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This submission reflects the reality of managing an allied health workforce in the public health system in Sydney.

Shortages of some skills
Many people state that there is a shortage of skills in allied health. We have found ongoing difficulty in

- recruiting podiatrists – which will soon become a crisis in NSW, and
- some community positions, which are eventually filled after perseverance

A young workforce prefers the support provided by being part of a critical mass, and look to large hospital departments as their preferred first point of employment. This is clearly demonstrated by the pattern of applications received when recruiting, and the demand for new graduate placements in pharmacy, which far outstrips the number of positions on offer. This is one factor that explains why allied health are reluctant to work in rural areas – lack of professional support. To resolve this, I suggest that hubs of rural allied health practitioners and other health care workers be established in central rural locations, with outreach teams working from this centralised point. This will ensure that specialist skills can be taught and supervised, and clinical competency maintained.

It has not been our experience that occupational therapists or speech pathologists are in short supply, and while there has been a recent shortage of physiotherapists, this seems to be resolving with the increased training places at universities.

Team Work
'Training regimes based on traditional professional demarcations can hinder the development of interdisciplinary and team based health care' (p. 19). I challenge the applicability of this statement towards the allied health workforce. Allied Health have always preferred to work within teams, and their professional training regimes have little impact on their team participation, which is high. In my experience, team work is adequate in community settings, although not including a doctor in a community team is a missed opportunity. Poor team work occurs in some hospitals where the doctors do not consider themselves as employees, and do not take the time out of their busy schedule to attend something such as a case conference where they are not getting substantially remunerated. For example, in one hospital in my Area Health Service, some VMOs perform their ward rounds at 5am, and therefore do not attend case conferences or team meetings. This is a culture that is more about remuneration than about the philosophy of team care. However, statements about professional training creating professional silos that create poor team work are still made in reference to allied health, which I strongly dispute.

Job Satisfaction
The literature on allied health job satisfaction in Australia is limited, however I have recently completed a doctorate on this topic, and have reviewed what literature there is, as well as completed a qualitative study. Job satisfaction is generally high in allied health, and stems from satisfaction with the work role, and from being an effective clinician. At the same time, allied health who are satisfied in their jobs also express

some dissatisfaction with their working conditions, including being overworked and undervalued by the system. Job satisfaction and job dissatisfaction are not mutually exclusive concepts.

Registration
On page 25 of the paper, problems with state based nursing registration are described. These problems also apply to state registered allied health professions (physiotherapy, psychology and podiatry), and create an unnecessary barrier to the ease of employment of allied health clinicians from other states.

Generalist vs. Specialist Skills
In believe that the allied health skill base required for work in a rural hospital is not dissimilar to that required in a metropolitan hospital, and reflects not so much a need for broad generalist skills, but rather a need for a range of specialist skills. Allied health in these settings do not have more generalist skills than allied health in other settings, but rather have a need to have a wider range of specialist skills at their disposal.

Workforce Retention
If employers are serious about improving retention rates in allied health, then I consider there are three very simply ways to do this

- recruit to vacant positions as they fall vacant, rather than leave positions unfilled for extensive periods, as an unspoken cost saving strategy
- ensure the allied health workforce is not discriminated against by virtue of its young female demography – and allow all maternity leave positions to be backfilled from the time an employee commences her leave, rather than from the time the employee commences her unpaid leave
- provide the encouragement and opportunity to be engaged in professional development activities such presenting papers at conferences, attending workshops, and running journal clubs etc. It is vital that allied health receive funding for professional development, as work based training units are usually run by nurses, and are unable to add value to allied health education.

Support for New Graduates
While it has been stated that allied health new graduates are usually able to commence as independent clinicians on graduation, I believe that there is an opportunity to enhance the support network for new graduates and their skill development. The approach to fieldwork education varies from university to university, and from profession to profession. Some programs structure field work placements so that students are exposed to the core elements of their role, while other have a much less structured approach, primarily motivated by difficulties in finding enough fieldwork placements in the required areas. Consequently, it is still common place for new graduates to require close supervision and support in their first position, which does not always occur. A new graduate program, similar to that run by the NSW Physiotherapy Association, where new graduates rotate through a number of clinical areas, and have their competencies in each area assessed. would add value to other allied health professions.

Silo Mentality in Allied Health
It is sometimes said that allied health work in professional silos, and that this tendency limits their scope of practice. I would like to put forward another view, it would be impossible not to have some form of professional boundary. If we remove one set of

boundaries, we replace them with another set, which could be even more restrictive. It is simply not possible in the health care setting for all people to be all things. Given this, I believe that allied health roles already have a wide application across the spectrum of health care. For example, physiotherapists are involved in treating people from birth to death, for trauma, chronic or congenital problems, and in hospital or community settings. They provide illness prevention and health promotion services, as well as very acute intervention in hospitals and ICUs. They are already a broad based profession who work within multidisciplinary teams, and as such, it is not accurate to say they have a limited scope of practice. I believe such statements are made without due reference to reality, and are repeated by people who have heard it said, rather then understand the reality.