a range of allied health professionals in rural and remote communities inhibits the development of a truly multidisciplinary approach to primary care, which can contribute to a decrease in sustainability of health services in these communities, including GP services which rely on this support.

- Given that significant numbers of allied health professionals are providing Commonwealth services, the Australian Government could assume greater responsibility for providing the incentives and support required for their recruitment and retention in rural and remote areas.

- Overall the availability of the selected professionals ranges from 2.66 per 10,000 people in the capital cities to 0.60 in very remote areas (Table 2).

Table 2: Allied health professionals per 10,000 head of population, by ASGC Remoteness

Allied Health Profession	Average	Major Capital	Inner Regional	Outer Regional	Remote	Very Remote
Audiology	**0.42**	0.51	0.33	0.12	0.18	0.00
Dietetics	**1.05**	1.21	0.78	0.76	0.61	0.59
Hospital pharmacy	**0.90**	1.09	0.62	0.48	0.18	0.15
Medical Imaging	**4.39**	5.05	3.62	2.52	2.02	0.78
Occupational therapy	**2.82**	3.19	2.31	1.86	1.37	1.42
Orthoptics	**0.23**	0.31	0.12	0.03	0.00	0.00
Orthotics/prosthetics	**0.19**	0.23	0.14	0.06	0.00	0.00
Physiotherapy	**5.41**	6.14	4.35	3.58	3.65	1.57
Podiatry	**0.92**	1.06	0.78	0.53	0.44	0.00
Psychology	**4.91**	5.92	3.44	2.43	1.87	0.83
Social work	**4.80**	5.45	3.85	3.36	2.51	1.27
Speech Pathology	**1.59**	1.73	1.42	1.16	1.23	0.59
Average:	**2.30**	**2.66**	**1.81**	**1.41**	**1.17**	**0.60**

Recruitment issues

Allied health professionals working in rural and remote areas experience many of the same barriers to recruitment and retention as other health professionals, including professional, social and cultural isolation. Lack of training and professional support, poor career pathways, shortages of locums and back-filling of positions, lack of educational and employment opportunities for their children and partners, low levels of income, long hours of work and on-call obligations and personal safety concerns all impact on recruitment and retention.

Undergraduate allied health student issues

Research shows that two of the best predictors of whether health practitioners will work in rural areas are a rural background and a positive exposure to rural practice early in their training[xiii,xiv]. The key determinants that make rural practice more likely for a health care professional are rural origin, a rural spouse and exposure to rural and remote practice during training, for example through rural placements. These predictors are stronger when they occur in combination.[xv,xvi,xvii]

Perceptions of rural practice

There is a need to improve undergraduates' perception of rural practice through a co-ordinated approach to selling and validating a rural career. As a result of pre-conceived and often unfounded ideas, compounded by an emphasis in the literature on rural disadvantage, many students consider rural practice to be somehow inferior to metropolitan practice (for example, that the pay is less or that they will be working in isolation). The reality is very different. Allied health professionals work in a diverse range of settings, often as part of a multidisciplinary team, using generalist as well as specialist skills. Their experience is broad and often more stimulating than that of their metropolitan counterparts. One way to improve students' perceptions would be to routinely invite experienced rural practitioners to lecture at universities. Another way is through rural placements (discussed below).

Scholarships program

An important aim is to ensure there is a continuing stream of students from rural and remote communities to complete undergraduate studies in allied health, thereby helping to address current workforce and service delivery inequities. Currently the Australian Government supports schemes for rural and remote medical, nursing and pharmacy students. It is recommended, therefore, that a similar scholarship scheme be developed for rural and remote undergraduate allied health students on a national level, including for hospital pharmacists who are currently not covered by workforce supports provided through the Pharmacy Guild of Australia.[2]

Rural placements

There is a general lack of funding for allied health student placements. The opportunity for rural allied health undergraduates to experience placements in rural and remote areas is critical to the recruitment of allied health professionals to non-metropolitan areas in the future. To be successful, rural placements need to be accessible, well co-ordinated and well-supported. If it is a good experience, the student is more likely to look favourably on rural practice when they have completed their respective degree[xviii]. Some allied health students undertake rural placements because there are none available in metropolitan areas. However, very few of these placements have specific rural learning objectives. It is essential that all rural placements are well-supported and have well-defined learning objectives linked to the needs of local communities.

A number of States have recognised the importance of the allied health professions to delivering health services and improving health outcomes in rural and remote areas, and are now providing rural allied health scholarships to students to enable them to undertake a rural clinical placement[xix]. The Australian Government has recognised the importance of an integrated program of support for pharmacists and pharmacy students, and this is a very good model which should be extended to allied health students. Furthermore, because rural and remote areas need 'whole health teams', the National Rural Health Alliance supports joint placements: i.e. medical, nursing and allied health professionals sharing placements together as a learning and working team.

Preceptors

While there are some schemes that provide funding for medical preceptors (e.g. Rural and Remote Areas Placement Program and the John Flynn Scholarship Scheme), there is no uniform funding approach to health services taking students. A survey of allied health professionals by SARRAH found that 39% of respondents had never supervised students and 67% had never received any training on student supervision[xx]. The ability to offer undergraduate clinical placements in rural areas is limited, with very few funded educator positions available. A number of University Departments of Rural Health (UDRHs) are running preceptor training programs, but there is no nationally consistent scheme.

[2] All of the issues described in this Paper for allied health professionals relate to hospital pharmacists. Generally speaking, the existing supports in place for the pharmacy workforce are only applicable to community pharmacy practice – that sector associated with PBS funding.

In some States there is no allocation to the Area Health Services for teaching, so that health service delivery dollars have to be used to support the education of students. Supervision of students by clinical staff leads to inefficiencies in he management of caseloads. Clinical staff providing supervision and clinical teaching are expected to clear their backlog of patients after the students have left, in spite of being already short-staffed. There needs to be proper recognition of the caseload inefficiencies that are created with the supervision of students in rural workplaces, and appropriate strategies instituted[xxi].

Joint academic positions

An increase in the number of joint academic/clinical allied health positions in rural areas would provide high quality professional support to allied health students, new graduates and local practitioners. Academics who maintain a rural clinical perspective to their role are more likely to have a realistic, true-to-life approach when teaching students. Many of the skills required would be generic across disciplines (e.g. mentoring and supporting new graduates and developing multidisciplinary programs). Joint positions also provide an opportunity to establish a mentoring and supportive role for relevant local practitioners and provide an alternative career pathway for allied health professionals, thereby increasing recruitment and retention potential within the regions[xxii].

A successful example is provided by a collaboration in radiography, nutrition, dietetics and occupational therapy between the New England Area Health Service and the University of Newcastle. The University of Newcastle has academic positions whose incumbents provide clinical services to clients in the New England region.

All UDRHs have pharmacy academic positions funded through the Pharmacy Guild's rural program. The Centre for Remote Health in Alice Springs also has an allied health academic position whose incumbent maintains a remote clinical load.

University Departments of Rural Health

Most universities continue to undertake discipline-specific education, but ideally interdisciplinary education should commence at the undergraduate level and continue through to the postgraduate level. A shift to multi-professional learning across the healthcare disciplines offers an opportunity to introduce practitioners to team management at an early stage.

The University Departments of Rural Health are among those agencies developing and implementing inter-professional education programs for health students in rural and remote Australia. The exact details vary from one UDRH to another but all have a strong multi-disciplinary focus in their education and training programs. This would be further strengthened by including allied health professionals on all relevant UDRH management committees.

Curriculum development

The development and implementation of rural curriculum content is currently not consistent between universities. While universities in rural areas have made significant progress in this area, many metropolitan universities need a greater commitment to rural health teaching within the course curriculum.

It would be desirable to include an appropriate rural element in the undergraduate curriculum for all allied health students, to provide future rural practitioners with the range of skills

required for rural practice and others with a better understanding of rural health care issues. This should include a multidisciplinary, population health and community-based focus. Students raised in urban areas may not go out to rural practice in their initial years following graduation, but they may do so later and need to be appropriately equipped.

Similarly, it is essential that the undergraduate curriculum for allied health students also addresses Indigenous health issues and cultural awareness training, similar to the medical school curriculum. Currently many allied health graduates working in remote areas feel poorly-equipped for cross-cultural work.

HECS Reimbursement Scheme

A student's academic debt can influence their choice of rural or urban workplace[xxiii]. A HECS reimbursement scheme would provide a significant financial incentive for allied health graduates to work in rural and remote areas. As is the case with the scheme applying to medical graduates in Australia, participants who provide allied health services in designated rural and remote areas should be eligible to have one-fifth of their HECS fees reimbursed for each year of service.

Promotion to rural secondary school students

Programs to promote rural health careers to rural High School students are important, particularly those targeting Aboriginal and Torres Strait Islander secondary students to encourage their entry to health degree courses. High School visits are a feature of the activity of a number of UDRHs, in conjunction with the National Rural Health Network and Rural Workforce Agencies in some jurisdictions.

One program undertaken in 2003 by a group of medical, nursing and allied health students to several schools in Alice Springs and the surrounding areas proved enjoyable for all participants and evoked an enthusiastic and positive response in students. The number of such programs needs to be increased and targeted at students in years 8-10, particularly Aboriginal and Torres Strait Islander students. This should go hand-in-hand with university initiatives to improve access to appropriate tertiary education courses, such as varied entry requirements for rural and remote students seeking to enrol in allied health courses (similar to medicine).

Publicly-funded positions

Establishment

One of the main issues impacting on the recruitment of allied health professionals is a historical shortage of publicly-funded establishment positions to meet community needs, particularly in remote areas. Battling workforce shortages through recruitment and retention initiatives is ineffective if the number of workforce positions does not come close to meeting basic community needs – one cannot recruit people to positions that do not exist. A lack of positions contributes to burnout, thereby exacerbating recruitment and retention problems.

Staff shortages and insufficient positions for health professionals are common features of the rural and remote context and services remain relatively under-developed as a result. Most staffing has happened in an *ad hoc* way, based on long-standing hospital-based arrangements. Workforce data show there are considerable inequities between States and Territories and between regions. For example, compared with Victoria, there are very few publicly-funded podiatrist positions in NSW, and only three in the whole of the Northern Territory. There is also a shortage of clinical psychologists in NSW and the Northern Territory.

There is often no correlation between allied health service levels and community need: for example NSW towns with a population of 40,000 can have 6, 8 or 13 allied health staff[xxiv].

Work is urgently needed to test assumptions about the relationship between a range of allied health services and population characteristics. This would enable the development of agreed minimum staffing formulae, for both rural and remote settings, as a way of overcoming current workforce deficiencies and providing appropriate levels of service for people living in these areas. Such services should be trialled in rural and remote communities, and evaluated to measure the benefit to clients, families, communities, health services, governments and the allied health professionals themselves, and established as benchmarks. UDRHs could develop partnerships to undertake this work. This would also help to establish the actual extent of workforce shortage.

Award structures

The existence of appropriate industrial awards to support rural practice is extremely important. A number of state award systems provide allied health professionals in rural and remote areas with little access to fixed incentives or career structures. Some States, including Queensland and Victoria, are moving to address this problem by providing rural practitioners with greater access to career structures within their clinical specialties and to commensurate remuneration. These developments need to be adopted by all jurisdictions.

Similarly, a number of Australian States, notably Victoria, are now offering innovative new career opportunities for physiotherapists, some of them based on the Enhanced Scope Practitioner concept. Key developments include:

- highly-skilled triage work in hospital emergency departments;
- aged care diversional services, designed to keep older people out of hospital when there are better alternatives available;
- orthopaedic triage in hospital outpatient departments; and
- creation of well-paid Grade 4 clinical positions for senior physiotherapists.

While such positions are currently being developed in metropolitan hospitals, they are also very relevant to larger rural centres.

There are some existing models that show that providing a range of salary and development incentives for allied health professionals to work in rural and remote areas can effectively increase rates of recruitment and retention.

Innovative service models at Mt Isa and Katherine have boosted the recruitment and retention of appropriate staff by upgrading their employment packages to include a good level of remuneration, a housing/rent subsidy, relocation costs, mentoring support, access to professional development, negotiated study leave for postgraduate training and enrolment in the Graduate Certificate in Remote Health Practice. In the Mt Isa program child care and paid conference leave and travel are also provided. Appropriate orientation, including cultural awareness training, is included. By supporting allied health professionals in this way and providing them with opportunities to maintain and increase their skills, retention rates are increased.

These are good examples of the sort of institutionalised support for allied health professionals that is possible, and that has beneficial impacts on recruitment and retention as well as workforce effectiveness.

Area of need program

The Department of Employment and Workplace Relations has listed shortages in eight allied health professions. There can be long vacancies for rural and remote allied health establishment positions in the public sector - services may have two to three unsuccessful advertising rounds in some disciplines without a single applicant. It is suggested, therefore, that those positions which fail to attract initial applications be designated by Health Departments as 'Area of Need' positions for that particular advertising round. The costs saved from repeat advertising could be used to subsidise additional incentives to attract allied health professionals to the position.

Retention issues

The retention of allied health professionals in rural and remote areas is affected by inadequate funding overall of health services and infrastructure, the difficulty and high cost of accessing professional development, and lack of discipline-specific supervision and mentoring.

Locum access

Access to locums varies between States and between professions. The study by SARRAH found that access to locum services is remarkably low, with access by only 26% of those surveyed. Those with access to locums are disproportionately spread across professions, with radiographers and physiotherapists most likely to have access and psychologists and audiologists least likely. Access is greater in the NT and Tasmania, and lowest in SA and NSW. Overall, only 19.8% of sole health professionals had access compared to 30.4% of those allied health professionals with a co-located peer.

Due to extremely low locum accessibility for all allied health professionals in rural and remote areas - and in particular for those working in sole positions - it is recommended that Governments consider funding appropriate locum support programs. Locum support programs must take into account various rural and remote practice situations and must be flexible in meeting the needs of rural communities.

Some State Health Departments are seeking to develop locum initiatives to aid retention. However, rather than depending on a small number of *ad hoc* programs, access to locums needs to be guaranteed for all allied health departments (as is currently the case in nursing). This could be achieved by building into the budget an allowance of an additional 0.1 Full Time Equivalent (FTE) relief position for every establishment position. While it is easier for larger departments with more staff to cover absences, this is particularly important for one-person departments, which should be funded for 1.1 FTE.

Access to mentors

A positive initiative aimed at retaining staff is the Central West NSW Allied Health Mentoring Project, which is being funded by the Australian Government through the Regional Health Services Program and commenced in July 2003. The aim of the project is to develop a mentoring model that is applicable across sectors and funding programs, which can be replicated in other rural areas where allied health staff are working in small rural communities with populations of 5,000 or under. The trial of the project will be completed in November 2004. There is also a mentoring program in the Northern Zone of Queensland Health.

Management issues

Management training is needed for both allied health professionals who move from clinical to management positions, and for managers of allied health professionals who are not themselves in that category. Both groups are likely to need training which includes aspects of primary health care and multidisciplinary practice, as well as specific issues to do with rural and remote areas, including cross cultural practice.[xxv]

Traditionally there has been poor quality management of allied health professionals in rural and remote health teams, with management groups usually comprising a business manager, doctor and nurse. This lack of allied health representation can lead to less than optimal use of allied health resources and expertise. This contributes to professional isolation and to staff leaving (i.e. higher attrition). It also undermines the development of multi-professional rural health workforce strategies. To help address this, allied health professionals should be formally represented on management bodies and groups in rural and remote areas to ensure that allied health needs, views and expert input are considered in decision-making.

Postgraduate education

The importance of access to postgraduate and continuing education cannot be overstated. The study by SARRAH (2002) found that a high proportion of allied health professionals intend to take on postgraduate studies, and a significant proportion will have to leave their positions to do so. SARRAH recommended that education and training providers, including UDRHs, actively pursue appropriate delivery of education and training programs at all levels to allied health professionals to encourage them to remain in their location. Programs should be available in clinical and management areas and use a range of education delivery strategies.

In this context two important initiatives are worth noting. The Australian Government Rural and Remote Health Professional Scholarships Scheme (initially known as the Commonwealth Allied Health Rural and Remote Scholarships Postgraduate Scheme) commenced in 2003 to help rural and remote health professionals to access continuing education by providing funding for individual clinical placements and short courses, conference attendance and tertiary qualifications. Funding is designed to assist those health professionals working in rural and remote Australia to overcome the barriers to accessing professional development to maintain and enhance the knowledge and skills required to provide quality services to local communities.

The Centre for Remote Health in Alice Springs has introduced a multidisciplinary Master of Remote Health Practice, which includes an allied health stream. The allied health component of the curriculum focuses on project management, population health, self-care and working in a culturally safe and appropriate way. An agreement between Queensland Health and the Centre for Remote Health provides support for its rural and remote allied health professionals to participate in this course. Allied health staff employed through Regional Health Services programs at Mt Isa and Katherine are also supported to do this course.

INITIATIVES PROMOTING ALLIED HEALTH SERVICES

At the Federal level, the education and recruitment of allied health professionals has traditionally been considered to be a State/Territory responsibility. However, in recent years links with the Australian Government have been considerably strengthened, with a number of specific initiatives, most recently the Australian Government Department of Health and Ageing's revised Rural Health Strategy, promoting allied health services and expanding allied health roles.

Of particular relevance is the creation of the Rural Primary Health Program in the 2004 Federal Budget. This program combines three programs from the previous Strategy: the Regional Health Services program, the More Allied Health Services (MAHS) program and the Rural Chronic Disease Initiative which are already delivering a range of allied health services (including dietetics, occupational therapy, physiotherapy, podiatry and psychology) to rural and remote communities under a range of different models of service delivery. By recommitting to funding these initiatives and combining them into a single program, there is opportunity for better co-ordination and maximising opportunity to focus on multidisciplinary delivery of health care services, which is essential in primary care. Other related initiatives include the Better Outcomes in Mental Health Care Access to Allied Health Initiative, Enhanced Primary Care (EPC) Packages, Primary Care Partnerships, and Strengthening Medicare, which for the first time will allow allied health providers direct access to Medicare rebates through GPs in certain circumstances.

These initiatives provide a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between care recipients' needs and services. While they demonstrate that the Commonwealth recognises the importance of allied health services in promoting health and well-being, further funding and training of allied health professionals are required to ensure needs are properly met. Otherwise these new initiatives may be affected by workforce shortages, particularly in rural and remote areas.

In addition, further input from allied health professionals is required to ensure that these programs operate to optimum capacity.

- The MAHS program needs to have a more even spread of funding across professions in proportion to the size of the respective allied health disciplines (i.e. greater representation of physiotherapists compared with dietitians or podiatrists), and clarification as to whether members of the nursing profession (i.e. practice nurses) are considered 'allied health'. To illustrate this, in a recent funding round, physiotherapists received 5.6% of MAHS funding compared to nurses who received 33%.

- A major failing with EPC packages is the inability to access public sector employees, which combines with the difficulty in accessing allied health professionals. There needs to be flexibility where the only access is through the public sector.

- The new initiatives under Strengthening Medicare are limited to patients with chronic disease. While recognising the importance of this initiative, a limit of 5 sessions does not recognise the time it takes to deal with patients with complex care needs. Such an approach would work better for early intervention strategies. There are also concerns with the low level of remuneration for allied health professionals under the scheme (e.g. $44 per session for clinical psychologists compared with a $170 rebate for psychiatrists for equivalent work) and consumer protection issues.

- There can be insufficient consultation by Divisions of General Practice with communities and allied health professionals on local needs. There have been instances where publicly-funded services (e.g. at the local hospital) have been replaced by MAHS-funded services. However, when the Division chooses to no longer fund these services, the community has been left with nothing - no hospital-based services and no MAHS services.

These examples reinforce the need for input from and involvement of both consumers and allied health professionals when allied health policies are developed at the State and Commonwealth level, to ensure the services are integrated and appropriate.

Service development in rural and remote areas

The challenges of chronic diseases, particularly in an ageing population, provide an unprecedented opportunity to explore new models of service delivery. Recently some new services in rural and remote areas have provided evidence about effective ways to recruit, orient, manage, develop and support allied health professionals in the future.

Models of service delivery

Remote areas

There have been some innovative initiatives specifically aimed at addressing the lack of access to allied health professionals in small isolated and remote communities.

- *The North-West Queensland Allied Health Service*, which is based in Mount Isa and commenced operations in late 2001. The Service receives funds of over $1 million per annum under the Commonwealth Regional Health Services Program to provide multidisciplinary allied health services to 11 culturally diverse remote communities. Many of these communities have a high prevalence of chronic disease, a large proportion of Indigenous people and a preponderance of youth. They are now receiving primary health care outreach dietetics, occupational therapy, physiotherapy, podiatry, psychology and speech therapy services on a 6-week rotational basis. A key component of the program is the recruitment of a network of local, community-based therapy assistants to provide additional support.

- *The Katherine Remote Allied Health Therapy Program* which commenced in 2002 and is also funded under the Commonwealth Regional Health Services Program to the level of $500,000 per annum. The focus of the program, which includes audiology, occupational therapy, physiotherapy, podiatry and speech pathology, is on the remote Aboriginal communities situated out of Katherine. The core elements of this model are an emphasis on aged and disability care, the employment of local residents as 'community disability co-ordinators' to work in collaboration with the visiting allied health professionals and a minimum of monthly visits to each community from each required professional. The service is strongly influenced by the philosophy and practice of community-based rehabilitation, and is being developed within a paradigm of Aboriginal community control - the allied health professionals are employed by an Indigenous health organisation, rather than by government or in private practice.

Rural areas

There are also some good rural examples of innovative service models in primary care.

- *The Clinical Psychology in General Practice Project: An early intervention approach to mental health service delivery in Rural Primary Care*[xxvi]. Since early 1998, the Project has trialled a new model of collaborative care for common mental disorders by providing psychological services in the primary care setting. The Project has involved Clinical Psychologists and Clinical Psychology Registrars from various Universities working in general practices in regional and rural areas of NSW and Victoria. An evaluation has shown that the collaborative model of mental health service delivery is having a significant and positive impact on patients' mental health and well-being when compared to 'treatment as usual' by GPs in the primary care setting.

- As a result of the above trial, further funding under the More Allied Health Services and the Better Outcomes in Mental Health Care Access to Allied Health Initiatives (BOMHC AAHI) has enabled the trial of four different funding models for psychological services in the Central West of NSW, found to be feasible in the Clinical Psychology Project. These are:
  - clinical Psychology Registrar stipends;
  - salaried positions within Divisions of GPs;
  - patient voucher systems; and
  - direct funding for group treatment programs.

- As a consequence of the original project, psychological services are now being provided to Bathurst, Blayney, Canowindra, Condobolin, Cowra, Forbes, Lithgow, Molong, Parkes, Tullamore, Trundle, Rylestone and Kandos. Thus, from extremely small beginnings (i.e. one clinical psychologist in a Bathurst General Practice for one session per week in 1998), quite wide articulation of this model of collaborative mental health service delivery has occurred.

These examples of service delivery in rural and remote areas illustrate a number of principles.

- They provide an evidence base for the benefits of allied health practice, flexible ways of delivering services and sustainable models of allied health outreach practice.

- They demonstrate models of service delivery for the future that could be usefully replicated across Australia through widespread dissemination of project findings, national leadership and ongoing funding. This will enure that successful projects are implemented nationally.

- They show the benefits of innovative service delivery by redistributing allied health positions from professionally isolated solo practice to integrated and supported teams, with appropriate financial and education incentives to improve recruitment and retention rates.

- They confirm the Australian Government's commitment to more comprehensive allied health service provision in rural, regional and remote areas.

NATIONAL LEADERSHIP

In the past a lack of formal allied health representation at senior management levels in Commonwealth and State Departments of Health has placed allied health professionals at a disadvantage, vis-à-vis medical practitioners and nurses, in the development of co-ordinated policies and programs to improve the delivery of health services and/or conditions of service for both patients and their professional group. However, there has been considerable progress over the last 2-3 years, including the appointment of Allied Health Principal Advisers in a number of State/Territory Government Health Departments, as well as moves by the remaining States in this direction.

Mirroring this with an Allied Health Adviser in the Australian Department of Health would foster co-ordination and co-operation on allied health issues with State and Territory Governments and help develop a broadly-based health workforce strategy for allied health professionals.

National health priority areas

There is also a need to recognise, value and reward the contributions of allied health professionals to the health community in representational and committee roles, through their involvement in planning processes and organisational structures. A lack of allied health involvement is particularly evident in relation to the management of the seven National Health Priority Areas. These reflect the main burdens of disease and illness across Australia: cardio-vascular health, cancer control, injury prevention and control, mental health, asthma, diabetes, and arthritis and musculoskeletal conditions. Notwithstanding the wide range of crucial services needed to help achieve the health goals and targets for these priority areas, allied health professionals are under-recognised in the management of these programs.

For example, while the HPCA is directly represented on the National Arthritis and Musculoskeletal Conditions Advisory Group, as is SARRAH, there is limited allied health input to the other areas, including diabetes, cancer and cardiovascular health, with minimal direct allied health representation on the expert advisory groups.

It is essential, therefore, that discussions are initiated with the Australian Government to highlight the important roles of the various allied health disciplines in caring for the rehabilitative, palliative and dietary needs of their constituents in rural and remote locations, and to ensure that allied health professionals are involved in all policy and program development for the National Health Priority Areas.

RECOMMENDATIONS

1. The Alliance notes that some difficulties have arisen with use of the term ‘allied health’, but recommends on balance that the term be retained, given the relatively clear understanding of the disciplines which have traditionally been regarded as being included under the term.

2. The Australian Government should raise awareness among both consumers and GPs in rural and remote communities of the wide range of services provided by allied health professionals, including in acute care, aged care, health promotion, mental health, palliative care and rehabilitation. The allied health professional needs to be considered an integral member of rural and remote multidisciplinary health care teams. This could be done in conjunction with the Government’s new Medicare allied health initiatives, to ensure people with chronic disease are aware of this new benefit.

3. To improve our understanding of the allied health workforce, the Australian Government should commission a national workforce analysis of supply and demand for allied health professionals across rural and remote areas, as well as their training and support needs. Accurate information on the number, distribution and specialist skills of the relevant allied health professionals would be helpful in ensuring the success of the new Rural Primary Health Program, Enhanced Primary Care Packages and Strengthening Medicare.

4. The Australian Government should provide specific funding to provide for:

    - the development of a scholarship system for rural and remote undergraduate allied health students on a national level, similar to that which already exists for medical, nursing and pharmacy students;
    - rural allied health placement subsidies, to facilitate students undertaking a rural clinical placement by subsidising their travel and accommodation costs, similar to the assistance currently provided to medical and community pharmacy students;
    - an increase in the number of joint academic/clinical allied health positions in rural and remote areas, to provide high quality professional support to allied health students, new graduates and local practitioners;
    - the development of an appropriate rural curriculum for all allied health undergraduate students to provide them with the range of skills required for rural practice. This should also address Indigenous health issues and cultural awareness training, similar to the medical school curriculum;
    - the introduction of a HECS fees reimbursement scheme for graduate allied health professionals undertaking rural and remote employment, similar to the scheme that applies to medical graduates; and
    - the promotion of rural health careers to rural high school students, particularly targeted at Aboriginal and Torres Strait Islander secondary students, to help increase the Aboriginal and Torres Strait Islander allied health workforce.

5. The Australian Government should, as part of its funding negotiations with University Departments of Rural Health, ensure that:

    - they all continue to have a strong multi-professional focus across their education and training programs, including the promotion of joint placements of medical, nursing and allied health students, where possible. This will require improvements to the related infrastructure: accommodation, learning centres and part-time academic positions in clinics - particularly in more remote areas;
    - allied health professionals are included on all UDRH management committees;
    - UDRHs form partnerships to research the needs of rural and remote communities for allied health services and to develop agreed, minimum staffing formulae, for both rural and remote settings, as a way of overcoming current workforce deficiencies and providing appropriate levels of service for people living in these areas; and
    - access to accommodation is provided for allied health students.

6. Due to extremely low locum accessibility for allied health professionals in rural and remote areas, and in particular for those working in solo positions, the Australian Government should consider funding appropriate locum support programs. Locum support programs must take into account various rural and remote practice situations and must be flexible in meeting the needs of rural communities.

7. The Australian Government should seek input from and involvement of both consumers and allied health professionals when it is developing policies and programs that involve allied health (for example MAHS, BOMHC AAHI, EPC and Medicare Plus) to ensure the services are integrated and appropriate.

8. The Australian Department of Health and Ageing should appoint a senior National Allied Health Adviser to foster co-ordination and co-operation on allied health issues with State and Territory Governments, to help develop a broadly-based health workforce strategy for allied health professionals in rural and remote areas. This would facilitate discussion on those issues under State and Territory control, including establishment positions, award conditions and area of need.

9. The Australian Government should recognise the important roles of the various allied health disciplines in caring for the preventive, rehabilitative and palliative needs of their constituents in rural and remote locations, and ensure that allied health professionals are involved in policy and program development for the National Health Priority Areas, and other relevant initiatives.

10. The Regional Health Services Program should have some emphasis on support for an integrated service model for rural and remote allied health professionals that includes well-resourced undergraduate placements, adequate numbers of positions in the public sector in rural and remote areas, strong professional development and postgraduate education support.

11. The Australian Government should provide national leadership, advocacy and funding to ensure that innovative and flexible models of sustainable allied health service delivery are replicated across Australia.

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