

Strengthening the allied health workforce: policy, practice and research issues and opportunities

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This special issue of *Australian Health Review* features original research articles, reviews and perspectives dedicated to the theme *strengthening the allied health workforce*. Of the total health workforce, more than 126 000 are registered allied health practitioners in Australia.¹ With the growing demands upon the health system from patients with complex and chronic conditions, there is a resurgence of interest in strengthening the allied health workforce. At the 2014 Victorian Allied Health Research Conference, the allied health workforce was viewed as the *glue in the health system with the potential to ease the pressure off the health system and to create system-level resiliency*.²

It is timely to reflect upon the allied health workforce, as over a decade ago a comprehensive review was conducted of the allied health workforce by the Australian Health Ministers' Advisory Council (AHMAC) to inform national-level workforce planning.³ The 2004 AHMAC review highlighted multiple key issues facing the allied health workforce, and multiple key actions areas under four key domains: workforce roles; data collection; education and training; and national structures. Later in this editorial I briefly reflect upon the substantial allied health workforce developments that have occurred since the 2004 AHMAC review.

In this special issue of *Australian Health Review* we publish a series of papers that aim to contribute to the evidence base to inform decision-making regarding allied health workforce policy, practices and research.

We start with two perspectives. Philip⁴ emphasises the unrealised potential of how allied health can address the many challenges facing the health system. Markham⁵ then highlights that the time has come to recognise that allied health leaders and clinicians can have an active role in leading health care reform.

Over the last decade, many national- and state-level, policy-focussed consultations and reviews of the allied health workforce have been conducted. Nancarrow *et al.*⁶ report on the findings of the Queensland Health Ministerial Taskforce review of the expansion of scope of practice of allied health roles. Skinner *et al.*⁷ then canvases key issues (regulatory, educational, evidence) that need attention and development to optimise allied health work in specialised advanced and extended roles. Pearce and Pagett⁸ provides a case study of the emerging role of allied health assistants in the Australian

Capital Territory. With the recognition that allied health assistants need to be working to their full scope of practice, Somerville *et al.*⁹ present a model to assist services to identify tasks suitable for delegation to an allied health assistant by an allied health professional.

Patient-centred care is a widely recognised underlying principle of all models of service delivery in health care. Harding *et al.*¹⁰ describe the findings of a qualitative study of patient's experience and perception of being seen by an expanded-scope-of-practice physiotherapist, specifically a musculoskeletal physiotherapist. Harding *et al.*¹¹ then also describes the process of developing a clinical education framework designed to support physiotherapists undertaking advanced musculoskeletal physiotherapy service roles.

With the increasing demands upon the health system, health workforce retention is a significant issue, especially in the hospital setting. Wilson¹² provides evidence that job satisfaction is an important predictor of intention to leave for allied health professionals working in metropolitan hospitals.

While compliance with evidence-based practice is a given, Ziviani *et al.*¹³ provide insights from a survey of allied health staff to propose new organisational structures that are required to enhance evidence-based practice by allied health practitioners.

The last two papers focus on building and embedding research capacity within the allied health workforce. Williams *et al.*¹⁴ present findings of a cross-sectional survey of the allied health workforce within Victoria to inform how to engage allied health clinicians in research activities. The special issue ends with an investigation into the research culture within hospital allied health departments. Skinner¹⁵ focuses specifically on physiotherapists working in hospitals to advocate that hospital allied health departments establish research registers and other strategies to improve research culture and productivity.

All the papers contribute to our understanding of the nexus between allied health workforce policy, practice and research and are designed to encourage readers to engage in conversations to inform future allied health workforce innovation.

To set the scene for this special issue, I now briefly reflect upon the 2004 AHMAC review of the allied health workforce, presenting key issues and developments that have occurred since the 2004 AHMAC review (Table 1).

Table 1. Summary of 2004 Australian Health Workforce Advisory Committee allied health workforce review issues and actions (based upon Australian Health Minister's Advisory Committee review)

Domain	Key issues	Key action areas
Workforce roles	<ul style="list-style-type: none"> No clear and consistent agreement on who comprises the allied health workforce Differing interpretations of the occupations and disciplines comprising the allied health workforce 	<ul style="list-style-type: none"> Defining the term 'allied health' Career choices of allied health practitioners assessment of employment issues, workforce dynamics, recruitment and retention Indigenous allied health workforce Allied health scope of practice Support for allied health professionals
Data collection	<ul style="list-style-type: none"> Fragmented and variable data source quality Data sets are focussed on workforce supply and not on the projected demand for allied health services 	<ul style="list-style-type: none"> Development of better allied health workforce data sets Supporting allied health professional associations to collect data compatible with existing national minimum data sets
Education and training	<ul style="list-style-type: none"> Limited coordination between the health and education sectors with regard to allocation of funding and placements 	<ul style="list-style-type: none"> Improved coordination between the government and university sectors regarding university intake levels, and with the health sector Innovative models of education Options to reduce the pressure on clinical placements for the allied health professions
National structures	<ul style="list-style-type: none"> Effective allied health participation in national workforce processes 	<ul style="list-style-type: none"> Establishment of a National Allied Health Advisory Committee

Allied health workforce

A recent review of Commonwealth Government health workforce programs stated that, while the term 'allied health' was useful when viewed as a collective profession, it was still resulting in a lack of clarity about the identity and scope of practice of each allied health professional by referrers and patients.¹⁶ This potentially results in inappropriate referral practices and service duplication. The lack of an agreed-upon definition has also led to questions about the value and contribution of allied health to increased productivity in the health system.¹⁶ The development of new allied health assistant roles, while recognised as enhancing and expanding allied health services,¹⁷ has resulted in further confusion, and calls exist for more research into the clinical effectiveness and safety of allied health assistants.¹⁶ Allied Health Professions Australia (AHPA) has advocated for the use of their definition of allied health, as it specifies the requirements of a professionally-defined and publicly-recognised core scope of practice for allied health professionals.¹⁸ Allied health definitional and conceptualisation issues require further investigation given the potential implications upon allied health workforce policy and practice developments.

The current National Registration and Accreditation Scheme (NRAS)¹⁹ of practitioners does not cover all allied health professionals (e.g. social workers, audiologists, counsellors, exercise physiologists, dieticians). This has resulted in further confusion about the identity and scope of practice of allied health professionals among health professionals and patients. The AHPA has also advocated for the introduction of an authorised self-regulation model for allied health professionals.¹⁸ Intense debate about the allied health workforce regulatory environment occurred at the 2013 Health Workforce Australia conference²⁰ and the recent 2014 Victorian Allied Health Research Conference.² The merits of having national regulatory standards versus local quality

risk-management regulatory approaches, which allow local flexibility and adaptability, requires further investigation.

Over the last decade the Commonwealth Government has also invested in multiple initiatives targeted at the allied health workforce to develop new models of care to improve access to allied health services and increased multidisciplinary care. Examples include the *Access to Allied Health Psychological Services* program that enabled general practitioners to refer consumers to allied health professionals to deliver focussed psychological strategies, and the *More Allied Health Services* program, designed to provide allied health services to rural populations and improve local linkages between allied health care and general practice. Programs such as these have demonstrated success,² however further investigation is required into the roles of allied health within existing models of multidisciplinary care.

Allied health data collection

The lack of allied health workforce data in general, particularly for those who fall outside of the NRAS, is still an issue.¹⁶ A recent environmental scan and inventory of the allied health workforce within cancer care by Health Workforce Australia also revealed a lack of data.^{21,22} Professional bodies have called for further work to quantify and predict allied health workforce requirements and distribution as a matter of urgency.¹⁸ Health Workforce Australia has provided the opportunity for evidence- and population-based workforce planning and modelling. Population-based planning framework for allied health services for chronic diseases have also been developed.²³ However population-based planning approaches are seen as limited, given the complexity and diversity of functions of the allied health workforce.¹⁶ Service sector workforce planning – where community needs for care and utilisation of allied health are considered – have been

suggested as providing potentially more meaningful data to assist workforce planning.¹⁶

Allied health education and training

Students are continuing to choose allied health professions as a career choice,¹ supported by a variety of schemes, such as the Victorian Department of Health Allied Health Assistant Implementation Program.¹⁶ Lack of sufficient clinical placement opportunities continues to be a significant barrier to entry into professional practice.^{16,18} Access to ongoing professional development, networking, and supervision, particularly for allied health workers in rural and remote communities, continues to be a challenge.^{16,18}

Allied health national structures

A wide array of allied health professional organisations and structures now exist; these are designed to provide leadership, lobbying, representation, advocacy, policy development and a platform for professional development for the allied health workforce (e.g. Allied Health Professions Australia, Indigenous Allied Health Australia, Australian Allied Health Alliance, Services for Rural and Remote Allied Health). Allied health leadership positions (e.g. Chief Allied Health Officers) have also been established by State,²⁴ Territory and Commonwealth Governments, to provide leadership to the allied health workforce and support allied health policy development, funding, education and service delivery. Given the need to rebalance and increase the productivity of the health system, the effectiveness of these allied health organisations and structures need to be evaluated.

Collectively the papers published in this special issue demonstrate that much good work has and is occurring across the allied health workforce policy, practice and research arenas.

Please feel free to contact me and provide your feedback about this special issue on the allied health workforce, and about the health workforce section more generally – whether it is engaging you and meeting your interests.

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