Tackling the Allied Health Worker Crisis: A Multiple Stakeholder Perspective on Career Attitudes and Longevity: Preliminary Results

A report on the early results of allied health workers’ careers interviews

16 June 2011

by

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“It’s been fantastic, moving up to NSW, working casually in a hospital as well as locum work around other hospitals. It’s a great career for someone who likes to travel and try different things, and see the world.” (IV42 Radio M30s Reg)

“Careers research has the potential to provide a conceptual bridge between micro- and macro-levels of analysis and an intellectual anchor to phenomena of keen interest to organisational scholars ... When careers are the means for understanding complex and important social phenomena, then careers research will move to the vanguard of organisation studies.” (Jones & Dunn, 2007, p 447)
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Executive Summary

There are more than 70,000 allied health workers playing a key role in the many layers of Australia’s health systems. While their medical and nursing colleagues attract significant research attention, the allied health workers’ stories are rarely heard. This report presents the early first cut preliminary findings of our research. This report gives voice to the allied health professionals as they discuss their careers, their career choices and their career options.

We listened to the voices of some 106 health and allied health workers around Australia who told us their stories. We listened, too, to representatives of the professional associations who are charged with nurturing and supporting those professionals as they move through their careers. We met with health service executives and private sector employers of allied health professionals and – uniquely, we believe – we listened to the perspectives of specialist health industry recruiters who meet allied health professionals at the turning points as they seek to make career change decisions. A total of 126 interviews informed this study.

We note that all allied health professionals work hard, have significant workloads and frequently run extensive waiting lists. They operate within an environment dominated by powerful medical and nursing cohorts. Allied health professionals recognise their work is not about making life and death decisions. Their work is about helping, caring, nurturing and improving the quality of life of fellow human beings. Not everyone is capable of being an allied health professional.

The study targeted five key allied health occupations, selected for their impact on the health system and their current and recent workplace planning situation. We found:

- **Hospital pharmacists** are quite distinct from their retail counterparts. Hospital pharmacists tend to move to corporate, including pharmaceutical companies, to gain professional development and career progression. After addressing a workforce shortage there is now an uneven distribution of early pharmacists, including some oversupply. Retention of experienced hospital pharmacists is now the main workforce issue. “Presenteeism” sometimes occurs when hospital pharmacists work while injured or ill because there is no replacement available. Once out of hospital pharmacy, the ability for this professional to return appears to be more difficult as there are strict re-entry barriers in this profession.

- **Occupational therapists** are proud of their holistic, diverse, creative and scientific approach, yet frustrated by the perception as being like physiotherapists or others who assume they can do their job. This reduced professional identity may change when the much-welcomed national registration commences in 2012. This profession offers a wide scope of roles and practice settings and is often delivered in a part time capacity, one of the main retention factors.

- **Physiotherapists** are the highest profile of the occupations we studied, with sports team roles the major attraction for newer professionals. The early reality of sore thumbs, insufficient sports team roles and generalist roles in public hospitals pushes many out of the profession early. Many of those who stay are attracted by the potential earnings of private practice. The specialising that is rewarding to metropolitan physiotherapists is rarely possible in regional areas. Burnout and lack of career progression see many physiotherapists leave the profession.
- **Radiographers** are often ambitious to move from the limited routine of the traditional generalist starting role into a specialty. Many will leave the profession if they are unable to find specialist training roles. The availability of 24 hour shifts provides attractive flexibility, including for professionals wanting to combine parenting with after-hours work. Radiographers are sometimes seen as “gadgets” people who are comfortable working with large medical machines – so medical technology companies are a natural destination for those seeking professional development and career progression.

- **Social workers** are the salt of the earth, often burned out from client contact. They work in shifts, residential or daytime in the community, hospitals or a clinic. They see a varied caseload, often through a series of fixed-term contracts when they work for nongovernment organisations who deliver services on behalf of the government. Those fixed-term contracts often force a natural transition into another clinical focus or, sometimes, out of the profession into an employer who gives them professional development and career progression. We think this fixed-term work often leads to diminished employment benefits such as educational support and we fear that combined with the complex social worker workload, fewer in this profession are able to gain the postgraduate qualifications that would strengthen their claim for more senior and management roles.

The most significant generic skills identified by all allied health professionals are sound communication and interpersonal skills, including the deep ability to listen, understand and respond to the patient’s needs. The importance of communication skills is a point worth reinforcing to health service executives, health authorities and to representatives of tertiary training programs.

The most consistent message we received from allied health professionals was their need to be recognised for their day to day contribution and achievements in their workplace. The thank yous they receive from patients and their families and from their colleagues and managers go a long way towards sustaining their participation in the health workforce. This low-cost retention strategy is easily implemented and greatly valued.

Thirty percent of the interviews were conducted in **regional Australia in three states**. We found regional lifestyle was an attractive pull not just for those of country origin, but also for city dwellers. Cheaper housing, relaxed living, less traffic and more outdoor pursuits were attractors. We note an increasing reliance on the allied health professional to support the funding of family farms. Unsurprisingly, regional allied health practices tended to be generalist rather than specialist, however the regions also have a growing need for specialists, in, for example, mental health and aged care. Continuing professional development and developing professional networks were rarely reported to be sufficient and there is a shortage of locums to backfill for absent staff. Regional allied health professionals were less likely to be supervised by an allied health professional than their metropolitan counterparts, leading to a diminished awareness and understanding of their roles by management.

This report details the initial findings from our interviews with **health service executives, professional association and recruiters** who we interviewed in order to gain a wider perspective on allied health careers. The report highlights public/private sector differences and differences between different clinical settings.
We suggest that allied health workers are:

- Justified in feeling neglected in terms of their professional and career development within the workplace, especially compared with the private sector. We note that hospitals and professional associations both provide professional development but we fear the allied health professional is noticing the attention being paid to professionals in the corporate world. We did not hear any discussion of allied health top talent, talent management programs, succession planning or talent retention programs. We are particularly concerned about the public health system as it tries to compete with the private sector for smart, qualified, capable professionals.

- Allied health workers are at the mercy of frequent change including change of government. The lack of continuity reduces a worker’s aspirations for roles they cannot see into the future. People in health are jaded by having to reapply for their own positions when restructures occur. Restructures and governance reform occurs continually and impact on everyone’s ability to do their job. Having to attend restructure transition meetings is no substitute for career development or training yet takes up valuable clinic time.

- Allied health workers are not reporting that they participate in traditional human resources practices such as performance review, career planning or goal setting meetings with their supervisor, or exit interviews when they leave. We ask where hospital-based allied health professionals get individual career development and mentoring? We wonder if it comes from a supervisor, a department head, an area health advisor or co-ordinator, or some other person? We wonder how often that person is of the same profession?

- Allied health workers are not all represented by their professional association. We suspect many allied health professionals are “falling between the cracks” of their professional association and their employer. Just 50% of physiotherapists are member, just 35 to 45% of occupational therapists are members, 33% of social workers are members of their professional association while 65% of pharmacists and around 70% of radiographers are members or linked to their association. It would be wrong for allied health employers to assume the professional development needs of their allied health professionals are being met by the professional associations.

- We suggest those allied health professionals who are not members of their association are most at risk of leaving the profession. We wonder whether Health Workforce Australia or another third party might be in a position to further support the keen and capable professional associations, generally under-resourced to support all members of their profession. It is possible that professional associations need further funding to be able to support their members.

We trust the detail of the report is helpful and look forward to your feedback as we continue to understand the employment issues facing the health and allied health workforces. We commend the report to you.

Dr Denise Jepsen, Janelle Craig and Marjorie O’Neill

June 2011
1 Introduction and Background

More than 100 world health leaders agreed that nearly all countries are challenged by health worker shortages, skill mix imbalances, maldistribution, negative work environments and a weak knowledge base (Chen et al., 2004). Addressing this issue, the Australian Health Workforce Strategic Framework (2004) requires Australia to have a sustainable health workforce that is knowledgeable, skilled and adaptable. Doctors and nurses have appropriately been the focus of the majority of health industry workforce research (for example, Borda & Norman, 1997; Cline, Reilly & Moore, 2003; Shen, Cox & McBride, 2004).

**Allied health shortages:** However, workforce shortages exist beyond medical and nursing to the entire health workforce spectrum (Russell, 2007) and include the allied health industry. Allied health has different definitions but is generally regarded as involving physiotherapy, psychology/clinical psychology, podiatry, occupational therapy, speech pathology, dietetics, social work, audiology, physical education, pharmacists, prosthetists, orthotists and hydrotherapy services (Community Services & Health Industry Skills Council, 2010). The workforce shortage is critical in rural areas, with an annual average length of rural practice of only 13-18 months (Struber, 2004).

**Allied health shortage research:** The critical nature of the allied health workforce shortage has been recognised in some individual allied health professions such as radiography (Probst, & Griffiths, 2007) and disability workers (Denham, & Shaddock, 2004). The NSW government has introduced an initiative to encourage school leavers into the allied health industry through the school-based completion of a Certificate III in Allied Health. However, little systematic research has been conducted to investigate why workers, particularly more experienced workers (Collins, 2003), leave allied health (Gerber, 2009).

**Aims of this project:** This project investigates the particular career attitudes and needs of workers in the allied health industry, with a preliminary emphasis on workers in regional compared with metropolitan areas and a subsequent emphasis on allied health workers aged 40 and over who might soon be expected to leave the labour market. The project aims to examine how these workers might be encouraged to continue in their professions and what specific practical interventions might be developed for employer organisations to encourage worker retention.

**Innovative project design:** The approach in this study is novel and innovative because a wider perspective is taken on the research problem, rather than the sole focus on the allied health workers themselves. The project design includes current and past workers, managers and executives in both private and public hospital systems as well as representatives from the professional bodies associated with allied health professionals. This comprehensive approach allows a more complete picture of retention of allied health workers to emerge.

**Context-specific research:** Beyond the benefits to the health industry, this project will extend the existing research by adopting an occupational focus on one of the most important research areas, that of employee retention and turnover. The majority of the retention and turnover literature relate to employees generally rather than adopting a context-specific focus. The recent calls for occupationally-based research (Johns, 2001, 2006; Rousseau & Yitzhak, 2001) have yet to be embraced in the allied health industry occupations.
1.1 Interviews with Multiple Stakeholders

A total of 126 interviews were conducted. Of the 106 allied health professionals, 86 (68%) were female and the average age was 40 years, reflecting health demographics generally:

- 83 current and former allied health professionals from the target occupational groups:
  - 18 hospital pharmacists
  - 17 occupational therapists
  - 21 physiotherapists
  - 8 radiographers and
  - 19 social workers.
- 23 non-target allied health professionals including speech therapists, podiatrists and some nurses who gave us a perspective beyond the five target occupations.

To ensure a full range of views and perspectives, 20 stakeholder interviews were conducted:

- 5 representatives from the target professional associations told us their main issues
- 5 representative executives from health services told us about hiring and managing allied health professionals
- 8 representatives from specialist health care recruitment agencies told us about allied health professionals when they were seeking new jobs
- 2 corporate health industry executives told us about hiring former allied health professionals.

In depth, in person semi structured interviews using an interview guide and standardized open-ended questions were conducted by all three researchers with professionals in each of the selected occupations over a five month period from January to May 2011. Stakeholder interviews were conducted in person, by phone or email with senior representatives from the professional associations, recruiters and corporate and health service executives. Adaptive interviewing allowed new ideas to be developed through analysing issues that were salient or absent (Corbin & Strauss, 1990, Jepsen & Rodwell, 2008). The interviews, 45 to 60 minutes, were conducted in a range of settings including the University, private settings such as private practice rooms or the interviewees’ home or workplace. Some interviews were conducted in public areas such as cafes and many were conducted on site at participating health services.

Particular consideration was given to clinical implications of the interviewing so that, for example, early morning or late afternoon interviews avoided the peak clinical load for interviewees. Written informed consent was obtained for all interviews which were digitally recorded and transcribed for accuracy. NVivo was used for coding of interviews and subsequent analysis. Only 50 of the 126 interviews had been transcribed and coded at the time of this report so we repeat that these are early results, based on the interviews at hand. In this report the coded attribution of quotes (e.g., IV23 F50s physio metro) refers to the interview reference code, interviewee sex (male/female), the decade of interviewee age, occupation abbreviation and metropolitan or regional location.
1.2 The Target Allied Health Occupations

Five occupational groups were selected for the study. The occupations were hospital pharmacists, occupational therapists, physiotherapists, radiographers and social workers. The total number of employees in these occupations was 69,688 in May 2010, as indicated in Table 1. That table also shows the number and proportion of the interviews conducted with each of the occupations.

The occupations were chosen based on meeting certain criteria. First, we wanted to keep the project manageable and so ideally wanted to target five to six professional disciplines. Second, we needed those disciplines to fall with the accepted but often debated terminology of allied health. Third, we wanted to study those professions where there was a significant number in that workforce. Fourth, the occupations needed to have a significant impact on organisational – usually hospital – functionality. Fifth, the occupations needed to have substantial impact on care delivery process and health care systems, particularly in relation to the ageing population and chronic disease management. Sixth, we wanted to target disciplines that were already experiencing workforce shortages. Seventh, we needed access to professional associations as well as the hospital or healthcare sites of those disciplines. Last, we selected professions that indicated a willingness to work with us. We note that these selection criteria could apply to a number of other occupations beyond those finally selected and look forward to working with other occupational and professional groups in future studies.

Table 1 Employment and Interview Statistics (Source: ABS Labour Force Survey, May 2010) (Interviews, n = 106)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number employed in Aust</th>
<th>Percentage of occupations employed</th>
<th>Interviewed</th>
<th>Occupations, percentage of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital pharmacists</td>
<td>4189</td>
<td>6</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>11400</td>
<td>16</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>18500</td>
<td>27</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Radiographers</td>
<td>15499</td>
<td>22</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Social workers</td>
<td>20100</td>
<td>29</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>23</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>69688</strong></td>
<td><strong>100</strong></td>
<td><strong>106</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
1.3 Recruitment of Interview Volunteers

Volunteers were recruited through three primary sources:

**Professional Associations**: Links were established early in the project with representatives from professional associations in order to engage them and their members in the project. In December 2010, the following associations emailed advertisements for volunteer interview participants to contact the researchers directly.

- Australian Association of Social Workers (AASW)
- Australian Institute of Radiography (AIR)
- Australian Physiotherapy Association (APA)
- OT Australia
- Society of Hospital Pharmacists of Australia (SHPA)

**Health Services** - Links with a number of health services existed prior to the project commencing, while new links with other health services developed during the course of the project. The health services each advertised for volunteer interview participants and arranged the logistics of the interviews for interview volunteers. In this way the researchers were removed from the recruitment process. Health services included:

- Sydney West Area Health Service (SWAHS): Auburn, Blacktown, Blue Mountains Anzac Memorial, Mount Druitt, Nepean and Westmead Hospitals
- Macquarie University Hospital
- Mid North Coast Local Health District: Kempsey and Wauchope Hospitals
- Northern NSW Local Health District: Grafton Hospital
- Victoria: Portland Health Service (Portland), South West Health (Warrnambool) and Western District Health Service (Hamilton)

**Medical technology association and employer organizations** advertised by email for volunteer interviewees to contact the researchers directly.

In addition, word of mouth (or snowballing) was also used to recruit interviewees. Those approached were known to either the researchers or other interviewees who suggested the researchers contact them.

**Regional interviews**: Recognising the particular complexities of rural, regional and remote location, we deliberately targeted regional allied health workers as part of our study. Of the 106 interviews with allied health professionals, 32 (30%) were conducted in regional areas in three states:

- 11 in mid north coast NSW
- 15 in south west Victoria and
- 6 in far north Queensland.
2 Voices of Allied Health Workers

We now present the preliminary interview results for each of the targeted occupations.

2.1 Hospital Pharmacists

We interviewed 18 pharmacists working in metropolitan and regional areas. Many of them had worked in other practice settings including retail pharmacy and pharmaceutical companies.

The traditional career path for pharmacists sees around 80% working in or owning a community pharmacy, while only 20% work in hospitals. The bulk of pharmacy graduates are female and around 33% of hospital pharmacists work part time. Recently, the role of consultant community pharmacist has evolved. Pharmacists in these roles work provide home medicine reviews and other services in community settings. Other settings as alternatives to hospital and community pharmacy include the pharmaceutical sector, industrial pharmacy, government and project work. The main issue for hospital pharmacists at this point in time is retention of experienced pharmacists.

The tension between retail pharmacy and hospital pharmacy was apparent during the interviews and was a definite reason why people choose to work as a hospital pharmacist. Many interviewees see the retail pharmacist as a ‘chemist’ – handing out white boxes and selling merchandise – instead of a pharmacist who dispenses drugs and provides pharmaceutical-related advice to other health practitioners and clients. From a former retail, now hospital pharmacist:

- “Retail pharmacy is de-skilling – like working in a supermarket.” (IV03 Pharma F60s Reg)
- “It [retail pharmacy] was boring. I didn’t like it. It’s what I call telephone box syndrome. Maybe it was the year that I came out. I came out of the university equipped with wonderful skills and moved into a job where those skills weren’t recognized, were not appreciated and where I couldn’t actually use them.” (IV24 Pharma F40s Metro)
- “[In retail pharmacy] we sell cans of salmon and peanut butter… so going to a hospital was a lot different. It was great after that, because I want to keep my hand in and I want to pick my skills up.” (IV29 Pharma F60s Reg)

Interviewees appeared to have a strong identity as a pharmacist, felt they were members of the healthcare team and generally liked their roles.

Some, particularly mid-career hospital pharmacists, reported dissatisfaction with a lack of career progression in public health. Consistent with messages we received from recruiters, some hospital pharmacists looked to move into retail pharmacy or to the corporate pharmaceutical sector. Salaries in retail pharmacy and the long term salary and professional development benefits of pharmaceutical companies were an important factor in taking these professionals out of hospital pharmacy. One recruiter, who sees around a hundred pharmacists per year, observed that pharmacists go to pharmaceutical companies for the professional development and the potential for career progression.

Further, female pharmacists who left hospital pharmacy for child rearing reported the financial strain of the public health wage is often the factor that takes them to retail pharmacy when they return to practice.
However, once out of hospital pharmacy the ability to return appears more difficult. Those that go into retail pharmacy tend to become de-skilled and find it hard to transfer back into hospital pharmacy. Hospital management spoke about their resistance to employ pharmacists from retail as they need considerable re-training.

Some hospital pharmacists report that understaffing results in “presenteeism”, or reporting for work when they should really be taking leave. The understaffing is sometimes confused as either a budget or manpower issue. One regional pharmacist reported on the lack of relief when off sick or otherwise away, as a result of trying to reduce departmental expenses:

- “I don’t have anyone who relieves me if I am sick… Like I took yesterday off, I come in today and it just means I face double work load.” (IV08 Pharma F20s Reg)

Like the other allied health professions, hospital pharmacy has limitations in terms of the physicality of the role. Pharmacists in both hospitals and community settings spend a large portion of their day standing, which can be difficult and demanding, particularly on ageing bodies.

- “I think the job is quite physically demanding and I think that it is quite physically tiring being on your legs all day.” (IV37 Pharma F40s Metro)

The issue of career re-entry was also commented on by the professional association who see the strict parameters on re-entry imposed by registration requirements as being a significant issue for pharmacists and the profession as a whole.

The availability of additional university training places means there is no longer a shortage of hospital pharmacists, however there is a maldistribution with shortages in regional and remote areas and oversupply in some capital cities, representing a turnaround story of workforce shortage to oversupply. This can result in many pharmacists leaving the profession because they are unable to find the job that they want. With more competition for few jobs, it is suggested that pharmacists who start their career in a less fulfilling role are more likely to leave their occupation.
2.2 Occupational Therapists

There were 17 occupational therapists interviewed as part of the research project. There were nine in public hospitals, five in community health, one each in mental health, aged care and a government department. The proportion in community health was higher in comparison to the other allied health professions interviewed.

Interviewees predominately enjoyed their role as occupational therapists. Many entered the profession because they wanted to work in health and sought to do something that would be challenging and interesting. Some interviewees spoke about the mix of creativity and science. They spoke about occupational therapy as a profession with great diversity and many opportunities.

- “So it [being an occupational therapist] is really very, very diverse… I think that is what I find rewarding. That you could be doing so much science – such different things throughout the day.” (IV27 OT F30s Metro)

Occupational therapists also spoke about the attributes people needed to do the role well. These attributes included excellent communication and people skills and the ability to think on their feet. Most important is the ability to take a holistic approach to their work and their clients.

The scope of roles and practice settings available to an occupational therapist raises issues including role definition and career identity. Interviewees spoke about having their patch trodden on by people who assume they can do the job of the occupational therapist. They lamented that occupational therapists are often grouped together with physiotherapists, they have fewer career options than physiotherapists and they are a less well recognized occupation than physiotherapists.

- “Occupational therapy is really hard to define exactly… I think there are people who are really not sure where they fit. I mentioned before people handing our skills on to others and you know… in a working environment we should on the whole be confident and comfortable with where we sit, but I think a lot of people probably find it hard to really define exactly what their role is and what we do.” (IV48 OT F60s Reg)

Despite a diminished career identity, occupational therapy provides flexibility to allow many professionals to engage in their other life roles. One occupational therapist re-trained as a lawyer where her professional identity was at last recognized by others. However, she eventually returned to the flexibility of occupational therapy to raise her children. Time will tell whether she remains in occupational therapy beyond her child-raising years.

Interviewees were receptive to, and positive about, the move towards national registration, effective from 2012. National registration is likely to create a greater sense of identity for occupational therapists. National registration is likely to raise the profile and status of occupational therapy not only amongst other health professionals but also with clients and the wider community.
2.3 Physiotherapists

Physiotherapy is a well known occupation. We interviewed 21 physiotherapists drawn from public hospitals, private practice and government agencies. A number of distinct issues arose:

Public vs private: While other allied health professionals work in private practice, the distinction seems more pronounced in physiotherapy. Interviewees expressed their like or dislike of working in each and placed themselves where they felt appropriate. One observation about private practice came in relation to new graduates entering directly into private practice. An ex-educator observed that there is the danger these new professionals will be exposed to a more limiting casemix of patients and may lose skills and later find it hard to transition out of private practice.

Specialisation: Physiotherapy, like radiography, is one of the two targeted allied health professions where interviewees emphasized the impact that specialisation had on career choices. Approximately one third of physiotherapists interviewed were specialists in their domain.

Salaries: Both interviewees and recruiters identified that money was a definite motivator for physiotherapists to change jobs and career direction. Further, early career interviewees considered that the UAI to enter physiotherapy was not commensurate to the salary earned. At some universities, the UAI is as high as entering a law degree, and the expectation was that they would be earning high wages upon graduating. They were shocked when this was not the case.

Understanding of the role: Occasionally there were misunderstandings or misconceptions about the physiotherapy role. Generation Y, particularly males, are often drawn into physiotherapy by the media attention and coverage in sports. However, they are disillusioned by the small amount of work that is available in sports physiotherapy.

Physicality of the role: Both interviewees and the professional association recognized that the physiotherapy role takes a toll on practitioner’s bodies. Thumbs in particular seem to not wear well and injuries can occur that take physiotherapists out of the discipline. Burnout and lack of career progression were other factors cited to remove physiotherapists from the profession. We would urge the profession to consider assessment of physical strengths and weaknesses early in the degree.

- “I opened a private practice because there were not a lot of men in management positions so I thought maybe I was on the wrong track. I opened a private practice after hours. I stopped it when I paid off my house so I could spend more time with the kids.” (IV07 Physio M60s Reg)
- “I think a lot of students go into private practice too soon, not only from the point of their limited knowledge but also from the maturity point of view. It will give physio a bad name and I also think, yes it does impact where the profession is going and what opportunities there are going to be especially in hospitals and particularly public.” (IV10 Physio F50s Metro)
- “I find hospital work… is more satisfying because you see the gains and the difference that you are making. Having a patient who has been involved in a car accident and then working with intensive care where we have the opportunity to help someone go home walking, compared to a sprained ankle. I know that they are going to get better in six weeks anyway. I can give them a few exercises to speed it up a little bit, but I just know they are eventually going to get better and so it is just different, like more satisfaction if you are helping somebody and making a big difference in their lives.” (IV26 Physio 30s Metro)
“I guess I can love people. I had a pretty sporting of background so there is that you know, I guess there is often a bit of an association with physio and sports.” (IV 02 Physio 20s Reg)

“For me it was either being a chiropractor or physio or medicine and then I am like no, I didn’t wanted to go do medicine because I decided that either it is a long time study and you won’t have a social life.” (IV25 Physio 40s Metro)

“I have got a couple of friends who are my age and they have gone to private practice and they just can’t take it, you know. So now they are going into medicine just to get away from the hands on work, just so that they can have a longer career because I think, you know, if they are already there and their hands are really sore, how long can I stay in that profession...?” (IV25 Physio 40s Metro)
2.4 Radiographers

Despite the efforts of the professional association, we were unable to access many radiographers. We interviewed only eight. We are not confident that we have understood the issues relating to radiographers, however some observations are noted now:

Radiography is perceived as an occupation that provides flexibility and transferability and can allow individuals to have a good work life balance. Unlike many allied health occupations, radiography has 24 hour shifts available. We were told that this means that mothers can take shifts outside of ‘mum duty’ hours – at night when their partner is home.

One of the major issues raised in radiographer interviews was the radiographer’s ability to specialise. We know that being a generalist in allied health can allow for greater career mobility however there is not the same variety in the generalist radiographer role as in other occupations, so there is an increased urge to specialise. Specialist training, however, is not available in all locations so there is often a lot of competition for trainee roles. Ultrasound, MRI, nuclear medicine and sonography are not available in all locations.

We were told that those who are unable to specialise tend to leave the profession due to boredom with the limited range of activities in the generalist radiographer role. An example is a radiographer with seven years in private practice who wanted to specialise in ultrasound. His employer did not provide him with the specialist training and he was unable to find work in a hospital that would allow him to re-train. He left his generalist radiographer job for a medical technology sales role. Radiography interviewees expressed similar ideas:

- “Generalist roles can be very boring, x-ray” (IV42 Radio M30s Reg)
- “I think that is a pattern with the radiography profession. Because a lot of the courses need high scores to get into as they are quite popular. So you have to be quite intelligent and motivated to get into the course and when you come out, you get stuck doing general. It’s just not stimulating so people are just not challenged and so many want to do more, to branch out or step up from radiography.” (IV42 Radio M30s Reg)
- “Just general x-rays was pretty monotonous and not really challenging after a little while. I wanted something a bit more challenging and something to stimulate me a little bit.” (IV42 Radio M30s Reg)

Ultrasound as a specialisation attracts women due to the intimate nature of the work and being close with patients. Radiographers who are planning to have children are also more inclined to go into ultrasound due to the physical risks associated with other specialties.

Recruiters said many radiographers want to move from clinical to corporate roles, radiographers were motivated by money and that radiographers want better career progression into training, development, marketing and sales. The ability to deal with technical equipment and selling high dollar value equipment is an attractive option to radiographers. The physical size of many medical machines and devices is said to require a large frame. We were told this was a transition for “boys and their toys” as the male former radiographers were seen to be selling “gadgets”.
2.5 Social Workers

We interviewed 19 current and former social workers from a variety of settings, including three in private practice. We note that most current social workers were women and most former social workers were male.

Social workers tend to become burned out from patient contact. Many social workers in their later career stage reported seeking roles that are less emotionally demanding than in their earlier career. An example of reduced emotional demand is taking private practice clients not requiring 24 hour on-call contact. This reduced emotional demand client base enables the social worker to go on holidays without feeling they are neglecting their clients. High demand patients require emotional contact and energy that many social workers report they lack in their later career.

We were told of particular problems with rigid treatment regimes in hospital settings, where social workers were required to comply with particular service dictates such as short consultations.

Some social workers reported that the experience of being a mother can provide invaluable experiences that are directly transferable to a social worker career, particularly when working with children and families. This is true of many allied health occupations that work with children but seems to be particularly the case with social workers. We were told that it is common for client families to ask their social worker whether they have children. While having children is not a necessity, the experience of being a parent can provide comfort to hurt families and give the social worker a deeper level of understanding.

Contract work leading to career transitions: Social workers differ due to the varied applications of their work. One of the consistent themes from the interviews was the use of contracts to hire social workers, compared with permanent roles seen in the other occupational groups. Social workers are often employed by non-government organisations who, under contract through a winning tender, are delivering the work of government. These contracts tend to be for one, two or three years. We spoke to social workers who saw the expiry of their contracts as natural transition points. The transition points allowed – or forced – these social workers to move into another area of social work, to seek similar work in another location or in some cases, to seek other more permanent work. One former social worker retrained to become a school teacher because he needed the stability of employment certainty to be able to raise a family. It would appear that as social workers mature and take on personal family and other responsibilities, the transient nature of contract work has a substantial impact on them leaving the profession.

Social Worker career at risk? Postgraduate qualifications: We see the social worker career as potentially at risk through a number of different avenues. First, the unregulated nature of the occupation allows for less-qualified workers to be employed in roles previously held by more qualified social workers. Second, the frequent use of social workers on a one, two or three year contract has repercussions for continuing professional development and in particular, postgraduate education. We heard that relatively few social workers go on to masters degrees, possibly because they are fully occupied on contract and less able to be supported by an employer to take time out to upgrade their qualifications. Social workers who might in the past have been permanently employed by different levels of government are now on contracts. Fewer permanent social workers are therefore entitled to traditional employee benefits such as educational support. The unregulated nature of the role means that professional development is not a statutory requirement of the short term contracts. Much of the work done by social workers is shift work or outside regular business hours, involves complex problems with sometimes subtle
solutions and often involves dealing with time-critical emergencies. These working conditions again limit the opportunities for social workers to participate in postgraduate study. Consequently, social workers appear to be rarely able to invest in their own professional development beyond the traditional CPD requirements. The apparent lack of social workers with postgraduate qualifications may mean social workers are less likely to be considered for management roles where other allied health workers, who do have postgraduate qualifications, are more likely to be given management roles. Given the lack of management roles for social workers or former social workers, a gradual deterioration in the organisational understanding of the contribution of the social worker is more likely. The expectation that others can do the role of the social worker has been well documented in the peer reviewed literature.

Having said that, we note so many social workers taking on high profile roles in the community including the Queensland premier, Anna Bligh, who was highlighted as an exemplar of crisis management in the recent (January 2011) Queensland floods. Beyond one career counselor telling us of three social workers now managing directors of local government councils, many other examples exist of former social workers taking leading roles in the community.

• “There are few social workers on the ground, very few and becoming fewer. We had a social worker in sexual assault and she has recently moved. So there is another vacant position. So in the country I guess the reality is that social workers are a rare commodity because retaining them is a real issue. Attracting and retaining social workers in this area is a… challenge.” (IV09 SW F50s Reg)

• “[How long do you see yourself doing this for?] Probably forever. I don’t think I am going to afford to retire. Every now and then in my profession the older you are, the more valuable you are. So that it is the good thing about private practice. There is a sort of premium on gray hair in a way. A lot of status… being older in my profession and more experienced and all that sort of stuff.” (IV18 SW F50s Metro)
3 Stakeholder Sentiments

3.1 Health Service Executives

To further round out observations of allied health professionals, we engaged with a number of health service executives to obtain their views and perspectives. This was an important component of the research project, since their positional and experiential base gives them the ability to present the ‘big picture’ perspective, or to step back and see allied health professions and issues in the wider health context.

Five health service executives were interviewed. Two were from regional health services in different states, two from metropolitan area health services, and one was currently employed in the private health sector. Two had nursing backgrounds and two had allied health backgrounds, while one was drawn to health from a business background. Four of these interviewees had direct responsibility for the services of the allied health disciplines being researched, while the fifth delivered corporate and clinical training and education at an area health level.

These interviews were particularly rich and diverse. At this early stage in our analysis and review it is difficult to report back on all issues. However key issues raised include the following:

**Management of allied health**: There were mixed perceptions about the importance of allied health professionals being managed and lead by senior executives who were former allied health professionals or who have a background in health, an issue also raised by a number of interviewees, notably regional professionals. While some health service executives believed being managed by other allied health professionals is immensely important, this background was not valued by those who believed that health is about process, similar to other sectors.

- “In my particular role, I have to sit at both tables [clinical and management]. Without that clinical experience, I couldn’t sit at the other table." (IV05 Mgmt F50s Metro)
- “I’m not here to give clinical direction, they don’t need clinical direction. We do that in another way. What I bring to this role is much more around what’s the best service model for our community.” (IV50 Mgmt F50s Reg)

All executives however did agree that the effective management of allied health professionals was important for the functioning of the health service. That is, they value the contribution that allied health professionals make to the care process and acknowledge that without adequate recognition and support, allied health professionals will potentially be driven from their professions and the health sector. To this end, they discussed ways of motivating them and working more actively to develop career pathways for movement along the managerial path, as this is an avenue many allied health professionals are reluctant to pursue. They see that providing support, training and development essential to access the pathways allied health workers take. Further, hearing what allied health professionals have to say about their work and careers was seen as critical. One health service executive spoke about the value of exit interviews and how these are used a part of the communication process – to hear what is being said, the positives and negatives and to use this feedback to inform change.

**Staffing and workforce planning**: Health services executives expressed sentiments on retaining allied health professionals in the workforce. Some of this dialogue focused upon younger women who had stopped work due to childrearing commitments, while other conversations were concerned with the ageing population and retaining older workers. Both demographic groups
required flexible workplaces that allow them to accommodate to their other life roles. While this is not an impossible task to achieve, it is something that requires strategic planning and time in order to create roles that allow these different groups to continue to participate in the workforce. Further issues were raised in relation to career re-entry and the need to have strategies in place to help accommodate return to work.

**Generational change:** Generational change was raised in relation to workforce planning and the need to give consideration to ‘Gen Y’ allied health professionals. One health service executive was particularly aware of the need to be conscious of the emerging allied health workforce with different perceptions and expectations to past allied health professionals. Many new graduates come into the health sector and realise ‘this isn’t for me’ or that ‘I don’t like working in hospitals’.

- “My generation was very status-oriented, high-achieving woman, you know, full participation in workforce will pay the full bit, we embraced the whole bit and we worked hard to get where we wanted to be, but we did have a degree of organisational loyalty. The younger ones don’t, they go this isn’t for me, I’m out of here.” (IV05 Mgmt F50s Metro)

It is important to point out that the interviewee wasn’t bemoaning this fact of generational change. Rather highlighting that it is a reality of life that may impact further on retention of practicing allied health professionals and the wider health workforce.

**Future roles for allied health:** The other key observation made by health service executives was in terms of health service reforms and the potential impact this will have on allied health professionals. Issues about work practice, roles of the professional disciplines, specialisation and genericisation are all catalysts identified as shaping the future of allied health.

- “We need to be smarter with how we use our professionals because they will be more precious. So what do they really have to do as opposed to maybe what they really like to do, and who does the stuff that clearly is more routine. We need to look at other health professional groups to do that work or other qualified or less qualified people to do that work.” (IV51 Mgmt M40s Metro)
3.2 Professional Associations

The Australian Association of Social Workers (AASW), the Australian Institute of Radiographers (AIR), the Australian Physiotherapy Association (APA), OT Australia and the Society of Hospital Pharmacists of Australia (SHPA) are the professional associations representing the five selected allied health disciplines. These associations were active participants in this research project and were engaged early in the project as a means to facilitate access to their members. Further, the associations were identified as being key stakeholders in the project with a keen interest in the outcomes of the project as they affect their members, their profession and the wider health sector.

It was important to hear the views of each association. We asked about the careers issues related to their members and their profession. While there were responses distinct to the individual professions, some aspects were of particular concern to all professions. Areas of common concern included retention of discipline members, career re-entry and catalysts driving change in healthcare:

**Retention**: All the Associations are aware of the need to retain practicing professionals and each has strategies in place to address retention. Some specific occupational issues include:

The APA reported physiotherapists leaving the profession due to:

- burnout
- physical injury, or
- to enter another career, including as a 'stepping stone' to a medical career.

OT Australia sees occupational therapists leaving practice due to:

- promotion into generic allied health and management positions and
- parental responsibilities and child rearing.

The SHPA reported numerous reasons why hospital pharmacists leave the profession:

- inadequate remuneration for the responsibility of the position
- job related stress
- inadequate resourcing of pharmacy services
- lack of recognition from patients, peers and hospital managers and
- feeling isolated and not part of the healthcare team.
Career re-entry: Apart from keeping professionals in the discipline, associations are cognisant of the need to allow others back to practice following periods of absence. However for some professions this is easier than for others. OT Australia believes the main obstacle to re-entry into occupational therapy is a re-entry course that is sufficiently broad to meet the diversity of clinical practice settings and environments. OT Australia has the development of refresher courses flagged in their Strategic Plan. Career re-entry is a major and complex issue for individual hospital pharmacists as it is aligned to registration. Refresher short courses that are available have a limited role, since re-registration may involve retaking final exams or completing a new intern year.

Future trends: SHPA see hospital pharmacy continuing to be shaped by changes in the use of medicines and hospital funding driving hospital-based practice. E-health initiatives have the potential to impact practice patterns. Demand for university places in pharmacy are already falling and if this continues will have a considerable impact on the numbers in the profession.

APA also sees e-health initiatives influencing the physiotherapy profession with an ageing population and new treatment modalities. The APA report trends of increasing specialisation, greater use of physiotherapists as the first-contact health professionals in public hospitals and a greater awareness of the capacity of physiotherapy to prevent and treat a wider range of disorders than is commonly recognised.

OT Australia also report specialisation as a factor that will influence the future of occupational therapy services, as well as extended scope of practice. They see health care reform and funding arrangements impacting on the profession, as well as allied health workforce shortages, the growth of allied health assistants and the ‘genericisation’ of allied health roles.
3.3 Recruiters

One of the more difficult segments of the workforce in this research project was those who had left the health sector and who were now employed outside the health sector, with just eleven interviews with former allied health professionals conducted. Access to exit interviews was not available and many said that exit interviews were not accessible or helpful data sources. Access to recruitment agencies who deal with health professionals exiting health was an additional way we could seek to understand the motivations and reasons that allied health professionals leave health. While these organisations could not give us access to individuals, their general observations are of interest. Eight agencies dealing exclusively in health recruitment were contacted. Most operate nationally, some in Asia-Pacific. One company declined to participate, while two felt it inappropriate to comment given their specialty was other than allied health.

Two agencies said that most allied health professionals want better career progression such as training and development and marketing and sales. Three agencies said that physiotherapists they dealt with were often seeking to move due to financial reasons. That is, physiotherapists tended to be motivated by money. One commented that mid career physiotherapists moving from private practice say there is a lack of career progression in that setting, while new graduates with six to 12 months experience often report they do not like working in hospitals because hospitals are not exciting or glamorous. One recruiter also reported seeing movement in physiotherapists because of the desire to specialise.

Those agencies who dealt with occupational therapists observed that many sought their services for recruitment to jobs in new locations or for life choice issues, rather than being discontent with their discipline or the health system. One reported occupational therapists as being ‘less picky’ than physiotherapists.

Only one agency had dealt with social workers, but their observations were that like physiotherapists, money was also a motivator for career change, as was direct patient contact or exposure. It was interesting that their observations saw social workers coming from acute care and community care wanting to reduce patient contact, while those in phone-based counseling roles wanted to move into roles with more face to face patient contact.

Observations from agencies with radiographers as clients see these professionals seeking to move from clinical roles into corporate roles with large medical technology companies. Also similar to physiotherapists, radiographers were often seeking to move into such roles in the pursuit of better salaries and career progression opportunities.

The agencies dealing with pharmacists observed the most common reason for those professionals seek a career change from the public health sector was a lack of career progression. Many males said that public sector remuneration is poor. One agency saw mostly mid-career pharmacists at a career ‘cross-roads’. Most said there were limited career options other than retail pharmacy. Another agency said that pharmacists commonly sought employment with large pharmaceutical companies in roles including sales and marketing, research and development and clinical trials. These applicants considered there were broader roles, scope and opportunities in the corporate pharmaceutical sector and those employers were more likely to nurture and develop their career. Most pharmacists were willing to take an initial drop in salary to get the perceived long term benefits, including salary packages, offered by the corporates.
Regional Issues

A total of 32 interviews with allied health professionals took place at three regional locations across Australia, namely Cairns in Queensland, Mid North and North Coast NSW and in South West Victoria. Respondents were similar to their metropolitan counterparts in views relating to why they entered their profession, the factors that keep them in or drive them away from their profession, their attitudes towards retirement and how they assess success. However, issues that were either unique to, or more pronounced in regional respondents included the following:

4.1 Lifestyle

The majority of interviewees expressed views related to the impact of lifestyle on career choices and career intentions. Twenty (63%) interviewees in regional locations were ‘born and breed’ country, either from the exact region in which they now were employed or from rural locations. These interviewees expressed definite ‘pull’ factors related to the sense of community that got them back to the country, despite the majority having worked in metropolitan health services, interstate or overseas.

- “A sense of community. It’s people that live a similar way of life. You feel like you know their backgrounds more, especially when farmers come in with strokes or even just a local tradesman, you feel like you know their background and how to relate to them. It’s easier to establish rapport…. Just giving back to people who have done things for you and even if they’ve passed on, then giving back in some way to someone else in the community and helping them.” (IV39 OT F20s Reg)

For regional respondents who were not born in the country, their decision to base themselves in rural locations demonstrated the importance of lifestyle. The cheaper housing, relaxed living, less traffic and outdoor pursuits were all drawcards.

- “I was offered a position closer to Melbourne but I dismissed it pretty quickly. Bringing up kids here was a far better place rather than picking them up and dropping them somewhere else. [This town] is a very good place. It is big enough to get lost but small enough to know as many people as you want to.” (IV06 Pharma M50s Reg)

Tied to the rural existence, the impact of farming was also raised. A number of interviewees were involved in farming, either being married to farmers or part of family owned and run farms. These respondents talked about the impact of the farm in terms of financial consideration or as an influence on career intentions:

- “The farm’s a big black hole to pour your money in. I’m the sole breadwinner. I have to keep working.” (IV16 Physio F50s Reg)

- “He [husband] is very tied to his family farm and I have a feeling that our retirement is going to involve farming.” (IV44 OT F30s Reg)

This finding may not be groundbreaking however it is a salient one to emphasis to health authorities, universities and professional associations particularly when decisions arise concerning rural training schemes, allied health programs in regional universities and bursaries in allied health professions for rural and remote students.
4.2 Generalised Regional Practice

Not surprising the majority of regional practitioners identify as generalists. Some lament they are unable to specialise in their current setting and acknowledge that may force their return to a more specialised facility in a city or metropolitan location to gain the necessary skills and expertise. However most recognise that generalists best suit the health needs of a regional community.

- “It [being a generalist] hasn’t limited my career, especially in rural areas, they always say you have to be jack of all trades, master of none. I find that the specialisations are not of much use in a smaller hospital, it would be a bit wasted.” (IV03 Pharma F60s Reg)

- “Being rural based I think you tend to be a general practitioner… [Interviewer: So has that limited your career or given you greater opportunities?] Both, it’s limiting in that I’m not specialised in any area but in other ways it’s better because you do have that that wider variety in everyday practice so it’s not all the same.” (IV41 Other F20s Reg)

- “I’ve chosen general, I suppose, patients from pre-birth right through to 80s and 90s so you can’t, being 260kms from Melbourne, specialise.” (IV06 Pharma M50s Reg)

4.3 Access to Resources

Continuing Education: Almost every regional interviewee commented on lack of opportunities for accessing continuing education. There were three specific issues raised. First, location as it is difficult to access metropolitan-based CPD from many regional areas. Second, time absent from the workplace is prohibitive, especially when positions are not backfilled during the CPD absence. Third, the cost to attend CPD and to backfill positions during the absence is often prohibitive.

Many interviewees went on to say that their professional associations addressed continuing education for rural members so poorly that it lead them to discontinue membership as they did not see ‘value for money’ in belonging.

Networks: Regional interviewees commented on the importance of access to a reliable network of colleagues for information, advice, peer support and mentoring.

- “City pharmacists definitely get information first about the new therapies and drugs. That’s the thing we people in the rural areas need to do, to link to the people in the city. We link in with the people in [town]… because the boss there came from here and I’ve got a very good relationship with him... My close links with [hospital] have waned a bit over the years because I’m just not in the office to be able to maintain them. I think that’s a very important thing that you must have a link with these big hospitals and that you try to get to conferences and rub shoulders with these people so they still know you’re alive.” (IV06 Pharma M50s Reg)

Staffing: Like their metropolitan counterparts, regional interviewees noted that staffing levels are problematic and have a definite impact on their roles and their service delivery. However the main point regional interviewees made in relation to staffing was the lack of access to locums to provide relief for sick and annual leave and short term leave to attend conferences. They explained that these positions functioned to provide relief across a geographic area, and when not deployed in this way the role was based (generally) at the largest facility to provide support there. Interviewees seemed to genuinely value these positions. However recent budget cuts have led to many of these positions being axed.
4.4 Privatisation of services

A recent trend in health has been the privatisation of services, so that entire health services operate as private enterprises, or particular service units within a public health facility are privatised. In this research, the service providers impacted most directly were radiographers and hospital pharmacists. A number of interviewees commented on the impact of this on their hospital, service area, and to them as practising allied health professionals:

- “The biggest problem… is a big brother hospital in [town]… With a private pharmacy in a public hospital.” (IV08 Pharma F20s Reg)

4.5 Regional management Issues

Discussion about careers inevitably raise issues related to management. While management was discussed in all locations, it was more often raised by regional interviewees. A common sentiment concerned a lack of awareness of, and understanding by, management as to the roles of allied health professionals. Further discussion revealed that many interviewees believed the lack of awareness and understanding was related to two main issues. Firstly, management structures often see allied health ‘lumped’ into inappropriate divisions. Secondly, many believed the lack of awareness and understanding stems from allied health professionals being managed by supervisors who are not aligned to allied health:

- “There is only one head of the department and even now they are having head of allied health and not having individual discipline heads. So it’s even fractured more. And then you have all this middle management, all these business people up there. They are making decisions. They are not getting down to grass root people and that’s what I find really sad.” (IV10 Physio F50s Metro)

- “I have seen that locally, whether that has driven people out, where they don’t feel acknowledged in any real way for the work they are doing, where you don’t have a voice, where you don’t have control over your work.” (IV09 SW F50s Reg)

- “There are too many people micromanaging us…It would be nice to say have a director of pharmacy, or a director of physiotherapy who we report to, so you had a professional who understands your situation.” (IV08 Pharma F20s Reg)

We heard that sometimes rural and regional allied health professionals might have access to funds for CPD but are unable to attend. When there is no backfill for their absence, the service area often breaks down on their return. Some regional allied health professionals reported they sometimes do not go on CPD, holidays or sick leave because of the pressure to keep the health service running. There is never a “right time” to be away. We heard of one professional who was so injured they were unable to drive themselves to work. Their employer (hospital) sent a car to pick them up each day, to enable the service to continue to deliver.

Given that the most resounding response by almost every interviewee, both metropolitan and regional alike when asked “how do you measure your success?” was recognition by patients, peers and management, the sense of being misunderstood and undervalued by management has significant implications in retaining the allied health workforce, not the least being regional allied health professionals.
5 Workplace Settings Findings

Of the 126 allied health professionals interviewed, 74 (59%) were currently employed in the public health system, 64 (51%) worked in hospitals, nine (7%) in community health and one (.8%) in mental health. Six (5%) interviewees worked in a private hospital, five (4%) in aged care, 11 (9%) with government agencies or departments, 10 (8%) ran their own practice, 15 (12%) worked in other health sectors, two (1%) were not currently employed and three (2%) were retired.

While the majority of interviewees currently work in the public health sector, this is not to say that their perspective is limited to this setting. Most have worked in a number of settings throughout their career. Some worked in private practice but chose to come back to the public system, some had worked with government and non-government instrumentalities, others in non-health sectors. Within public health, many interviewees had exposure to a variety of practice settings: acute care, rehabilitation, mental health, aged care and community and home based services. Only a few interviewees had stayed in the one setting during their career - affirmation of the transferability of allied health professional's knowledge and skills base. Diversity of workplace settings in turn gives rise to a great range of opinions and perspectives on the positives and negatives of each setting. These sentiments are reported below.

5.1 Acute care public hospitals

Almost every interviewee had worked in a public hospital at some point in their career. The majority of interviewees still do. Most recognise the value of this experience and commented that this part of health provides safeguards and security of tenure. Public health is characterised by a strong commitment to multidisciplinary teamwork and the casemix of hospitals is diverse, interesting and allows for specialisation:

- “I find hospital work and working with key patients is more satisfying because you see the gains and the difference that you are making.” (IV25 Physio F30s Metro)
- “You have relationships with doctors and with nurses and with all the other multidisciplinary staff in the hospital and that is really exciting. It is exciting to be part of a team like that.” (IV34 SW F40s Metro)

However interviewees acknowledged that hospitals are often difficult places to work – they are complex organisations, sometimes messy and chaotic and more often than not, slow to respond to change. Hospitals have distinct cultures and power bases and are steeped in bureaucracy and rules. They are also plagued by a lack of funding and staff shortages.

- “You felt you had to apologise in the hospital system that you are going to treat someone because you weren’t going to get to into a committee meeting. If you wanted to spend longer with somebody you couldn’t. If you wanted to see somebody six times instead of four you couldn’t.” (IV13 Physio F30s Metro)
- “Public health bureaucracy and the scrutiny of public health system takes you away from clinical work.” (IV34 SW F40s Metro)
- “The public health system does have that security, you know, you can’t be sacked.” (IV14 Pharma F30s Metro)
5.2 Private practice

Around 60% of physiotherapists and 80% of non-hospital pharmacists are in private practice. We interviewed a one occupational therapists and a few social workers in their own practice but did not interview any private practice radiographers. Interviewees in private practice were either owners of private practices or employees working in a private practice. They cited positives of this domain as being autonomy, flexibility in terms of the way they practice and not being constrained by the bureaucracy of the public health system. Specifically, that meant less meetings, less paperwork and less red tape.

However the economic imperatives of running and managing a business introduce new pressures. The importance of being competitive and operating a sustainable enterprise, of marketing and selling services, and of charging or billing clients do not always sit easily with allied health professionals, yet those issues are implicit in private practice. In many cases interviewees identified these and the business administration and human resources duties as a negative of private practice as they take the professionals away from the clinical role. Those who have gone into health for moral and ethical reasons with a desire to help others can find it difficult to adjust to billing people. They feel the daily need to be providing a worthwhile valuable service.

Further, some interviewees felt this area of practice was not rewarding as their caseload often became boring and repetitive and clients were ‘churned through’. This resulted in little time to establish a relationship:

- “I was told I was too client focused, you know, and I remember just thinking, oh I thought that’s what I was supposed to be.” (IV44 OT F30s Reg)
- “Going to private practice for me, I just found I was doing the same thing over and over again and eventually became bored.” (IV25 Physio F30s Metro)

5.3 Community health

Interviewees working in community health identify it as a rewarding workplace, a sector that affords employees flexibility in terms of work arrangements and conditions and an environment that genuinely embraces the concept of multidisciplinary team based care:

- “I much prefer community based care, not the hospital environment.” (IV20 OT F50s Reg)

The major negative factor associated with community health reported by interviewees currently and previously employed in this sector was the nature and complexity of cases. Often interviewees said they found it extremely difficult to disconnect from their cases, which in turn left them feeling stressed and burnt out.

5.4 Aged care

Interviewees who currently work in this sector and those that have worked here previously emphasise the tremendous satisfaction they gain from working in aged care. They believe it to be a rewarding and fulfilling segment within health and consider they make a real difference – albeit sometimes only a small difference – to the life of their clients:
- “I like working with older people. They are very much more appreciative than younger people and say thank you a lot. And I’m respected here which is a nice thing.” (IV45 Physio M50s Metro)

- “I like working in aged care partly because it’s done so poorly that, you know, you can only improve it… I enjoy working with the people and they are just fun to work with. They are very, very knowledgeable. They’ve got lots of stories they can tell you. They are very practical people.” (IV10 Physio F50s Metro)

Interviewees concede this is an unrecognised sector by allied health, management and government and a situation that needs to be addressed as the Australian population ages.

- “Most of them didn’t see themselves with a career in aged care and a lot of it was because they made assumptions that when you actually looked at what they were saying, it was just untrue. So they are ill-informed about aged care.” (IV10 Physio F50s Metro)

- “It’s a very viable career option. There are a lot of different levels in aged care that people can work… other allied health people also.” (IV10 Physio F50s Metro)

5.5 Corporate

Medical technology and pharmaceutical organisations are popular destinations for the former allied health professional. Medical technology companies themselves acknowledge the potential problems of not having enough employees and are addressing their workforce planning issues as an industry. Generally, recruiters and managers in medical technology firms like to employ experienced health employees. Those employees are more likely to understand the protocols and bureaucracies of the health systems and hospitals and therefore require less training on those aspects of their work. However, some former-health-worker-turned-med-tech-employees, after being socialised into health system bureaucracies, need extra training in working in a corporate environment. We heard instances of new medical technology employees from health asking for instructions such as how to clock on and off, asking for permission for a lunch break and telling people when they went to the bathroom.

We found that former health and allied health workers could see the transferability of their skills from clinical into corporate environments. Some will take a pay cut in order to have the opportunity for more long term benefits. One former nurse, now in med tech, said corporate employers recognise the transferable skills of the health and allied health worker. Corporate health organisations tend to allow transfers within the organisation without loss of salary or status. Large corporates can offer a varied career with potential for a high salary. The major reasons that allied health professionals tend to move to corporate health, other than increased salary, include the perception that health corporate is a more glamorous life with a company car and high heels but no uniforms or shift work. These benefits are coupled with perceptions of increased attention and nurturing of the individual’s career as corporates use the latest human resources practices including reward structures and training and development opportunities.
6 Education and Regulation

6.1 Education

Each of the participating allied health disciplines undergo different training programs in order to qualify for professional practice. Most of those interviewed (49, or 59% of the target occupation interviewees) had undergraduate Bachelor of Applied Science degrees in physiotherapy, occupational therapy or diagnostic radiography, or bachelor degrees in pharmacy or social work. Four (5%) late career interviewees trained before their programs were incorporated into the university sector and so hold diplomas from colleges of advanced education. Most upgraded the diplomas to degrees, but a few did not. No interviewees had undertaken the newly introduced graduate entry masters (GEM) programs offered by some university health science faculties.

Interviewees recognised the value of their initial training in allowing them to practice in their chosen profession and for providing them with career mobility:

- “What influence has my skills and education had on the role I am doing? Everything. I think they shaped the way I work. I would say it has been critical to developing me as a practitioner.” (IV09 SW F50s Reg)

- “It’s been fantastic. I’ve moved up…, worked casually in a hospital as well as locum work around other hospitals. It’s been a great career for someone who likes travel and go and try different things and see the world.” (IV42 Radio M30s Reg)

However some still question their preparedness for the workforce and questioned people’s aptitude to enter into allied health roles

- “It doesn’t prepare you academically and it doesn’t prepare you for the skills that you have to pick up as the years go by.” (IV03 Pharma F60s Reg)

- “Uni does not prepare people for real work… Some people are just not cut out for allied health and there are many who don’t find this out until they have finished their degree.” (IV25 Physio F40s Metro)

While not a common theme, this does raise whether there is value in considering interviews and/or supplementary testing, as per entry into graduate medical programs, in order to assess aptitude for entry into allied health roles.

There were 27 (32%) interviewees with postgraduate, mostly masters, qualifications in areas such as health administration, accountancy, business and management, or a masters specific to their discipline. We interviewed three (4%) allied health workers with PhDs.

Those who did not have postgraduate qualifications cited time, costs, accessibility, family commitments and the inability to juggle multiple roles as the main reasons they had not pursued postgraduate education. They did consider they kept up to date, however, by participation in activities conducted in-house by their employers and by their professional associations. These activities included conferences, seminars and continuing professional development (CPD) programs.
6.2 Skills

Interviewees identified generic skills they considered imperative for their practice in addition to skills specific to their discipline and practice domain. Skills identified included:

- navigating the health system and working in different health environments and practice settings
- advocacy, negotiation and liaison skills
- legislation and law
- organizational, management and HR skills particularly as they move into management roles
- working flexibly and innovatively
- clinical decision making
- problem solving and analytical skills, and
- working cooperatively and in team based care.

The most consistently reported and valued generic skill was communication and people skills. Interviewees strongly identify the importance of communicating regularly with patients and carers, of communicating effectively to allow orders and instructions to be understood and followed and of taking a holistic approach to understand the patient and their circumstances.

- “I think it’s being able to empathise with people and think it from the patient’s perspective.” (IV43 Physio F50s Metro)
- “Yeah, I think I’m a good delegator. My family told me I’m a good delegator. I delegate too much and I also can prioritise. When you have trained in acute care and you have got 30 patients to see on an ICU if you don’t delegate who’s most important, someone could die. But obviously that’s not going to happen to me but when you have facility like we do… you need to know who to see first. It’s important.” (IV15 Physio F50s Metro)

6.3 Registration and Accreditation

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA’s operations are governed by the Health Practitioner Regulation National Law Act 2009, which came into effect on 1 July 2010. This law means that for the first time in Australia, 10 health professions are regulated by nationally consistent legislation. The professions regulated by the AHPRA are chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry, psychology. On 1st July 2012 occupational therapy will become a nationally registered occupation. AHPRA supports the National Health Practitioner Boards that are responsible for regulating the 10 health professions. The primary role of the Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

Responses from interviewees recognise the importance of such a scheme, from the perspective of the patient, the health service and themselves:
• “I think it’s a good thing for the profession. I think it gives you guidelines and gives you standards. It gives you advice, the registration board. I think it’s important to be registered. Most professions you have to be registered in some way – engineers, doctors.” (IV16 Physio F50s Reg)

• “Well I think registration means that you are a professional.” (IV11 Radio M50s Metro)

• “People ask about our registration in terms of other disciplines and they are quite shocked that were not. I think it would be good for the OT field.” (IV07 OT F20s Reg)

• “Fantastic. It can make a big difference.” (IV21 OT F60s Metro)

There was some discussion of reciprocal international registration:

• “I wouldn’t have been licensed in Australia if there hadn’t been a reciprocal agreement with Britain. If a Canadian pharmacist wants to come to Australia they have to do whole lot of exams. I just had to do a law exam.” (IV03 Pharma F60s Reg)

• “Pharmacy has been a very transferable skill between UK and Australia. The training between the two countries is quite uniform, or certainly was in the late 1990s when reciprocal recognition of registration was in force. It is a shame that they are no longer in place. I think the pharmaceutical registration bodies in both countries have a lot to answer for on that front.” (IV33 Pharma M40s Reg)

6.4 Professional Development, Recency and Resumption of Practice

As the body of knowledge grows faster every year and technology enables techniques and practices previously unheard of, it is even more important to ensure that professionals are competent to practice and maintain their professional standards. Continuing professional development (CPD) is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence and develop the personal and professional qualities required throughout their professional lives. Professional development activities includes participation in formal learning activities such as attendance at courses or conferences as well as non-formal learning through self-directed learning, peer review, practice experience and interaction with colleagues.

Under the Health Practitioner Regulation National Law Act 2009, all registered health practitioners must undertake CPD. The number of credits, points or hours that practitioners must spend each year on learning activities varies according to the discipline. For example, physiotherapists must complete at least 20 CPD hours per year, while pharmacists require 20 hours of CPD for 2011 registration, 30 hours for 2012 registration and 40 hours for 2013 registration. We note that nurses and midwives require 20 CPD hours per year. Some professions provide additional guidelines in their Codes of Conduct and bylaws for membership of their professional association, for example participation in CPD is a mandatory requirement for membership of OT Australia.

Recency of practice (ROP) as a barrier to career re-entry: Recency of practice (ROP) means that a practitioner has maintained contemporary practice in the profession since qualifying or obtaining registration (AHRPA). Some profession registration boards have a ROP requirement in addition to CPD. ROP is a relatively new concept and may have more implications for the career
intentions for allied health professionals and for health workforce participation. Career re-entry is a major issue, particularly in the female-dominated allied health professions. Gaps in practice for child rearing, for example, mean that if a woman leaves the workforce for childcare duties and does not resume work until their child starts school, they may be ineligible to practice. Similarly, time out to undertake roles as carers for ageing parents – a scenario likely to increase in frequency as the population continues to age – have to be carefully considered if an allied health professional wants to resume practice after a period of absence.

Registration usually also entails demonstrating ROP. All registered physiotherapists practicing in Australia are required to maintain their competence to practice. Physiotherapy practice has to have been undertaken during the five year period immediately prior to the commencement of the registration period. Pharmacists need a minimum of 450 hours in the last three years (i.e., 12 weeks in three years) to demonstrate recency of practice.

For both CPD and ROP, practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. For the purposes of registration standards, practice is not usually restricted to the provision of direct clinical care. It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe effective delivery of services in the profession or use of their professional skills.

CPD and ROP place additional responsibilities and expectations on allied health professionals. While some interviewees raised issues of cost and accessibility in relation to CPD, all accept CPD as a tacit requirement for professional practice and a positive to help ensure they are up to date with contemporary practice.

• “Well, I think it should be fine, I mean, now we have gone to compulsory CPD points. So we have to have 20 [hours of CPD] this year, 30 next year, 40 the year after, but in a country town up here we don’t have access to too many actual face to face CPD activities, so we will be able to subscribe to PSI and get the magazines to do the work that way. That is about $500 just to get the magazines and to be a member.” (IV08 Pharma F20s Reg)

Additional CPD requirements: There are two additional considerations we noted with some CPD requirements:

• First, some CPD standards require CPD to be administered by persons with the same or higher qualification.

• Second, many standards require that the CPD be directly related to the current context or area of practice.

These requirements pose a potential barriers to the allied health professional’s expansion into new practice areas – where the qualifications of the educator are not from the same profession. For example, an allied health professional attending a mental health CPD activity presented by a psychologist may not be given CPD credit.

These requirements may be especially difficult for allied health professionals in some regional areas. Especially when combined with the relevant qualifications requirement, often there are not enough senior and experienced allied health professionals to be able to provide CPD to mid-career professionals.
Interviewees reported their need to have a reliable network of colleagues for peer support, conferencing, funding and travel to CPD. Interviewees reported often there is no funding available for part time allied health professionals, who then have to self fund their own CPD.

**Resumption of Professional Practice (RPP):** Given the potential barrier of ROP requirements, the availability of refresher programs or resumption of professional practice (RPP) schemes therefore becomes critical. Some allied health disciplines have RRP schemes in place. The Australian Institute of Radiographers has developed a programme for diagnostic radiographers and radiation therapists resuming professional clinical practice after an extended absence. Their Resumption of Professional Practice (RPP) program aims to provide a structured pathway to facilitate the recommencement of professional practice. The RPP program is customised for each individual to reflect differences in academic qualification, previous experience and the duration of absence from professional clinical practice. Each RPP programme incorporates a professional clinical practice placement and may include academic study requirements. The RPP programme concludes with a competency based assessment, after which a validated statement of accreditation is awarded. Fees for assessment range from $440 to $1100.

OT Australia recognise that an obstacle for career re-entry is the absence of a refresher program that is sufficiently broad to meet the diversity of clinical practice areas in which occupational therapists work. However this item is to be addressed in the upcoming strategic plan for OT Australia. Likewise, the Society of Hospital Pharmacists of Australia acknowledge that short refresher courses are available for pharmacists, however they have a limited role to regain registration. Pharmacists must complete workplace-based training which may involve completing a full new intern year or resitting final exams.

While ROP and RRP schemes were not commented on widely by interviewees, it is suggested that close consideration be paid to career re-entry for allied health professionals. Given the recent conversion to national registration and consequent likely increase in the formality of registration requirements to include CPD and ROP for many allied health professionals, we suggest this aspect of professional development will require increasing attention. We believe that there will be larger numbers of allied health professionals who choose to not return to their profession after a break to care for either children or parents due to the perceived difficulty of maintaining CPD and ROP activity. We consider this is a major area for further research and practitioner attention.
Professional Association Membership

Interviewees confirm that membership of their professional association continues to be an individual and personal decision. Regardless of age, gender, practice setting, work location or allied health discipline, the decision to belong to a professional association varied considerably.

Many interviewees were members of their professional association, some were active members and members of subcommittees and special interest groups, while others were members of more than one professional association relevant to their particular discipline and practice needs. These interviewees reported advocacy, representation and professional indemnity insurance coverage as important services, while continuing education was the most commonly stated reason to belong.

- “The opportunity to do courses, be part of an organisation that is out to promote… around the world, promote the members and the profession. And I think it’s important to be a member of your professional society per se.” (IV04 Physio M60s Reg)
- “Lots of things, continuing education which is compulsory for our registration, that’s probably the key thing. It’s also a voice – they represent and advocate.” (IV41 Other F20s Reg)

Some interviewees considered that membership was more relevant to different practice settings.

- “I think if you are in private practice it is very important to be part of the association because the insurance, the discount that you get and the advertising discount that you can get, you know. I think it is good for your patients to know that you are part of the association if you are in private practice, but if you are working in a hospital, I don’t think it’s as big a deal.” (IV25 Physio F40s Metro)

Interviewees who were not members of their professional or any association most commonly cited cost and lack of value for money as being the reason for non membership. Some of these respondents commented that they had never been members of their association, while others had let their membership lapse.

- “It’s too expensive and it doesn’t give the benefits that you pay for.” (IV07 OT F20s Reg)
- “I am not after who does the, you know, American Express card, gives you freebies and things like that. I am more interested in the educational updates.” (IV10 Physio F50s Metro)

Two interviewees commented that they considered their industrial union to be more relevant and effective in representing their professional needs:

- “I have found for me the union have been the people who have been there for me and not just from fighting for salary rises, but where there have been issues with regard to work.” (IV48 OT F60s Reg)
7 The Health and Career of the Allied Health Professional

7.1 Health of the Allied Health Professionals

We observed that interviewees reported physical problems that were a direct result of their occupation. Well known examples include the worn-out thumbs of the physiotherapist and the aching back of the radiographers. However, we also saw the effects of the social worker with a bad back from spending so much of their day sitting and listening to client stories. We understand that hospital pharmacists (and likely for community pharmacists too) frequently suffer from the long hours standing. These and other physical effects are likely to increase as the workforce ages:

- Allied health workers will look to alternative careers that are less physically taxing
- Some of those careers will take them out of the health system and
- Those moving out of the health system will need to be replaced.

We recommend that job analyses be conducted to ensure the daily, weekly and annual strain on the long term allied health worker is sustainable. Some small job or workplace re-design may extend the career of many allied health workers.

The emotional aspects of much of the work of allied health workers is rarely acknowledged in the literature or elsewhere. Examples of emotional work include telling the parents of a newborn baby that their child is blind, or the social tragedy seen every day by social workers.

7.2 Career Success

We asked what career success meant to the allied health professionals. Female interviewees seemed to have different concepts about career success to male interviewees. The women were less interested by upwards career progression. They seemed to desire job satisfaction and were rewarded by outcomes and recognition. Beyond gender differences, it is clear that allied health professionals do not go into the public health system to make money. Our interviewees were well aware of the financial limitations of working in health. They were drawn into health because, they said, they want to help people. This is reflected in how they measured their career success:

- “It’s always good to get feedback, that’s makes your day and you pass it on to your staff. I had a medical practitioner give good feedback last week which I passed on to the staff and that gives you a lot of satisfaction.” (IV03 Pharma F60s Reg)
- “Yes I want to be happy in the role. As I said I’m not ambitious in the sense that I have to aim for bigger things. I have a clinical role, I don’t want to give it away.” (IV04 Physio M60s Reg)
- “I just measure it [career success] on how you enjoy your job, whether it provides you with the lifestyle you want to lead. I wouldn’t say that I have a career, I have a job so if it provides enough for myself and my family to live where we want, go and do what we want – then that’s success to me.” (IV42 Radio M30s Reg)
- “I think it [career success] for me is coming home at the end of the day and feeling like you’ve made a difference. Just feeling really good about yourself leaving the workplace thinking that I’ve helped all those people.” (IV39 OT F20s Reg)
7.3 Career Choice and Mobility

Attraction to allied health careers: The older allied health professionals had few role models when they were making career choices and many reported stumbling on their career through unplanned serendipitous events. Many knew little about the job when starting, making career choices based on scant information, hearsay or recommendation from “a friend of a friend”. One OT who researched before selecting her career tells:

- “I wasn’t quite sure what to do [when I finished school]. I was actually thinking of being a kindergarten teacher at the school at that time. And then there just happened to be an OT living up the street… I think she was working part-time at Princess Alexander Hospital and I was allowed to visit the department and have a look at what an OT did there… she was basically a neighbour but she was also a friend… I was in year 12 when I was trying to determine what majors I was going to do and everyone was elbowing you. My mum… was a social worker, so she was sort of really aware of the health system and health professions and some of the things like that so she was aware of what an occupational therapists did, etc. And you know, she had a bit of contact with Louise and yeah …it was just an option that she put forward. And Louise was there to provide me with the information and experience of an OT department.” (IV01 OT F50s Reg)

- “I didn’t even know how to spell physiotherapy, I didn’t know what it was, but the local GP thought that maybe I would be interested in doing that and so I pursued it and found that I really enjoyed it.” (IV10 Physio F50s Metro)

- “I think just a fascination with making up medications which you did in those days, it was much more of an art. I’ve always liked to do that but it’s a lost art. When I was a teenager I worked in the local Boots the chemist on a Saturday and thought yes, this is interesting. I’d thought of doing dentistry but I’m glad I didn’t.” (IV03 Pharma F60s Reg)

- “I started teaching at uni and realised it wasn’t for me, I’d always enjoyed health at school and I like to be around people and a friend was doing OT and explained it to me, I just thought that sounded interesting, did a work experience placement and quit my teaching course.” (IV07 OT F20s Reg)

- “I always liked something in the medical area. I thought about doing medicine, but I didn’t have the marks and time and this was something that was a shorter course, three years… Radiography, as I said I always wanted to do something intimate. I have a passionate side to me, you know, I have always warmed to trying to help people and I thought this is honorable and admirable to do, something in medicine. I suppose that’s the real core of it and I just, you know, I just sort of went that way. Radiography was a shorter course and I thought – my marks allowed me to do that sort of thing and when I got into it and the fact that you liaise with a lot of others. It’s a teamwork in hospital sort of thing. I really enjoyed it and I don’t think I have made the wrong decision.” (IV11 Radio M50s Metro)

- “I liked science and I suppose I was interested in how I could use my interest in science particularly in chemistry in a career that I could easily find work… And so at school my science teacher sort of advised me, even my chemistry teacher advised me to go into pharmacy because she said oh, you can find part-time work, fulltime work and can work in a variety of places and, you know, you need to have that grounding in chemistry to be able to do pharmacy.” (IV14 Pharma F30s Metro)
Younger allied health professionals seem to have a different perception of where their career is headed than older professionals. Some allied health workers are motivated by glimpses of the so-called glamour seen on television, such as sports physiotherapy. We note this lack of role models is in contrast with nursing and medical role models, prolific through Australian and international television dramas such as Country Practice, All Saint’s, Grey’s Anatomy and ER.

**Allied health as a foundation for other health careers:** There is belief that being a health worker provides a good foundation for future careers. It is a stepping stone into other careers, not just in health:

- “If I had to do retraining, I would. But I would be hopeful that my skills as a health professional would carry me through.” (IV41 Other F20s Reg)

- “Having OT as a background allows you to work in health prevention roles. [My skills include having a] problem solving approach because answers aren’t always black and white in OT. Having a holistic approach, looking at a client but it’s not just looking at them in one area. It’s all the roles they do, looking at the environment and their occupations as well. I think we have a very global view of a person and being able to apply that to a community. I think that would allow you to maybe work with perhaps the council.” (IV39 OT F20s Reg)

**Alternative “fantasy” careers:** The majority of the allied health professionals we interviewed were happy with their careers. They were mostly of mature age and well established in their careers. However, we heard yearnings for alternative career paths. We came across allied health professionals who think about alternative careers sometimes as a fantasy to leave the stress and responsibility of health care behind. These alternative careers, unlike health, are perceived as glamorous and easy. Alternative careers tend to be the type of job a worker can walk away from and not feel the guilt of the health care worker who leaves work ten minutes early to pick up children or to beat the peak hour traffic:

- “I’ve often thought about being a fashion designer, or a check-out chick...” (IV41 Other F20s Reg)

**Sequential health careers:** Four interviewees had been nurses in a former career, indicating nursing and could be a potential source of new allied health recruits. Nurses tend to have the foundation health skills and often want to change career into another part of health without losing the rich health background they accumulated as nurses. The advantage of mostly daytime and often part time allied health work is attractive to many former nurses.

**Dual allied health registration:** Only one interviewee was multi-skilled in two allied health disciplines, being a nutritionist and an occupational therapist. She does not, however, use both skills sets and has dropped one registration due to the costs and demands of dual registration.

**Portfolio or concurrent careers:** We note that allied health professionals are different to nurses who are able to do a small amount of nursing “on the side”. Nurses will often do one, two or three shifts to maintain their practice. Shift allowances for evening and night shifts can generate a weekly wage in fewer shifts. For the target occupations of this study, that 24 hour shift work is available mostly only to the radiographer in a hospital or occasionally to the social worker in a residential or emergency services setting. A possible implication of this is the “all or nothing career” of the allied health worker.
Availability of part time work: We note that a great many allied health professionals have taken advantage of being able to work in part time daytime roles. The advantage of the daytime hours means the career fits in with much of society and is less disruptive than, say, a nursing shift roster. Many interviewees reported being able to fit family commitments such as raising children around their part time roles. The flexibility of only working three days a week, or finishing a shift at 3pm in time to pick up children from school, was important to many allied health professionals at appropriate times.

Ramping in and out of allied health: Human resource management practitioners sometimes refer to employees “ramping in” or “ramping out” of their organisation. Ramps in to the organisation are for those employees coming in to the organisation, such as starting part time and converting to full time, starting casual and converting to permanent, or returning to part time work after a period of maternity leave. Ramps out of the organisation are at the other end of the employment cycle. Ramps out of an organisation include converting from full to part time employment, moving from employment to consultancy or taking extended sabbatical or long service leave prior to retirement. These ramps are intended that both the employee and the employer benefit from an orderly transition. We note that professional registration, CPD and recency of practice costs and requirements are barriers to ramping in and out of many allied health careers.

Small regular hours to maintain registration: Because allied health roles are usually daytime roles, an allied health professional considering a change to a business or corporate role, for example, is generally required to make a full career change. This contrasts with a nurse who may be able to “ramp down” their nursing and keep a few weekend shifts “on the side” in case things do not work out, or as supplementary income. The allied health professional is less likely to be able to do a shift or two of casual, occasional or “on the side” allied health work. We understand that when the allied health professional moves out of allied health, it is almost always a permanent move as the perceived barriers to re-entry are too costly. The allied health workforce is thus depleted of those professionals who might otherwise be willing to work a little “on the side”. We would encourage allied health employers to consider offering short or occasional regular shifts for those professionals who might otherwise leave the allied health workforce entirely. One example we were offered was for a physiotherapist to be able to keep their hand in and maintain their registration with a single weekly shift of yoga lessons.

Use of recruitment agencies: We also note that allied health professionals are less likely to use specialist recruiters when compared with other sectors such as business. This may say something about the allied health professionals’ methods of job search, their perceptions of their own skills and the services available to them when job seeking. Many allied health workers often do not appear to value their interpersonal, relationship, analytical, reporting and communication skills. The allied health professionals may not be as adept at marketing their skill set as those other professionals who take advantage of recruiters, career counselors and other internal or external career coaches.

Career progression and mobility: We noted that those allied health professionals who had left the health sector were more likely to report a limited career path in health than those who stayed within the health sector. Those who stayed within the health sector seemed to be aware of their career options. Many still within the health sector suggested their career progression was more likely to be about luck and opportunity of being in the right place at the right time when an appropriate vacancy was available.
However, many other allied health professionals saw a great deal of career mobility and opportunity in the skills acquired in their allied health training. In response to the question “To what extent do you think your education and training have allowed you to have mobility in your career”, we were told:

- “It’s been fantastic, moving up to NSW, working casually in a hospital as well as locum work around other hospitals. It’s a great career for someone who likes to travel and try different things, and see the world.” (IV42 Radio M30s Reg)

- “If an opportunity came up to teach nurses about medication at TAFE, I would seriously look at that.” (IV03 Pharma F60s Reg)

- “The fact that I’ve been able to do post grad education, courses that I’ve been funded for... That all shaped and trained me so I feel up to date with physio. We have in-services twice a week so people who have done courses can tell us what they’ve learned.” (IV04 Physio M60s Reg)

- “I think it was really hard for me to leave that job at [hospital] because even though I had been there for that short time I moved around in a lot of areas but I had really only been at [specialist centre] doing exactly the same thing. It took me a long while, in my head, to be able to walk away from that because it was secure. But I had also learned so much. But once I did that, it enabled me. I wasn’t afraid of change anymore.” (IV15 Physio F50s Metro)

- “More experience, different opportunities, seeing how other people do things. I have tried never to say no to higher duties or, you know, standing in for people and things that seem interesting.” (IV21 OT F60s Metro)

- “I just took a new opportunity that was there to develop new skills myself, so I think the thing is new challenge. New challenge, new skills, okay? And there's a common theme. It’s a common theme, stepping up, you know. Yeah, and then you find that you like it, or you don’t like it. But mostly I’ve liked it.” (IV28 SW F40s Reg)
7.4 The Career as a Specialist

Some allied health workers prefer to specialise rather than generalise:

- “I started off just being a generalist because that was my experience but over the years I gradually narrowed it down because… these days you can’t be a generalist, you have to specialise and there was a paediatric practice started up and a hand therapy practice started up. So I felt right, I don’t need to do that, then. I can specialise.” (IV01 OT F50s Reg)

On the other hand, some – especially in regional areas – prefer to stay as generalists:

- [I have stayed a generalist] “Because I think you can lose those skills… if you specialise. I mean I think it is great to be a specialist and… perhaps if you are renal specialist you work with the renal team… But, you know, you lose other skills. So I think… it is like being a GP or a specialist I guess. You know, I want to keep all those skills up and if you specialise you will lose them for sure.” (IV29 Pharma F60s Reg)

- “I’m a generalist. I’m not a specialist. My love is musculoskeletal physio. I like the back, neck, knees and hips. Clients walk in the door, coming frightened after having had a fall. They have a fractured hip, can’t walk. Getting them going and seeing them go home and pick up their lives again. That’s satisfying, a good big geriatrics role which is important. And I have been here so long that I’m known by everyone.” (IV16 Physio F50s Reg)

And sometimes there is uncertainty:

- “In terms of getting another position, I think it helps having a taste of everything, to be generalist but down the line I’d like to specialise in rehab.” (IV07 OT F20s Reg)

Some allied health professionals take the call to management:

- “Initially I was going to stay with neuro. I really liked neuro, you know, the head injuries and these minor fractures and things like that and if this role didn’t come up then I probably would have stayed in neuro. But I found that as a senior physiotherapist there is only so far you can go. And then it just started to become stale, you know, that this is as far as I could go, you could just be specialised in this area and work in this clinical area for the rest of my life. But I got a little bit bored so an opportunity presented to step into the deputy position where it was a variety of clinical as well as management and you could do different things. I jumped to that opportunity because it was something different.” (IV26 Physio F50s Metro)

We saw few instances of mid career allied health professionals changing their specialty or going from specialty to generalist. We are advised, however, that there is a growing need for experienced specialist allied health professionals. Allied health professionals with experience in mental health, working with disability and aged care are some of the specialties highlighted.

**Early career specialisation:** There was a common theme that early career specialisation is limiting to a professional’s later career choice. Early career specialisation simultaneously de-skills the allied health professional as well as reduces exposure to a broad range of potential work environments. The major recommendation from allied health professionals is that new graduates should not go to private practice too early.
Job change when specialising: We observed that workers seeking specialisation would often be forced to leave their current employer in order to make that career change. For example, radiographers wanting to move into ultrasound would need to move to a bigger hospital where the modality is offered and where there are developmental positions.

There is a perceived lack of opportunities by specialising who perceive that they limit their career movement. An example of specialisation is recent trials for occupational therapists in new health system departments. This poses the dilemma of how an employer organisation attracts allied health professionals to those roles when the specialist nature of the role may limit their later career options. There is an assumption is that the specialist role will limit the opportunities of the allied health professional, while in reality it should not limit their career options.

Generalists outside the city: Acceptance of the generalist role is more dominant in regional areas because the varied caseload of a wider community. In addition, working alone or in smaller professional teams means there are fewer opportunities for regional allied health professionals to specialise than there are opportunities for city or metropolitan allied health professionals where specialisation is often the most effective way of working. Regional allied health professionals told us that if they wanted to specialise then they would generally have to leave their current job and therefore also their home, to go to the larger employers in the city.

Professional Associations response to specialisation: Physiotherapists have reported an inability to specialise as being a driver of career change out of physiotherapy. One said they felt lucky to have found a new specialist area because a colleague fell pregnant and created a vacancy. The APA has developed a career development path to keep physiotherapists within that profession. The APA has developed specialisations and fellowship membership with “specialist physiotherapist” nomenclature to recognise the career path of the experienced practitioner. OT Australia also recognises the increasing trend to specialisation in occupational therapy. Other allied health professions such as psychology are fiercely protective of their specialties, not dissimilarly to the medical professions’ college structure which has significant entry hurdles.

Multi-skilling or multi-specialty of the allied health roles is an attractive alternative for health service executives. Multi-skilling is seen as an important part of the solution to improve workforce innovation and flexibility. Health service executives have increased flexibility with workforce allocation when traditional role boundaries are blurred. This flexibility is currently the case for allied health assistants and less so for allied health professionals at this stage.

Professional identity: Role boundaries play an important component in professional identity, as professionals are normally defined by specialist training to perform work that is not able to be performed by others. Blurring of role or job boundaries, therefore, is in direct contrast to the intense personal desire of many individual workers who seek the respect of a professional identity and the recognition that brings in the workplace and the community. Professional associations, too, tend to work to retain the identity of their professionals.

- “I would suspect the actual professionals all think they are in a world of their own but certainly the allied health assistants already work across different areas, so I certainly see a place for that.” (IV32 Pharma F40s Reg)
It is important to be aware of the possible impact of role blurring on allied health professionals at all career stages. Further research is required in this area. One allied health professional reported:

- “I was running out of staff and appointed a guy who was an exercise physiologists to do physio work on a limited basis. But some on my staff were not happy. They felt threatened... One of my staff was in tears saying “you can’t do that”. I said “this is my choice”. But I made sure I checked it with my Director.” (IV04 Physio M60s Reg)

Some allied health professions scoffed at the idea of “a generic, multi-skilled allied health worker”:

- “So someone who goes across the whole thing, so they’d have minimal skills and do a half-assed job? About the only thing that could be good for would be liaising across the departments maybe. But from a radiography point of view we don’t need to know what the others are doing. If they require us they just come and ask. As a department we work independently from the rest of the hospital so it’s not really required.” (IV42 Radio M30s Reg)

There is a risk that the increased call for generalisation as a short term vision for the health service may result in allied health professionals being more likely to leave the health service and result in a long term loss of resources to the system. There is also the risk that the health service may be perceived as less attractive as an employer, thereby creating greater workforce pressures.
7.5 Retirement

The allied health professionals told us there was no standard age of retirement. Rather, they want to transition out of the workforce, or “ramp down” slowly. Most of the allied health professionals we spoke with who are coming to their later career stage are looking to continue to participate in paid employment but not in a full time capacity. They said they get immense personal satisfaction from their work and most would like to work as long as they physically are able:

- “The most terrible thing is thinking about waking up at 8.30am and thinking will I get out of bed or not and then at 9.30 going to talk to the milk-bar owner for half an hour otherwise you have to go back home. It’s terrible to lose the skills of somebody aged 65 not because of ability, dumping them just because of age determining if someone is redundant! I like to think I can go on for a while before that concept gets to me and I feel I have to retire and go around in my caravan or play golf or something. What a waste of skills!” (IV04 Physio M60s Reg)

Allied health professionals are often forced to retire from their professions due the physical limitations of their body. The lifting, the driving to work, their reading and so on deteriorate naturally with age. However, many allied health professionals said they expected to still have a desire to maintain a connection to the workforce due to the satisfaction of continuing to work. Older workers appear to want give back to their profession also, with many interested in taking volunteer, mentoring and educational roles in their retirement:

- “No, it’s hitting 60, I don’t want to retire and do nothing. I’ll be going to do something else, I’d like to come in here for a couple of days, let the new person get started, set their agenda and I’ll come in and do the dirty work.” (IV06 Pharma M50s Reg)

- “I don’t see myself stopping in the near future. I mean, I put a number on it – five years but I mean what’s five years? It will be here before you know, so I think I will just see how things pan out. But I have got no intention of stopping next December and saying, well that’s it, my work life is over. Because even if it’s volunteering, I’ll still be doing something.” (IV10 Physio F50s Metro)

- “Down the track I think I will always have an interest in physio. It has been a good profession to me.” (IV10 Physio F50s Metro)

- “I will continue to work for as long as I can contribute something, so physically maybe I may not be able to and mentally I may not be able to.” (IV20 OT F50s Reg)

Allied health professionals’ choice to retire appears to be influenced by their ability to participate in their other life roles. Older workers do not want to participate in full time work because they have grandchildren, children living overseas and other hobbies and interests that they would like to enjoy.

On the other hand, older allied health professionals do want to continue working because for many it is a large part of their identity and their social circles. Many older allied health professionals we spoke with said they feared that by stopping work altogether too young, they will be ‘lost’.

Women in particular appear to be unaffected by their husband’s retirement. Many suggested they will continue to work despite their husband retiring from full time paid work:
• “I don’t want to be stuck at home with my husband, you know. We have 10 acres, so it is just a little bit of independence and to keep the mind going. And it is not the money thing because I don’t really need any money.” (IV29 Reg)

It is important to note, too, that many allied health professionals reported their role as “children for life” as they care for their ageing parents as well as their own children. Sandwiched between these two generations, the sometimes immense pressure of caring for parents on top of all that is expected of them in their full time carer occupation is particularly stressful for many allied health professionals.
8 About the Research

8.1 Ethics

The project was conceptualised as part of a wider research program examining employment and careers in health and allied health. The study was approved by the Macquarie University Human Ethics Research Committee (MQ 5201000936), the Sydney West Area Health Service -West Campus: Nepean (HREC 10/56) and South West Health, Victoria. Written informed consent was obtained from all interviewees.

8.2 Limitations

Limitations to this research include the single interview, self-report method of data collection which creates bias in the results, some of which is overcome by the multiple perspectives of the stakeholders. Other limitations to this research include:

- We are acutely aware that we have not interviewed enough former allied health workers to really understand the outcomes of those who have left their professions and we look forward to conducting that research in the future.
- While we have visited regional areas in three parts of Australia there are many remote and rural areas not represented in these results and we cannot claim to understand all their issues from this limited range of interviews.
- We have much more to learn from the professional associations whose sole focus is on their profession’s issues and we look forward to developing closer understanding of the professional issues from their perspective.
- We have not consulted with other important stakeholders such as workplace supervisors, family members, educators, health funders and broader government and policy making representatives whose views would have helped paint a more detailed picture of the research questions. We have, however, consulted with representatives from Health Workforce Australia and continue a dialogue with that organisation.
- Our focus on older workers and late career issues meant we necessarily neglected early career issues other than career choice, however we feel those issues are often capably addressed by the professional associations and increasingly are addressed by workforce planners.
- This report is limited to the voices of the interviewees and does not include a literature review or document analysis.

Finally, as stated earlier, due to time constraints and because interviews finished just two weeks prior to our funding and reporting deadline, this preliminary report is incomplete, merely a preliminary report based on our impressions of all, but detailed analysis of only some of the interviews. Many more interviews are awaiting transcription, coding and analysis. Deeper analyses will be prepared over the coming months as academic and practitioner conference and journal papers and those deeper results will be disseminated widely.
8.3 Authors and Contributors

This project was generously funded by a 12 month, $43,000 Macquarie University Research Development Grant to Dr Denise Jepsen. Funds were spent mostly on interviewer salaries, travel costs and transcriptions. Dr Jepsen was paid her standard salary for her work on this project and was not paid from project funds. We estimate that commercial rates for this project would probably be costed at around $90,000.

We thank the representatives from the professional associations, the health services, the recruiters and the corporate employers for their time and support for this project. We acknowledge and thank Therese Gerber and Brenda Bradbury who were instrumental in initiating and enabling this project. We are so especially grateful to the health and allied health workers who gave up their time and gave us their voices for the interviews. So many of them touched our hearts as we heard their stories – we wish them well.

The authors of this report are:

Chief Investigator: Denise Jepsen, BPsys(Hons), MOrgPsych, PhD, PGDipHE, MAPS, FAHRI is an organisational psychologist with extensive research and consulting experience in organisational behaviour and human resources. Denise is an international award winner for her careers research, has written one book on local government and four books on career transition. Denise is a Senior Lecturer in the Faculty of Business and Economics at Macquarie University. This project falls within Dr Jepsen’s broader research on employee attitudes, workplace relationships, careers and older workers.

Co-investigator: Marjorie O’Neill BA, BBus(Hons) is a researcher with experience in women in organisations, in particular the issues surrounding paid maternity leave and their career choices. Marjorie is completing her PhD focusing on late career choices, with particular attention on the social reasons behind retirement choices.

Co-investigator: Janelle Craig BAppSc, MComm has over 25 years experience in the health and the tertiary education sectors. She has worked in public and private healthcare in a variety of settings in Australia and overseas, including lecturing at the University of Sydney and the Singapore Institute of Management University, working for the National Health Service in England and conducting health consultancies for the World Health Organisation and AusAid. Janelle’s Project Manager role has combined her interest and expertise in health, organisational behaviour and management.

We were assisted by additional contributors including:

Philomena Brandt, BA(Admin), is an experienced management consultant and educator with experienced in the public and private sectors. Phil has a wealth of experience managing and consulting in the career transition field. Phil’s role on this project has been to support the administration of the project.

Toni Barker, BCommMgmt, PG Counselling, has over 25 years in human resources across a broad spectrum of industries including nonprofit, tertiary education and pharmaceutical sectors, with recent focus on leadership and career coaching. Toni’s role on this project included background research on the health industry occupations.
8.4 Next steps

We hope this research demonstrates part of our commitment to health workforce research as we join others investigating this important but neglected research domain. We hope you will join us in responding to some of the challenges of health workforce research. Our next steps include:

- Disseminate this report to relevant stakeholders and interested parties
- Prepare and submit detailed reports and academic papers for industry, professional associations and academic peer-reviewed conferences and journals
- Develop and work with a Health and Allied Health Research Taskforce to identify the research questions and projects that academics like this team are able to address
- Identify external funding opportunities to extend this and similar research in health and allied health workplace and employment issues, such as:
  - Interview former allied health workers across a range of disciplines to establish their career paths and retrospective perspectives on those professions
  - Supplement the qualitative interviews from this study with quantitative results from a self-report survey of allied health workers
  - Broaden the scope from the five targeted occupations to other allied health roles, from allied health occupations to the new Medicare Locals settings, to General Practitioner careers and late careers issues or in other ways
  - Establish the career options landscape for health and allied health workers
  - Investigate occupation-specific research such as: How many pharmacy graduates do not practice as pharmacists? Where do they go? How is their job satisfaction?
  - Work with career counselors and the Career Development Association of Australia to disseminate career information for mature health and allied health workers
  - Identify and assess the workplace relationship and human resources issues such as psychological contract breach and violations, organisational justice, citizenship and stress and strain impacts on health and allied health workforce, and
  - … about one hundred and one other research ideas.

As a final note, we appeal to readers for funding support. Many funding sources will support university research where there is a financial or in-kind commitment from participating organisations. Those funds are then at least matched and frequently tripled, thereby maximizing the research dollar. We urge you to contact us through denise.jepsen@mq.edu.au to discuss possible research options and participation. We are not seeking consulting or commercial work, only rigorous research of both applied and academic interest.

We commend these preliminary results to you and look forward to your feedback,

Denise Jepsen, Marjorie O'Neill and Janelle Craig, Sydney, 16 June 2011
9 References


