Allied Health Access and Maldistribution of Allied Health Workforce

Allied health professions have evolved rapidly in the recent past in response to the growing need to deliver specialised health services. Allied Health Professionals (AHPs) comprise a substantial proportion of the workforce and make a significant contribution to the health and wellbeing of the Australian population\(^1\). Allied Health workforce makes up about 25 per cent of the health workforce in Australia\(^2\).

In very broad terms, allied health professionals provide services to enhance and maintain function of their patients (clients) within a range of settings including hospitals, private practice, and community health and in home care. Allied health professions also have a large role in the management of people with disabilities from childhood to adult.

There is no specific definition of the Allied Health professions as a group, has been universally accepted in Australia. SARRAH uses the allied health definition of the Australian Allied Health Forum which is a collaborative of representatives from allied health organisations who work together on issues of national importance to the allied health professions and the Australian public\(^3\).

Why do Australians need access to Allied Health Services?

Allied health services must be available across Australia regardless of the geographical locations. Evidence shows that better access to allied health services provides value to the community in terms of economic and social outcomes, in addition to the wellbeing of individual consumers. Timely access to allied health services may reduce hospitalisation and workload of the general practitioners.

What does “access” look like?

---

\(^1\) Keane S et al. 2008, The rural allied health workforce study (RAHWS): Background, rational and questionnaire development.


\(^3\) The Allied Health Forum consists of members from the Allied Health Professions Australia (AHPA), Indigenous Allied Health Australia (IAHA), National Allied Health Advisors Committee (NAHAC) and Services for Australian Rural and Remote Allied Health (SARRAH)
It is SARRAH’s position that all Australians should be able to receive allied health treatment or care at the point in time that is optimal for recovery, within a reasonable travel distance from their home, at a cost that is affordable given their economic status, and that the treatment, or care provided is delivered in accordance with best practice evidence.

**Barriers to access**

Access to allied health is more than just physical or geographical access. Affordability of services, waiting lists and convenience of services, choice of service provider, quality and appropriateness of the service (e.g. sub-speciality skill sets) are also important considerations when identifying accessibility issues.

A major access barrier is affordability. The majority of allied health professionals are private practitioners and current Medicare rebates and other funding sources for allied health service delivery are inadequate. Very limited number of consumers benefit from having the capacity to access appropriate Allied health services either through a Medicare or self-funded model, including private health insurance. Less than 50 per cent of the Australian population has private medical insurance as at March 2015.!

Culturally appropriate services are also an important element of access for Aboriginal and Torres Strait Islander people. Cultural, economic and social factors will also impact on the access to allied health services.

**Relationship between access and workforce**

Distribution of allied health services is not uniform throughout Australia. Allied health services in rural and remote, or very remote areas are critical compared to the urban centres. Even in urban areas where allied health services are more widely available and allied health workforce numbers are higher, people can find that allied health services are not available when needed, or waiting times are long. Limited existence of allied health services in rural and remote areas does not even guarantee the ability to access. For example, people in rural and remote may not have transport facilities to access to required services, this has become more critical when people need to access multiple allied professionals depending on the type of services that are required to access.

**What is needed to improve access?**

The range of strategies can be implemented to improve access in terms of physical access such as:

- Distribute allied health services to communities based on need rather than historical patterns of service delivery and support AHPs to establish viable practices in areas of need.
- Improve allied health services locally and providing transport to rural community for allied health services.

---


• Improving flexibility in setting appointments when the services are needed.
• Improve/introduce home visitation.
• Improve access to private health insurance and private health services.

Addressing cultural competence, acceptability and appropriateness of the Aboriginal and Torres Strait Islander people are also vital through certain strategies such as:

• Employing indigenous allied health professionals and workers to promote culturally safe service delivery.
• Providing services in non-traditional settings that support individual’s cultural background including improved communication styles.

Maldistribution of Allied Health Workforce

There is a perception that allied health workforce in some allied health professions is inequitably distributed and this is critical in rural and remote areas of Australia and indigenous communities in all parts of Australia. A lack of existence of strategies for recruitment and retention of allied health workforce may have led to maldistribution of allied health workforce in rural in remote areas. There is strong anecdotal evidence suggesting that allied health professionals are twice as likely to leave rural practice compared to nurses and medical practitioners. AHPs are more likely to stay longer in regional areas than remote locations. Despite the lack of evidence of evaluation measures of the effectiveness of the recruitment and retention programs, some research revealed that there was an overall low retention rate of AHPs after four years. Retention of AHPs also influenced by allied health profession for example podiatrists stayed on average 18 months in rural practice whereas social workers remained four years6.

Major barriers in rural and remote practice

Barriers to practice in rural and remote cannot be discussed keeping all allied health professions in one bucket due to the diversity of allied health professions which could also include age and life stage, gender and location. However, common barriers identified by many researches include:

• Professional isolation and a lack of access to continuing professional development.
• Inadequate mentoring and supervision for sole rural practitioners.
• Fewer opportunities for career advancement.
• Limited social opportunities.
• A lack of student exposure to rural content and rural experience.
• A lack of standard recruitment strategies to capture differences such as age, gender and professions.

---

What is needed to eliminate the maldistribution of allied health workforce?

Acknowledging the diversity within, and between allied health professionals and the range of rural contexts in which they work. A more targeted and innovative approach to attracting and retaining their services in rural areas is necessary which should include:

- Increase student placement in rural and remote areas and invest in establishing rural based university or postgraduate centres that can also grow rural workforce. Evidence shows that allied health students who had a positive rural placement experience were more likely want to practise rurally.
- Increase use of information and communication technology including telehealth ad inter-professional teams to reduce professional isolations.
- Increase organisational support to improve supervision and mentoring and providing education and training for supervisors and mentors.
- Develop new roles and increase allied health professionals’ promotions to a higher grade.
- Providing relocation costs and support for temporary accommodation.
- Introducing allied health workforce system in regional services to rural and remote allied health services to provide CPD opportunities, networking and rural experience.

SARRAH Recommendations

Improved access to allied health services - Affordable, accessible and high quality allied health services

SARRAH asserts that in order to equitably access allied health services:

- Allied health services must be available, affordable, acceptable and appropriate.
- Introducing Medicare coverage for allied health professions beyond medical profession and re-direct funding which could be better utilised via allied health rather than medical treatments.
- Providing professional development opportunities consistently and equitably across the allied health professions.
- Introducing a retention bonus to increase the retention rate of the AHPs in geographical areas of need.
- Employing workers to promote culturally safe service delivery in non-traditional settings.

Eliminate maldistribution of allied health workforce

- Invest in programs that increase recruitment of new allied health graduates to geographical areas of need and retention of the current allied health practitioners.
- Development and implementation of best practice funding models on clinical and practice supervision and support for newly graduates in improving the recruitment of new graduates.
Introducing inter professional teams to reduce professional isolation.
Providing financial support to cover relocation cost, and
Improve networking.

SARRAH believes that investing in developing a national dataset on allied health workforce from self-regulated profession is essential.

There is limited data available on the workforce distribution of allied health professionals, especially those who fall out of the registration scheme of National Registration and Accreditation Scheme (NRAS)\(^7\). Currently there are no reliable data sources that indicate the level of employment of the allied health workforce across the different sectors and settings. Therefore, finding demographic characteristics of the allied health workforce, especially geographical distribution across Australia is challenging.

Government data sources more or less are focusing on the professions regulated by the Australian Health Practitioner Regulation Agency (AHPRA). The data available in AHPRA has limitations even for the regulated professions for example, not all those regulated professions have compulsory registration or include all those currently practicing. Registration is not compulsory for medical radiation practitioners although is strongly advised by professional organisations representing the profession. Data relating to self-regulated allied health professions is less accessible, however is available through different sources although the data has been gathered at different times and for different purposes\(^8\).

Workforce data for nurses and medical practitioners is available compared to the allied health workforce. Allied Health is the least represented in very rural and remote Australia, where the need is greatest. There is an acute need for improved Allied Health workforce data especially from self-regulated professions to effectively manage the current workforce and inform future workforce planning. For comprehensive workforce planning information is required on:

- Shortages across the various professions.
- Distribution across geographical regions.
- Training and other support needs.
- What the optimum professional to population ratio should be.

Improving the accessibility of information for the professions under NRAS is also essential. The cost involved in accessing the information available for professions under NRAS, held with AHPRA, impedes to determine the effectiveness of current allied health workforce investment programs. SARRAH suggests that a standardised national dataset for all allied health professionals should be developed at the earliest opportunity.

SARRAH also believes that a definition of ‘Allied Health’ must be developed and agreed upon by all stakeholders.

---


\(^8\) 2015, Christine Ashley Consulting, Research Paper – Effectiveness of Nursing and Allied Health Scholarship and Support Scheme
SARRAH believes that much of the issues relating to the workforce analysis and planning for the allied health workforce relates to the lack of clarity surrounding the use of the term allied health (the multiple professionals include health professionals who are not a doctor or nurse) and the complex nature of the term allied health impedes in attempting to collect data and allied health workforce planning. A lack of agreed definition also led to difficulties in building identity for allied health at an individual, organisational and at a community level.

SARRAH suggests developing a definition of allied health professions by all Governments and agencies to promote consistency ensuring that all datasets interpret the information accurately represents the role of allied health professions and can assist in workforce planning.

About SARRAH

SARRAH takes the view that equitable levels of health care are a right of every citizen irrespective of place of residence, cultural background, ability, gender or age. SARRAH is recognised at the national and State/Territory level as a peak body representing the interest of rural and remote allied health professionals. SARRAH has a particular interest and experience in the value of multidisciplinary health workforce and has successfully provided a common voice for the rural and remote allied health workforce in dialogue with the Government Department of Health and in a number of jurisdictions such as rural workforce forums.