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Recruiting and Retaining Allied Health Professionals in Rural Australia: Why is it so Difficult?

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ABSTRACT
Rural communities in Australia have particular health needs, and the recruitment and retention of Allied Health Professionals (AHPs) is a significant concern. Despite the increasing number of AHPs being trained, vacancy and attrition rates in rural areas continue to rise. Professional and social isolation combined with rapidly changing health service delivery structures are identified as major deterrents to long-term rural practice. While strategies are now being implemented, endeavours to resolve the issues lag well behind initiates offered to Medical and Nursing staff. Given the wealth of political, professional and health related issues underlying the recruitment and retention of AHPs to rural areas, total resolution of this issue may not be possible. A unified approach by AHPs combined with concerted effort and collaboration on the part of all the stakeholders may, however, allow management at a level required to sustain a viable rural AHP workforce.

INTRODUCTION

Recruitment and retention of Allied Health Professionals is a long-standing issue in rural Australia. Despite increasing attention over the past decade little progress has been made in addressing the problem. The 30% of Australians living in rural areas have unique health concerns that relate directly to their living conditions, social isolation, cultural diversity and distance from health services.[1,2] Their health status is measurably poorer than that of their urban counterparts and declines along a continuum as one moves away from the capital cities.[3-7] Dispelling the illusion of a 'healthy country lifestyle', major risk factors contributing to poor health in rural areas include: physical inactivity, overweight and obesity, smoking, risk taking behaviours and harmful alcohol consumption. These are further compounded by low socioeconomic and educational status, fewer employment opportunities and poorer access to health services.[6,8-10]

AHPs are recognised as an essential and significant part of the rural health workforce. Demand is expected to increase as demographic changes (eg aging of the population), and epidemiological changes in the patterns of disease and disability (eg increased chronic disease), continue to re-orientate health service delivery.[11-15] Increasing AHPs in rural areas would not only provide much needed services in a timely and cost-effective manner,[11,16] but would also contribute to the sustainability of rural health services.[17]

RURAL ALLIED HEALTH WORKFORCE ISSUES

Although there has been a steady increase in the number of AHPs trained in Australia over the past decade (eg occupational therapy, 59% increase; podiatry, 20% increase; physiotherapy, 30% increase), critical shortages remain across all disciplines (6% vacancy rates).[11,14,18-20] This is particularly evident in rural areas, which have 60% less practicing AHPs per 100,000 population than capital cities.[10,17]

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More educational institutions are offering Allied Health programs and intake quotas continue to rise, yet positions in courses remain highly sought after and competitive with low attrition rates.[21] Difficulties are therefore seen as more closely related to retention than recruitment with:

- Turnover rates in the public sector of 42% within two years
- Annual rural exit rates of almost 29% compared to metropolitan rates of 19%
- Average length in rural practice 13-18 months
- High levels of non-practicing AHPs.[11,15,22,23]

High workforce attrition rates have been attributed to: family responsibilities,[24] burnout,[25,26] disillusionment,[27] high stress levels,[28] lack of management support,[11] desire for change,[15] travel [21] and leakage to postgraduate medical courses.[17.]

Over 90% of the current AHP workforce is female and less than 1% is indigenous.[18.24] Ninety-three percent of rural practitioners are Australian graduates who span the whole age range, but tend to cluster in the younger (new graduate) and older (returning to work after children) age groups.[11,15,17,19] Implications therefore arise for undergraduate and return-to-work courses of study, and pragmatic issues like maternity leave, childcare and schooling.

AHPs are recognised as working across many sectors; not only health, but also education, welfare, disability services, aged/elderly care, private practice, veterans' affairs, non-government organisations and industry. Yet the majority of rural AHPs (75%) are employed in the public health system, predominantly under recurrent State government funding. This funding is under threat from the declining share of health expenditure being directed to public hospitals, which has seen a 25% reduction in Allied Health funding over the past five years.[12,17,29,30] Thirty-six percent of rural AHPs are sole practitioners, 56% routinely conduct outreach services which require them to travel to one or more geographical locations outside their principal place of employment, 81% regularly perform unpaid overtime and 75% have difficulty obtaining locums for periods of leave.[11,15,17] In light of these statistics, it is perhaps understandable that AHPs identify the following as disincentives for rural practice:

- Lack of management support
- Lack or appreciation and/or recognition of their role
- Lack of professional supervision, support and/or mentoring
- Difficulties accessing professional development/ skills development
- Lack of support for ongoing/post graduate education
- Professional isolation
- Lack of career structure/progression/stability
- Lack of resources
- Income and terms of employment
- Difficulty obtaining locum cover
- Large caseloads and excessive travel
- Lack of orientation to the community
- Lack of employment and/or education opportunities for spouse and children
- Social and cultural isolation
- Personal safety fears.[2,11,17,28,31-33]

CHANGING SERVICE DELIVERY MODELS

While the bed-based local hospital has traditionally been seen as the cornerstone of the rural health system, the past decade has seen unprecedented structural change to the social, political, economic and technical forces that drive rural health service delivery.[3,34] This has included pressures from alternate funding initiatives such as Casemix, technological advances, the advent of telehealth and the recognition of the value of a primary health care approach.[7,13,35,36]

The adoption of primary health care models was envisioned as promoting a collaborative, interdisciplinary approach to health care, in which AHPS were recognised as playing an essential role.[17,36] Instead, the resultant redefinition of roles has contributed to the inherent power struggle between health care professionals.[3,37] The subsequent re-orientation of many health services has seen the focus moving away from the institution and towards the community. This has seen pressure exerted on AHPs, in pragmatic and financial ways, to investigate alternate venues and diversify their service delivery models.[7,15,34] Rural AHPs have been catapulted into an environment of trans-disciplinary service delivery, with both vertical and horizontal encroachment on their

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professional territories. They are ill-prepared or this by either their undergraduate training or the change-management strategies adopted within most organisations.[3,11,20,38]

Although the scope and complexity of their work requires rural AHPs to become 'specialist generalists', the challenges and advanced skills associated with rural practice, and the increased pressures associated with initiating new services, are seldom acknowledged by organisations or reflected in salary structures.[3,11] New graduates are often attracted to these wide-ranging caseloads in the belief that the experience gained will enhance their career prospects. Research, however, indicates that rural practice may inhibit rather than enhance prospects because specialist not generalist skills are more professionally valued.[23] Those clinicians who wish to specialize clinically or seek further career progression, available primarily through supervisory or service management roles, are largely lost to the rural workforce as there are limited promotional pathways outside of metropolitan areas.[11,21]

RECRUITMENT AND RETENTION ISSUES

Over the past decade a number of State Health Department Taskforces have reported on Allied Health recruitment and retention issues; New South Wales in 1993,[39] Queensland in 1999,[21] South Australia in 2000,[40] and Western Australia in 2002.[11] The recurrence of the taskforces, despite "evidence of substantial confirmation of previous findings,"[11]was contributed to by the employment of AHPs under different industrial awards between States and between the private and public sectors. Recommendations from the taskforces were similar and tended to be inward looking, focusing primarily on; resourcing, career pathways, service performance, service provider levels, workforce planning, recruitment strategies, professional development, management structures, improved clinical education and closer inter-sectoral and community links.[11,21] While the taskforces were not specific to rural AHPs, they identified many of the same issues raised by rural practitioners. Little widespread change has occurred in their wake however, as those issues that were addressed were approached from a workplace-specific rather than a profession-wide level. Services for Rural and Remote Allied Heath (SARRAH) undertook a national study of AHPs in rural areas in 1999-2000.[15] Their recommendations were more overarching than those from the taskforces, being concerned with the development of the professions as well as the practitioners. Current strategies for recruitment and retention of AHPS will be considered in light of a number of these broader recommendations.

- A definition of 'Allied Health' must be developed and agreed upon by all stakeholders.

In Australia, variation in the inclusion/exclusion of professions under the umbrella term Allied Health may fluctuate in relation to the goal of the collaborative exercise, political expediency, the clinical setting and the source or purpose of the identification.[15,17,41] This has led to difficulties in the perception of an identity for Allied Health at an individual, organisational and community level.[11,15]

The More Allied Health Services (MAHS) program is a Federally funded program ($49.5 million over four years), managed by the rural Divisions of General Practice and designed to increase AHP services in rural areas. However, in April 2002, only 85.4 (52%) of the 164.4 current positions were held by AHPs, the remainder by nurses (28%) and other health practitioners (20%).[42] This latitude has been made possible by the lack of a clear definition of ‘Allied Health’.

- Access to appropriate education courses and opportunities at undergraduate and postgraduate levels for potential and practicing rural AHPs must be enhanced.

The shortage of rural health professionals has been attributed, in part, to the urban focus of tertiary health education.[11,43] Courses are perceived to lack flexible programs that are locally, culturally and socially appropriate, resulting in rural participants being under-represented.[11,13,27] Given that the strongest predictor of rural recruitment and retention is a rural background for health professionals and their partners, rural recruitment may ultimately be the most cost effective option.[23,33,44] Provision of rural-bonded undergraduate scholarships for rural Allied Health students are beginning to be offered, but lag well behind the number and range available for medical and nursing students.[11,12,17] It is imperative that rural clinical schools and health related courses in rural universities, currently restricted to medicine and/or nursing, are expanded to include Allied Health, as this will increase critical mass, local infrastructure and local skill mix.[8,11,13,17,33,44]

The low representation of indigenous students in Allied Health training programs is a particular concern. The largest single contributor to the poor overall health of rural communities is the very poor health status of indigenous persons, who make up 20% of rural but only 1% of metropolitan populations.[1,6,7,45] Recognising that this is at least partially due to a lack of culturally

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appropriate intervention programs, the Federal government has set a target of 2.4% indigenous staff across all sectors of publicly funded health services by 2010.[16,45] This is being supported by cadetships for indigenous Allied Health trainees, although uptake levels remain low.[46]

Gaining access to, and financial support for, post-graduate education are also ongoing issues, which are not well addressed in most AHP employment agreements.[17]

- Allocation of resources to assist the preparation of AHP graduates for rural and sole practice is required.

AHP graduates feel poorly prepared for the complexities of rural practice. In response to this there has been a call for undergraduate curricula for all health disciplines to include: management skills, primary health care, population health, cross-cultural (particularly indigenous) awareness and cultural safety to better equip graduates to meet current industry needs.[11,13,17,21,38,44,47,48]. Rural healthcare policy and practice developments favour primary health care models incorporating collaborative practice, which may necessitate working outside traditional professional boundaries, and this needs to be reflected in educational settings.[13,49,50] Achieving this requires the introduction, early in training, of active, hands-on, inter-professional programs aimed at improving the effectiveness of interdisciplinary work through sensitising students to a variety of professional roles, developing teamwork skills, and enhancing holistic attitudes to patient care.[13,33,51] While a number of programs have begun trialing this concept, the inclusion of AHPs lags behind the teaming together of doctors, nurses and/or pharmacists.[33,37,50] The largely mono-professional focus to Allied Health training in Australia makes it difficult to come to terms with the subsequent sharing of care in practice.[13,50]

- The key factors underlying Allied Health students' decisions to pursue a rural career need to be examined.

Positive rural experiences for students through rural practicum placements and involvement in student rural health clubs are being widely promoted as low-cost options for creating interest in and increasing positive attitudes towards working in rural areas.[11,17,23,33,38,49,53] These strategies have been shown to improve initial recruitment, with rural vacancies most likely to be filled by new graduates. Concerns should be raised, however, when sole positions are frequently filled by graduates with minimal experience and limited access to professional development and support.[15,21,23] Currently 35% of the rural AHP workforce is under twenty-five years of age.[21] Results on long term retention are also equivocal, with major concerns centred on social and professional isolation.[33,44] The socio-cultural and economic conditions that make the recruitment of extra AHPs to rural areas imperative are the same issues that make retention difficult.

- AHPs should be formally represented on policy and program groups, management committees etcetera that impact on rural health.

The development of coordinated policies and programs to effect changes in service delivery and/or workforce conditions for AHPs has been hindered by the lack of formal Allied Health representation at the senior management level in the Commonwealth and State Departments of Health, and on University committees.[11,15,17,28] Allied Health is attempting to address this through the use of representative organisations such as the Health Professions Council of Australia, Services for Australian Rural and Remote Allied Health, the recently formed National Rural and Remote Allied Health Advisory Service and Allied Health Advisors to some State governments.[53-55]

- Programs are required that address the issues of support and long term retention of skilled and experienced AHPs.

Many of the issues that impact on the recruitment and retention of AHPs to rural and remote communities are similar to those impacting on General Practitioners (GPs).[17] Yet, despite emerging evidence that investment in Allied Health services results in cost savings for the government and enhances the recruitment of GPs to rural areas, the bulk of rural support and incentives, in terms of both policy initiatives and financial input, continue to be directed at medical practitioners.[3,11,17,56] This occurs partly because communities perceive GPs to be their most urgent need, and partly because of the 'political clout' of the medical profession.[3]

- Employers must ensure that rural AHPS have access to same-discipline support, either on or off site.

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Face-to-face contact with a more experienced same-discipline AHP is the preferred means of support, particularly by new graduates, but this is often not available in rural settings.[23] Mentoring provides a demonstrated cost effective alternate model for providing professional and personal support to new and existing practitioners through the transmission of cultural values and practical advice, while fostering independent thinking and problem solving. It has been used successfully by professional associations and State health services and has the potential to expand with the increasing accessibility of affordable distance technology.[15,28,57]

- Innovative practice arrangements in rural areas need to be supported.

Increasing AHP Private Practitioners in rural areas, including rights to private practice for part-time public employees, has been proposed to take pressure off the predominantly public services.[15] Barriers to its implementation, however, include; lower levels of private insurance in rural areas, restrictions on private provider numbers, artificial program boundaries for service provision and the refusal to include AHP services in Medicare.[9,15,33]

- Service provision models that are responsive to community needs, particularly sustainable models of outreach service, are required.

The Regional Health Services (RHS) Program is a Federally funded initiative designed to support small rural communities (population < 5000) to develop new, or expand existing, local primary health services which are tailored to suit their needs.[16,35,58,59] While the guidelines allow for applications from a range of government and non-government organisations, endorsed by community support, the majority of existing programs are under the auspices of State health services.[59] Although a collaborative initiative at the government level, pragmatic difficulties can arise in the workplace when staff within the same department are employed under either Federal or State funding, with different line-management and/or reporting requirements.

Supplying outreach services to small communities without a population base sufficient to warrant employing their own AHPs is one of the most wearying components of rural practice. It is financially costly for the organisation, which must fund the extensive travel and sometimes overnight stays; and personally costly for the practitioner, who is away from family and professional support. Alternate methods of service delivery such as telehealth and local Allied Health Therapy Assistants should be pursued more aggressively.

Comprehensive data collection specific to the Allied Health workforce is imperative.
Relatively little research has been commissioned into the workforce distribution of AHPS in Australia generally and rural areas in particular, resulting in a dearth of relevant information.[15,17] Significant gaps exist in the data and information on AHPs in rural locations related to:

- shortages across the various professions
- distribution across geographical regions
- training and other support needs
- what the optimum professional to population ratio should be.[17]

Without this information it is impossible to make informed decisions on service provision that is responsive to community needs.[15]

As the Federal government moves towards 'needs based' funding there is also an urgent need for more research and inter-agency data collection to establish both the determinants of health and true health care needs in rural Australia, with particular emphasis on indigenous communities.[4,9,35]

Current Strategies
Current strategies for increasing the presence of AHP in rural Australia primarily involve:

- Recruitment - through attracting individual students to rural areas via rural scholarships, rural practicums and rural student clubs.
- Retention - through workplace reforms. Reforms initiated by State Health Departments do not necessarily have a rural focus. Where specific rural incentives are offered they are done at an individual organisation

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level, which makes some organisations more attractive to work in and their staff more employable, but does not address more widespread underlying issues.

What is lacking is an overarching approach at a profession-wide level and the ability of AHP training organisations to keep pace with the rapidly changing face of rural health service provision. Contributing to this are a number of issues related to the basic structure of Allied Health in Australia, including:

- Lack of solidarity under the Allied Health banner due to:
- Lack of recognition of the contribution of the collective group, rather than the individual professions, within the health industry and the general public.[11,60]
- Division of loyalties for AHPs between Allied Health and discipline specific goals and agendas.[11,17,61]
- Lack of statistical data pertaining to AHPs as a group.[15,17]
- Lack of political influence to affect policy and funding changes due to:
- Comparatively small numbers in relation to Medicine or Nursing
- Lack of a strong national representative body in comparison to the Australian Medical Association or the Australian Nursing Union.
- Dichotomy of political control of health service delivery
- The Federal government has a leading role in the development of National health policy and the funding of health services
- State and Territory governments have primary responsibility for the provision of most public health services
- However, aged/elderly care, indigenous community controlled services, programs such as RHS and MAHS, and many initiatives such as scholarships are overseen by the Commonwealth Department of Health and Aging.

CONCLUSION

Recruitment and retention of health care staff was recognised as a pivotal issue in addressing the distinctive health care needs of rural Australians over 25 years ago and, despite concerted efforts over the past decade, it remains so today.[3,62] The underlying issues do not have easy solutions, as they are intricately entwined with the health concerns they attempt to address. Further research into the complexities of the determinants of the current rural health status is required before their implications on the employment on AHPs can be fully understood.[3]

Given the wealth of political, professional and health related issues underlying the recruitment and retention of AHPs to rural areas, full resolution of problem may never be possible. Simply managing the problem will require concerted effort and collaboration on the part of all the stakeholders; practitioners, professional bodies, tertiary educational institutions, governments, health services and communities. While this is beginning to occur, it lags well behind the initiatives developed on behalf of Medicine and Nursing. It will be interesting to see whether the recent advent of the National Rural and Remote Allied Health Advisory Service will help to consolidate the position of Allied Health in the Australian health system and drive the changes required to sustain a viable rural AHP workforce.

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