



S·A·R·R·A·H

Services for Australian
Rural and Remote Allied Health

Position Paper

Provision of Allied Health Services to Australian Regional & Remote Aboriginal and Torres Strait Islander Communities

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Introduction

Services for Australian Rural and Remote Allied Health (SARRAH), is a nationally recognised peak body representing regional, rural and remote allied health professionals (AHPs). As a 'grassroots' organisation its membership consists of individual AHPs across regional, rural and remote Australia. SARRAH's primary objective is to develop and provide services to enable AHPs who live and work in regional and remote Australia to confidently and competently carry out their professional duties in providing a variety of health services.

The term allied health incorporates a core group of professionals which includes but is not restricted to: Audiologists, Dietitians, Occupational Therapists, Orthoptists, Physiotherapists, Podiatrists, Prosthetists/Orthotists, Psychologists, Radiographers, Social Workers, Speech Pathologists, Pharmacists, Optometrists and Oral Health practitioners. The focus of each profession is provided in Appendix A.

The purpose of this paper is to provide guidance and support for employers, service providers and funding bodies aspiring to establish a high quality Allied Health Service in regional and remote Aboriginal and Torres Strait Islander Communities in Australia. The paper outlines SARRAH's principles and guidelines on Allied Health service delivery for residents of these communities and the effective recruitment and retention of Allied Health staff. SARRAH finds the current gap in health outcomes between Indigenous and non-Indigenous Australians unacceptable, and supports the Close the Gap campaign.

Regional and Remote Context

On a wide range of health measures the 34% of Australians living in regional and remote areas (see Table1) do worse than those living in major cities. Overall health status worsens on a continuum as you move away from metropolitan centres. Contributing factors include:

- Social and economic disadvantage including reduced opportunities for education and skilled employment (Table 1) and higher costs of living;
- Poorer access to health services and a range of health professionals;
- Higher levels of health risk behaviours such as smoking, risky drinking and lack of physical activity;
- Environmental factors including poorer housing, distances traveled and higher risk occupations; and
- Disproportionately large Aboriginal and Torres Strait Islander (A&TSI) populations (Table 1) with poorer overall health.

Table 1: Selected characteristics of populations by remoteness area (AIHW, 2006)

	Major City	Inner Regional	Outer Regional	Remote	Very Remote	Total (Percent)
Total population	66	21	10	2	1	100
A&TSI population	30	20	23	9	18	100
Population per area who are A&TSI	1	2	5	12	45	2.4
People living in most disadvantaged SEIFA* quartile	20	28	33	26	53	24
People living in least disadvantaged SEIFA quartile	34	14	8	10	2	26
Adults not in workforce or unemployed	41	46	43	35	39	42
Adults employed in primary production and mining	<1	4	11	20	16	3
Youth starting tertiary study	39	26	23	12	10	33

* SEIFA refers to Socio-Economic Indexes for Area and is used by the Australian Bureau of Statistics as an index of relative socio-economic disadvantage.

Aboriginal and Torres Strait Islander Communities

While A&TSI people in the cities tend to live as dispersed minorities, as one moves away from the cities, A&TSI people tend to form larger proportions of the regional populations, and to cluster in communities where they form the majority of the population. 92,960 (20.4%) A&TSI people live in 1,187 discrete communities dotted throughout the rural and remote landscape (ABS, 2006). While most communities are small family outstations, the majority of the remote, if not regional or rural, A&TSI population is clustered in just 107 communities of more than 200 people, where health and other services tend to be located. These larger communities are located in regional and remote areas of New South Wales (3), South Australia (7), Western Australia (14), Queensland (32) and the Northern Territory (51) (Ellis & Kelly, 2005). Only 17 discrete A&TSI communities have populations greater than one thousand, and most (14) are located in Queensland and the Northern Territory. The largest community contains less than 2,500 people. Each community is unique in its culture, language and history, and requires a localised response developed to meet expressed community needs.

There is only one statement that holds true for all A&TSI communities: regardless of where they are located, they present a picture of poverty, disadvantage and inequity compared to mainstream communities, regardless of which measure is used to assess this.

The small, dispersed nature of A&TSI communities, regional mobility of populations, lack of the infrastructure required to establish and maintain health, the extraordinarily high levels of morbidity and mortality, extreme poverty and disadvantage, all pose challenges to the delivery of safe, high quality health care, and serve as strong drivers for innovation.

Despite the drive to innovate to overcome these challenges and to provide culturally appropriate care, the duty of care of health service providers is not mitigated by the context of care, and innovation

should only occur if professional standards in relation to safety and quality of care can be maintained. A&TSI communities should be provided with high quality, culturally appropriate, evidence-based AHP care, which is in line with national standards.

Allied Health

AHPs contribute substantially to improved health as part of multi-disciplinary teams providing community based care. Yet rural and remote areas have less AHPs per head of population than urban areas in remote areas. A&TSI communities in remote areas often have very little or no access to AHPs

A key feature of remote allied health service delivery is the strong partnerships with communities which promote participation, develop community capacity and support the provision of quality, culturally appropriate and accessible services (Dade Smith, 2005).

Service Development

Current Infrastructure

Remote AHPs have traditionally been employed within state/territory government public health and community health services. However, in recent years allied health services have been expanded under Australian government rural and regional health funding initiatives with services now being provided by non-government organisations such as Aboriginal community-controlled organisations, Divisions of General Practice and the Royal Flying Doctor Service.

Principles of Allied Health Service Delivery

Working in rural and remote areas of Australia can be a very rewarding career option, but also brings with it many challenges. Due to the complexity of care needs, the youth and inexperience of much of the AHP workforce, and the diversity of cultural, geographical & professional environments, it is important that AHPs are provided with optimal support and resources to enable them to provide high quality services within this unique and challenging environment.

SARRAH has developed a set of principles to guide the development of allied health services in remote A&TSI communities. Key principles include, but are not restricted to:

- a. Effective engagement with remote A&TSI communities;
- b. Development and support of the local A&TSI health workforce;
- c. Integration with existing structures and programs delivering services to A&TSI communities;
- d. Striving to meet community-expressed needs, without compromising the quality and safety of care provided or exposing the practitioner or client to any risk of harm;
- e. Adherence to professional and ethical standards set by professional and other regulatory bodies;
- f. Coordination of services provided by state and other allied health providers;
- g. Delivery of services through multi-professional primary health care teams;
- h. Inclusion of principles of community development in service delivery; and

- i. Inclusion of appropriate evaluation to ensure delivery of effective services that are responsive to expressed community need. This should include feedback from community members and consumers of allied health services.

Service Delivery Framework

Employing organisations should be appropriate to meet the needs of communities as well as providing a supportive environment for AHPs to ensure effective service delivery. This includes providing appropriate management structures that recognise the particular support needs of AHPs working in remote A&TSI communities.

There are a number of possible approaches to planning the delivery of remote allied health services. The preferred option is a 'hub and spoke' model. This is based on the concept that a central employer will enable recruitment of the 'critical mass' of AHPs required to provide a multi-disciplinary team to service remote A&TSI communities.

Using this model, the central employer should develop Memoranda of Understanding with each community describing the type and frequency of services to be provided. North and West Queensland Primary Health Care and the Royal Flying Doctor Service have successfully used 'hub and spoke' models to deliver sustainable allied health services to remote A&TSI communities in Queensland.

Community organisations that prefer to employ their own individual AHPs will need supportive networks and clear strategies to achieve effective recruitment and retention and professional support.

Community Partnerships

Employers should encourage, support and enable AHPs to dedicate time during each visit to develop and nurture community relationships. Infrequent fly in / fly out services without opportunities to develop relationships are of limited effectiveness. If this is the only option then links with the local workforce will be the key to success.

The ability of AHPs to access communities in a meaningful, effective and sustainable way, can be enhanced if they work in collaboration with the local A&TSI and health workforce. This approach improves the cultural safety of both practitioner and client. Remote allied health service planning should include appropriate levels of funding for the employment, training and mentoring of local community members in community based co-worker roles, to ensure program sustainability.

The community itself should have input into the design, development, delivery and evaluation of AHP services, which should aim to meet expressed community needs.

Risk Management

An essential step in developing any new service is a risk assessment of any hazards that staff may be exposed to as part of their roles. In addition to this, on-going *organisational* risk assessments should

be an essential component of service development to monitor clinical governance and potential risk to clients. These assessments should be reviewed each time changes or innovations in service delivery occur.

Policies should be developed to manage these risks, and employment contracts should include a requirement to adhere to organisational occupational health and safety and risk management strategies (SARRAH, 2000). This is particularly salient for remote AHPs, many of whom tend to be young and female, who are required to provide community based care in distant and disadvantaged communities.

A requirement that AHPs accept on-going professional supervision, adhere to the standards of care set by their profession, and abide by the need to develop and deliver evidence-based care, can assist in managing these risks. Overconfidence in AHPs with less than 12 months experience in A&TSI communities should be monitored, and closer supervision provided to manage any professional and organisational risks associated with this.

Evaluation

Effective evaluation mechanisms must be built-in during the development stage of service delivery. Programs and services should be subject to performance indicators relevant to remote communities that demonstrate effectiveness of services and contribute to the evidence base for remote allied health service provision with the Measuring What Counts program as an example. Any evaluation should include feedback from A&TSI consumers of the AHP service.

Organisational Support

SARRAH, with appropriate funding and resources, could support employers by providing advice on recruitment, management structures, and on-going professional support and supervision for AHPs.

Staffing

Remote areas frequently attract new allied health practitioners (those who have graduated in the past two years), often because the positions are offered at the base grade level. Despite this low grading, practitioners are often expected to work at a higher skill level, across a broader range of activity and with less professional support than would be expected in metropolitan areas (Harber, 2005). Job satisfaction and retention can be reduced by conditions such as working as a sole therapist, difficulties collaborating with their colleagues and lack of a supportive environment (Bent, 1999).

High levels of job related stress are a feature of remote health practice. Preventable job related stresses include: health care provision beyond legal and professional boundaries; health care practice beyond training; lack of adequate orientation and preparation; lack of policies, protocols and evidence-based guidelines; conflicting and unrealistic expectations of remote practitioners; and a lack of cross cultural education (Kelly, 2002).

Cultural Competence

Many remote AHPs have not worked with A&TSI peoples until they come to their job, and generalised cultural awareness courses may not be complete or appropriate for the local environment and conditions. AHPs may wonder whether they are offending people, doing things 'the right way' or imposing themselves upon unwilling communities or individuals. This can reduce confidence and job satisfaction. Unless a level of cultural competence is achieved service uptake will be limited.

In order to promote cultural competence, AHPs need to be supported to attend cultural safety / competence courses (rather than simply cultural awareness) and provided with information specific to each of the communities they will be servicing. AHPs should also be encouraged to create and nurture links with A&TSI community members, cultural brokers and community co-workers, who can provide them with ongoing education and cultural mentoring opportunities, as well as inform the community about what type of services the AHP can offer.

Professional Development

AHPs need to continue building their skill and knowledge base, and if they are not supported to access these opportunities they will be unlikely to remain in their positions. They should be encouraged to be involved in their professional associations and related interest groups, and supported to undertake further study and training (SARRAH, 2000). An allocation of funding and paid study days should be incorporated into workplace agreements, taking into account the degree of remoteness and associated travel requirements.

Salaries

Salary packages for remote AHPs need to reflect and offset the increased cost of living and the challenges of living in a rural or remote area, including reduced access to goods and services. The literature suggests that for the regional and remote environment, AHPs should receive above-award wages, rental allowance, study allowance and leave, six weeks annual leave and a mentoring allowance (Allen, 2005). The ability to salary sacrifice may also be an incentive.

Management

Management issues may include lack of professional support, inadequate orientation processes, and lack of understanding and recognition of AHP services, skills, knowledge and roles. These are compounded when rural and remote AHPs, who are often sole practitioners, are managed by non-AHPs (Bent, 1999). Non-AHPs may not be aware that AHPs are required to adhere to professional and ethical standards set by their profession and other regulatory bodies and may be personally liable if these are breached. Good management should ensure access to discipline specific mentoring and supervision (Fitzgerald, Hornsby & Hudson, 2000), cultural mentoring systems, and support for AHPs to effectively meet their duty of care to their client group and other legislated requirements set down for their profession.

AHPs should be integrated into the broader health team, valued for their professional opinions, and have the opportunity to input into the strategic directions of their organisation.

Education

Although many of the allied health professions are educated in universities with a multi-disciplinary focus, only a small proportion of the curricula are designed to develop the teamwork skills necessary post-graduation (Duckett, 2000), and few provide A&TSI content in undergraduate curricula. Collaborative education options are needed which provide on-site education for allied health students to better prepare them for working in multi-disciplinary teams and provide realistic perspectives of working in rural and remote A&TSI communities. Flexible study options for post-graduate programs that consider the needs of rural and remote A&TSI populations are also required (SARRAH, 2000).

Conclusion

If remote AHPs are to be effective and sustainable in their roles, they require support to safely adapt to their roles in A&TSI communities. Identified issues need to be addressed through strategies such as:

- Educational and employer-sponsored programs which adequately prepare AHPs for practice in rural and remote A&TSI communities;
- Careful development of services including management structures;
- The provision of appropriate orientation and on-going cultural mentoring, which has the aim of developing cultural competence of AHPs and AHP services;
- Rigorous on-going discipline-specific professional supervision;
- Access to enhanced employee assistance services so that early detection and intervention can occur if difficulties arise; and
- Implementation of strategies to mitigate the effect of some of the stressors associated with rural and remote practice (Kelly, 2001).

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APPENDICES

Appendix A

Allied health workers

Occupational Therapist:	Assesses the function of people whose abilities and daily activities are impaired.
Optometrist:	Performs eye examinations and vision tests to determine the presence of visual, ocular and other abnormalities, and prescribes lenses, other optical aids or therapy.
Physiotherapist:	Assesses, treats and prevents disorders in human movement caused by injury or disease.
Speech Pathologist:	Assesses and treats people with communication disorders including speech, language, voice, fluency and literacy difficulties or people who have physical problems with eating or swallowing.
Podiatrist:	Prevents, diagnoses and treats medical and surgical conditions of the feet, including those resulting from bone and joint disorders, muscular pathologies as well as neurological and circulatory diseases.
Dietitian:	Assists individuals, groups and communities to attain, maintain and promote health through good diet and nutrition.
Audiologist:	Provides diagnostic assessment and rehabilitation services related to human hearing defects.
Orthoptist:	Diagnoses and manages eye movement disorders and associated sensory deficiencies.
Orthotist:	Designs, builds, fits and repairs splints, braces, callipers and related appliances to restore functions or compensate for muscular or skeletal disabilities.
Psychologist:	Psychologists practice in a range of specialist areas. The most commonly known specialisation is a counselling or clinical psychologist. However, psychologists specialise in industrial and organisational settings, education, community issues, sport and health.
Radiographer:	Radiographers operate X-ray and other imaging equipment to produce radiographs (X-ray films) and other images which are used in the diagnosis and subsequent management of disease or injury.
Social Worker:	Social workers help people to deal with personal and social problems, either directly or by planning or carrying out programs that benefit groups or communities.
Pharmacist:	Pharmacists supply, dispense and manufacture medicines and drugs in hospitals and community pharmacies, and advise on their

appropriate use.

Oral Health practitioner: Oral health practitioners such as dental therapists or dental hygienists, can diagnose oral conditions and manage the care of the patient across the decades of life.

Therapy Aide: Provides assistance to occupational, diversional or physiotherapists in therapy programs and care of their patients.

Source: Adapted from ABS/AIHW 'Health and community services labour force, 2001'.