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Services for Australian
Rural and Remote Allied Health

Submission to the Senate Community Affairs Reference Committee

‘The factors affecting the supply of health services and medical professionals in rural areas’

December 2011

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Introduction

Services for Australian Rural and Remote Allied Health (SARRAH) welcomes the opportunity to provide a submission to the Senate Community Affairs Reference Committee inquiry into factors affecting the supply of health services and medical professionals in rural areas.

SARRAH is nationally recognised as a peak body representing rural and remote allied health professionals (AHPs) working in both the public and private sector.

SARRAH's representation comes from a range of allied health professions including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These AHPs provide a range of clinical and health education services to individuals who live in rural and remote communities. AHPs are critical for the management of their clients' health needs, particularly in relation to chronic disease and complex care needs.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and core to Australians' health care and wellbeing.

General comments

Much of the information contained in this paper results from the Rural Allied Health Workforce (RAHW) survey. This collaborative research between 4 University Departments of Rural Health across NSW, Tasmania and the NT, was coordinated through the SARRAH Research Alliance.

The research team[1] conducted in 2008-2009 a survey of the entire rural allied health workforce in NSW, Tasmania and the NT, with follow up focus groups conducted in NSW in 2009-2010. In total, 3391 rural AHPs responded to the survey. Reports for each jurisdiction can be obtained from the following URL's:

- New South Wales:
  http://www.ircst.health.nsw.gov.au/__data/assets/pdf_file/0009/65799/RAHWS_Final_Report_IRCST.pdf
- Tasmania
  http://fcms.its.utas.edu.au/healthsci/ruralhealth/files/tas-ah-and-oh-wf-study.pdf
- Northern Territory

[1] Led by Sheila Keane, with co-authors Tony Smith, Shelagh Lowe, Michelle Lincoln and Narelle Campbell

http://www.flinders.edu.au/medicine/fms/sites/northern_territory_clinical_school/documents/Research%20Publications/The%20Northern%20Territory%20Allied%20Health%20Workforce%20Study.pdf

Comments against the Terms of Reference for the Inquiry

a) The factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres.

The sustainability of the rural and remote allied health workforce relies on three inter-related factors: 1) overall workforce supply; 2) recruitment to rural practice; and 3) retaining the existing rural allied health workforce.

Workforce Supply

Increasing workforce supply has been a major thrust of Health Workforce Australia, and this is to be commended. However, some consideration should be given to prioritisation of under-supplied professions (e.g. Social Work) compared with other professions where future workforce supply (e.g. Pharmacy) appears to be adequate. This cannot be accomplished without accurate and up to date information about the existing rural allied health workforce.

While workforce data are regularly collected and analysed for the medical and nursing professions, there is less information available describing the various allied health professions. This is not a desirable approach to workforce planning.

Recommendation:

For effective workforce planning, existing data from the Australian Bureau of Statistics Census and information collected by the Australian Health Professions Registration Agency should be regularly analysed to identify shortfalls in particular allied health professions, not just in aggregate “allied health”.

Data must also be collected and analysed from Self-Regulating Professions in order to form complete picture of the allied health professions (for example: Dietetics and Audiology).

Recruitment to rural practice

Rural origin

Well over half of the existing rural allied health workforce grew up in a rural area. Encouraging rural youth to train in a health profession is currently supported by the provision of entry level, post-graduate and clinical placement scholarships through the Commonwealth Government funded Nursing and Allied Health Scholarship and Support Scheme (NAHSSS).

Mentoring programs for these young people whilst undertaking their study, delivered by the University Departments of Rural Health or as an outreach of the university’s allied health course, could also prove to be an effective recruitment strategy.

However funding levels of the allied health streams of the NAHSSS, which are administered by SARRAH, need to be significantly increased to meet ongoing demand.

> **Recommendation:**
>
> Given the success of these initiatives, SARRAH recommends consideration is given to increasing the amount of scholarship support available to rural youth who want to train in an allied health profession.

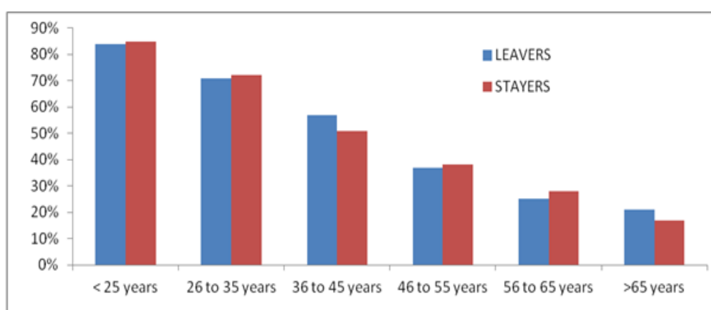
Rural student placements

Results from the RAHW survey indicate that rural student placements may not have a robust impact on retention, but they do appear to increase recruitment of new graduates into rural practice in the short term. Of the 312 NSW RAHW survey respondents who are less than 30 years old, 77% have had a rural placement. The chart below indicates the number (%) of young respondents who intended to stay or leave their current job.

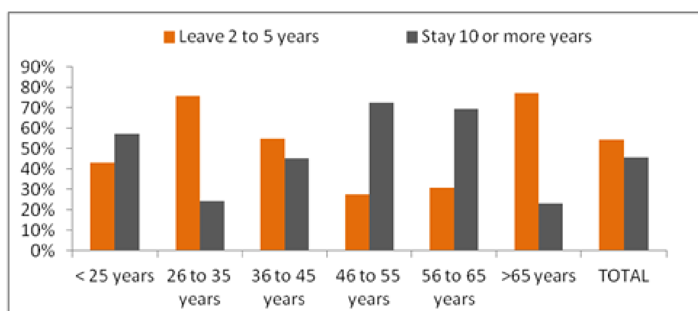
	Leave (w/in 5 yrs)	Stay (10+ yrs)
No Rural Placement	40/57 (70%)	17/57 (30%)
Had a rural placement	141/243 (58%)	99/243 (41%)

The data from the NSW RAHW survey is suggestive that for younger AHPs having a rural placement has a small influence on their retention rates. Younger people tend to be very mobile as a function of their age, and anecdotal evidence suggests that many of them do return to a rural setting when they are ready to settle into a more stable lifestyle.

The data was analysed with respect to the age of the AHP, their intention to stay or leave their job within 5 years, and whether they had had a rural clinical placement as an undergraduate. The next chart shows the proportion of respondents who had a rural placement who intended to stay or leave their job. For those who had a rural placement across age groups, there did not appear to be any difference in the intention to stay in their current job. Instead, intention to leave appears to be a function of age.



However, for those who did NOT have a rural placement, the picture was mixed as to whether this affected the intention to stay or not.



For the relatively young and inexperienced AHPs who had most recently graduated (less than 25 years of age) the data suggest that the lack of previous rural experience may lead to a longer stay. In order to determine whether rural clinical placements do have a significant impact on rural recruitment and retention for AHPs the data from the RAHW survey requires further analysis.

Recommendation:

Given that a good deal of investment is being made in supporting rural student placements, evaluation of this policy should be vigorously pursued. SARRAH suggests that such an evaluation should include comparison between recruitment to rural and remote practice for the medical professions where training and clinical placements in rural areas are better supported and of longer duration (12-24 months as compared to 4-10 weeks for allied health students).

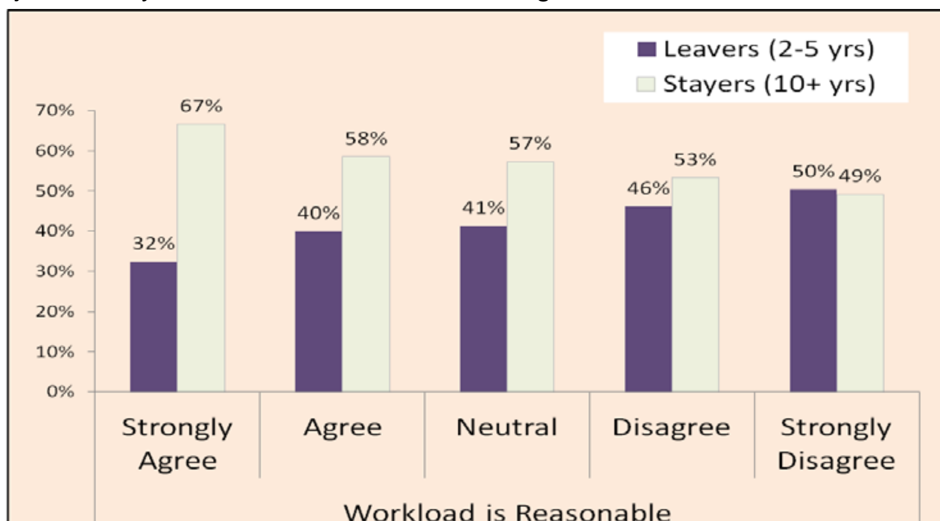
Rural lifestyle & type of work

In the 2008-09 RAHW survey, the majority of respondents indicated they were attracted to their job by a desire to live in a rural area (life style and work life balance) as well as being attracted to the variety and challenge of the type of work found in rural practice. Recruiting to these qualities may be helpful to draw health professionals into rural practice. Inclusion of rural health in university courses would also raise awareness of the attractions of rural practice.

Retaining the existing rural allied health workforce

Workload

In the RAHW survey, significantly more allied health professionals intended to remain in their jobs if they felt their workload was manageable.



Unfortunately, heavy workloads are a feature of rural practice in a context of severe workforce shortages. The introduction of Certificate IV qualified Allied Health Assistants (AHA's) into the rural health workforce could reduce workload pressure, but there are safety and quality risks associated with this change. As the role of the AHA is new, the existing allied health workforce require training in the skills of clinical delegation & supervision of qualified clinical support staff, such as that available through the Rural Health Continuing Education Program.

Recommendation:

Further investment in training of Certificate IV qualified Allied Health Assistants should be accompanied by a consultative process with the relevant allied health professions to establish appropriate clinical governance and regulatory policy, particularly in the rural context.

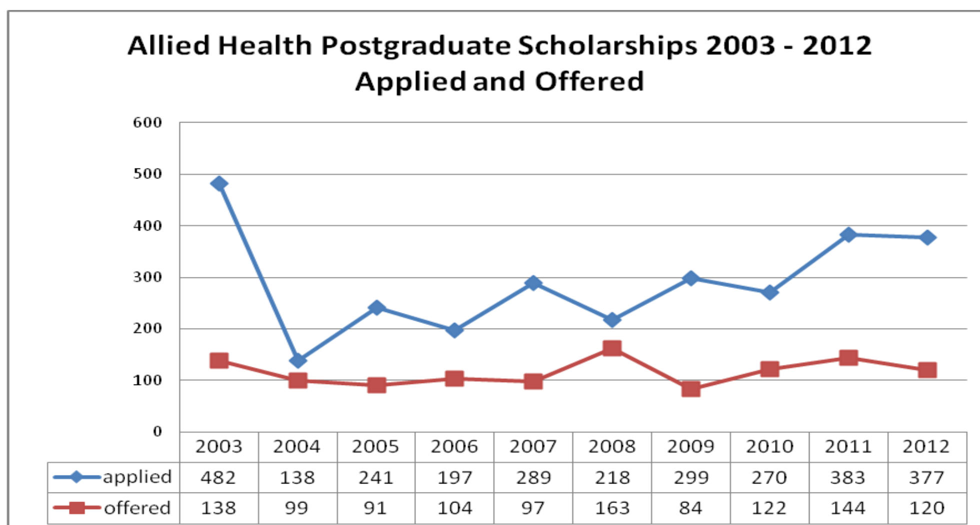
Access to continuing professional development (CPD)

While workload contributes to burnout, so also does the difficulty of gaining access to professional education. RAHW survey data shows a strong link between CPD access and increased job satisfaction, as well as reducing burnout.

Access to CPD is limited most by the pressures of workload and the time and cost of travel. While online training does provide some solution, it cannot fully meet the need for professional contact and the development of resource networks that enable rural practitioners to thrive in a context of highly varied clinical practice.

Access to CPD is particularly important for new graduates and isolated practitioners, but it is also essential to retain experienced allied health practitioners as this workforce forms a stable core that anchors the quality and safety of service delivery where there is considerable mobility of younger practitioners.

The Commonwealth Government has recognised the higher costs for AHPs from rural and remote communities to access postgraduate education through the funding of the allied health postgraduate stream of the NAHSSS. This scholarship scheme provides funding support for AHPs living and working in rural and remote areas to access formal postgraduate study, short courses and attending conferences. However, the ability to meet the demand for scholarship funding to contribute towards the costs of accessing professional development for rural and remote AHPs has fallen short in every application round. Since 2003, the overall success rate of applicants applying for this scholarship has been 44%. Between 2010 and 2012 the number of applicants has increased by 39.6% while the number of successful applicants over the same period has decreased by 1.6%.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
applied	482	138	241	197	289	218	299	270	383	377
offered	138	99	91	104	97	163	84	122	144	120

Recommendation:

Expand the postgraduate scholarship stream of the Nursing and Allied Health Scholarship and Support Scheme to better reflect the numbers of rural and remote allied health professions and professionals being supported to access continuing professional development through the scheme, and to further address unmet need.

Locum support

As with members of the medical profession, for AHPs working in private practice, or in sole practice positions, being absent from the place of employment in order to access further education is a major issue. The Commonwealth Government has recognised problems relating to the lack of locum support and established a Nursing and Allied Health Rural Locum Scheme (NAHRLS). However, NAHRLS may not be successful in the geographical areas of most need because of the narrow scope of the scheme such as the short duration of the locum placement and no funding for locum wages.

Recommendation:

The Nursing and Allied Health Rural Locum Scheme guidelines should be reviewed and modified to increase the uptake of locums in rural and remote settings.

Mentoring

Mentoring has been identified by grass roots rural and remote AHPs as a critical component to retention in rural and remote allied health practice. This has been a key recommendation at the National SARRAH Conferences since 2004. There is currently an ad hoc approach to mentoring for the AHPs in rural and remote Australia. Mentoring for public sector staff is provided by some jurisdictions but not all. Mentoring for new graduates is provided by some professions but not all. There is no national coordinated scheme for mentoring professionals new to rural and remote practice.

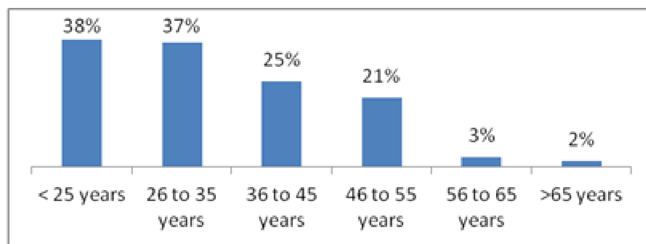
Recommendation:

A national mentor program for AHPs new to rural and remote practice should be developed, funded and implemented.

Career opportunities

Of the 278 NSW RAHW survey respondents who were under 35 years of age, 103 (37%) indicated they were leaving to seek better career options. The ability to specialise provides a career pathway, and could aid in the retention of experienced clinicians who are so necessary to the functioning of the more transient members of the rural allied health workforce.

The following bar chart shows the % of respondents indicating they intended to leave their job to seek better career options (by age group).



Recommendation:

Recognition of rural and remote allied health practice as a specialisation, appropriately recompensed as per the Rural GP program, would make working in these settings more attractive to AHPs.

Rural community infrastructure

Retention of rural AHPs is cemented by their integration into the local community, including employment for spouses and schools for their children. Local communities also play a part by providing a vibrant and welcoming social environment. Access to education, housing and transport also contributes to retention of the existing health workforce.

For example flight services between regional centres and capital cities are essential in providing access to professional development, and retaining workers on shorter term assignments as trips to visit family and friends can help to sustain them in an isolated rural or more remote practice.

Rural health service resources

In the RAHW survey, 60% of respondents agreed or strongly agreed with the statement that "there are service gaps because of limited human resources".

While health facilities and equipment are necessary to the delivery of health services, the single most important infrastructure is human resources. There can be no retention of AHPs in positions within the public sector if they are not funded or, if funded, not recruited.

Investment in training local community members to become Certificate IV qualified Allied Health Assistants can increase the available workforce providing they have adequate and appropriate supervision from a qualified AHP. Local community members are also likely to be retained, and are particularly important in more remote communities where health professionals are stretched to capacity and beyond.

Amongst others, West Australia Country Health[2] has developed clinical governance structures to guide the supervision of remote AHA's.

b) The effect of the introduction of Medicare Locals on the provision of medical services in rural areas.

Medicare Locals are emerging from the current Division of General Practice (DGP) Program. The DGP program by its nature largely supported the delivery of medical services. Theoretically the expansion of the program to include coordination and support of health services delivered by a multiprofessional health care team, including medical, nursing and allied health services, should improve access to these services by rural and remote communities. If implemented correctly, AHPs should be better supported by through services

[2] http://www.wacountry.health.wa.gov.au/alliedhealthassistants

commissioned by Medicare Locals. However, these services will need to be periodically measured and evaluated.

Recommendation:

The Medicare Local program must be evaluated not only for their impact on the provision of medical services in rural areas, but also on allied health services. The evaluation should include the impact and effectiveness of the Medicare Local on the provision of primary health care services by the multiprofessional health care team.

c) Current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:

i. their role, structure and effectiveness,

ii. the appropriateness of the delivery model, and

The incentive programs for AHPs are very limited and in fact inequitable when compared to incentives available to doctors and dentists. For doctors and dentists there are a broad range of incentives such as: reimbursement of HECS fees, relocation expenses, family support, rural practice incentive retention bonus payments and support to set up new practices. These incentives should be extended to AHPs which would assist with the recruitment and retention rates in rural and remote settings.

Recommendation:

The current incentive programs for the recruitment and retention of doctors and dentists should be evaluated. Incentives found to be effective for the medical and dental workforce will also be effective for the recruitment and retention of allied health professionals in rural and remote communities.

iii. whether the application of the current Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) classification scheme ensures appropriate distribution of funds and delivers intended outcomes.

SARRAH is unable to comment on this point from the aspect of medical and dental incentive programs. However, the ASGC-RA classification scheme is used to administer and distribute the funding available under the NAHSSS. Whilst this classification system goes some way to addressing the issues which existed under the Rural, Remote and Metropolitan Area (RRMA) classification structure previously used, flaws in the system are still evident such as:

- The inner regional classification includes areas of major capital cities such as Sydney and Melbourne. Such areas should not be considered rural for the distribution of rural program funding.
- Both inner regional and outer regional are broad areas containing many communities. Inner regional also contains communities which in terms of health workforce, socioeconomic status and health status could be considered as communities of need. Removing inner regional communities from any rural funding

program will remove communities from accessing funding which can assist in addressing workforce shortages and local health needs.

SARRAH suggests that socioeconomic status also be considered by organisations who administer Commonwealth Government funded programs for the allocation/distribution of funding to address community health needs and health workforce distribution.

d) any other related matters.

Demand for allied health services

Having sufficient workforce levels to meet health needs is not only about the availability of personnel. Some consideration also needs to be given to the extent and nature of the need for allied health services, which will increase as Australia's population ages and the burden of chronic disease increases. Primary health care, with its focus on prevention of illness and the delivery of team based health care, is also going to increase demand for AHPs.

There can be a perception that allied health services are 'discretionary' in nature. This may be true in some circumstances and not in others, not unlike the medical equivalent. We are familiar with the concept of elective surgery for example, but there are medical conditions where surgery is essential. Few would argue that the work of Optometrists is discretionary, or Exercise Physiologists conducting cardiac rehabilitation or Speech Pathologists treating life threatening swallowing disorders in acute hospitals. The diagnostic professions in radiography and medical technology provide doctors with information vital to medical treatment, and a person whose spinal cord was cut in a car accident would not consider rehabilitation services to be optional.

In many circumstances, allied health services are not an "extra". In 2010 Catherine Earl undertook a research study investigating the "Social cost of service cuts"[3] with a focus on child protection, allied health services and rural health for the Public Service Association of Australia. She concluded:

> *"Research indicates an increasing need for these services because of changing demographics, and further long-term costs would result from a lack of adequate early intervention. Workers in these areas report a current inability to meet the needs of our community. Services such as child protection, allied health and rural services contribute to a strong social fabric. Weakening these services would have a significant negative impact on all South Australians."*

Due to a paucity of research funding, there is a miniscule evidence base on which to prioritise what allied health services should be supported as 'essential services', and which can be considered elective in certain circumstances. Two recent studies[4] funded by the

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[3] Earl C; 2010; The Social Cost of Service Cuts; available from: http://cpsu.asn.au/sa/sa/webnews/THE%20SOCIAL%20COST%20OF%20SERVICE%20CUTS%20.pdf; Accessed 5 December 2011

[4] Bird S, Noronha M & Sinnott H; 2010; *An integrated care facilitation model improves quality of life and reduces use of hospital resources by patients with chronic obstructive pulmonary disease and chronic heart failure*; Australian Journal of Primary Health 16(4) 326-333; and

Mitchell G; 2011; The role of allied health in the management of complex conditions in a multidisciplinary comprehensive primary care setting; Australian Primary Health Care Research Institute (reports to be published on APHCRI in 2012)

Australian Primary Health Care Research Institute (APHCRI) have identified the substantial impact of allied health interventions in reducing hospital admissions and improving health in the frail aged. While neither of these studies were conducted in a rural context, it is nevertheless useful to understand the role of the allied health professions in the overall pattern of health care delivery. It is not clear whether or how the success of these interventions can be translated to a rural context. Indeed, there may be circumstances particular to the rural setting where the need for specific allied health services and ways in which those services can be delivered differ from the metropolitan context.

If the Australian Government does not take measures to retain an allied health workforce and to increase supply to meet the demand, services will shut down as a result of vacancies.

The rural allied health workforce can only be sustained through training of Australian graduates, successful recruitment to rural practice, and retention of transient health professionals which may be overseas trained professionals. Vocationally trained AHAs and community health workers are likely to be a helpful addition to the rural allied health workforce but they must be appropriately regulated, trained and supervised to ensure quality outcomes for clients and communities.

It must be recognised that the profile of the allied health workforce is not the same across rural and remote communities, with some variation between States. For example, the allied health workforce in the Northern Territory is much younger and more mobile than that of remote New South Wales.

Difficulty also arises when grouping all health professions that are not medical or nursing under the one umbrella and calling them ‘allied health’. The assumption could be made that each of the different professions known as ‘allied health’ has a similar profile in rural and remote communities. For example, the RAHW survey demonstrated that the Dietetic and Speech Pathology rural and remote workforce was generally younger than that of the Pharmacy workforce. The former two professions also comprise more females than that of the Podiatry workforce. Private practice is more predominant in the Podiatry and Physiotherapy professions than in Dietetics or Occupational Therapy.

Conclusion

In conclusion, the factors that impact on the recruitment and retention of the allied health workforce in small regional communities are the same as that which impact on the medical workforce. A summary table of factors identified for staying or leaving a position in a rural or remote community, identified by the RAHW survey is provided as Appendix 1. Incentives that are shown to be effective in increasing the medical workforce in rural and remote Australia will also be effective for the allied health professions.

SARRAH, as the peak body representing AHPs delivering health services to people residing in rural and remote communities across Australia, is well positioned to work with Governments and other stakeholders to address the factors affecting the supply of allied health services in these settings.

Appendix 1

Themes from 6 focus group interviews across regional and rural NSW in 2009-2010[5].

Theme	"Push" factor (leave job)	"Pull" factor (recruit / retain in job)
Personal factors	Jobs & schools for family members Age: leaving to care for elderly parents or retire For younger allied health professionals: - limited social opportunities in rural areas - desire for adventure/travel.	Enjoy a rural lifestyle Feel it's a good place to raise children Embedded in the community, married to a local resident Came from the area or from another rural setting.
Career progression	Better career opportunities in metropolitan settings Lower income, smaller market for rural private practitioners Limited rural senior positions.	Award structure accelerating promotion for new graduates in rural practice settings Recognition by peers and others "Rural specialist" and advanced work roles Appropriate remuneration.
Workload and type of work	Unmanageable workload Crisis mode of service, reactive not preventive Paperwork, reporting requirements.	Making a difference Strong desire for direct individual patient care Generalist practice with advanced work roles - 'specialist generalist' Challenge, variety and intellectual stimulation embedded in the job.
Continuing Professional Development (CPD)	Limited access to CPD due to: - high workload demands - time away from work - lack of management support to attend CPD events - cost of travel - expensive registrations (metropolitan courses).	University campus in regional centres increases CPD access Access to CPD: - reduces professional isolation - is an indicator of management support - improves job satisfaction - is essential for new graduates and isolated practitioners Assures that senior clinicians skills remain up to date Provides intellectual challenge and opportunities for career progression.
The impact of management	Perceived inequitable or inappropriate resource allocation Nurse managers may not understand allied health issues Failure to recruit vacant positions Constant change Managers who are unresponsive to suggestions Feeling de-valued Ethical compromise – fiscal vs. clinical imperatives Move to private practice to escape public sector "management".	Supportive line managers Support for CPD access Clinical mentorship for new graduates Flexible work hours Autonomy Equitable resource allocation sufficient to deliver clinical services Realistic estimate of workload capacity.

[5] From the Rural Allied Health Workforce Study, Unpublished results Keane S (2011)