

Allied Health Recruitment and Retention Project



Phase 1 Executive Summary, Key Findings, Recommendations and Literature Review April 2005



This research was conducted as part of a Victorian Department of Human Services (DHS) funded rural workforce strategy, the Allied Health Recruitment and Retention Project (AHR&RP) in the Central Hume region, under the auspice of the Central Hume Primary Care Partnership (CHPCP).

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Key Findings

- + Incentives and reasons for choosing rural practice**
Rural lifestyle, variety of work and job availability were the most frequently cited incentives or reasons why allied health professionals (AHPs) chose rural/regional practice.
- + Disincentives to rural practice**
Allied Health Professionals considered the major disincentives to rural and regional practice to be limited access to education and training, professional isolation and lack of a career path.
- + Length of service and seeking other employment**
While a slight majority of allied health professionals indicated they intend to stay in their present positions for 2-5 years or more, it is challenging to note that nearly 40% indicated their intentions to remain in their current practice for less than 2 years. Just over half of all the respondents have looked for other employment opportunities in the last 12 months. Of note is very few private practitioners indicated they had looked for other employment.
- + Professional, social and geographic isolation**
The isolation experienced in rural practice in the domains of professional, social and geographic were reported as occurring sometimes to frequently. Strategies to assist the AHPs through this sense of isolation were professional development, peer support, social activities, structured professional associations, formal & informal networking, mentoring, supervision and tapping into metropolitan AHPs or functions.
- + Professional Training**
Over one third of AHPs felt their professional training needs were NOT being met, another 1/3 reported mid-range satisfaction. Despite many indicating there was an opportunity to meet these training needs more adequately, or taking their own initiative, nearly half of all the respondents believed there was a commitment by their organisation to allied health staff training. However, agencies/practices believe that the training opportunities offered by their organisations meets the AHPs' needs more so than the respondents from the staff surveys believe their training needs are being met.
- + Problems, issues and barriers to accessing professional training**
Problems, issues and barriers to accessing professional training opportunities identified by the AHPs included location and cost of training, travel time, time away from clients, cost of travel, heavy workload, lack of leave relief, and pressure to meet targets. Family commitments, time/duration of the course, type of training and lack of organisational support were other noted issues by the practitioners. Location of training was clearly a major factor for both agencies/practices and practitioners. Service mappings revealed time away from clients and lack of leave relief were of slightly greater concern than did the AHPs, who ranked cost of training and travel, time for travel and pressure to meet targets as greater issues than their agencies.
- + Overcoming the barriers to professional development**
Ideas about how to overcome the barriers to professional development offered by AHPs included more regionally based workshops and courses; formal links with regional Universities and professional associations as would interagency training opportunities. Employer and funding bodies support to meet costs and time of training and acknowledgement of their value, locum or leave relief, and flexible learning options such as videoconferencing, satellite broadcasts and distance education were also suggested. Over half the AHPs indicated they would like professional training offered in the region quarterly.
- + Regional/local professional networks and special interest groups**
Just over half the AHPs attended regional/local professional networks and special interest groups.

The majority who attended agreed the value of attending these groups included networking, professional development, keeping abreast of professional issues, sharing information and resources, joint problem solving and case conferencing, professional contacts, debriefing & support from isolation, as well as comparing work practices and collaborative & strategic planning. Non-attendance reasons included travel time and location, not relevant to role, not aware of any, lack of time, held out of work hours or doesn't fit with work schedule, not supported by employer, family commitments and time or cost not justified for outcomes.

Professional Supervision

The majority of service mappings reported a policy in place in relation to professional supervision for allied health staff. However, some AHPs who indicated it was a requirement advised it doesn't happen, and others noted that it was not discipline specific supervision. Other AHPs reported a variety of processes with various levels of satisfaction. The perceived value and benefits of professional supervision to the AHPs was debriefing and support, education and skill development, case conferencing and information sharing.

Debriefing and the challenges of professional supervision

Informal processes and networks which AHPs used to debrief were colleagues from the same agency, family, friends, colleagues from different agencies, and peer support groups. Formal mechanisms to debrief are supervision from team manager, professional supervision, peer support networks, and attendance at professional associations or interest groups. The limitations of these formal and informal processes were seen as inability to find qualified, relevant supervisors, lack of time on the part of respondents, colleagues and/or supervisors, challenges of small communities and lack of confidentiality, distance, isolated practice (peers from other disciplines) and lack of timely access. The perceived value and benefits of professional supervision to the AHPs was debriefing and support, education and skill development, case conferencing, information sharing and networking. Allied health professionals rated debriefing as top priority whereas service mappings ranked it as 5th. The service mapping responses indicated they believed staff professional supervision needs were being met more adequately than the staff themselves did. The two areas of difference between the AHPs survey and service mapping responses in the problems, barriers and issues in accessing professional supervision were pressure to meet targets and cost of the supervision. Pressure to meet targets was ranked 5th by AHPs, but only 8th by service mapping respondents. Conversely cost of the supervision was ranked 5th in the service mapping, but 8th by AHPs. These differences in responses between agencies and staff were mirrored in the findings for professional training.

Peer Support

The majority of agencies reported not having a peer support policy. Yet AHPs replied that having a policy did not always mean this peer support occurred in a meaningful way, and others indicated they had well functioning peer support without a formal policy. Peer support occurred internally with co-workers in over half the responses and informally, where the worker was supported by management to seek peer support through their own informal networks and of their own accord. The value and benefits of peer support were perceived by both AHPs and agencies to be general support, information sharing, debriefing, case consultations, education and skill development and networking. Again, the same discrepancy that was found in professional training and professional supervision occurred in peer support: service mappings believed that the peer support needs were being met more adequately than believed by the AHPs. The problems, issues and barriers to accessing peer support by both AHPs and service maps was time away from clients, heavy workload, location, pressure to meet targets, travel time and lack of leave relief. The part-time nature of the work meant it was often difficult to meet with other peers, as well as issues of developing safe relationships. Strategies that would assist AHPs to feel more connected to their colleagues across the region included networking opportunities, prospects to work on collaborative partnerships, organised peer support groups, informal social gatherings, and informal support from colleagues.

Other strategies noted were financial support for professional supervision and networks, professional development and rotations within other agencies.

✚ **Clerical, management, human resources and Allied Health Assistant supports**

There were various levels of senior management, clerical, human resource and allied health assistant (AHA) support systems in place within public and private services. In many instances there was no direct funding for this support, yet services could not function without them, so they were self-funded. Most indicated they felt there was a need to increase support systems for more efficient use of time & resources. AHAs were an area identified in the public sector as being under resourced and increased capacity would greatly enhance care and effectiveness.

✚ **Support, decision-making and representation at senior management level**

In terms of allied health needs, concerns and issues being adequately represented at senior management/executive level within their organisations, over 1/3 of AHPs felt they were adequately represented, another 1/3 felt it was inadequate, with the balance responding mid-range. The structures and processes which worked well in organisations to provide formal opportunities for participation in decision-making activities related to AH management issues were identified as team/staff meetings, access to team leader/management, seniors' meetings, performance appraisal and good communication. Some others felt that even though processes were in place, it did not always result in action or feelings of inclusion or being valued.

✚ **Funded vacancies**

The service mappings revealed a number of vacancies, many of which had been vacant for extended periods of time, from 2 months to over 1 year in the case of podiatrists. Three physio positions were vacant, one advertised 3 times. A counsellor for youth work was vacant for 6 months, a social worker for family work and a Clinical Psychologist were all not filled. Two dietitian positions and a diabetes educator were also funded vacancies.

✚ **Recruitment issues as identified by service mappings**

Service maps recruitment challenges centred around finding appropriately qualified and suitable staff and those who were willing to relocate; professional, social and geographic isolation; the cost of advertising, devising advertising campaigns that work and lack of HR support; the type of work not attractive or lack of commitment to the sector; lack of a critical mass of AH staff and sole practitioner positions. Funding and pay scales were mentioned by several, combined with lack of full-time positions. Lack of personal and professional development opportunities, professional diversity, support and networking for AHPs were also identified, as was lack of employment for spouse and educational opportunities for children. Lack of promotion and career paths and new graduates wanting specialisations and specific packages which are not available rurally were also noted.

✚ **Recruitment ideas generated by allied health professionals**

Ideas on how to recruit AHP peers into the region included increased access to professional development, professional supervision, increased support including socially, better pay and conditions, incentives, promoting the area and rural lifestyle, being innovative and responsive to individual practitioner needs, career advancement, role structures and relationships with Universities.

✚ **Retention issues according to service mappings**

According to the service mappings, issues which impact on retention included a lack of job diversity and variety, as well as a lack of support and funding for initiatives. The pressure of insufficient staff, lack of locum/leave relief and control of workload and burnout were seen by agencies as major challenges in retention, as was poor physical environment, lack of resources and up to date equipment. Lack of a career path, especially for sole practitioners, and ability to offer adequate remuneration for experience and parity of wages between public and private were also issues. Lack of facilities and social opportunities, limited peer support and professional development, and organisational cultures were noted by service mappings as other challenges.

- ✚ Strategies and supports AHPs needed to offer a more effective service to consumers**
Strategies and supports needed by AHPs to offer a more effective allied health service to their consumers included support for and access to professional development as the dominant theme, encompassing training, supervision and mentorships, in both public and private systems. Increased access to professional journals, links to and information regarding evidence based best practice, access to and opportunities to participate in research and time to source resources on the Internet were noted. Resources, (both financial and equipment), facilities such as office space and therapy rooms, IT, funding for travel or access to vehicles were frequently mentioned, as was attempting to decrease unnecessary travel for workers servicing other geographic areas.
- ✚ Appointment or promotion beyond experience**
Due to a lack of competition for advertised positions, sometimes staff in rural areas are appointed and/or promoted beyond experience and maturity. This leads to burn out, stress and resentment.
- ✚ Valuing staff and acknowledging their contributions**
A recurring theme ran through the AHP staff surveys, of the importance of feeling valued as an employee, acknowledged for the professional work done and respected for their place in multidisciplinary health care. While this is not a tangible retention strategy, the frequency of response indicates it is a vital motivation to stay or leave. Feedback, respect and understanding seemed key factors in feeling supported.
- ✚ The value of allied health care needs promoting**
The value of allied health to other health care professionals, consumers and the Central Hume Primary Care Partnership needs more awareness and promotion.
- ✚ Acknowledge factors which are out of your control regarding retention**
There are influencing factors which are out of the locus of control of agencies and private practices in terms of retention. The predominantly young female composition of the AH, the desire for experience by new graduates and other factors must be acknowledged and accepted when considering reasons why AHPs are a mobile workforce.
- ✚ Barriers to adequate AH service provision**
Barriers and issues to adequate allied health systems and service provision identified by the service mappings centred around challenges of recruitment, understaffing, lack of leave relief and funding issues including fractional EFTs, distance to be travelled for outreach workers, clients and lack of public transport, lack of access to services, including those of lower socio-economic status. Lack of communication amongst agencies, lack of resources and resource sharing, lack of management support and not enough time for networking and development groups were also cited. Waiting lists, downsizing, competition, lack of evidence on AH and understanding in the community and cross-border issues were also mentioned.
- ✚ Service coordination, barriers, and overlaps**
AHP suggestions for improvements in service coordination centred around increased partnerships and interagency communication, coordinated recruitment and joint positions or rotations, greater awareness amongst AHPs and other health care professionals of services in the region, minimising travel for workers, amalgamation of allied health services, better use of and validation of the role of AHAs and more coordinated referral systems. Better use of agency and community resources were highlighted, such as employing local AHPs to reduce travel time from other towns, services to the Mansfield district and those of the Rural Allied Health Team (RAHT). Services for disability clients were also noted as having some overlaps.
- ✚ Gaps in service delivery**
The breadth of allied health services were seen as having gaps, of particular note, public podiatry, mental health, availability of locums and leave relief, neonatal hearing screening and driving assessments in the public sector have all been identified as gaps.

+ Waiting lists

Waiting lists exist for every discipline within the scope of this allied health project. This varied between public and private, and wide variations in length of wait time was found between public agencies. Two to 3 weeks wait were common, with 3 to 18 months wait lists reported for clinical psychology, continence nursing, occupational therapy, physiotherapy, audiology, counselling, diabetes education, dietetics, driving assessments and podiatry by various agencies.

+ Sole therapists

Sole therapists have unique challenges in terms of accessing same discipline professional supervision, unmanageable workloads and lack of peer support.

+ Evaluation of the Steering Committee

The project Steering Committee are evaluating their effectiveness as a team, and have identified some areas to be built into the implementation framework for strengthening the partnership.

Executive Summary

Allied health professionals and their services are an important resource capable of contributing to the health, economic prosperity and cultural life of the communities they serve. The changing nature of healthcare, the impact of an ageing population, the dynamics of a relatively young mainly female allied health workforce, and issues unique to rural communities have implications for the recruitment and retention of health care professionals, including allied health practitioners.

There are five main service providers that employ allied health staff in the Central Hume region of North East Victoria. These include Northeast Health Wangaratta, Ovens and King Community Health Service, Alpine Health, Benalla and District Memorial Hospital via Delatite Community Health Service and Mansfield District Hospital. Collectively these agencies provide services to a population of approximately 90,000 people spanning a range of modalities including in-patient, outpatient, community health, ambulatory and outreach, and covering the full spectrum of care for people from birth to end of life. As stand alone services, the organisations involved recognise that the relatively small budgets allocated to allied health provision imposes limitations to effective management and team structure.

This Allied Health Recruitment and Retention Project (AHR&RP) is funded by the Victoria Department of Human Services as one of 20 rural workforce projects state-wide, and is auspiced by the Central Hume Primary Care Partnership (CHPCP), with a Steering Committee comprised of a senior executive representative from each of the above organisations and DHS regional office.

The project which consists of 3 phases commenced in October 2004 and concludes in June 2006. Phase 1 was designed to obtain a 'snapshot' of allied health services in the Central Hume region, to get a clearer understanding of the numbers, classifications and roles of allied health professionals and support staff, services offered, partnership arrangements, service system issues, overlaps and gaps. It sought the perceptions of AHPs, senior managers of public agencies and private practice owners on the issues of recruitment and retention of this allied health rural workforce, including professional development, supervision and peer support.

The rationale for the project is that more attractive employment arrangements for allied health teams can be established in the Central Hume PCP catchment through the establishment of an interagency collaborative model and that recruitment and retention rates will be enhanced as a result of an agreed model.

The research approach was diagnostic and was conducted internally by the project officer, who is employed part-time which had implications for the level and scope of research that was undertaken. An inductive approach was used; the researcher did not begin with a preconceived concept of rural recruitment and retention, but rather gained meanings and insights from the literature review, surveys and interviews as the project progressed.

Service mappings were undertaken by 16 public health services and 15 private practices. Anonymous staff surveys were completed by 110 allied health professionals in both the public and private sectors. Exit interviews were conducted in person or by telephone with 10 AHPs who had left employment within the region during the previous 12 months.

As the project evolved, more of a participatory action research approach was adopted, where as the findings were being written up, they were taken back to the Steering Committee and allied health professionals for their input to develop recommendations and action plans for implementation of the findings.

This report defines allied health as it relates to this project, presents a literature review of Australian and international thinking and trends in allied health studies, defines the Central Hume region and explores and describes the methodology and findings of this research into recruitment and retention of rural allied health professionals within this region. Recommendations are made to progress the project into the next phases of implementation and evaluation.

In terms of allied health disciplines, the scope of practice for this project is inclusive of the following public and private practitioners:

- Allied Health Assistants
- Audiology
- Clinical Psychologists
- Continence Nurses
- Counselling services
- Diabetes Education
- Dietetics
- Occupational Therapy
- Physiotherapy
- Podiatry
- Social Work
- Speech Pathology

The findings of the research undertaken in Phase 1 corroborate the literature in terms of workforce composition, incentives and disincentives to rural practice, length of service in rural agencies, professional, social and geographic isolation, lack of access to professional development (which incorporates training, supervision and peer support), issues around clerical, management, human resources and Allied Health Assistant supports, funded vacancies and recruitment and retention challenges, service coordination, system barriers, gaps and overlaps and issues particular to sole therapists.

Recommendations

Recruitment and retention issues to be the focus of project interventions

Without appearing to state the obvious, the project implementation focus should centre around strategies to improve recruitment and retention rates of allied health staff across the Central Hume PCP. The findings indicated a slight majority of AHPs signalled they intend to stay in their present positions for 2-5 years or more, however it is confronting to learn that nearly 40% indicated their intentions to remain in their current practice for less than 2 years.

Initiatives aimed at increasing AH representation at decision-making, senior management and executive levels, increased supports such as management and clerical, increased access to professional development, developing guidelines for professional supervision, reducing social and professional isolation, increasing numbers and scope of AHAs, improving the job satisfaction of existing AHPs, job rotations, improved service coordination and interagency sharing may all assist with retention of existing practitioners.

Increased retention rates may reduce, but not negate, on-going innovative recruitment strategies. These may take the form of exploring affordable and sustainable incentives, actively promoting the attractions of the Central Hume area and rural lifestyle benefits (which may be in conjunction with the community and tourism association), promoting health careers to high school students, relationships with Universities around student clinical placements and graduate programs, attending job and career shows, recruitment for joint positions, being responsive to individual

practitioner needs role and career structures and increased Human Resources assistance to those responsible for allied health recruitment.

These strategies could form a starting point for the implementation framework, which should be underpinned by a set of guiding principles and focus on sustainable short (i.e. the term of the project) and longer-term (i.e. 2-5 years) plans.

Engage with the Steering Committee and the field regarding implementation

Engagement with the project Steering Committee, public agencies, private practice and a broad cross-section of AHPs will be necessary to ensure appropriate development, uptake and sustainability of the implementation framework. A series of workshops are to be held, one initially with the Steering Committee and another with the Steering Committee and AH managers, team leaders, discipline chiefs and a variety of other levels of allied health professionals, including private practice. The purpose of these workshops is to develop an appropriate, relevant implementation plan which will address the findings and construct workable, sustainable solutions to recruitment and retention. Three information sessions are then to be held around the Central Hume region to advise the findings and project progress to interested shareholders, and engage further them in the process.

Trial a network of local allied health managers

Peer support, networking, job rotations and inter-agency communication were all issues identified as needing improvement. Trialling a network of local allied health managers, team leaders and private practice owners if appropriate, may help to break down some of the barriers currently being experienced by agencies and practitioners, open up lines of communication, and assist with innovative and flexible solutions to the challenges of recruitment and retention which are impacting on service delivery and job satisfaction in Central Hume region. This network could be expanded to include discipline chiefs, which would offer more inter-agency sharing and inter-professional networking.

Professional Development initiatives require enhancement

While professional development is not the direct focus of this recruitment and retention project, issues around lack of access and difficulties attending various forms of professional development (pd = training and education, professional supervision, networking and peer support) by AHPs was one of the key findings of this research. This finding is mirrored in the literature and not unique to the Central Hume area. It was also found that the responses of the service mappings contrasted with those of their practitioners, in that the AHPs felt that their professional development needs were being met less adequately in the areas of professional training, professional supervision and peer support compared to their agencies and practices. Employers have a responsibility to ensure that rural allied health professionals have equitable access to professional development as do metropolitan AHPs, and that the type of pd and mode of delivery must be tailored to the needs of the individual disciplines in rural practice. Professional associations also have a responsibility to develop appropriate programs and delivery modes for their rural members. These notions are supported by SARRAH, the Services for Australian Rural & Remote Allied Health (Fitzgerald et al 2000).

Rural Allied Health Network

A model of a rural allied health network is operating successfully in the Loddon Mallee region of Victoria. The aim of the network is assisting communication, co-ordination of professional development and support for Allied Health within the region. The paid network coordinator convenes the annual rural network conference and other services such as a monthly newsletter, assisting sub-regional groups & establishment of a website. Other similar network models have also been successfully used in breast care and cancer services.

Consideration could be given to sourcing funding to establish a similar model in Central Hume region, which would greatly enhance networking, professional development and linkages, as the AHPs have been requesting. This model would aim to work with and strengthen the existing regional professional associations.

Professional Training and Education

Continued identification of training needs and increased access to appropriate training and resources should be facilitated. Further investigation is warranted to source the contact and event details of all the regional professional associations and special interest groups that operate in Central Hume, and to offer supports to strengthen these groups within the region.

These professional groups could be encouraged to coordinate more regionally based networking and training sessions to meet the diverse needs of their members. The School of Rural Health at the Shepparton campus of the University of Melbourne has agreed in principle to bring the Primary Health Care Research and Evaluation Development (PHCRED) workshops to the Central Hume region at no cost except promotion, venue and catering. These and other pd sessions relevant to AHPs could be listed on training calendars, such as those produced by regional services like Women's Health Goulburn North East, and various e-mail networks such as the Info Tree and DHS HP e-lists.

Findings suggested that agencies felt their staff pd needs were being met more thoroughly than the AHPs did. It would also be useful for agencies and practices to have communication with staff about their specific pd needs, the criteria for approval and budgets for this professional development. There appeared to be some lack of transparency or uncertainty about this by AHPs.

AHPs requested better access to evidence based research to inform their practice and pd. Access to the Cochrane Collaboration library, amongst other databases, could be promoted amongst AHPs as a reliable and readily accessible source of on-line evidence-based health resources. The Cochrane Library is a unique source of reliable regularly updated information on the effects of interventions in health care, designed to provide information and evidence to support decisions taken in health care and to inform those receiving care. The National Institute of Clinical Studies successfully negotiated free national access to the library for all Australians; previously the library had only been accessible via paid subscription (NICS 2005; Cochrane 2005).

Professional Supervision

Rural AHPs require access to a level of same discipline supervision, just as their metropolitan colleagues receive. In instances where the direct supervisor is of a different profession, options such as mentors (including the MentorLink program) or other clinical support should be offered. This could be a professional who is not necessarily co-located, but in conjunction with their direct supervisor can ensure appropriate standards of non-clinical and clinical issues are being addressed.

The Upper Hume PCP are undertaking a rural counselling project and have done some initiatives around supervision, including a workshop to provide an overview for managers and counselling practitioners about the functions and purposes of professional supervision. 72 people from across the region attended. Following this workshop the attendees identified other issues about which they would like to receive further information or training, and there may be an opportunity here to do some joint planning and collaboration about professional development for allied health practitioners (Washington 2005).

There is also an accredited Supervision Training Course currently being developed by LaTrobe University Albury/Wodonga to increase the pool of supervisors available in the region. This course should be promoted and encouraged among public and private services and AHPs who wish to extend their skills and offer supervision to others in their area.

Peer Support and Networking

AHPs reported they experienced isolation in rural practice in the domains of professional, social and geographic. Strategies which may assist the AHPs through this sense of isolation were professional development, peer support, social activities, structured professional associations, formal & informal networking, mentoring and supervision. Therefore, structures need to be formalised to enable these supports to occur in a sustainable manner.

One example of this is anecdotally there appears to be scope to establish a regional Podiatry network, possibly in conjunction with a Charles Sturt University journal club. The feasibility of a network and/or the Uni club need more investigation with regional podiatrists and the University.

Where appropriate, project and systems strategies to include both public and private practitioners

Private practices were engaged in this research through development of the service mapping survey to ensure it was relevant to both public and private sectors, private practitioners completing the staff survey and practice principals completing the service mappings. With increasing partnerships and contract arrangements between public agencies and private practice, there could be some increased service coordination and recruitment and retention strategies to be gained through this project by facilitating these public/private links. This may take the form of job rotations, private practitioner inclusion in AH events and input to the project implementation framework, for example. One of the limitations of this research is that further analysis has not been undertaken in the differences of the responses between public and private AHPs or service mappings. This is an area that could gain from more sophisticated analysis techniques and investigation, as analysis to date indicates there are significant differences in responses to some issues between public and private, and there could be some key learnings to be gained.

Service coordination to be strengthened and streamlined through interagency communication

Facilitated discussions amongst agencies may develop some innovative solutions to systems or structural barriers, and promote interagency sharing and partnerships. In the first instance, conversations between the Steering Committee members of Mansfield District Health Service, Ovens and King Community Health Service and Delatite Community Health Service can be scheduled, as well as between Northeast Health Wangaratta and Alpine Health. The trialling of an allied health manager's network would also aid service coordination and interagency communication.

Consider publishing a hard copy and on-line version of a directory of allied health services in the Central Hume region

Findings indicated a need for increased awareness and promotion of allied health services within the Central Hume region, from both practitioners and service mappings. This could be easily achieved by using the directory found in Appendices # & # in a print version which could be distributed along with the key findings and executive summary of this report to all AH services/departments within the region. This could also be uploaded to the Central Hume PCP website as an on-line version. While there are issues of currency with any directory, developing this directory could meet the needs identified by the surveys, and assist with service coordination, peer support and networking into the near future.

It can also be used as a communication strategy, keeping all shareholders in the loop about project progress and initiatives.

The value, training and resource issues of additional Allied Health Assistants to be explored

With a scarcity of AHPs and an ageing workforce, redesign of the workforce is vital. Exploring options for increasing AHP support through the training and employment of more allied health assistants throughout the region may enhance service to consumers, ease the workload burden

on therapists and impact positively on budgets. While this idea of role redesign and employing para-professionals may be viewed contentiously by AHPs, the notion is to assist their practice, not deprive them of a position.

Develop a sub-regional approach to locum/leave relief

A sub-regional approach to the issue of locum/leave relief across allied health disciplines may assist in supporting the continued professional development of rural allied health professionals, and allow for continuity of care during times of annual or sick leave and reduce burnout and workload.

Establish community engagement and social supports

Consideration could be given to providing new graduates and new (albeit experienced) recruits entering rural practice with some types of community and social supports. This should start at the recruitment phase, with community involvement in promoting the benefits of the region (for example in conjunction with the tourism association) and assistance with employment for spouses or services for children. Retainment strategies could include involvement from colleagues, service clubs or other community groups, acting as 'buddies', which may be of the same discipline, another health care professional (promoting multidisciplinary care) or members of the local community. The advantages may help to reduce the anxiety related with separation from networks, family and friends, and help them assimilate into their new community, encouraging them to stay longer. Further exploration should be done to establish what the Victorian Department of Communities (who have a regional office in Central Hume) can do to assist with this notion of community engagement.

Define 'consumer' involvement in the project

Further discussion needs to take place to determine who are the 'consumers' of this project. Are they patients, for whom health services exist? While recruitment and retention issues per se are not consumer issues, the implications for service delivery are. Are the allied health professionals who are impacted by this project and its implementation framework the 'consumers'? Is DHS one of the 'consumers' of the outcomes of this project? Whoever the project consumers may be, their voice and perceptions are useful when planning workforce and service reform; therefore involvement of appropriate 'consumers' should be considered for the next phases of this project. This could be via invitation to the information sessions which are to be held, involvement in workshops or other mechanisms as deemed appropriate.

DHS state-wide funded projects to have a co-ordinated approach for resource sharing and networking amongst projects, and commit to implementing recommendations

Twenty rural workforce projects have been funded in the 2004-2005 year by the Victorian Department of Human Services (DHS), including this Allied Health Recruitment and Retention project in Central Hume region. Each appeared to be working in isolation, without the benefit of a coordinated state-wide network of project officers to share resources, information and findings.

The project officer for CHAHR&RP was previously the Program Manager (PM) for the Hume Breast Services Enhancement Program (BSEP), under the umbrella of BreastCare Victoria, DHS. A network was established at the start of BSEP where all 9 state-wide PMs and staff met bi-monthly or quarterly to network, debrief, share strategies and resources. While easier to achieve due to the singular nature of the program (i.e. breast care), this was an invaluable source of support for all the staff, led to some inter-program collaboration on trialling initiatives in metro/rural regions, and sharing information and products which could be brought back to our regions to resource other stakeholders.

It is recommended that DHS facilitate state-wide networks for all projects which have related aims, such as rural workforce issues. Additionally, governments and funding bodies need to commit to more coordinated, adequately funded long-term research with rigorous evaluation, to determine the effectiveness of all workforce initiatives, including rural workforce recruitment and retention

strategies. They then need to commit the resources to implement the findings and recommendations of this research.

There may also be an opening to form a network of project officers in the Hume region. The work of project officers is different to many occupations, and requires a unique set of skills and abilities. This would enhance peer support and capacity building for project workers.

Research to be conducted, where possible, avoiding holiday seasons

While unavoidable in this project due to the commencement of the project officer late in the year, the development and trialling of both surveys was rushed so that they could be distributed by early to mid-December, with a requested return before Christmas. Piloting and trialling the surveys more thoroughly may have resulted in a more validated tool and gleaned additional information pertinent to the issues.

It is not known whether distributing the surveys in such a busy time as pre-Christmas resulted in a lower response rate to either survey. Follow-up of the service mappings however was hindered in early to mid-January, as many of the respondents were on annual leave. Once they were contacted later in the month many agreed to complete them. This delayed collating and analysing the mapping data alongside the staff survey data, and the report was unable to be finalised until all data was input and analysed, extending the process by two months.

Build in on-going evaluation strategies to the AH model, including strengthening the Steering Committee partnership

Evaluation is a vital aspect of any project or service, and should not be an 'end-point', rather it should be built into the project framework as on-going throughout the life the project. The benefits and drawbacks of internal vs. external evaluation also needs some discussion.

The desire of the project Steering Committee to evaluate themselves exhibits a mature approach to their responsibilities and partnership. The completion of the VicHealth Partnerships Analysis Tool by the project Steering Committee members identified some areas of opportunity to strengthen the partnership. Therefore, strategies are to be built in to the project implementation framework and evaluation to address the areas identified by the SC. Further evaluation of the Steering Committee could be conducted using exemplars from, for example, Kiel, Nicholson & Barclay's book *Board, Director and CEO Evaluation*, alongside other methodologies.

Literature Review

The changing nature of healthcare

One of the key challenges in the future of healthcare is that people have traditionally viewed hospitals as the basic building block of their health care service. While this access to hospital care is fundamental to the health needs of a community, there is an increasing focus on health promotion, long-term care and innovative services before and after hospitalisation and within other models of health service delivery (NRHA 2002).

There are many emerging issues universal throughout the health workforce that have a significant impact on performance, job satisfaction and career decisions, which mandate thinking more strategically about the future health workforce. These trends include (AHMC 2004; Queensland Health 2001; Struber 2004):

- new and varied approaches to health care delivery
- increased consumer participation in health care and health care decision making
- pressure to demonstrate effectiveness and efficiency as managers and clinicians
- work practice changes which are driven by funding, technology, demographic and other societal changes played out in a highly politicised and public environment
- new roles for old disciplines and new disciplines
- pressure from alternate funding initiatives such as Casemix & WIES

- pressure to define core business which results in not all priorities being met, and less opportunity to exercise professional autonomy in decision making
- continuous requirements to maintain up to date knowledge and skills in a global environment where overwhelming amounts of information are widely available
- recognition of the benefits of a primary health care approach
- continuing demographic change and shift
- increasing reliance on team based services as the mechanism for workforce organisation and service delivery, which is problematic in a competitive environment.

The Queensland Health taskforce groups on allied health recruitment and retention (2001) also reported a steady increase in workloads with decreasing length of hospital stay. Rural and remote allied health employees spend significant time travelling to provide services and report regular unpaid overtime associated with these services. The proportion of allied health professionals who reported working paid and unpaid overtime is higher in remote areas than for other geographical areas. Initiatives to reduce surgical waiting lists have also reportedly intensified pressure to increase allied health service activity. Yet the allied health services component of such initiatives has been largely unfunded. Some clients indicated they must wait extended periods for services.

Health and welfare of rural and remote residents

There is evidence that identifies a discrete culture within rural communities (Davis, Williams, Redman, White & King 2003). People in rural and remote Australia are culturally, economically, sociologically and spiritually seen as being different from their metropolitan counterparts (in Schoo, Stagnitti, Mercer & Dunbar 2004). In terms of the Hume rural region, rural is defined as including regional centres and country towns in rural areas (Davis et al 2003).

Some researchers have proposed that the rural lifestyle is associated with a greater self-reliance and independent lifestyle, and therefore people from rural health may define health in more practical and functional terms (NBCC & NCCI 2003).

People in regional and rural Australia face many difficulties as a result of their relative isolation from metropolitan centres and major health care facilities. Amongst the most common obstacles are lack of access to a full range of treatment options, lack of availability of appropriate medical and other support expertise, the need to travel long distances for some treatments, separation from families and support systems during treatment, increased costs due to travel and accommodation, and difficulty accessing information and support services (NBCC).

Considerable disparities exist in the health status of rural and metropolitan Australians. Data collected by the Australian Institute of Health and Welfare (AIHW) recorded that rural and remote residents (who comprise 32% of Australia's population), generally have a lower health status, lower life expectancy and a broad range of welfare and socio-economic problems at higher levels than urban Australians (in Mills & Millsted 2002; in Hegney & McCarthy 2000; Sivamalai 2003). The AIHW data also reveals that non-metropolitan populations are disadvantaged as medical services are not easily accessible in many rural and remote regions, with the number of per capita health professionals falling sharply with increased remoteness (in Hegney et al 2000), lowering access to GPs, specialists and allied health professionals. The one-third of Australia's population which lives rurally is serviced by just 15.6% of the nation's doctors (Laven, Wilkinson, Beilby, Pratt in Struber 2004).

Rural populations experience greater isolation (both geographical and technical) and encounter more difficulties in accessing health care, compounded by the poor condition of many rural roads (Sivamalai 2003). For example, rural and remote residents die in motor vehicle accidents at double the rate of those residing in metropolitan areas (Hegney & McCarthy 2000), and many of the rural arterial roads with the highest number of road crashes per kilometre are in the Hume region of Victoria (CHPCP 2004). Men in rural and remote areas have higher mortality and hospitalisation rates for injury and burns. Death rates for coronary heart disease, incidences of stroke, asthma, diabetes, emphysema, ulcers and arthritis increase with remoteness from large cities. People in remote and rural regions have higher levels of risk factors, such as harmful alcohol consumption and smoking, physical inactivity, overweight, high blood pressure, poor nutrition, less use of sun

protection, exposure to violence, mental health issues and suicide, further contributing to a lower health status and life expectancy. Australia's Indigenous population, concentrated in rural and remote areas, continues to experience much poorer health than other Australians. The Indigenous population increases death rates in regional areas by 5-10% and by 50% in remote areas. People in the bush have lower levels of education, lower levels of employment, lower household incomes to purchase goods and services, (which come at an increased cost of between 10-23%) and higher Indigenous populations. (AIHW in O'Kane et al 2003; in Kenny et al 2003; and in Hegney et al 2000).

An evaluation of the Rural Communities Access Program also found that stress related problems are on the increase. Rural health workers reported increased substance abuse; low morale and depression; and long hours of work that lead to greater risk of accidents and withdrawal from community activities and involvement. With the closure of support services and the difficulty of accessing medical services, families have less access to help (1997).

Essentially this rural health and welfare profile results in greater rates of morbidity and mortality indicated in almost all categories, with increased, rather than decreased, need for allied health services (O'Kane 2003). Despite higher levels of need for allied health services in rural areas (Strong et al in Schoo et al 2004), urban Australians receive more than double the level of service provision by AHPs compared to their rural counterparts (in Schoo et al 2004).

Grimmer and Bowman conducted a study on the differences between metropolitan and country public hospital allied health services (1998). They found that rural allied health patients were older, had a higher proportion of chronic conditions, and were less likely to be eligible for rebates for private allied health services in the community because these services were not available. They felt it was likely that country patients travel further for their health care than their metro counterparts, thus incurring greater opportunity costs such as travel and accommodation, loss of income and family disruptions, than their city counterparts.

Rural and remote clinical practice varies widely in the context in which it is delivered and some evidence-based practice simply can't be applied in some areas because of a lack of specialist services or because of the particular constraints that rural care imposes (NICS 2003). The fundamental challenge is 'finding ways to deliver an increasingly complex and expensive service to a population that is older, sicker, more geographically dispersed, ever more ethnically diverse and less economically secure than at any time in recent memory'. While these problems are not exclusively rural, they are more prevalent and their impact is greater in rural communities (Dean 2004 p 20).

Recruitment and retention of rural health care professionals

Attracting and retaining professionals and skilled people to live and work within regional and rural communities is one of the major challenges in building sustainable regions into the future. Communities that are self-sufficient in terms of tradespeople and professionals are more likely to retain their residents and attract new ones (SCORD 2004).

Health workforce planning is one of the significant challenges faced by health systems both in Australia and internationally. When staff turnover occurs, there's a negative impact on personnel budgets, staff morale and patient care (Kupperschmidt 2001).

Studies (Leggat 2003; McKay in King 2003) confirmed that factors important for rural recruitment were different from the factors important for retention of health professionals in rural areas. Activities directed at attracting health professionals to services prior to their arrival in the community are considered to be recruitment, while retention is concerned with the processes that happen after the professional has been recruited (NRHA in Leggat 2003). Both recruitment and retention need to be addressed in order to make a positive contribution to the health status of rural communities and reduce the on-going costs of recruitment (Mills et al 2002). It has been assumed (incorrectly) that recruitment to a rural area will automatically lead to retention (Millstead 2001) and there are suggestions that workforce retention has been poorly distinguished from other supply

issues such as retention, and the literature reflects a poor understanding of determinants of retention (Humphreys in King 2003).

It is imperative to distinguish between the reasons for job satisfaction in rural and metropolitan areas, as information obtained from metropolitan research is not generalisable to the rural sector. Strategies designed for recruitment and retention in metro health services will not work for non-metro areas, because of the marked differences between the demographics and the context of practice of health professionals who chose to work in rural areas (Hegney & McCarthy 2000).

The availability of health care providers is the foundation for health care delivery. While the recent emphasis in improving care is focused on changing practice behaviours by encompassing evidence based practice, many communities are still struggling to find providers to deliver health care. A prerequisite to the implementation of evidence based care is the availability of providers (Merwin, Hinton, Dembling & Stern 2003). Workforce planning aims to ensure an adequate supply of AHPs. This does not imply there will not be turnover of staff, rather that continuity of care will be maintained. Therefore recruitment incentives need to attract sufficient AHPs to rural practice in times of need, and retention strategies need to be directed towards ensuring an adequate length of stay (Belcher, Kealey, Jones & Humphreys 2005).

Practice in rural & remote communities promises a mix of incentives and disincentives that contribute to health workforce recruitment and retention. The National Rural Health Strategy (NRHS) acknowledges that despite a high degree of professional satisfaction gained by working in rural areas, and the many advantages of a rural lifestyle, there are problems of workforce shortage, maldistribution, excessive turnover and problems with access to on-going education (AHMAC in Hughes 1998).

The problem of recruiting and retaining health care professionals is particularly troublesome for rural communities, yet rural populations are found to be older, poorer, sicker, less educated and often perceived as having a lower level of health than urban populations (Rourke 2000 & 2001 and Ministerial Advisory Council on Health 2002 in Curran & Rourke 2004). A lack of access to cross-disciplinary health care professionals in many rural and remote communities contributes to this poor health status (Comer & Mueller in Mills et al 2002).

Direct and indirect costs related to staffing rural and remote health positions are considerable. These include the expenses of employing staff, unfilled vacancies, costs associated with hiring, termination costs, orientation and training costs, and the expense of decreased productivity of new personnel (Friesen & Conahan in Mills et al 2002). One study found that a staff turnover of 3% in a 300 bed hospital costs \$400,000 (The Nursing Executive Centre in Bray 2001). To solidify retention planning, it has been recommended to quantify dollars currently spent on recruitment and retention and partially reinvest those dollars in workforce assessment and strategy development, forming an on-going retention budget (Jacobs in Bray 2001).

The cause of recruitment difficulties are multifactorial, including the pressures of the increasing focus on rapid discharge from hospitals and the implementation of a range of initiatives to address hospital demand issues. These positive innovations have provided a range of additional opportunities for allied health professionals, as they are well positioned in view of their expertise and skill base to lead and implement these new programs (McKinnon & Collins, undated).

The challenges remain however with increasing demand for services, but the assurance of supply through public sector funding is less assured and may provide a brake on expansion. One Queensland study for example identified greater needs for allied health services in the areas of mental health, preventative care, health education, home health care, long term care and aged care (Boyce 1996).

Advantages, factors and incentives which influence choice to practice rurally

The positives of rural practice as perceived by students and allied health professionals include (Solomon, Salvatori & Berry 2001; Fitzgerald, Hornsby & Hudson 2000; CURHEV 1999;

Wolfenden, Blanchard & Probst 1996; Motshidisi, Chang & Devereux 2003; Mitchell 1996; Butler & Sheppard 1999; Schoo et al 2004; O'Callaghan 2005):

- √ relaxed rural lifestyle factors (including less stress, healthier)
- √ availability of leisure and recreation activities
- √ practical skills development
- √ opportunity to use skills & multi-skilling opportunities
- √ fast tracking early career paths
- √ closer professional relationships
- √ challenge of the position
- √ ability to develop management skills
- √ a sense of autonomy
- √ the ability to be flexible and creative
- √ job diversity, scope and variety of caseload, and range of procedures performed each day
- √ friendly and welcoming community and the ability to form close community relationships ~ a sense of belonging to the community
- √ lower cost of living
- √ family ties, spouse and family contentment
- √ seeing more of Australia.

Various studies (in Brooks, Walsh, Mardon, Lewis & Clawson 2002; Mitchell 1996; Hays et al in Veitch 2003; Bruening and Maddern in Motshidisi 2003) analysed pre-medical school factors that related to recruitment and retention, consistently finding that rural upbringing was positively associated with doctors and surgeons practicing in rural areas. Washington (2004) cites a number of studies which indicate student placements in rural settings are identified as a valuable strategy to enhance recruitment and retention of staff to rural health and human services. Three Australian studies however demonstrated that prior rural experience (including the completion of a rural clinical placement or living in a rural area) does not necessarily play a role in the recruitment of newly graduated physiotherapists or social workers to rural areas, but it can have a positive role in the making of an informed career choice, if rural roles and responsibilities are learned (Butler et al 1999; Motshidisi et al 2003; Krieg Mayer 2001). The evidence suggests the earlier the exposure to rural practice and the longer the duration of that exposure, the more likely the students will choose to work in a rural setting (Brooks et al in Motshidisi et al 2003), and that familiarity with living and working in small communities was a strong influence on student attitudes towards practising in rural areas following graduation (Paterson, McColl & Paterson 2004 and Causby 2003).

This early exposure and recruitment may begin in rural high schools. While the studies are not strongly conclusive, there is research suggesting that students who have a rural background are more likely to have a long-term career in a rural area, therefore targeted programs aimed at recruiting young people to a health career may encourage them to undertake rural practice (Ontario Rural Council in Motshidisi et al 2003). Alexander and Fraser found that improving rural high school students' experience of health career promotional activities can lead to an increasing number of enrolments in health courses (in Motshidisi et al 2003).

Many of the issues that impact in the recruitment and retention of AHPs to rural communities are similar to those impacting on GPs (NRHA in Struber 2004). Yet, despite emerging evidence that investment in AH services results in financial savings for government and enhances recruitment of GPs to rural areas, the bulk of rural support and incentives, both policy and monetary, continue to be directed at medical practitioners (in Struber 2004).

Incentives and appropriate remuneration packages which recruit and retain allied health professionals in rural and remote areas may include (CURHEV 1999; Stanley-Davies & Battye 2004):

- √ low rental accommodation
- √ long term contracts
- √ access to professional development, peer support and professional supervision
- √ develop a social support network or buddy system to welcome new recruits and families

- √ assistance in finding employment for partners or spouses
- √ mentorship
- √ preceptorship
- √ home, car, salary, childcare package
- √ accessible teleconferencing and videoconferencing facilities.

Disincentives to rural practice and factors associated with leaving

Disadvantages to and factors associated with practitioners leaving rural practice included (Huntley in Fitzgerald, Hornsby & Hudson 2000; CURHEV 1999; Wolfenden et al 1996; Motshidisi et al 2003; Mitchell 1996; Butler et al 1999; Millsteed 2001; Struber 2004; Schoo et al 2004; O'Callaghan 2005):

- √ geographic, professional and social isolation
- √ lack of recreation venues (theatre, entertainment)
- √ difficulties accessing professional development/skills development
- √ lack of support for on-going/post graduate education
- √ lack of professional supervision, support and/or mentoring
- √ lack of support from management and organisation
- √ lack of educational and employment opportunities for spouse and children, or inability of partner to adjust and absence of family support
- √ lack of financial incentives
- √ lack of locum or agency relief
- √ poor staffing levels and heavy workload (lack of a critical mass of professional support)
- √ restrictions on service delivery
- √ limited funding, material resources & facilities
- √ lack of public transport & excessive distances to be travelled
- √ lack of autonomy, privacy and confidentiality
- √ lack of appreciation and/or recognition of their AHP roles and the perception that experience in the city is more highly regarded
- √ lack of opportunity to use special skills and lack of speciality services
- √ lack of career structure/progression/stability
- √ lack of orientation to the community
- √ relatively low remuneration levels
- √ working as sole practitioners.

The lists of incentives and disincentives to rural practice clearly have some similarities, and a positive factor in one situation can be viewed as a negative in another situation.

Professional development of rural practitioners

Personal and professional development (pd) is a life-long process. Undergraduate training provides the basic foundations of disciplinary knowledge and skills. Postgraduate training and continuing education are necessary to keep up with change and build on these foundations (Sheppard & Mackintosh 1998), particularly with the need to be highly skilled for a diverse rural caseload, and therefore continuing professional development must support the wide variety of clinical, administrative and management competencies required in rural practice. Professional development and support needs are therefore different in rural areas than urban (Lannin and Longland 2003).

Professional development as defined in this report includes continuous learning, education and training, skill development, peer support, networking and professional supervision.

The literature is abundantly clear that provision of continuing professional development is recognised as one of the key factors affecting the recruitment and retention of AHPs in rural Victoria (O'Reilly 2003; Leggat 2003; Solomon et al 2001; Queensland Health 2001; CURHEV 1999; NRHA in Glynn 2003; King 2003; SCORD 2004; Millsteed 2001). Access to continuing pd is a key factor in job satisfaction, maintenance of clinical competence, development of clinical confidence and willingness to work in rural areas (Queensland Health 2001). A study into the

extent to which relief arrangements affect access to professional development activities found that of the AHPs who would consider leaving an organisation, 80% indicated that better access to pd in the city would influence their decision (CURHEV 1999).

Priority recommendations from the 6th National Rural Health conference (NRHA in Durey, McNamara & Larson 2003 p 148) states that '*flexible education and training programs that are locally, culturally and socially appropriate are key concerns in the delivery of health services in rural Australia*'. This is particularly relevant for rural and isolated practitioners, who have been identified as one of the most educationally disadvantaged groups (Blue & Howe-Adams in Parkin, McMahon, Upfield, Copley & Hollands 2001). It has been proven that rural AHPs spend less time in professional development activities (2.7% of their time) than their metro counterparts at an average of 4.1% (Queensland Health 2001). Rural and remote nursing and medical professions are also supported by government funding for their pd, unlike allied health (Glynn 2003).

The challenges and barriers to accessing pd to develop new skills and learn different theoretical models are many (Washington 2004; McCormick in Leggat 2004; Queensland Health 2001; Hegney & McCarthy 2000; Sheppard et al 1998; Parkin et al 2001):

- ⊕ lack of availability/opportunity in rural areas
- ⊕ geographical isolation and long distances to be travelled to attend sessions, including the time and costs associated with this travel
- ⊕ limited access to resource libraries and journals
- ⊕ finding relief or locum cover to attend pd
- ⊕ the constraints on time for lengthy workshops which results in a lack of depth of information delivery
- ⊕ lack of support or understanding from organisations about the value of pd
- ⊕ lack of knowledge of, access to and support for technology and the cost of this technology
- ⊕ loss of income due to time away from clinical practice and travel time (particularly private practitioners), fees, accommodation and childcare
- ⊕ organisational budgeting and cost issues, therefore lack of financial support to attend
- ⊕ being required to attend pd activities on rostered days off or weekends
- ⊕ lack of information about the availability and timing of courses
- ⊕ workload demands
- ⊕ family commitments and childcare needs.

Increasingly there is a requirement by some professional associations to undertake a quota of continuing professional development to maintain registration and/or membership of the professional association. This is yet another reason that improved access is needed by rural AHPs (Fitzgerald et al 2000).

It must be acknowledged that professionals have a responsibility towards their personal and professional development. Cost sharing arrangements between the AHP and their organisation should be encouraged, and efforts made towards increasing access to pd activities in rural areas.

University qualifications and student clinical placements

Preparation of rural practitioners is different from the preparation of practitioners for metropolitan areas (Leggat 2003), and metrocentric approaches to health care professional education means that the needs of rural health services are also not met (Kenny et al 2003). One study of allied health professionals reported satisfaction with their preparation for clinical practice but dissatisfaction with preparation for rural practice, health systems issues, workload, business and personal management and team processes (Queensland Health 2001).

In 2001, only 19.1% of Australian university students came from rural and remote areas, a figure dramatically below the equity reference point of the approximately 30% of the population living in rural areas (Durey et al 2003). It has been argued that it is the "social responsibility" of universities to go beyond research and provision of education to..."ensuring underserved populations have access to essential health services by preparing graduates to work in areas of need" (Kamien in Belcher et al 2005 p 25).

This highlights the need for developing higher education opportunities for all Australians, regardless of where they live, that are addressed by long-term strategies that take into account both structural and cultural barriers (Durey et al 2003). One strategy used by La Trobe University Bendigo campus to encourage students with an appreciation of rural lifestyles to consider a physiotherapy career is to offer a small ENTER bonus for prospective students in the Loddon-Mallee region who place the Bendigo Physiotherapy program on their tertiary entrance preference list (Leggat 2003).

Better workforce preparation and fit can only occur where there are more collaborative, cooperative and constructive relationships with the university departments which train the allied health workforce, professional associations and employers. Traditionally academic environments are generally not interdisciplinary, yet practice environments are increasingly so, which poses a serious disconnect (Humphris 2005). One Victorian university (Cohen 2005) and a UK New Generation project (Humphris 2005) have revolutionised university curriculum into learning units and common subjects (such as enabling change in practice, law, ethics & communication skills, interprofessional problem solving and multicultural issues in health sciences), with a mixed cohort of students such as nursing, midwifery, allied health and medicine. In the UK this has partly come about as the health faculties at universities are funded by the government health departments to deliver what health services require, not funded by the government education department as they are here in Australia. The New Generation project view is that major partnerships with industry are the only way forward to train the upcoming workforce (Humphris 2005).

Rural clinical placements provide a good grounding for rural allied health practice and provide allied health practitioners and health services with valuable links to universities and opportunities to keep updated with developments in clinical practice and theory (CURHEV 1999). Allied health students are increasingly offered rural placement opportunities, but they lack infrastructure, funding and support for issues such as accommodation and travel (Neil and Taylor in Motshidisi et al 2003; Leggat 2003; Swerissen & Raynor 2005). The provision of financial support to meet some of these costs, together with educational and on-going support, have proven to be determining factors in encouraging interested students to practice in smaller communities (Paterson et al 2004). It is clear a more coordinated and resourced approach to student clinical placements would be welcomed by allied health students, health services and Universities alike. CURHEV (1999) recommended a more coordinated approach, that they in conjunction with professional associations and universities, foster coordinated approaches to clinical placements across AH disciplines and explore the development of shared professional education in subjects such as working within multidisciplinary teams, marketing, business planning and budget management. The Victorian Universities Rural Health Consortium (Swerissen et al 2005) are undertaking a project on developing sustainable health placement models for medical, nursing and allied health students across rural Victoria. Recently there has also been some discussion amongst regional Victorian universities to possibly establish a state-wide student placement coordination centre, if funding was obtained (Neumayer 2005). This concept would need to be progressed by university Deans to become reality, and may be enhanced should an Allied Health Workforce Agency be established within the Victorian Department of Human Services, as recommended in the Victorian Universities Rural Health Consortium (Belcher et al 2005).

Community involvement in recruitment and retention

Evidence suggests that active and dynamic communities reach better outcomes in areas such as health, education and economic development (Thwaites in Schoo et al 2004). There appears to be considerable merit in a community development approach to workforce issues and rural recruitment and retention, with collaboration between communities, health services and educational providers to address the critical shortage of health care professionals (Veitch 2003; Shannon 2003; Francis 2003; McDonald, Bibby & Carroll 2002; Wallis undated; Veitch, Harte, Hays, Pashen & Clark 1999).

Building healthy communities is an important goal in regional and rural Australia, and can be achieved through a strengths based approach to community development and funding to support

local initiatives. Connectedness, capacity, innovation and sustainability are themes which can be addressed through community development (Leggat 2003; RPRC 2004).

The interrelationships of health care services and the local economy have also been acknowledged (Shannon 2003). Rural systems tend to be small, flexible and adaptable, which can contrast with commercially driven systems that can dominate urban communities (Dean 2004).

The literature abounds with factors that affect recruitment and retention, many of which are locational, lifestyle, familial or social, which are directly or indirectly within the control of the community. As a result of their importance in decisions to take up and/or stay in practice in a community, addressing community issues should be a part of recruitment and retention strategies. Integrating the community and health care into these efforts increases their success (Felix, Shepherd & Stewart 2003; McDonald et al 2002; Wallis). Communities and employers need to recognise that as recruitment does not equal retention, there is need for involvement in selling their community to prospective recruits, as well as on-going support mechanisms to for a considerable length of time to aid retention (Veitch 2003). One nursing study identified factors which could be incorporated into marketing strategies to attract health professionals to rural areas, including the high level of job satisfaction rural health care workers derive from constructive community relationships, which are more easily fostered in smaller rural health services (Hegney & McCarthy 2000).

Characteristics of allied health professionals

The literature describes rural health care professionals as being multi-skilled, innovative and self-directing (Francis, Bowman & Redgrave; Hegney; Best in Francis 2003). Lonne indicates that adjustment to a rural practice is facilitated by the worker possessing qualities such as competence, innovative zeal, self-reliance, emotional resilience and a sense of humour (in Krieg Mayer 2001) and requiring flexibility and initiative (Butler et al 1999).

Rural practice requires workers to be generalist & generic workers, multi-tasked and able to fulfil a variety of roles in the community. They need to be able to cope in places where there are few of their own profession and be a resource specialist, but also able to cope with a lack of resources. Workers have to handle professional and personal isolation, while often dealing with 'personal and family issues arising from rural relocation' and inadequate support from employers for relocating and working in rural settings (in Krieg Mayer 2001 p 92). The role of the non-urban AHP has been defined as a "specialist-generalist", with a need to provide expert knowledge over a wide range of areas (Sheppard in Butler et al 1999).

The allied health workforce is predominantly female (75%). This does vary among the disciplines with Occupational Therapists, Dietetics and Speech Pathologists almost exclusively female workforces. Depending on your definition of youth and aging, it would be reasonable to suggest that the Australian allied health professional workforce is relatively young with 60% between 25-45 years (O'Kane et al 2003). The CURHEV study (1999) concurred, with the majority of their allied health respondents being under 30 and female.

The 2000 SARRAH study of allied health professionals in rural and remote Australia (Fitzgerald et al 2000) analysed that at least 13 percent of the health workforce in Australia is allied health. They calculated that the proportion of allied health professionals to other health professionals is:

- Five allied health professionals for every 7 doctors
- Four allied health professionals for every 21 nurses
- Four allied health professionals for every one dentist and
- Three allied health professionals for every one pharmacist.

In Australia there are 60% less allied health practitioners per 100,000 population working rurally than in metro areas (AIHW in Struber 2005; AHMC 2004), with a turnover rate of 42% in 2 years (Fitzgerald et al in Struber 2005) and exit rates at 29% in rural areas compared to 19% in metropolitan (Queensland Health in Struber 2005).

Generational challenges in the recruitment and retention of rural professionals

There is about to be a global phenomenal shift in the profile of labour. For every new young person entering Australia's workforce today, there are 7 people over the age of 45 that are available. In the decade 1982-1992, 32% of our workforce was over 45 years of age; in the present decade of 2002-2012, 85% of the workforce will be over 45 (Rolland 2005). The number of people aged 65 plus in Victoria is projected to increase 127% between 2001 and 2031 (Service and Workforce Planning Branch 2005).

According to the Department of Health & Aged Care, currently Australia's national workforce grows at an annual rate of 170,000 per year. By 2020 this is predicted to be just 12,500 per year, or to put it another way, for the whole of the decade 2020-2030, the workforce will grow less than it currently does each year (AHMC 2004). This is due to the baby boomers ageing, and the drop in Australia's birthrate from 3.5 in 1961 to 1.7 per woman in 2001, well below the world's average, with Victoria having lower fertility rates than Australia as a whole, at 1.63. The numbers of women of childbearing age in rural areas are projected to be lower than metropolitan areas due to the older age structure in rural areas. This means that fewer children are likely to be born in rural areas relative to death (Service and Workforce Planning Branch 2005).

Despite the overall ageing of the population, we have already determined that Australia's allied health professional workforce is relatively young. Many young allied health graduates seek rural positions to start their career, and thus rural regions have been described as "professional nurseries" (Miles et al in Schoo et al 2004). The importance of recognising the needs of new graduates cannot be underestimated. As young and inexperienced practitioners they will need to be supported in their clinical practice, and many may also need assistance with their transition to full-time employment and living away from home. They also need to learn about working in an organisation and how to inter-relate with other professionals, clients and management. These are skills which many AHPs and management take for granted as they have developed them throughout their working life, yet they are required to be nurtured and supervised in young staff (CURHEV 1999).

A dynamic needs to be considered when dealing with any younger members of the workforce, often referred to as 'Generations X and Y'. Workforce trends have been noted in the different age groups of workers. Generation X is the term used to refer to those born between the early 1960s and 1980 (Kupperschmidt; and Hill in Schoo et al 2004), whereas Generation Y is born after that date. Trends noted with Generation Y include wanting to work in a team environment (McKenna in Schoo et al 2004) and are committed to teams that nurture the individual (HR News 2005). Generation X wants to be mobile and flexible, whereas baby-boomers (born post World War II to ~ 1960) plan to retire in the not too distant future (Miles et al in Schoo et al 2004). Generation X has been described as being empowered, self-directed, techno-competent, flexible, and wanting to change jobs more frequently when dissatisfied with work conditions (Kupperschmidt in Schoo et al 2004), and Gen Xs seek clear goals and quick, specific feedback on performance (Ashworth, Battye & Symons 2004).

The Generations X and Y have different perspectives on their individual needs and work/life balance (McKinnon et al), and different expectations and support needs than their older colleagues who may come from the baby boomers era or older. Many baby boomer bosses are failing to pass along information to younger generation employees due to not understanding their communication styles and a possible fear that they will outshine their bosses.

A survey found that there is a perception that bosses over the age of 40 don't know what younger employees want, and that baby boomer managers who believe that younger generations have short attention spans do not understand their communication habits and learning styles. If such managers aren't able to come to grips with this, there will be a further increase in staff turnover – "put simply generation X/Y's won't hang around unless they feel they're contributing and appreciated for their contribution" (HR News 2005). Figures # 1 & # 2 highlight the diverse needs of the 3 generations of the workforce.

Optimising workforce recruitment for members of three generations: Baby Boomers, and Generation X's and Y's.*

Baby Boomers	Generation X	Generation Y
Value experience and maturity	Making a difference as an individual	Emphasise the mission and actively demonstrate it
Support professional development and acquiring new skills	Balance, time off and support are important	Value multiple career opportunities
Desire to get ahead	Fun in work environment	Value making daily differences in the lives of others
Desire to achieve balance in the job	Value technology and autonomy	Forefront of technology

Figure # 1

Optimising workforce retention for members of three generations: Baby Boomers, and Generation X's and Y's.*

Baby Boomers	Generation X	Generation Y
Provision of mentoring	Provision of quality training that is easily accessible	Competing in pay and benefits
Recognition of contributions	Encouragement of working independently	Demonstrating ways to progress
Creating harmony in the workplace	Pointing out project opportunities	Desire to speak up and take part in projects
Name recognition	Provision of direct feedback	Teamwork and inter/intra departmental collaboration
Flexible working hours	State of the art technology	State of the Art technology
Point out value to organisation	Recognition of balance as an important factor in life	Dislike for corporate politics
Recognition of achieving balance in life	Recognition of the need for job / career changes	Value optimism, diversity and updates on status quo

Figure # 2

(* Tables composed from McKenna and the Spin Sweeney Report in Schoo et al 2004).

These findings will challenge existing recruitment and retention practices and are likely to have ramifications in relation to management and forward planning of rural workforce requirements (Spin Communications and Sweeney Research in Schoo et al 2004).

It needs to be acknowledged that young practitioners are a highly mobile section of the workforce, so reasonable expectations of their length of stay must be recognised. Rural practice could therefore be promoted as a positive start to their career, rather than always implying a long-term career choice when recruiting new graduates (Belcher et al 2005).

CURHEV reported the objective in employing new graduates should not be focussed on retention, but rather making the experience of rural practice satisfying and challenging. It is hoped that when these young practitioners (almost inevitably) leave to broaden their experience, travel or be closer to family and friends, they do so with a view that they may return at some point in the future or recommend rural practice to their metro colleagues (1999).

Rural workforce initiatives

Workforce supply is a worldwide issue and is partly driven by demographics which will be further compounded by the aging population and inevitable increase in demand for health services. There are a plethora of projects and research earnestly exploring these health sector workforce issues,

reflecting the concerns raised in a number of jurisdictions, but unfortunately resulting in a somewhat fragmented approach (McKinnon et al).

The learnings from all of these workforce initiatives support the strategic and accessible use of evidence-based health care for rural workforce issues. Funding bodies and researchers need to invest in rigorous evaluations that are then made widely available. Policy and program development can benefit by drawing upon sound research knowledge. Rural communities can also become more informed and discerning consumers of this information (McDonald, Bibby & Carroll 2003).

The Australian Commonwealth, State and Territory governments and the National Rural Health Alliance (NRHA) have agreed that specific future directions are needed for collaborative work at a national level. Special areas of emphasis include 'continuing to work to monitor and enhance the health workforce with special emphasis on nursing and allied health workforce info' (NRHA 2002 p 13).

The Healthy Horizons Outlook (NRHA 2002) lists the National Health Priority Areas which are aligned to the Chronic Disease Initiatives, many of which have ramifications for rural allied health services. Some of these are:

- Mental Health – promotion, prevention and early intervention
- Suicide and attempted suicide for at-risk groups, which includes rural residents. The risk associated with suicide and attempted suicide has been shown to increase with severe drought conditions and other hardships facing rural communities
- Diabetes detection and management targeted towards prevention, early diagnosis and self-management in rural, regional and remote areas
- Heart, stroke and vascular disease to improve prevention, treatment and management programs to reduce the impact of these diseases in rural areas
- Cancer, with a particular focus on support information and services for women with breast cancer in rural areas
- Chronic disease initiatives being actioned across Australia to assist people in rural areas
- Injury prevention and control plan recognises that rural regional and remote communities are at higher risk. Primary producers and farm workers are known to be one of the highest risk groups for occupational injury, illness and disease
- Arthritis and musculoskeletal conditions
- Substance abuse initiatives to minimise harm, including health information, education and counselling.

Isolation issues for rural practitioners: professional, social and geographic

Studies reveal that some of the major concerns to health professionals considering rural practice were related to professional and social isolation (Mitchell; NRHA; Pashen & Germain in Leggat 2003). This sense of isolation has been confirmed in consistent findings that rural and remote physiotherapists, for example, had more diverse roles and less access to multidisciplinary teams than those physios working in larger communities (Butler et al and Sheppard in Leggat 2003).

Belonging to the community in which you work brings a layer of complexity unique to rural practice. At the same time generalist practice in rural settings may offer the advantage of the opportunity to develop and practice with a wide range of skills. The strains come from high visibility, dual and multiple roles, boundary overlap, confidentiality, personal privacy and safety (Green in UHPCP 2004). Issues of privacy, confidentiality and choice are also exacerbated within the confines of small town living (Manaszewicz, Fisher, Williamson & McKemmish 2002; Bell 2001; Shepherdson).

Professional supervision and mentoring

Good quality supervision has been demonstrated to be a key factor in job satisfaction among human services personnel. This standard of supervision requires organisational commitment to resources, planning, and valuing of the practice, and should include the three functions of administration, support and education, as described by Kadushin (UHPCP 2004).

The Auckland District Health Board's Professional Supervision of Allied Health Practitioners policy document (Mueller 2004 pp 3-5) defines supervision and its value to health practitioners.

Supervision is a formalised, regular, sustained process in which the supervisor enables and facilitates the supervisee in meeting their professional objectives. It takes place within a structured, contractual relationship between the organisation, the supervisor and the supervisee and is protected time for in-depth reflection on practice. Supervision aims to enable the supervisee to achieve, sustain and develop a high quality practice through the means of focused support and development.

Supervision is an important component of the practice of every health practitioner and should continue throughout their career. Whilst effective supervision should include discussion of self, *it is not a counselling relationship*. Personal issues may be identified and appropriate services will be arranged to manage these issues external to the supervision relationship.

Functions of supervision for all practitioners (will include)...providing input into service delivery...focussing on clinical work...(and) facilitating professional development.

Lack of supervision has been highlighted in rural research (Krieg Mayer 2001) as it was either not provided or focussed on maintaining agency standards rather than development of knowledge and skills.

The strains of rural practice can be mitigated by the provision of adequate supports, such as supervision. 'While rural practice offers significant advantages in relation to breadth of experience and independence, supervision and support are also required to ensure that confidence is maintained and that approaches to clinical practice remain contemporary' (CURHEV 1999 p 21).

The recent VURHC study found that AHPs in smaller rural towns were more likely to be dissatisfied with their professional support or supervision or mention these as a reason to leave. Therefore the researchers claim that improved peer and professional support may assist retention (Belcher et al 2005).

Some literature declares that employers must ensure that rural AHPs have access to same-discipline support, either on or off site, and that this may take the form of mentoring. 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 (Lee & McKenzie in Struber 2004).

Peer support and team approaches

Peer support (formal or informal) has been recognised in the literature as one of the key determinants in staying in a job. It has been argued that allied health has a model utilising peer support, case supervision and multidisciplinary assessment. This collegiate way of working is central to how many practitioners go about their jobs, therefore working as a sole practitioner is challenging.

Networking has been found to be a crucial component of rural/remote practice (Welch et al in Parkin et al 2001), and physiotherapists were better able to cope with stress when they sought support from colleagues and managers (Broom & Williams in Leggat 2003).

Social supports to reduce a sense of social isolation

Community, social capital and a sense of belonging have been identified as central to people's sense of wellbeing, according to the Australian Unity Wellbeing Index, compiled by academics and researchers from 3 Australian Universities. Social capital, that is the extent that people feel connected to others, has an enormous impact on how people feel about their lives. 'Feeling socially isolated is bad for wellbeing', according to Professor Cummins from Deakin University's Australian Centre on Quality of Life. Factors that increased wellbeing were perceived to be very difficult to achieve in urban centres, but appears to be highly evident in country towns. 'People in rural and regional communities are more dependent on each other and therefore become a more socially cohesive group. This has a very positive impact on their wellbeing. And the further towns

are away from capital cities, the higher their sense of belonging, safety and security' (Our Community 2005 p 10).

Scammon, Williams & Li (in Felix et al 2003) discovered the nurturing of newly recruited physicians can help integrate them into the community, which has been identified as a crucial factor in rural health care provider retention.

Cutchin et al (in Veitch, Harte, Hays, Pashen & Clarke 1999 p 206) demonstrated that 'sociocultural integration' is the pre-eminent retention issue for rural practitioners and that communities can play an important role in this regard.

Certain types of support networks have been shown to ameliorate work related stress and boost individuals' sense of self-efficacy and control (Bandura, Kavanagh in MacPhee & Scott 2002). Bandura has also shown that when people interact as teams in the workplace, a "collective efficacy" can be accomplished (in MacPhee et al 2002 p 265).

Leadership and management support in allied health

There is considerable consensus that committed leadership is essential for implementing best practice (Preston et al in Compton et al 1997). Leadership must happen at multiple levels of the workforce. Allied health professionals require leadership from the tops of organisations, within divisions and departments, within the various professions and from within allied health, as a separate entity (Compton et al 1997). Yet the AH workforce has been described as largely un-managed or under-managed and this has been attributed to the lack of meaningful participation, or mutual appreciation of goals, at the executive level of their organisations (Boyce 1996). Australian research indicated that the main contributing factor to the poor recruitment and retention of allied health professionals related to management (Fitzgerald et al 2000; Queensland Health in Ashworth, Battye & Symons 2004; O'Kane et al 2003; Best in Leggat 2003). The issues identified included:

- Appropriateness and effectiveness of a management and supervisory structure
- Lack of advocacy
- Inappropriate line supervision i.e. by non-allied health professionals or non-clinical people
- Lack of clinical and professional support (particularly sole therapists)
- Difficulties in accessing professional development due to geographic isolation, cost and lack of information technology access
- Lack of orientation
- Unrealistic expectations and pressure on allied health professionals for large caseloads including excessive travel
- Rigid work environments
- Failure to backfill or delay in recruiting vacant positions, leading to loss of esteem for the allied health positions and a backlog of work.

Medical domination of the health system has been a major factor influencing the histories of nursing and allied health professions. Traditional AHPs have been described as being "handmaidens" to medicine and shaped by "traditional 'feminine' attributes such as passivity, subservience and selfless devotion". However alongside significant societal changes, evolving changes to the delivery of health care have brought about a steadily growing independence for these professions (Belcher et al 2005 p 31). Given this background, there appears to be a greater tendency for managers to regard AH staff as autonomous. It has been suggested that by regarding allied health in this way, a degree of confusion may have developed between the issue of allowing allied health staff "*autonomy*" and leaving them to their own devices where they feel "*unloved and under-valued*" (CURHEV 1999 p 17).

Factors such as the leadership and vision of the organisation, the relationships between allied health professionals and their managers, staff morale and the management of change have been cited as affecting the sustainability of allied health in rural communities (Huntley & Boyce in CURHEV 1999). A key finding of sustainable models for rural allied health practice is that 'as an overarching principle, it is clearly important that there be a senior practitioner to manage and

represent allied health as a whole' (CURHEV 1999 p 12). This was corroborated in the SARRAH study which indicated that when the immediate supervisor was an allied health professional, more positive support/management structures existed to support the clinician in their professional role. Yet over half of their respondents indicated they were supervised by someone other than an AHP who were co-located (Fitzgerald et al 2000).

Orientation programs for new staff

New graduate orientation programs have been shown to be effective tools for recruitment and retention (Owens et al in Squires 2002). Rural health services may have difficulty attracting and retaining new graduates without such programs available to provide the necessary social, educational and emotional support to new grads (Squires 2002). This orientation should be extended to all new recruits, as research suggests orientation programs linking practitioners into social, cultural and sporting groups may accelerate the development of a sense of belonging to the community (Wolfenden in Washington 2004).

Career advancement

There are limited, if any, opportunities for allied health practitioners to advance in smaller rural organisations, and it is felt that retention rates are undoubtedly influenced by the fact that many practitioners are seeking advancement for professional as well as financial reasons (CURHEV 1999). Movement to higher level positions, be they middle or senior, are limited in rural services due to the smaller and flatter structure of the organisations and limited number of practitioners and grades (O'Callaghan 2005).

The absence of a clinical career pathway is a major factor influencing avoidable loss of experienced allied health clinical staff. There is a high level of dissatisfaction within the allied health workforce with the existing career pathway which is based on supervision of work units, not clinical expertise. Allied health professionals occupying sole positions and those in numerically small disciplines or teams are disadvantaged by the present application of the award, irrespective of their responsibilities and expertise.

This is a particular feature of rural and remote practice and a factor in undesirable turnover (Queensland Health 2001).

For younger AHPs, career opportunities both attract and cause them to leave in the short to medium term. Perhaps it may be realistic to consider successful retention of these practitioners as maximising their length of stay, which may be prolonged by supporting their individual career aspirations (Belcher et al 2005).

Issues of workload for rural practitioners

A proactive approach to the management of workload, including the distribution of work and the type of work undertaken appeared to be an important issue for rural allied health practitioners' job satisfaction (CURHEV 1999). It has been recommended that employers and AH managers should ensure that working conditions of AHPs are structured to maximise professional satisfaction and avoid occupational stressors. There should also be research conducted by DHS and professional associations to develop workload and staffing guidelines for individual professions to ensure that an appropriate number of positions are allocated to meet demand (Belcher et al 2005).

Lack of locum/leave relief

Studies on retention identify relatively consistent factors with a positive impact on retention rates for nurses, doctors and AHPs, including availability of locum cover (NRHA 2002, Battye & McTaggart 2003, Inoue et al in Leggat 2003).

Although not perceived as impacting on recruitment and retention in the same way as it does for GPs, the provision of locum relief is an issue for rural allied health practitioners. Evidence suggests that getting locum relief to attend courses or take leave was 'almost impossible' and seen as a barrier to practice by many AHPs (CURHEV 1999 p 21; NRHA in Motshidisi et al 2003). With less than 1 in 5 sole AHPs having access to locums for leave or professional development, this is likely to discourage them from taking any leave (Fitzgerald et al 2000).

When health services do not fund locums or relief for sick, recreation or study leave, this can adversely affect workloads and continuity of care. This situation is inconsistent when compared to the medical and nursing workforces. Rural recruitment challenges also have an impact, as when funding for locum relief is allocated in the budget, there is frequently no locum support available (Queensland Health 2001).

The VURHC study (Belcher et al 2005 p 8) found that AHPs were least satisfied with “the availability of locums”. This did not feature highly in the “like least” category, suggesting that lack of availability of locums is an accepted, or expected, part of rural practice.

Community of Practice as a project model

The evolution of this Central Hume allied health recruitment and retention project has evolved into a Community of Practice model, albeit unintentionally. Communities of Practice (CoPs) are described as ‘groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an on-going basis’ (Wenger, McDermott & Snyder 2002 p 4). Their purpose is to ‘cross organisational, sector and geographic boundaries to foster learning and innovation in specific topic areas’ (Snyder & Briggs in Amos & Goodrick 2004 p 2). The principal motivation to develop CoPs comes from their potential as an effective instrument for harnessing and managing both tacit and explicit knowledge. A CoP, when functioning effectively, will develop and share knowledge that builds social capital within the community and will influence knowledge to enhance practice. CoPs in health care have the capacity to build upon existing relationships and provide a vehicle that channels common interests and motivations to improve understanding and relationships, learning in practice and ultimately care for consumers.

Rather than attempting to simplify the practice and context, the CoP methodology embraces the complexity of the system, working with the multiplicity of interests to build capacity and responsiveness in an environment (Amos & Goodrick 2004).

Successful models and strategies of AH recruitment, retention & support

Specialists in the area of organisational performance and change assert that each organisation must analyse its own environment and adapt what it can from other “successful” organisations and models in terms of its own environmental needs. This is a necessary precursor to prevent fixed formula approaches and ideologies about management and organisation being a barrier to positive change (in Boyce 1996). To inform the development of an achievable and sustainable recruitment and retention framework for the future of Central Hume’s allied health services, other successful Australian and international models and strategies were explored.

Dr Nancarrow (2005) claims there are four directions in which the existing workforce can change: diversification, specialisation and vertical and horizontal substitution. Some models and strategies which encompass these directions are described below.

Community participation in recruitment and retention of health care professionals

Broad based community involvement in a community capacity building approach to recruitment and retention has been used successfully within Australia and North America, particularly for GPs, and this community building approach could be used by any rural community to play a key role in shaping their own futures, including allied health care. It is the community that best knows its needs and expectations, and are therefore best placed to create positive changes. Collaborative planning amongst shareholders that integrates local community support with government and professional strategies have been used. The underlying philosophy was that communities share responsibility for finding solutions to local problems and that locally supported solutions were better than imposed solutions. In these case studies, facilitators worked with communities & other significant groups to determine local needs, identify available resources and reach agreement on strategies that better match applicants to communities. There is a community resource manual for community capacity building in recruitment and retention published in Australia which would be valuable to assist this approach (Wallis undated; & Veitch et al 1999).

It has been surmised that if people settle in rural areas and develop family and social ties there, they are more likely to stay for the long term (Belcher et al 2005).

Case studies in 'best-in-class' ~ Divisions of Allied Health (Boyce 1996)

The objective of this project was to examine innovative approaches to rural and remote AH management and organisation and assess the utility of a comprehensive managerial approach as a strategy to redress identified problems and the general nature of AH practice. The innovative managerial approach identified was the *division of allied health* model. An overarching recommendation from the project findings is that models of organisation for allied health professionals should ensure that there are transparent processes for, and adequate resources to support, direct self-representation and meaningful participation in the full range of corporate/executive level policy, planning, financial and decision-making forums.

The *division of allied health*, as a model of organisation, contributes to the effective management of problems associated with rural allied health practice via 3 primary capabilities: the capacity to redress the neglect of the management function, the benefits of a 'whole of organisation' managerial focus and the development of a culture of allied health. This was achieved through innovation of the organisational structure as a departure from the traditional AH department reporting to a medical manager.

The role and competency of leadership is a factor which is associated with best practice culture and an environment which fosters innovation (Carr & Carnegie in Boyce 1996). In the project case studies, directors of allied health at Toowoomba Hospital and Whyalla Hospital and Health Service were widely acknowledged as significant players in shaping the rural allied health agenda in local, regional and national contexts.

Observations that rural allied health staff typically report to the executive through either a medical superintendent, director of nursing, director of community health or CEO, led to conclusions that it

did not confer any real measure of control to allied health personnel over their respective destinies. Moreover, such lines could not be expected to bring to bear special knowledge or an intimate understanding of allied health service delivery. This could clearly redound to the disadvantage in the representation of allied health interests in executive forums (Gadiel & Ridoutt in Boyce 1996).

Very positive recruitment and retention outcomes for both case study sites were consistently attributed to the implementation of a structurally-mediated management framework in which there was clear AH organisation and infrastructure which was led from the top through the office of the director of allied health. It was determined that a strategic framework underpinned by a division of AH model would deliver greater certainty of supply in the AH workforce, greater job satisfaction in the existing AH workforce and better HR and financial management in relation to AH services. This is due to the 'concentrated focus given to allied health issues and the organisation expectation of human resource management development and cross-professional problem-solving' (p 29).

Succession Planning (McKinnon & Collins undated)

The principles of succession planning have been used as a framework to guide the development of an integrated allied health management model. A commitment to management and leadership training and the identification of opportunities for staff to undertake other roles to broaden their expertise also supported the model. Northern health found these key strategies underpinned their retention strategy, with fewer vacancies, vacancies were easier to fill and there was an increased number of applications for advertised positions.

North West Queensland Allied Health Service (Stanley-Davies & Battye 2004)

The Commonwealth Regional Health Strategy was identified by the Northern and Western Queensland Primary Health Care (formerly the Northern Qld Rural Division of General Practice) as an opportunity to address the gaps in allied health services in North West Queensland. The Commonwealth Regional Health Strategy targets rural and remote communities with populations of less than 5,000.

The planning process identified several key requirements of an outreach model to meet the needs of the target communities. These were:

- Provision of regular and reliable allied health services delivered in a culturally sensitive and appropriate manner, operating in the paradigm of Primary Health Care
- Successful recruitment and retention of appropriately skilled and experienced allied health professionals
- Development of community participation including capacity building, health promotion and 'therapy assistants' within the communities to provide or monitor ongoing treatment between allied health professional visits, and
- Successful integration of the NWQAHS with other service providers.

The NWQAHS delivers services using a hub and spoke model, with Allied Health Professionals based in Mt Isa. The disciplines provided include physiotherapy, podiatry, dietetics, occupational therapy, speech pathology and psychology.

The model was developed in response to the context in which communities wished to see services delivered, as well as addressing obstacles to the recruitment and retention of allied health professionals in rural and remote practice. The key features of the outreach allied health service model proposed in the original submission were:

- Allied health professionals travelling in functional teams
- Development of a 6 month calendar of service delivery in conjunction with other visiting services to avoid clashes with other services in the communities
- Each community visited on a 6 weekly basis, but AHPs spending 2-3 days in the community (dependent on population), in order to undertake direct one to one service provision as well as develop primary health care activities
- A centralized booking number for referrals
- Development of therapy assistants in each community to support follow-up care between allied health visits, and develop skills of local people
- Use of videoconferencing to support the therapy assistants, clients and carers
- Case conferencing with local health professionals at each visit
- Transport by charter aircraft to the Gulf and Highway precincts to minimise clinical time lost to travel, and enable service provision during the wet season.

The model also included the development of a cost recovery practice in Mt Isa in order to improve access to allied health services in the regional centre, and also to create a second funding stream to support the employment of additional allied health professionals in order to spread the outreach load across a greater number of people and sustain service delivery.

The recruitment and retention strategy developed for the NWQAHS sought to address the professional and personal factors identified by the Australian studies. The professional factors included:

- Line management by an allied health professional
- A salary package recognizing the complexity of service delivery and responsibility of working in an isolated or solo position, the arduousness of travel, compensate for the increased cost of living in rural and remote areas, and personal cost of relocating away from the generally preferred urban or coastal centres and from family and friends
- Development of service delivery schedule and staffing requirements so that allied health professionals would not be working in communities more than 50% of the time

- Access to professional development i.e. expenses for attendance at a minimum of two conferences per year
- Orientation to remote practice and indigenous cultural awareness through compulsory enrolment in the Graduate Certificate in Health (Remote Health Practice)
- Professional mentoring.

The personal factors included:

- 6 weeks annual leave
- Annual airfare back to “home”
- Housing subsidy of \$150/ fortnight
- Assistance with relocation expenses
- Assistance in finding employment for partners or spouses
- Childcare subsidy.

The complexity of the position for allied health professionals working in North West Queensland is a result of the diversity of the communities in which they work, and the need to operate differently in the indigenous communities compared to the pastoral communities i.e. more community focused activity compared to one on one service delivery; and the diversity of working in the cost recovery practice compared with outreach. Strategies identified to address the complexity of the positions include (and are not mutually exclusive):

- Developing rosters where an individual is assigned to a community “type” if this is preferable to having a mix of communities
- Allocation of staff to work only in the cost recovery practice for a period of time
- Identifying Mt Isa as a “place” or community and scheduling time for the cost recovery practice
- Discontinue reliance on solo disciplines and recruit at least two of each discipline as a retention tool; to reduce reliance on locums; and increase capacity to cost recover in Mt Isa
- Increased utilization of administrative support personnel for appointment booking and client scheduling

A policy of the NWQAHS is that there is no criteria to be met to allow access to the service. It has been recognised that delivery of this outreach model is more expensive than delivery in provincial or metropolitan centres, however the evaluation demonstrated the following key positive impacts on the health and wellbeing of people in the target communities categorized into:

- Assisting agencies within communities to develop capacity to manage individual clients locally
- Assisting agencies to expand the range of services they can provide
- Supporting older people and people with disabilities to remain in their own home and community rather than being placed in institutional care in regional centres
- Facilitating the early discharge of patients from tertiary and base hospitals back to their local hospital for management eg. road trauma, head injuries
- Savings to the District Health Service under the Patient Transport Scheme as clients (and often carers) can be treated locally rather than travel to Mt Isa or Townsville
- Providing speech and occupational therapy services to children who would not have been treated within the education system due to lack of capacity or severity of disability below threshold for services.

The NWQAHS has also impacted on the viability of other services by meeting shortfalls in capacity to assess and treat clients, creating a critical mass of allied health professionals to assist in recruitment to other agencies, providing debriefing and counselling services to local community service providers eg. police, SES workers, providing clinical expertise to non-clinical ATOD workers, and mental health professionals to improve client management and provide professional support.

Addressing the shortage of female GPs in rural Australia: a way forward (Velez 2005)

While these strategies are aimed specifically at recruiting female GPs to rural and remote areas, the strategies have transferability to other health professions. The National Rural Female GP Steering Committee suggests several recruitment initiatives to local communities implementing local recruitment solutions:

- √ Consult with the potential or new recruit to assess their partner's (if applicable) employment or recreational needs. Offer workforce support for partners by contacting local councils, organisations and small businesses and putting forward possible employment opportunities and contacts
- √ In some areas, service clubs such as Rotary will provide assistance in finding accommodation and/or help with social orientation within the new town. Undertaking a range of promotional measures to raise the profile of the district's leisure attractions will also encourage the recruit to consider settling more readily and more permanently in the community
- √ Providing adequate childcare arrangements, which may incorporate services being run by locals in their homes to assist with the shortage.

Managing Age and Work Ability (Rolland 2005)

For every new young person entering the Australian workforce today, 7 people over 45 are available. Migration is one solution to skills shortages and a major Australian strategy, however studies have shown increasingly that 55-64 year old age group participation in the workforce (currently 50% in Australia – low by OECD standards), has proven to be more useful. The *Managing Age & Work Ability* model from Finland is a holistic & integrated approach to age management rather than discrete interventions, and based on 4 actions: adjustment to physical work environment; adjustment to psycho-social work environs; health promotion and updating skills.

Creating sustainable practice supervision in the allied health mental health workforce, (Hall F 2005)

The practice supervision policy as it relates to allied health in mental health was developed and implemented in Queensland Health Mental Health Services beginning in 1998. Embedding practice supervision in workplace culture was essential for the success of the state-wide policy, driven by strong leadership at a local level. A top-down, bottom-up implementation of supervision: policy, leadership, MOUs, supervision training operational plans and an on-line supervision resource centre from the top down. Bottom up was agreements signed off by practice supervisors and line managers, links to performance appraisals, flexibility in delivery, sustainable training and follow-up, and developing networks of supervisors and supervisees.

Tribes, nations and professional supervision in the healthcare environment, (Mueller 2005)

Following a major organisational restructure in 2002 within the Auckland District Health Board, professional supervision was identified by the allied health staff as an area which needed immediate attention. An integrated supervision policy was developed for the 650 AH staff across the organisation from 9 different professional 'tribes'. This policy incorporates a set of principles and a decision tree when to support external supervision.

Recruitment begins at the undergraduate level (Hillbig 2005 and Neumayer 2005)

The physiotherapy department at the Angliss health service stresses the effectiveness of a quality undergraduate student program as an effective recruitment strategy for allied health. The student program has been their most effective recruitment strategy in the past decade by providing the opportunity to promote their assets of people and culture, in an environment conducive to optimal learning. A current review of staff showed 70% were former students. This concurs with the Albury campus of Charles Sturt University, with 70% of their AH graduates employed rurally.

Health workforce design for the 21st century -

Increase skill mixes and numbers and scope of practice of AHAs (Duckett 2005) and

Implications for workforce supply, having the 'right' numbers in the 'right' place at the 'right' time (AHMC 2004)

There are current recorded shortages of most health care professionals, but there is an argument that future workforce planning should not be based on providing more of the same, but rather the roles of health professionals will need to change and workforce planning needs to place a stronger emphasis on issues of workforce substitution, i.e. a different mix of responsibilities. This will also require changes in educational preparation, in particular an increased emphasis on inter-professional work and common foundation learning. In the future there will be an increasing reliance on multidisciplinary group practice, with a possible move from AHPs treatment performing to treatment prescribing: assessment & referral.

Workforce substitution vs. workforce growth will see an increased mix of multi-skilled AHPs (rehabilitationists) and para-professionals (trained at TAFE level) Allied Health Assistants (AHAs). This is a contentious issue by AHPs – professionally threatening to AHPs to increase support workers/AHAs. Duckett's view (vs. that of professional associations) is that increased number of therapists in itself is not necessarily a good thing in itself – instead give them more intellectual stimulation & cognitive higher order skills to do, graduate same numbers of AHPs and increase numbers and scope of the role of AHAs.

The Australian Health Minister's Conference concurs, in their National Health Workforce Strategic Framework. There is a continuing need for currency of planning advice and data collection that support this planning. Beyond planning there are also clear implications for strategies around both retaining the existing workforce and putting in place future supply. This however is still pretty much the status quo, with probably an increase in numbers. The more challenging issue will be that types of health care workers will likely change and that these changes will also be impacted by technology. So ensuring the right practitioner mix will be crucially important and this is likely to involve a mixture of new disciplines and new roles for old disciplines. Boundaries and established professional roles will need to evolve; and new knowledge and skills will be acquired, maintained and expanded. In all this there will be issues of 'turf', affordability, priorities, incentives, disincentives, payment and the traditions.

The most common model of AH service delivery is the traditional one-to-one direct service provision by an AHP. This is felt to be an ineffective model of service delivery to rural communities when outreach services are infrequent and wait lists are lengthy. There is scope for better use of therapy assistants and support personnel, given that competencies can be defined, appropriate training is available and acceptable levels of supervision can be arranged (Queensland Health 2001).

Assistant practitioners – issues of accountability, delegation and competence, (Mackey & Nancarrow 2005)

The UK NHS Modernisation Agency, alongside workforce shortages in occupational therapy, has led to increasing interest in the role of assistant practitioners (APs) in the delivery of health and social care. APs were introduced and evaluated in OT, empowered to work independently in a limited number of interventions and services within an NHS Trust. Their definition of an assistant practitioner is: 'A support worker who through extra education and training is able to practice autonomously, making clinical decisions & instigating treatment based on those decisions, and is accountable for his/her own practice'. The evaluation concluded that issues of accountability, delegation and competence of assistant practitioner roles need to be clarified to optimise the relationships between staff, clarify the roles of team members, and ensure service users receive the most appropriate care from the most appropriate practitioner. It was also recognised that the AP profession needs to have career advancement opportunities too.

Addressing disparities in access to mainstream health care services for Aboriginal and Torres Strait Islander populations (Jessup 2005)

The Aboriginal and Torres Strait Islander (ATSI) population have a life expectancy 20 years lower than non-Indigenous Australians. Traditionally utilisation of mainstream tertiary health services by this target group has been low. Northern Health and a university collaboratively offered a position to an ATSI to study Podiatry, while concurrently working as an Allied Health Assistant. The position recognises that up to 19% of ATSI have diabetes, increasing to over 55% of the older Indigenous population. This position was supported through Commonwealth funding through the National Indigenous Cadetship Project, \$15,700 paid to the cadet plus travel to school/work. Full-time study & 12 week work placement – 4 year undergraduate degree. University provides HECS free & tutorials. Northern Hospital has used this for an Indigenous podiatry clinic. 1900% increase in ATSI client use of services, 2 elders referred to other services @ NH, large amount of community support for the position. Clinic trialled at the hospital but changed to home visits due to Koorie time.

Workforce flexibility – balancing the needs of the individual, the team and the department (McCallum 2005)

The Speech Pathology Department of Princess Alexandra Hospital has had a challenge of retaining the valued skills of experienced clinicians on a job share or part-time basis under parental leave provisions. Queensland has a policy of offering part-time employment upon return of maternity leave up to the child's 2nd birthday. The impact of corporate work life balance policy and flexible work practices has been evaluated, and a working party formulated guidelines, a set of principles, a yearly departmental plan and an agreed departmental culture to support flexible work practices.

Orientation programs (Millsteed 2001; Leggat 2003; Mills et al 2002)

The difficulties associated with providing discipline specific orientation or handover in rural settings have been noted, yet other strategies can be utilised. All staff should receive at a minimum a generic orientation to the health service, the clinical setting, responsibilities of the position and general introduction to the community. Combined, these give therapists an idea of the structure and dimensions of the position, provide a sense of what is expected from them and provides a more detailed orientation to their new community. Recruitment material should include community orientation and rural lifestyle promotional packages, and new recruits, prior to commencing in the position, should be supplied with information packages incorporating community facilities, local attractions, sporting clubs and community groups.

Job rotations (Queensland Health 2001; Leggat 2003; Belcher et al 2005; LMRSSB 2002)

Recommendations from both Victorian and Queensland research suggest implementing mechanisms and funding to support staff rotations, secondments and exchanges between metropolitan, regional and rural sites. This would assist with greater professional experiences, development and support, as well as increasing the understanding within metro practices of the nature of rural allied health practice so that skills required for rural practice are awarded greater recognition in metro areas, and encourage metro AHPs to broaden their approach to flexible service delivery. It would also assist networking, peer support, resource sharing and may offer a number of practitioners who are familiar with various workplaces to be available for locum & leave relief.

Mentoring as a form of professional support

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 (Fitzgerald et al 2000; Casey & McKavanagh; NRHA in Struber 2004).

MentorLink-Allied Health is an initiative of the Allied Health Professions Alliance (Vic) and is a facilitated mentoring program open to occupational therapists, physiotherapists, podiatrists, social workers and speech pathologists working in both the public and private sectors across Melbourne and rural Victoria (MentorLink 2005). An evaluation of the then MentorLink program was completed under the auspices of OT AUSTRALIA Victoria, and results indicated that the MentorLink program was successful and that it met its anticipated goals (Wilding 2003), however there is some question as to continuity of funding post December 2005 for this program. If it were to continue it may be a valuable source of support for rural practitioners within the scope of disciplines of the mentor program.

Rural Allied Health Network (Hall K 2005; RAHN 2005)

A Rural Allied Health Network was established in the Loddon Mallee region of Victoria in 2003 and is funded by the regional office of DHS. The approximately \$50,000 per annum funding is on-going and pays for a .5 network coordinator, the annual rural network conference and other services such as a monthly newsletter, assisting sub-regional groups & establishment of a website. The aim of the Allied Health Network is to assist with the coordination of professional development and to provide opportunities for allied health professionals to discuss sectorial and service issues. Assisting communication, co-ordination of professional development and support for allied health within the region are the primary goals of the network. The network reference group supports the operation of the network, provide links with organisations that can assist this process and provide guidance to issue resolution. A comprehensive evaluation has not yet been undertaken, however the evaluation mechanisms to date include: evaluations from two conferences, emails from individual members, IT survey completed and results of this provided to Loddon Mallee DHS office and ongoing regular meetings with DHS to discuss issues brought up through the network.