

# Victorian Allied Health Workforce Research Project

## Allied Health Assistance Workforce Report

July 2016

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Except where otherwise indicated, the images in this publication show models and illustrative settings only, and do not necessarily depict actual services, facilities or recipients of services. Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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## Abbreviations and acronyms

AH	Allied health
AHA	Allied health assistant
AHOMT	Allied Health Organisation Mapping Tool
AHP	Allied health practitioner
AHWQ	Allied Health Workforce Questionnaire
CPD	Continuing professional development
HSU	Health Services Union
NFP	Not for profit
NSW	New South Wales
PD	Professional development
TAFE	Technical and Further Education
VET	Vocational Education and Training
VPSC	Victorian Public Sector Commission

# Executive summary

## Overview

This report provides an overview of the allied health assistance workforce in Victoria in 2015 - 2016. It is based on survey responses from 334 individual allied health assistants (AHA) (approximately 33% of the workforce); three focus groups involving nine participants, a supplemental qualitative survey of 66 practitioners; and surveys from 71 organisations providing services across 272 different locations or sites. The age and gender of survey respondents are comparable to recent statistics collected by the Victorian Public Sector Commission (VPSC) (2015) relating to public health sector employed AHAs.

## Findings

Allied Health Assistants	Survey	VPSC, 2014 <sup>a</sup> <sup>b</sup>
Victorian population	334	1,009
Female	87%	88%
Aboriginal and / or Torres Strait Islander	2%	1%
Australian trained	96%	
Age 30 years and under	21%	18%
55 years and older	26%	27%
Median age (years)	47	49
Median income / annum	\$40,000 to \$49,000	\$50,700
Public sector	65%	
Private sector	14%	
Not for profit sector	17%	
Principal area of practice	Aged care - 45%	
Clinical stream	Multidisciplinary	
Reporting advanced scope of practice role	20%	
Reported use of telehealth	4%	
First qualification to practise	Certificate IV - 63%	
Hold PhD	0%	
Intention to stay in profession for more than 5 years	50%	
Work for two or more employers	10%	
Most common professional supervisor	Allied health professional - 79%	
% of workforce primary role in non-metro	33%	

<sup>a</sup> Source: Victorian Public Sector Commission (VPSC): Victorian public health services workforce dataset (2015), public health service employed only

<sup>b</sup> Numbers in the private sector are unknown.

The AHA workforce is a unique, skilled and educated group with broad life experience. This workforce comprised a diverse skill-set, with 80% entering the profession from previous roles and / or professions; 25% hold a bachelor degree and the majority had a Certificate IV as their main qualification for their AHA role.

AHAs worked across diverse roles and settings, with the vast majority working for a single employer in the public sector. Most AHAs worked in a community setting with adults, particularly older adults, providing rehabilitation services. They worked with a wide range of allied health (AH) disciplines, in particular physiotherapy where over 60% of surveyed physiotherapists reported working with AHAs.

The AHA workforce is unregulated and does not have a formal organising professional body. Supervision and support structures for AHAs appeared to be somewhat ad hoc and inconsistent between organisations.

There was little evidence of workforce shortages for AHAs, with few unfilled positions and large numbers of applicants for vacant positions. However, AHAs felt that their skills could be used more appropriately in organisations where they worked. Similarly, the use of AHAs allow organisations to provide services that may otherwise not be provided (such as therapy groups), and was proposed to have increased service efficiency through reducing waiting lists and promoting early discharge. A shortage of AHAs was believed to reduce the efficiency of other allied health professionals (AHPs) because certain roles and tasks could be delegated to AHAs therefore improving productivity.

The retention of AHAs was hindered by structural barriers. Some survey respondents indicated that organisations tended to fund AHA positions on short term, temporary or part-time contracts; however the VPSC data showed the majority (80%) of positions were ongoing. Other barriers to retention may include the over-qualification of AHAs who were looking for more challenging or senior roles, lack of career pathway opportunities beyond a grade 3 AHA, poor remuneration, lack of recognition and under utilisation of their roles. While most AHAs had access to supervision, many reported limited access to mentoring or peer support. The self-reported attrition rate from the AHA workforce was very high; while only 4% intended to leave the profession in the next 12 months, this jumped to 50% within five years. The majority of survey respondents who were planning to change their job said that they were leaving because their role was not challenging, for better job opportunities and pay, or because their current position was too low status.

AHAs were motivated by achieving a positive work / life balance, the type of work they did, clients they worked with, and having access to professional development opportunities. They were reasonably satisfied with the type of work they performed, the clients they worked with and their work-life balance; however they were dissatisfied with their pay, professional status and career advancement opportunities.

There were no systemic skills gaps identified for AHAs; however several organisations identified a mixture of clinical and generic skills that would be of local benefit.

AHAs have the capacity to work across numerous roles, disciplines and services where they are able to effectively fill service gaps. However, because of the lack of standardised competencies and training for AHAs, the quality and consistency of knowledge varies widely and the majority of training occurs on the job. This perceived inconsistency of skills and knowledge may limit the transferability of roles between settings and sectors. In addition, this lack of shared understanding and recognition of the potential and capabilities of AHAs may serve to further their underutilisation and create a situation where there is inappropriate use of AHAs by AHPs.

## Conclusions

Key areas of consideration for the allied health assistant workforce going forward include:

- A cost-benefit analysis of the added value of employing AHAs to help support business case development for their future employment.
- Improving clinical governance and support for AHAs.
- Identifying a set of core competencies and a standard training framework for AHAs.
- Embedding supervision of and delegation to AHAs into AHPs' undergraduate training.
- Exploring the development of explicit career pathways between AHAs and AHPs.
- Developing leadership within the allied health assistance workforce to provide this workforce with a single basis for negotiation and future direction.

# Introduction

The Victorian Allied Health Workforce Research Program (the Program) aims to contribute to the evidence base of 27 selected Victorian allied health (AH) professions in the public, private and not-for-profit (NFP) sectors in Victoria. The data will be used to inform the policies and programs of the Department of Health and Human Services, provide a platform of evidence on which to build further understanding and development of the allied health workforce as well as guide any improvements to the associated education and training system.

This report presents the data arising from surveys and focus groups of the allied health assistance workforce in Victoria.

**Please note:** terminology used in this report reflects that used in the survey process by Southern Cross University, rather than standard Department of Health and Human Services terminology.

# Background

## Who are allied health assistants?

Allied health assistants (AHAs) support and assist the work of allied health professionals (AHPs) by undertaking a range of less complex tasks (both clinical and non-clinical); this enables the AHPs to focus on more complex clinical work and provide care to a greater number of patients. AHAs commonly work with and are supervised by dietitians, physiotherapists, podiatrists, occupational therapists and speech pathologists in a variety of settings including acute, rehabilitation, outpatient, community and mental health. AHAs are also known as rehabilitation assistants, therapy assistants, therapy aides, technicians, support workers and attendants. Within Victoria, the scope of an allied health assistance role is defined by grade 1, 2 and 3 AHA role classifications.

AHAs do not require any formal qualifications to work as a grade 1 AHA. Grade 2 and 3 AHAs require a Certificate III or IV respectively; this is provided by the Vocational Education and Training (VET) sector, or an equivalent qualification.

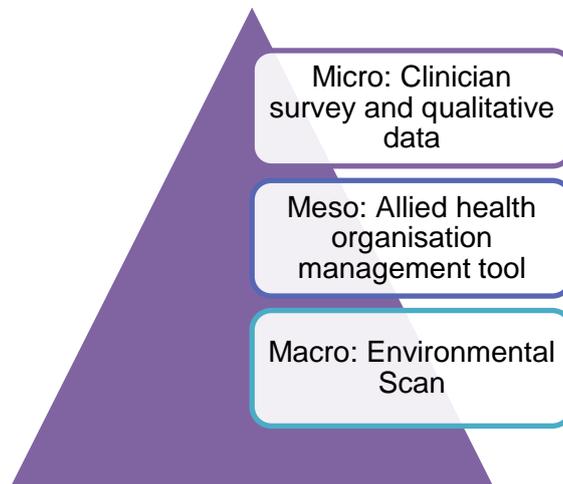
Allied health assistance is not a registered or regulated profession and they are not represented by a single professional body.

Based on the most recent available data, there was a workforce of approximately 1,009 AHAs working in Victorian public health services in 2015 (Victoria Public Sector Commission (VPSC), Public health service workforce dataset 2015). There is no data available for the AHA workforce in the private sector. The VPSC workforce profile was 88% female with an older cohort of employees; only 18% of AHAs were 30 years and under.

# Method

A three tiered approach was used to capture workforce data at macro, meso and micro levels (Figure 1).

**Figure 1: Three tiered research approach**



## Macro

### Environmental scan

The environmental scan examined 27 AH professions in Victoria during the first six months of the research program. The process involved engagement with each of the professional associations or other organisations regarding workforce trends and issues alongside the analysis of a range of existing data sources. A ‘snapshot’ was generated for each profession including key workforce statistics as well as workforce trends and issues presently affecting the profession, and those likely to affect the profession in the future. An environmental scan has been produced as a stand-alone document for each profession. Relevant findings from the allied health assistance environmental scan have been incorporated into this report.

## Meso

Subsequent to the environmental scan, four professions (speech pathology, physiotherapy, allied health assistance and sonography) had in-depth analysis undertaken at organisational and individual levels using the approaches described below. The rationale for focussing on these professions was that they were all high priority professions for Department of Health and Human Services and existing data sources offered different coverage for each one. Therefore, the in-depth analysis for each of the four professions required different research methodologies and consultation strategies to achieve the project aims.

### Allied Health Organisation Mapping Tool

At the meso level an Allied Health Organisation Mapping Tool (AHOMT) was developed which provided information on the profession’s size, location, skill set, recruitment and retention issues, and organisational contexts. The AHOMT was developed using a Qualtrics online survey tool and distributed electronically. It was completed at a regional or organisational level, typically by a team leader or human resources department, to provide detailed information about the workforce structure and organisation.

The AHOMT was adapted from a previously developed tool called the Service Proforma, which was designed to be completed by a multidisciplinary team leader to provide team or service level information about the staffing size, organisation and configuration. The Service Proforma tool was substantially modified for this project to be completed at an organisational level for specific disciplines. Despite substantial initial piloting, the first iteration of the AHOMT presented some challenges for complex organisations with multiple sites. In particular, organisations providing services across geographic locations felt that the nuances of specific sites were not being addressed (for example, outer Melbourne has different recruitment issues to inner metropolitan Melbourne).

To address this issue, a modified version of the AHOMT (AHOMT2) was developed that could be completed at a team level, and a new tool, the Allied Health Human Resource Tool was developed to capture the whole of organisation workforce data (workforce numbers and location).

## **Allied Health Human Resource Tool**

As outlined above, the Allied Health Human Resource Tool (AHHRT) was introduced after the first round of data collection to address a perceived gap in the data, i.e. the geographic location, numbers and grades of workers, particularly for large, complex organisations. This tool was also developed online using Qualtrics and distributed electronically.

## **Micro**

### **Allied Health Workforce Questionnaire**

Individual clinician data were captured through the Allied Health Workforce Questionnaire (AHWQ). The AHWQ captured information about education and training, the nature of work, location of work, job satisfaction and career development opportunities, as well as open ended questions exploring issues that the profession specifically identified as being important.

Participants who completed the AHWQ were invited to provide their contact details for future follow-up.

### **Focus groups**

Survey respondents who agreed to be followed-up via email were invited to participate in one of four focus groups, stratified by grade (or equivalent pay level), rurality and public / private sector. The focus groups explored issues that were highlighted in the survey responses. The questions were developed in consultation with the reference groups and Department of Health and Human Services. Each focus group was held via teleconference using GoToMeeting and took around 90 minutes. The focus groups were recorded and detailed contemporaneous notes were taken and used as the basis for analysis. Where necessary the recordings were accessed for clarity or confirmation.

## **Research governance**

The research was overseen by an overarching research advisory group comprising experts from many health disciplines and sectors. In addition, each of the four professions had a discipline specific reference group comprising members of the profession who represented specific sectors or subgroups (such as new graduates, public, private and NFP sectors, and academics). The advisory group and the reference groups were consulted about the research approach, survey distribution methods and engagement strategies, as well as providing substantial input into the survey content and piloting. The discipline specific reference groups also advised on the content of the focus group questions, aided the interpretation and verification of the final reports, and provided feedback on the penultimate drafts of the discipline specific reports.

## Distribution approaches

Surveys were initially distributed through the reference groups, the professional associations and Department of Health and Human Services contact lists. In addition, a communications database was developed comprising employers, professional networks and associations, individual professionals and relevant contacts for each profession. This database evolved during the project and continues to evolve.

The AHWQ and AHOMT surveys were circulated from October until 31st December 2015. The Allied Health Human Resource Tool and modified AHOMT were circulated during February and March 2016.

Other methods of distribution and marketing included Department of Health and Human Services newsletters and road shows, a stand at the National Allied Health Conference, and regional conference presentations.

## Analyses

The Qualtrics survey tool generates descriptive results for all questions in Microsoft Word and Microsoft Excel formats. In addition, all survey data were exported directly into SPSS V21 where they were analysed descriptively, and where appropriate, correlations and ANOVA analyses were performed.

## Data limitations

- The challenge of distributing and marketing a survey commissioned by a single government department to distributed health services, non-government services, and private providers meant that the data may not be representative of each profession.
- Distribution of the revised AHOMT (AHOMT2) may have confused some respondents and created some challenges for data analysis.
- There was no single organising body for allied health assistance; consequently established networks were relied on for distributing the survey. While attempts were made to access a wide range of service types, it is possible that results are skewed towards public sector employees as they appear to be easier to access and have greater levels of organisation than other sectors.
- The focus group participants were invited from the AHWQ respondents who agreed to be followed-up. This may have resulted in selection bias. More than half of all survey respondents agreed to further follow-up.

# Results

The source of data in the tables and figures going forward is AHWQ or AHOMT survey response data unless otherwise specified.

## Responses and respondents

Respondent numbers for each of the different data collection methods are presented in Table 1 below.

**Table 1: Respondent numbers by data collection approach**

<b>AHWQ (individuals)</b>	<b>HR survey (organisations)</b>	<b>AHOMT1 (organisations)</b>	<b>AHOMT2 (organisations)</b>	<b>Focus groups</b>
334	16 (59 sites / locations)	51 (222 sites)	20 (70 sites)	1 x Grade 1 8 x Grade 2 & 3

## Allied Health Workforce Questionnaire

The AHWQ survey consisted of 69 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

In order to gather more information about the work that AHAs do on a day to day basis, and the types of clients they work with, an additional qualitative survey involving 11 questions was undertaken. This survey contained predominantly open ended questions where the respondents could provide as much detail as they liked about the work they undertake. Sixty six (66) AHAs completed this second survey. The responses to this survey are included with the responses from the focus groups in the qualitative responses distributed throughout this report.

A total of 334 AHAs completed at least one question on the AHWQ survey and submitted their survey<sup>1</sup>. The range of responses to an individual question was from 261 to 1,257<sup>2</sup>. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

The 334 AHAs who submitted the AHWQ survey represent a 33% response rate based on the 2015 VPSC data; however this is public service employed data only and no data was available relating to the private sector. Therefore the true size of the workforce is unknown. Only a small percentage of survey respondents (7%, n=22/295) reported the private sector as their primary work setting. Based on this percentage, it could be estimated that there may be another 70 to 80 AHAs who work in the private sector, therefore bringing the total number of AHAs in Victoria to around 1100. However for consistency and the purposes of this report, only the VPSC data will be used as a comparison to the AHWQ survey findings.

The vast majority of the survey respondents (99%) were employed as an AHA in Victoria at the time of completing the survey. Only one respondent was actively seeking work as an AHA.

<sup>1</sup> A survey was considered complete if the respondent answered the last survey question and submitted the survey, even if they did not provide answers to every survey question.

<sup>2</sup> Some questions allowed for multiple responses



## Capacity

Capacity refers to the ability of the profession to meet the needs of the community in terms of workforce numbers and allocation of staff, skill mix, ratios, geographic distribution, organisation of the workforce, and their ability to influence these factors at the political, professional and organisational level (Figure 2).

**Figure 2: Workforce capacity framework**



## Key findings

- AHAs predominantly worked in the Victorian public sector; in the community with older clients, and provide rehabilitation and / or aged care services.
- No shortages of skills were identified for the allied health assistance workforce, but evidence was found of a 'kettling' effect where the workforce is increasing its skills and knowledge, but with nowhere for these skills to be directed.
- AHAs filled important service gaps due to relatively fluid role boundaries and workplace training.
- There may be a perceived view that AHA are used as a substitute for AHPs.
- There is a perception that graduate AHAs are not as work ready as graduate AHPs.
- There appeared to be relatively equitable distribution of AHAs delivering services in regional and rural areas in comparison with other AH professions. This may be an area to explore further to understand and learn from for other professions.
- AHAs had no formal career pathways beyond grade 3, they lacked access to supported professional development thus there is little capacity to grow this group of practitioners. The potential transition from AHA to AHP is another area of potential further exploration, as there is a valuable base knowledge that AHAs have that could be easily transferrable to AHP through an appropriate pathway.
- AHAs predominantly worked for a single employer.
- There was evidence of AHAs being employed at a level lower than their qualification or skill because of funding restrictions within the organisation.
- Only 7.4% of respondents were employed in the private sector.
- The AHWQ showed that while geographic distribution changes slightly over the course of an AHA's career, the profession may be becoming slightly less metro-centric.

## Workforce distribution

### Demographics

Respondents were predominantly female (87%) with a mean age of 44 years (range 19 to 68 years) and median age of 47 years (Figure 3). One quarter of respondents were 55 years and older while 21% of respondents were 30 years and under (Table 2). These findings are similar to the 2015 VPSC workforce data, with the VPSC data demonstrating a slightly older profile (VPSC, 2015).

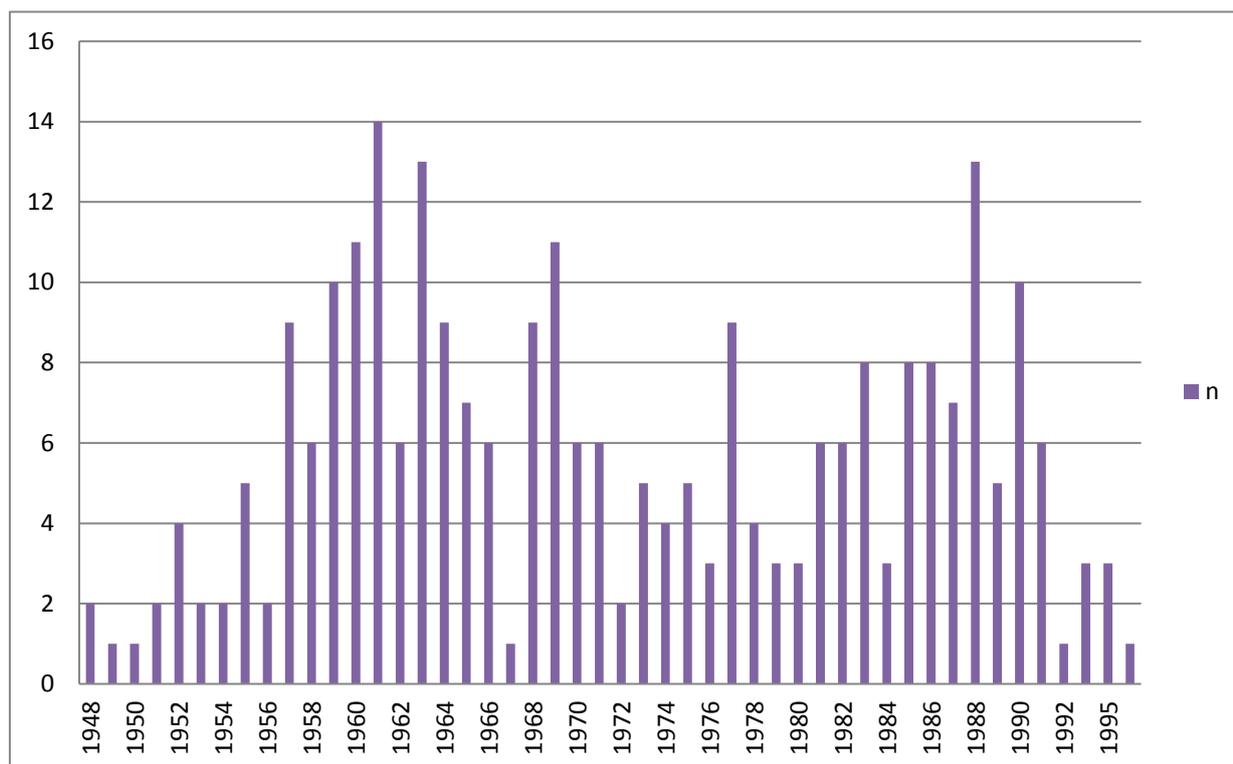
**Table 2: Demographics (n=334)<sup>a</sup> compared with VPSC 2015 data**

Demographic	AHWQ		VPSC 2015 <sup>b</sup>
	n	%	%
Female	236	87	88
Aboriginal or Torres Strait Islander	6	2	1
Australian citizen / permanent resident	269	99	N/A
Aged 55 years and older	68	26	27
Age 30 years and under	55	21	18
Public sector		65	
Private sector	713	14	N/A
Not for profit sector		17	

<sup>a</sup> Question had multiple responses, with a number of respondents working in multiple sectors (n= 492)

<sup>b</sup> Source: Victorian Public Sector Commission (VPSC), 2015. Numbers in the private sector are unknown.

**Figure 3: Year of Birth (n=265)**



**Geography**

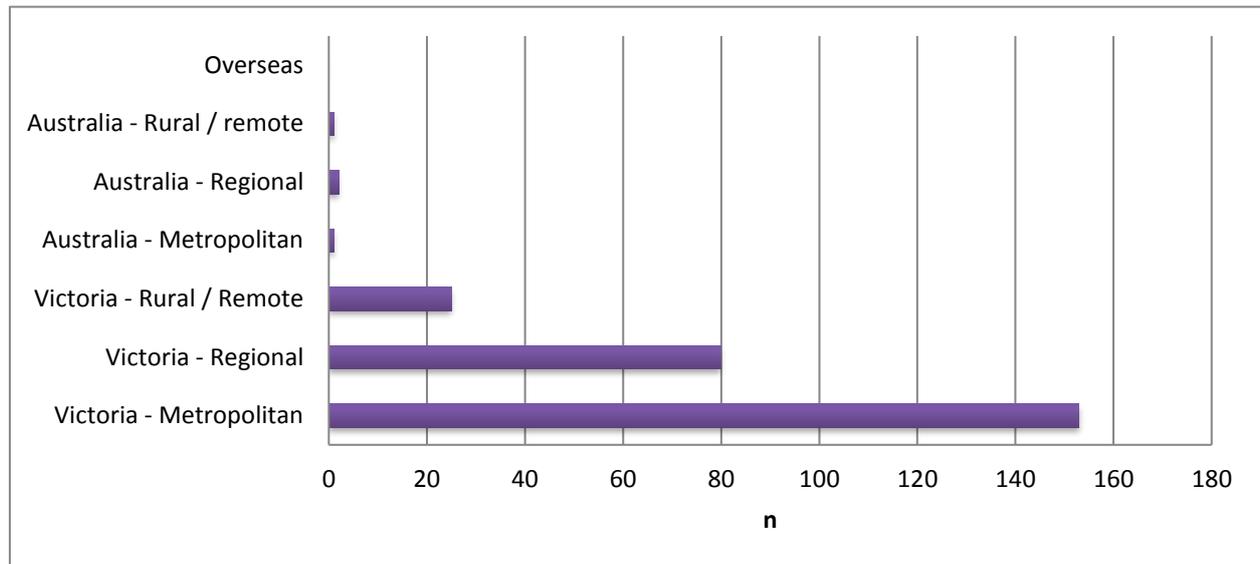
The allied health assistance workforce distribution from the survey has been compared to the VPSC data. The VPSC data shows slightly more AHAs working in the regional areas than the survey data. Of the survey respondents over half (58%, n= 153) worked in metropolitan Melbourne, while one third worked in regional areas (30%, n=80), and almost 10% (n=25) worked in rural or remote Victoria (Table 3 and Figure 4).

**Table 3: Geographic distribution (n=451) <sup>a</sup> compared to VPSC 2015 data**

Victorian region	Barwon South West	Gippsland	Grampians	Hume	Loddon Mallee	Northern and Western Metro	Eastern Metro	Southern Metro	Other Australian State	Unattributed	Total
Primary location (AHWQ)	9	30	22	48	30	84	49	80	63	0	415
Primary location (AHWQ) %	2	7	5	12	7	21	12	19	15	0.3	100
Primary location (VPSC 2015) %	15	13	7	9	11	17	28	0.0	0.6	100.1	

<sup>a</sup> Respondents could select more than one response.

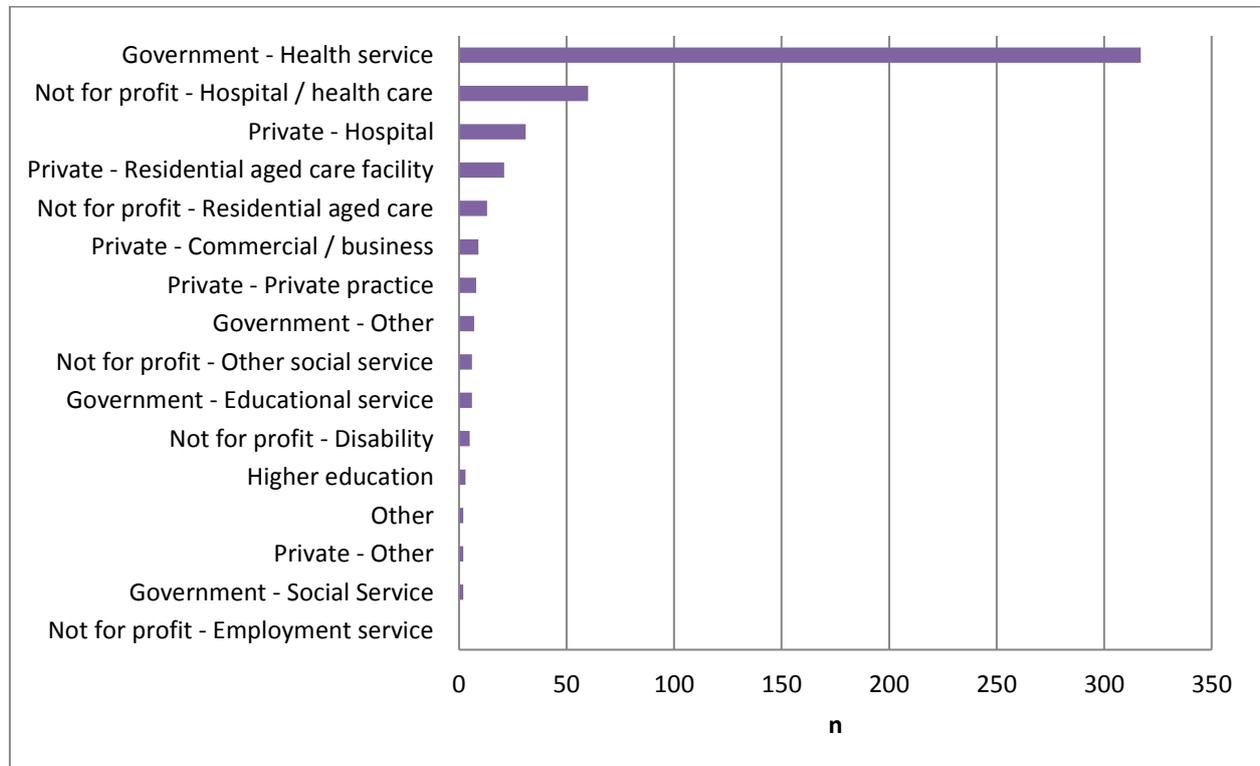
**Figure 4: Current geographic region of work (n=261)**



**Sector**

The majority (65%) of responding AHAs were employed by the public sector health service; however AHAs worked across a range of settings including the private sector (14%) and NFP sector (17%). They worked in residential aged care, disability and educational services (Figure 5).

**Figure 5: Employment sector of current main employer (n=492)<sup>a</sup>**

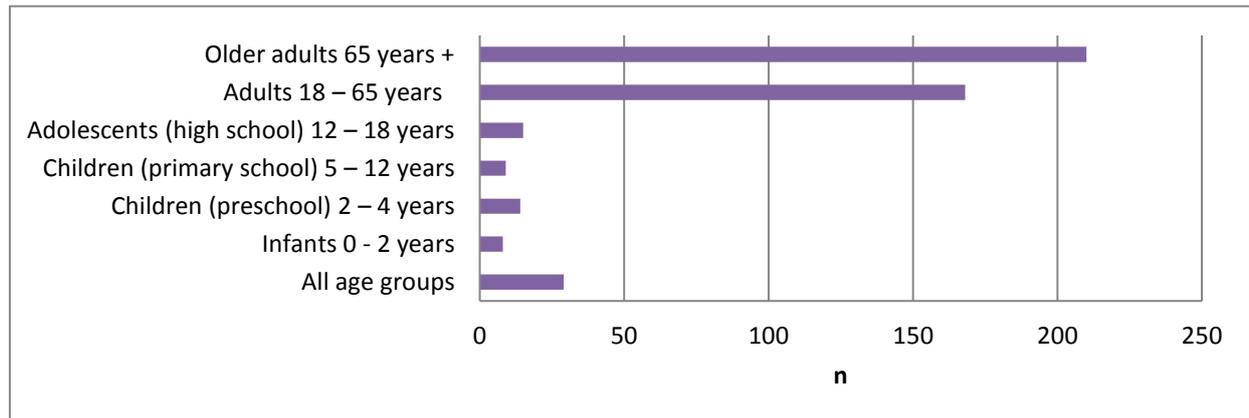


<sup>a</sup> Respondents could select more than one response.

## Clients

AHAs predominantly worked in clinical roles with adults (69%) in the areas of rehabilitation, aged care or community based care. A small proportion worked across all age groups and less than 15% worked with children or adolescents. The largest proportion of respondents identified their primary area of clinical practice as aged care (45%), followed by musculoskeletal (42%), neurological (28%) and cardiorespiratory (25%) (Figures 7, 8 and 9).

**Figure 7: Clients by age (n=453) <sup>a</sup>**

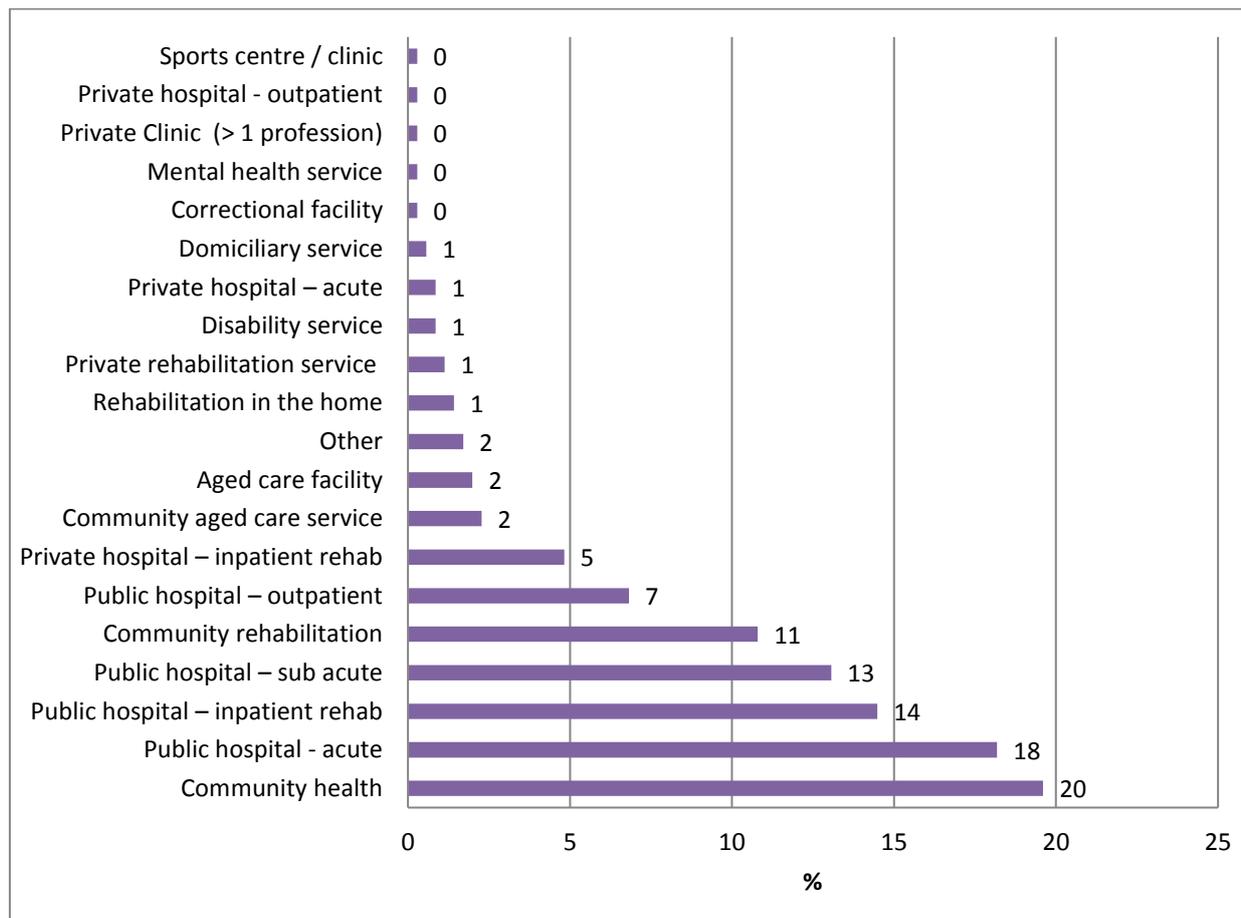


<sup>a</sup> Respondents could select more than one response.

## Settings

The most common primary setting for allied health assistance clinical service delivery was the community (20%), followed by public hospital acute care (18%) and public hospital inpatient rehabilitation (14%). Only 14% of respondents reported working in the private sector (n=49/352) (Figure 6), with only 7% (n=22/295) reporting that their principal employer was in the private sector.

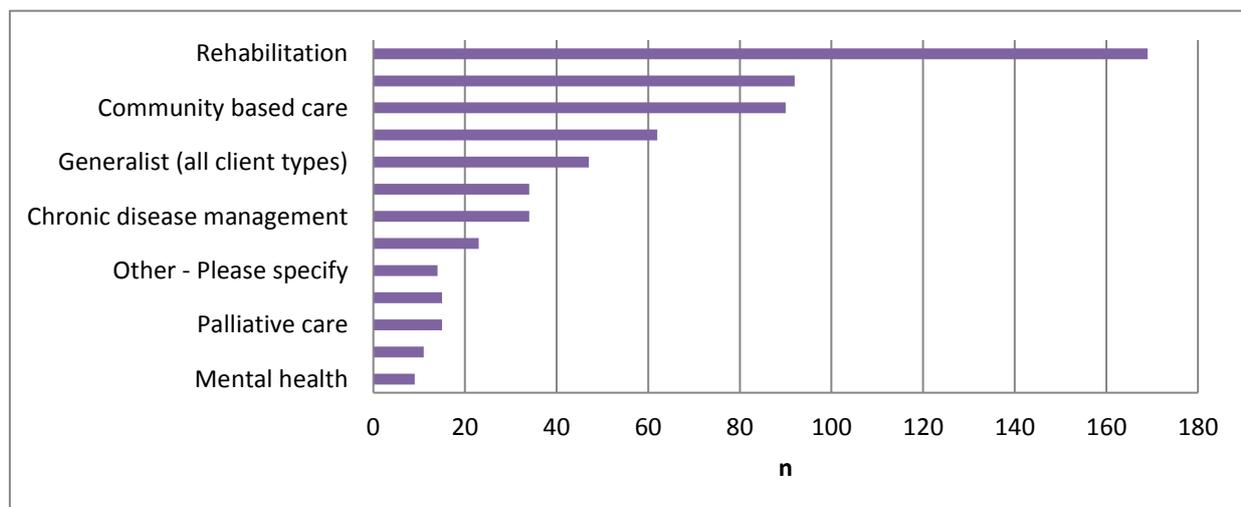
**Figure 6: Primary Setting for Service Delivery (n=352) <sup>a</sup>**



<sup>a</sup> Respondents could select more than one response.

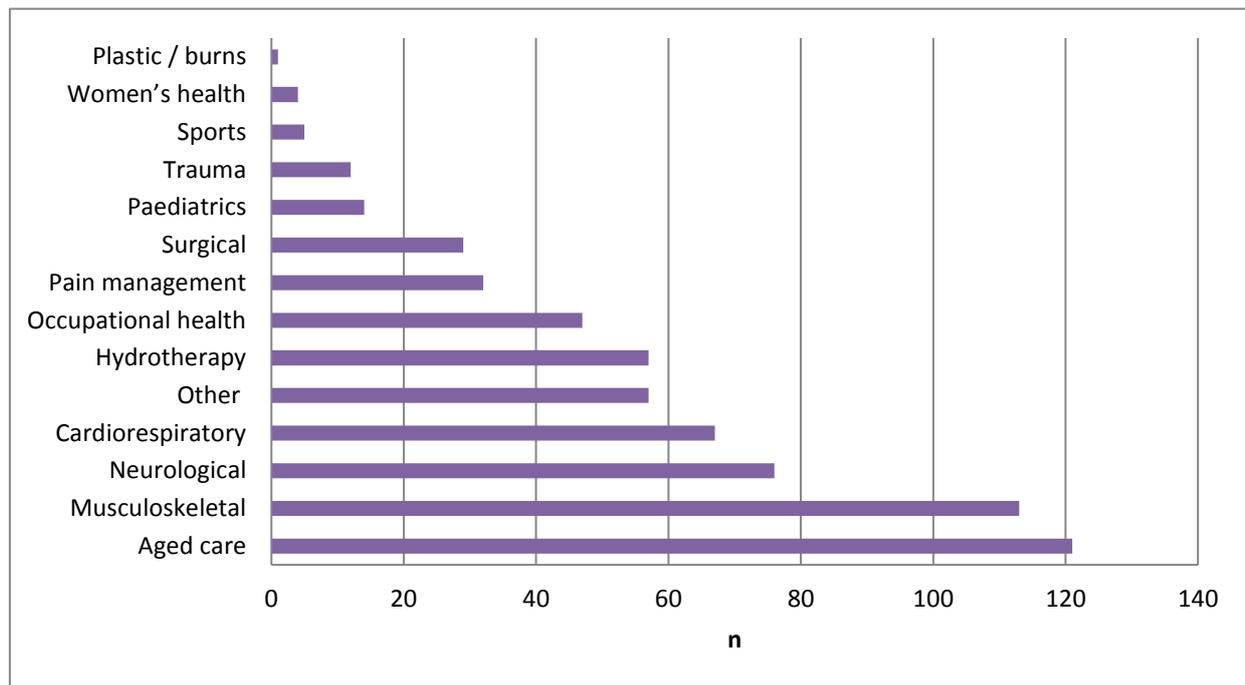
**Area of practice**

**Figure 8: Area of practice (n=622) <sup>a</sup>**



<sup>a</sup> Respondents could select more than one response.

**Figure 9: Area of clinical practice (n=644) <sup>a</sup>**



<sup>a</sup> Respondents could select more than one response.

<sup>b</sup> Other included: specific professional roles (podiatry, social work, nursing, occupational therapy, speech pathology, medical imaging, physiotherapy, general medicine, dietetics), rehabilitation, care coordination, radiation therapy, exercise, community gym, cardiac rehab, falls, geriatrics, diabetes, youth mental health, falls and balance, movement disorders, community health, general foot care, oncology, planned activity groups, preparing resources.

There was evidence that AHAs were used to fill service gaps across multiple disciplines with relatively fluid role and service boundaries.

*“I have four roles: Health Promotion Project Worker 4 hours per week; Tobacco Treatment Specialist 12 hours per week; Acute Ward AHA 10 hours per week; and Spirometry Clinic- performing Lung Function tests 4 hours per week”*

*“As an AHA in the Social Work Department, I see patients with financial difficulties, services on discharge and regarding other referrals to different organisations.”*

## **Demand**

AHAs worked under the supervision of other AHPs, as a result there were no areas of population need identified that were specific for AHAs. However, AHA is a relatively new profession and this does not necessarily mean that there would not be a future need for AHAs in specific populations as the articulation of this is developed for the profession and AHPs they support.

## **Supply**

There are a number of factors that interact with and influence the supply of AHAs. These include the size of the AHA workforce, the number of graduating AHAs, the profession's age and gender profile, employment grades, remoteness, remuneration, and local approaches to recruitment.

### **AHA workforce**

There was little reliable data available on the AHA workforce. The most recent statistics available in Victoria (VPSC 2015) suggested that there were around 1009 AHAs working in the public sector and

extrapolation from the private sector response rate to the AHWQ may add another 70 to 80 to this number.

This was a difficult group of workers to capture systematically as they lacked any formal organising structure. Focus group data suggested that there may be some misclassification of the allied health assistance workforce. For example, if there was not an existing category for a specific staff member, they may be conveniently labelled as an AHA, even if this is not an accurate classification for their role.

*“In this organisation, if people don’t fit into other criteria, like a nurse, they’re called AHAs, even if they’re not. It’s really difficult.”*

### **Workforce supply**

There was little empirical evidence of workforce shortages of AHAs. Only one organisation (of 35 responding organisations) reported having an AHA position unfilled for six months or more. Nevertheless AHA focus group members identified that they may be underutilized in the workplace and that their skills could be used more widely in the organisations where they were employed. Examples of this included evidence provided by organisations suggestive of AHA shortages:

- inability to run specific programs due to AHA shortages
- the belief that AHAs can assist in reducing waiting lists, length of stay, promote early discharge and therefore provide cost savings and that this was not taking place as effectively as possible.

And some specific reported impacts of AHA shortages:

- lack of service provision
- possible increases in length of stay
- inefficiencies due to AHPs performing tasks that could be delegated to AHAs

*“Lack of AHA's means that we will often then employ part time allied health clinicians“*

Conversely, the *Victorian Allied Health Workforce Research Program Physiotherapy Workforce Report* identified examples of AHAs being employed to compensate for an inability to recruit physiotherapists. This suggests that some organisations may perceive that an AHA could be used as a substitute to deliver certain tasks usually attributed to specialised AHPs.

### **Recruitment**

Recruiting AHAs was generally not difficult, but there was variation in the response rates to advertised vacancies. One organisation reported receiving over 100 applications for an AHA role while two other organisations received between 20 and 50 applicants and one organisation had no applications. Of those organisations that reported advertising within the past 12 months, 40% (n=10/25) were able to fill their vacancies within 10 weeks.

Twenty percent (n=6/29) of organisations reported having unfilled AHA positions. These were due to either a lack of applicants (n=2/29), lack of suitably qualified applicants (n=2/29), or lack of funding (n=3/29). Barriers to recruiting AHAs may also be associated with the terms of employment contracts. Short term and part time contracts were reported to be more challenging to fill and there was a perceived lack of permanent positions.

*“Small FTE [full time equivalent] is not attractive to staff who want to work full time“*

There were also suggestions that AHA positions attracted a large number of applications but the applicants were not always appropriate for the positions.

*“Very broad range of applicants - pool of quality applicants is usually very small.”*

One organisation said that they avoided employing AHAs due to the significant investment in training and re-training required and preferred to employ new graduates instead. Other organisations indicated that they employed AHP students in AHA roles as this gave them employees with useful foundation skills.

*“AHAs are not work-ready when employed in our clinical settings; they require significant periods of orientation and induction. Their skills at recruitment are highly variable. Quite often we would be better off employing additional grade 1 professionals rather than AHA due to the amount of work required to train and retain”*

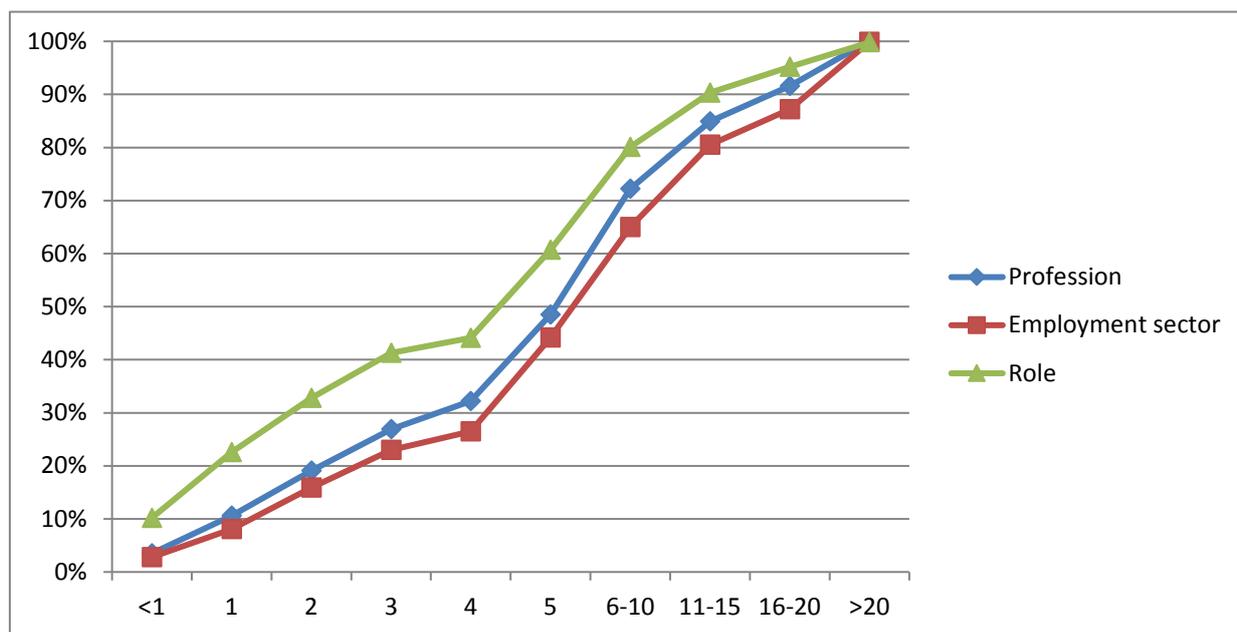
*“For the organisation, there are benefits in employing AHP students because they’re upskilled already so there’s not as much development needed for those staff.”*

The most successful recruitment strategies were reported to be local approaches such as use of local media (newspapers) and word of mouth (Appendix Table 8).

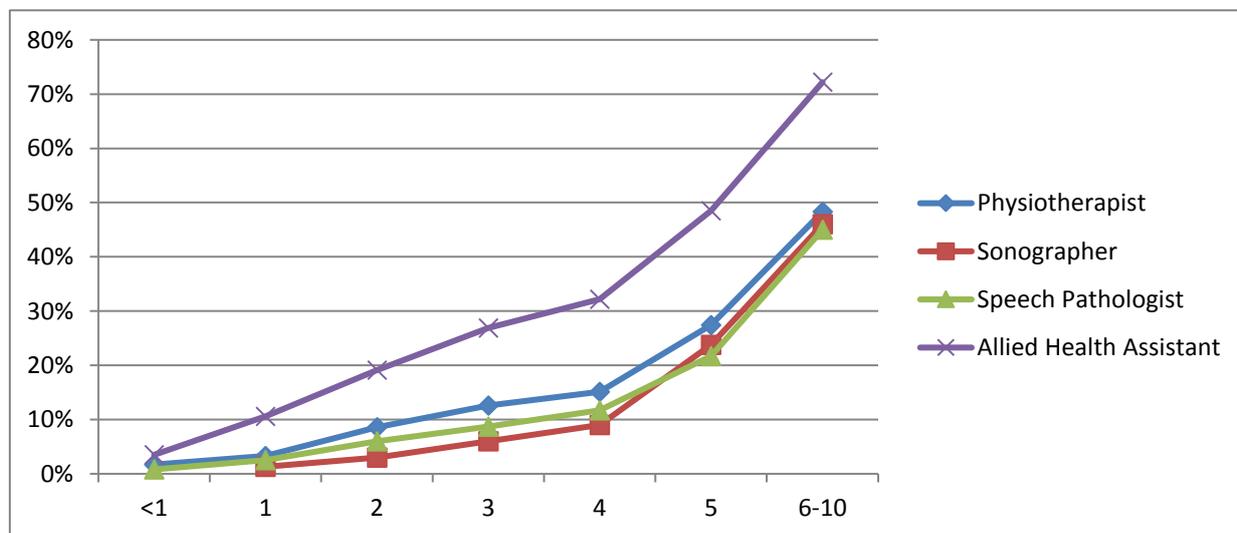
### **Retention**

Retaining AHAs was more difficult than recruiting AHAs. Nearly 50% of the AHA workforce reported intending to leave their profession within five years (Figure 10). This rate was much higher than with other surveyed professions (Figure 11). AHAs also had the highest intention to leave their profession within the next twelve months. Those intending to leave the profession within the next 12 months were younger, with a mean age of 28 years.

**Figure 10: Cumulative intention to change current job situation by years (n=277)**



**Figure 11: Comparative cumulative attrition rates of professions over the next 10 years**



For those planning to change roles in the next 12 months, the main reasons for AHAs changing their role or situation were because their current role was not challenging (n=15); to seek a better job opportunity (n=15); for better pay (n=10); or because their current position was low status (n=10) (Figure 12, Table 8).

**Figure 12: Career intentions over the next 12 months (n= 83)**



All others referred to "return to study".

**Table 4: Reasons for changing job in the next 12 months**

Reason	n	%
Current role not challenging	15	52%
Better job opportunity	14	48%
Better pay	10	34%
Position is low status	10	34%
Change of career	7	24%
Return to education / training	6	21%
Other (please specify)	4	14%
Contract terminates	4	14%
Better benefits	2	7%
Relocation to preferred location	2	7%
Better working conditions	2	7%
Travel	2	7%
Commute	1	3%
Family reasons	1	3%
Physical work environment (e.g. space, equipment)	1	3%
Maternity leave	1	3%
Health reasons	1	3%

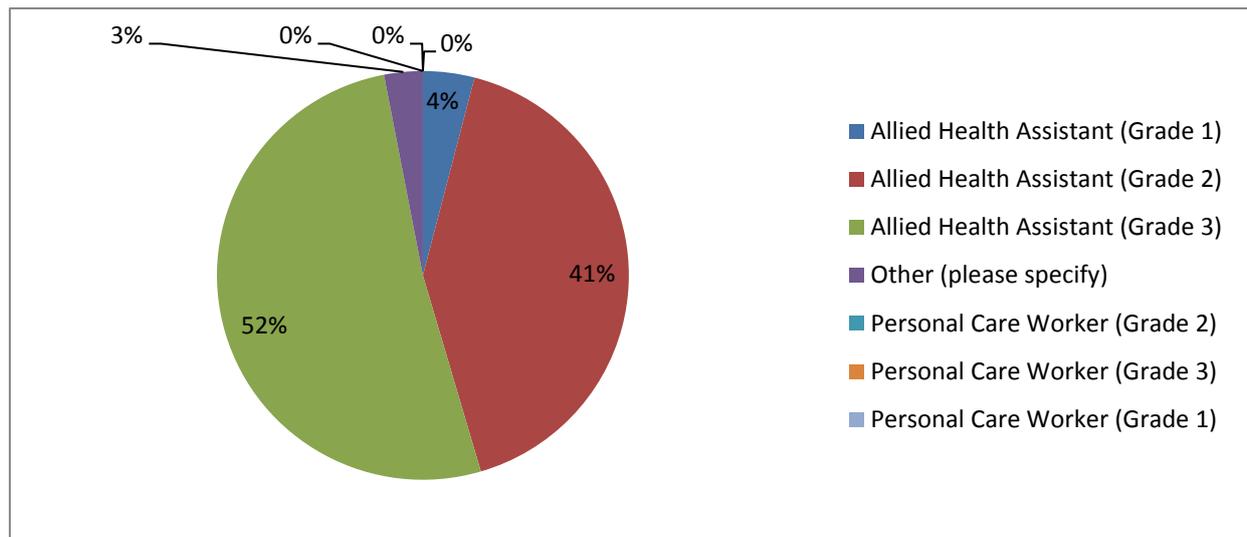
## Organisation of the workforce

### Pay and Award

The most common employment grade / level reported by respondents (51%) equated to a grade 3 AHA (Figure 13). A small number of respondents who indicated the 'other' category stated they were employed at a grade below their qualifications (n=7).

*"I completed a cert IV but get paid as a grade 2 as there is only 1 position as a grade 3 cert IV"*

**Figure 13: Current job title and grade**



Most respondents (96%) earned less than \$60,000 per year, with 43% earning less than \$40,000 per annum (Table 5). The median reported income for AHAs was \$40,000 to \$49,000 per annum.

**Table 5: Total annual income last year, before tax (n=261)**

Annual Income	n	%
Less than \$40,000	113	43
\$40,000-\$49,999	74	28
\$50,000- \$59,999	64	25
\$60,000-\$69,999	6	2
\$70,000-\$79,999	2	1
Greater than \$80,000	2	1

Most respondents (75%, n=202) were employed by the public sector, followed by 16% (n=43) in the NFP sector (including residential aged care and disability), and 7.4% (n=22) in the private sector.

## Hours of work

Most respondents performed their duties between 7am and 7pm Monday to Friday (89%) however a small proportion worked on Saturday (3%) and / or Sunday (1%) (Table 6). Other working patterns included those working part time across different combinations of week days between the hours of 8.00am - 4.30pm.

**Table 6: Working pattern during normal working week (n=304) <sup>a</sup>**

Working pattern	Count	%
Monday to Friday between 7am and 7pm (day)	256	89
Shifts that change from day to day, or week to week	3	1
Other working pattern	30	10
Saturday	9	3
Sunday	4	1
Monday to Friday between 7pm and 7am (night)	2	1
<b>Total</b>	<b>407</b>	<b>100</b>

<sup>a</sup> Respondents could select more than one response.

A typical working week for respondents involved an average of 21 hours performing clinical work (range 0-51 hours), 10 hours of management and administration (range 0-36 hours) and four to five hours of teaching, education, research or project work.

## Number of employers

The vast majority of respondents reported being employed on a permanent basis (n=302), often by one (n=260) or two (n=24) employers (range one to five employers). Of those who reported self-employed, contract or casual employment status (n=50) there was a tendency to be employed by multiple employers (Appendix Table 2).

The majority of AHAs who worked 32 to 40 hours per week did so for one employer (n=131). However, respondents who worked less than 24 hours per week were more likely to have more employers. This was particularly the case for those who reported working 0 to 16 hours per week; they worked across three or more employers (n=70) (Appendix Table 1).

## Role

Half of participants reported their primary role as clinical (56%, n=196) with only a small percentage reporting management (2%, n=7) or teaching (2%, n=8) (Table 7). Of note were the large numbers who reported 'other' for their main role (n=140, 40%). The predominant other role recorded was a combination of stores / equipment maintenance / equipment cleaning / stock (n=11) (Appendix Table 3).

**Table 7: Primary role across all current employers (n=352)**

Role	n	%
Clinician	196	56
Manager	7	2
Teacher / educator	8	2
Researcher	0	0
Project worker	1	<1

Other	140	40
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## Scope of practice

### Advanced practice

The following definition of advanced scope of practice was used and respondents were asked to describe their advanced scope of practice role.

*Work that is currently within the scope of practice for your profession, but that through custom and practice has been performed by other professions. The advanced role requires additional training, competency development as well as significant clinical experience. Examples include non-medical prescribing (e.g. pharmacy, podiatry), physiotherapy led post-operative review clinics; physiotherapy and occupational therapy led spasticity and intervention clinics.*

Nineteen per cent (19%, n=53) of respondents reported working in an advanced practice role. The types of roles described covered a range of diverse activities within multiple disciplines. These activities included:

- Care coordination or discharge coordination
- Education and training e.g. equipment use, pre-op education (physiotherapy/arthroscopy)
- Lead and run group therapy autonomously e.g. upper limb group, DADL groups, mobility sessions, child and parent groups, paediatric speech and fine motor skill groups, falls prevention groups, strength training, tai chi, public transport retraining, cardiac failure group and lungs in action group
- Prescription of exercise therapy and equipment e.g. Pre Op crutches prescription for arthroscopy patients, on home visit provide equipment suitable to both environment & patient
- Assessment procedures e.g. intake/triage for physiotherapy clients, swallow screening, dysphagia screening (n=2), "Priority 4 patients have been handed to AHAs if appropriate for physical maintenance program and documenting in progress notes"
- Other – plaster casting, cardiac rehabilitation, student supervision, multidisciplinary roles, assisting with videoflouroscopy

Advanced scope of practice is largely not defined for the AHA workforce as yet, so it is unclear as to whether these activities would be termed as advanced practice or not as this is a relatively new profession.

### Telehealth

A small number of respondents (n=10) reported using telehealth.

## Workforce movement

To identify movement between sectors and settings, respondents were asked to describe the location, sector, role and duration of their first position (starting position), most recent position, and their three most significant positions in between. The numbers of respondents for each role are summarised in Table 8, and Figures 14 to 17 (next pages) illustrate broad trends in shifts between locations, sectors and settings.

**Table 8: Number of respondents for each position**

Position	Numbers of Respondents
Most recent	268

Position 2	128
Position 3	49
Position 4	24
First (starting) position	42

### Changes in location

Evidence shows that originating from a rural or regional area can be a predictor of location for future study and work, as can the location of study / training be of location of work.

Almost two-thirds (n=177, 66%) of respondents were trained in the city; of which 23% (n=40) came from regional centres.

Of those educated in regional centres (n=93), 66% (n=61) were originally from regional areas.

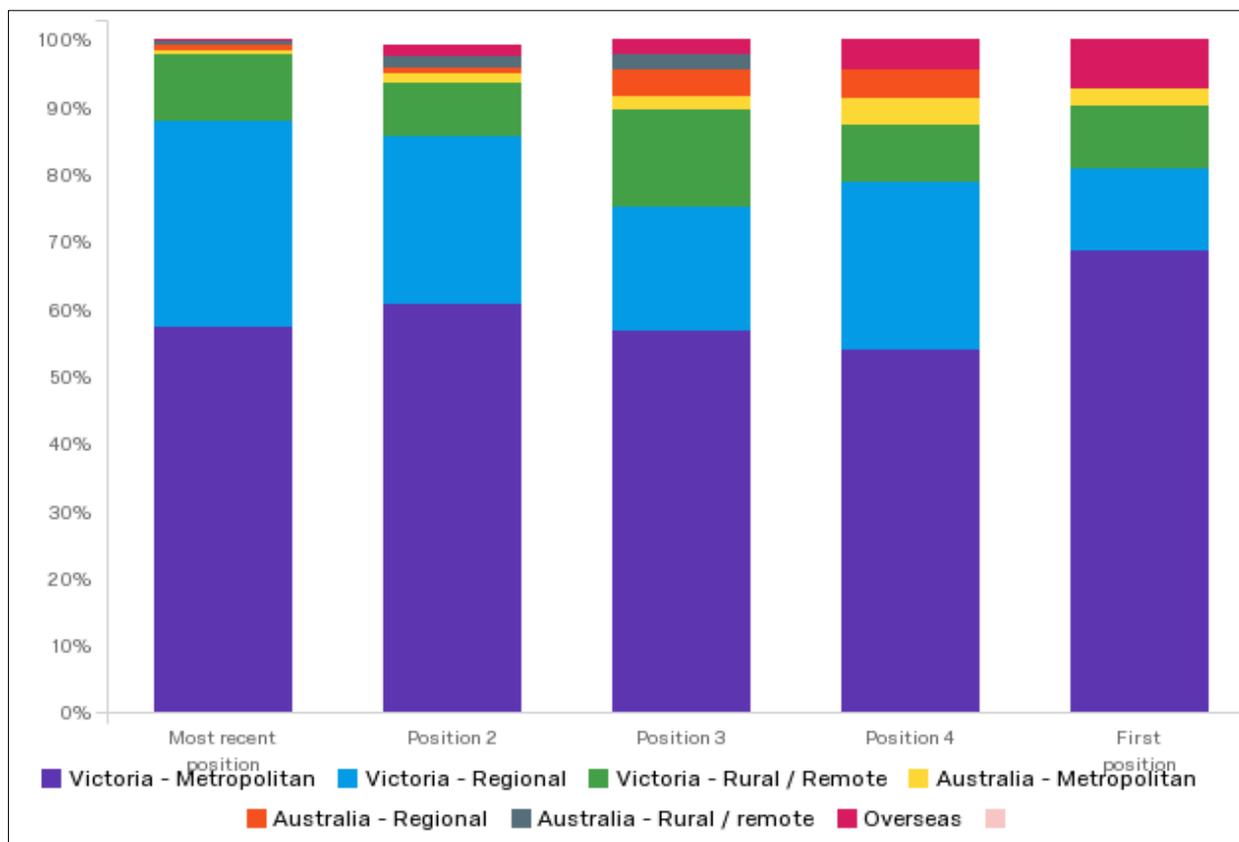
The odds ratio (OR=6.5) indicates the odds that AHAs educated in the city were raised in the city is 6.5 times greater than the odds that AHAs educated in regional areas were raised in the city (Appendix Table 5).

Over half, 62% (n=165) of respondents were city-based; of which only 18% (n=29) came from regional areas.

Of respondents in regional areas (n=103), 70% (n=72) grew up in regional areas. The odds ratio (OR= 10.9) indicates that the odds that an AHA currently working in a regional / rural area had grown up in regional / rural is 11 times higher than that of an AHA currently working in the city having grown up in a regional / rural area (Appendix Table 6).

Of the respondents who studied in the city, 82% (n=151) were currently working in the city, while 25% (n=25) of respondents who studied in the country were also now working in the city. Of those respondents who currently work in regional / rural areas (n=106), most were educated in regional / rural areas (n=72, 68%). The odds ratio (OR = 12.8) indicates that AHAs working in the city were 13 times more likely than AHAs working in regional / rural areas to have been educated in the city (Appendix Table 7).

**Figure 14: Changes in location across the career path**

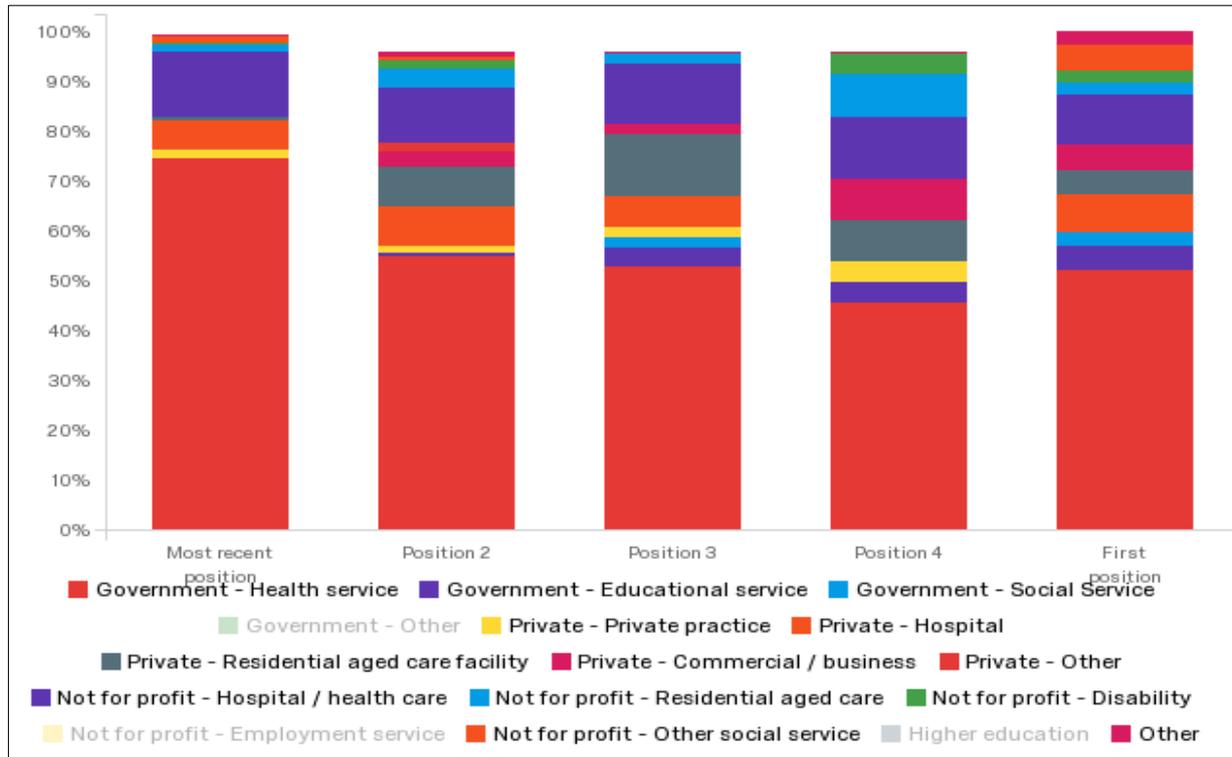


The AHWQ showed that while geographic distribution changes slightly over the course of an AHA’s career, the profession may be becoming slightly less metro-centric. While the first position tended to be metropolitan (far right bar in Figure 14), the proportion of AHAs that were based in the city tended to decrease over subsequent positions.

**Changes in sector**

The change in employment sector over the career path of AHAs tells an interesting story and reflects the diverse backgrounds of AHAs. It is also possible that these questions have been answered with respect to their whole career, not just their AHA role. As expected, the largest employer of AHA at all stages of their career was the public health service sector, followed by the NFP sector; however private and NFP residential aged care featured in career pathways. AHAs reported surprisingly little involvement in disability services (Figure 15).

**Figure 15: Changes in sector over the career path**

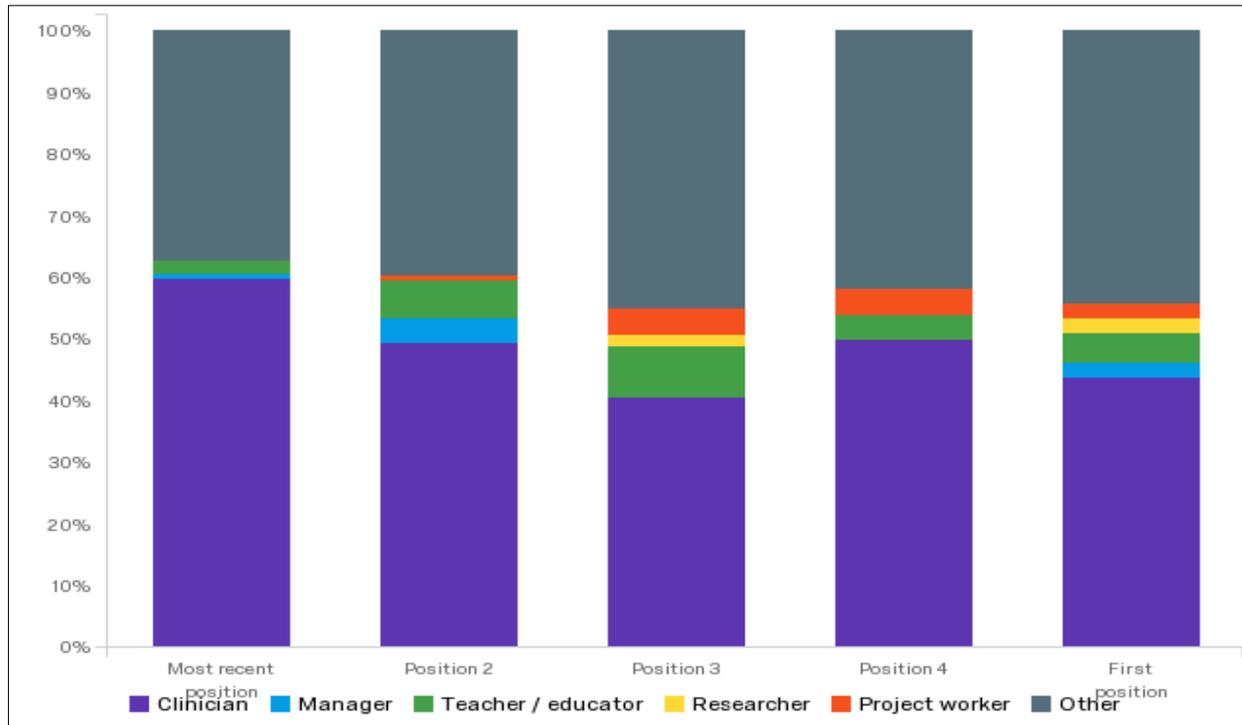


*Note: some of the potential sectors were suppressed in this output due to small numbers of respondents which is why the bars do not total 100%.*

### Changes in role

The majority of AHAs worked primarily in clinical or 'other' roles. This question did not identify what the AHAs meant by 'other'. A small proportion of AHAs reported some teaching / educating work during their career pathway, however the clinical role increased over their career path. (Figure 16)

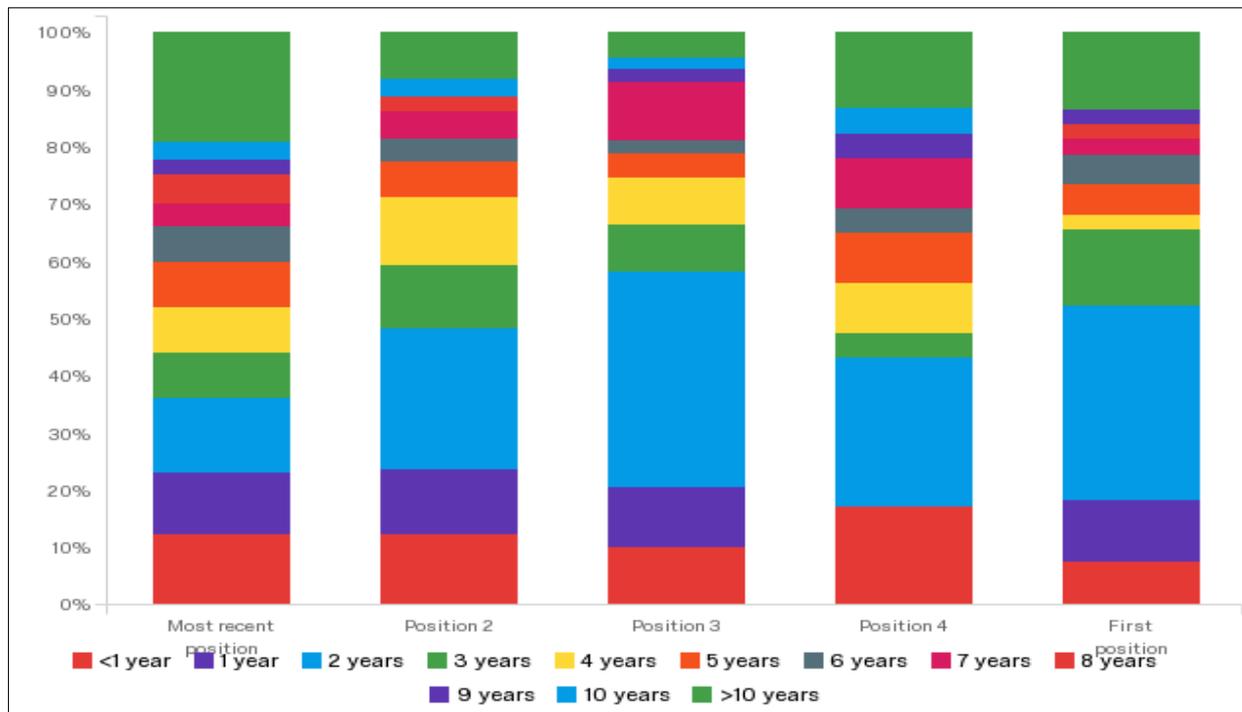
**Figure 16: Changes in role over the career path**



**Years in role**

The time that AHAs spent in each role varied greatly, however broadly it became more stable over the duration of their career. Sixty five percent (65%) of respondents reported that they stayed for three years or less in their starting position. In comparison, 22% of respondents reported that they stayed for 10 years or more in their most recent position (Figure 17).

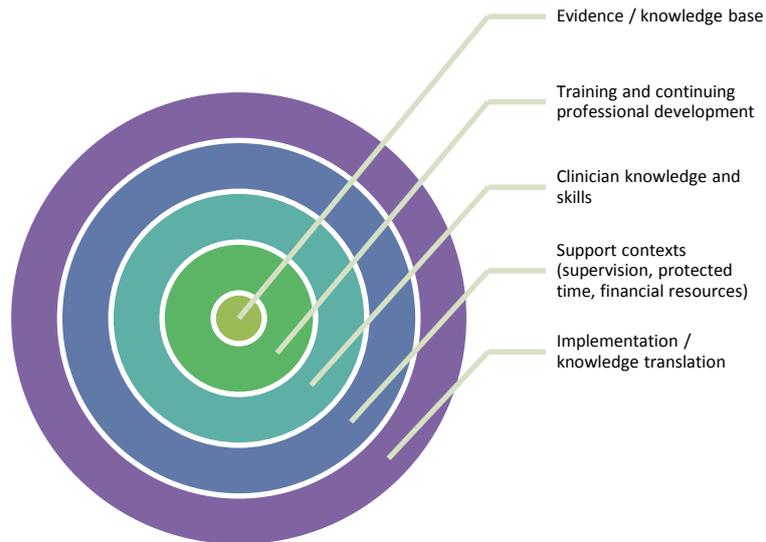
**Figure 17: Years in each role over the career path**



## Capability

Capability refers to the extent that practitioners have the appropriate skills to perform their work, the strength of the evidence underpinning that activity, access to ongoing training / CPD to develop the appropriate skills, the support contexts available (supervision, support, protected time and funding), and the opportunities for change in practice that occurs (i.e. knowledge translation and implementation) (Figure 18).

**Figure 18: Workforce capability framework**



## Key findings

- The AHA workforce comprised a diverse skill-set, with 80% coming from previous roles / professions; 25% held a bachelor degree and the majority have a Certificate IV as their main qualification for their AHA role.
- AHA training is highly contextually dependent and the most valuable training occurs on the job, however AHA access to appropriate CPD is limited, particularly in regional and rural areas. There was a view that the certificate IV has limited clinical placement opportunities to be work-ready and that not all disciplines are included in the training for AHAs (eg. Physiotherapy is included, but dietetics isn't). This could be an opportunity for training providers to consider flexible, responsive training options that can be introduced at specific sites according to their context and needs.
- As AHAs were largely trained 'in situ' there was less likelihood of them needing to travel to a metropolitan center for training, increasing the likelihood of a more geographically stable and locally sourced workforce.
- The majority of respondents (78%) qualified before 2002, with a number attaining their qualifications in 2009 and 2010 (n=32, 31 respectively); the numbers have decreased consistently since then.
- Employers of AHAs would value the standardisation of specific competencies across the sector / state. This would also increase the transferability of individual AHA roles and skills.
- There was a perception that AHAs were underutilised or inappropriately used by other health professionals.
- There was a general lack of opportunity and of recognition and remuneration for those practitioners who had progressed their skills by performing managerial, advanced or novel roles.
- Employment of AHP students in AHA roles was also noted to limit AHA career opportunities.
- AHAs were working in fluid roles that often cross multiple professional boundaries and enable them to fill service gaps.
- AHA career progression was extremely limited within clinical, administrative and management roles.
- They were generally not recognised or rewarded for their capability to work across numerous roles, disciplines and services.
- Most AHAs had access to supervision (70%), but reported limited access to mentoring or peer support. Supervision and support structures appeared to be ad hoc and inconsistent between organisations.

## Evidence / knowledge base

The work of AHAs is primarily delegated from other AH professions, therefore they do not have claim to their own unique evidence / knowledge base. Much of their learning is acquired 'on the job' and is dependent on the context in which they work and the types of AH professions with which they work.

## Training and continuing professional development

### Prior work experiences

The vast majority of respondents (80%) reported that they had worked in another role or profession prior to becoming an AHA. These other roles predominantly included non-health related business (24%), administration (22%) or other health related jobs such as nursing and personal carer (Appendix Table 4).

## **Qualifications**

The main qualification held by respondents was a certificate IV (n=214); this was also the dominant qualification used as entry to practise as an AHA. One quarter of the AHAs who responded to the survey were university educated and held a bachelors, honours, master's degree or advanced diploma (Table 9). While these qualifications were not a requirement or specific to the AHA role, this does imply that many of these practitioners bring additional expertise and knowledge to their role.

**Table 9: Qualifications held or currently studying (n=287)**

Qualification	Current qualification/s	Qualifications currently studying	Main qualification to practise
Certificate III	66	3	56
Certificate IV	214	11	119
Associate diploma	32	4	8
Advanced diploma	18	3	7
Bachelor degree	73	10	51
Honours degree	3	2	0
Graduate Certificate	6	1	1
Graduate Diploma	20	2	3
Master's degree - Graduate entry	3	0	0
Master's degree – Clinical	11	0	2
Master's degree - Management (e.g. MBA)	0	0	0
Master's degree - Research	1	0	0
Professional Doctorate	0	0	0
PhD	0	1	0
No formal qualifications	12	0	24

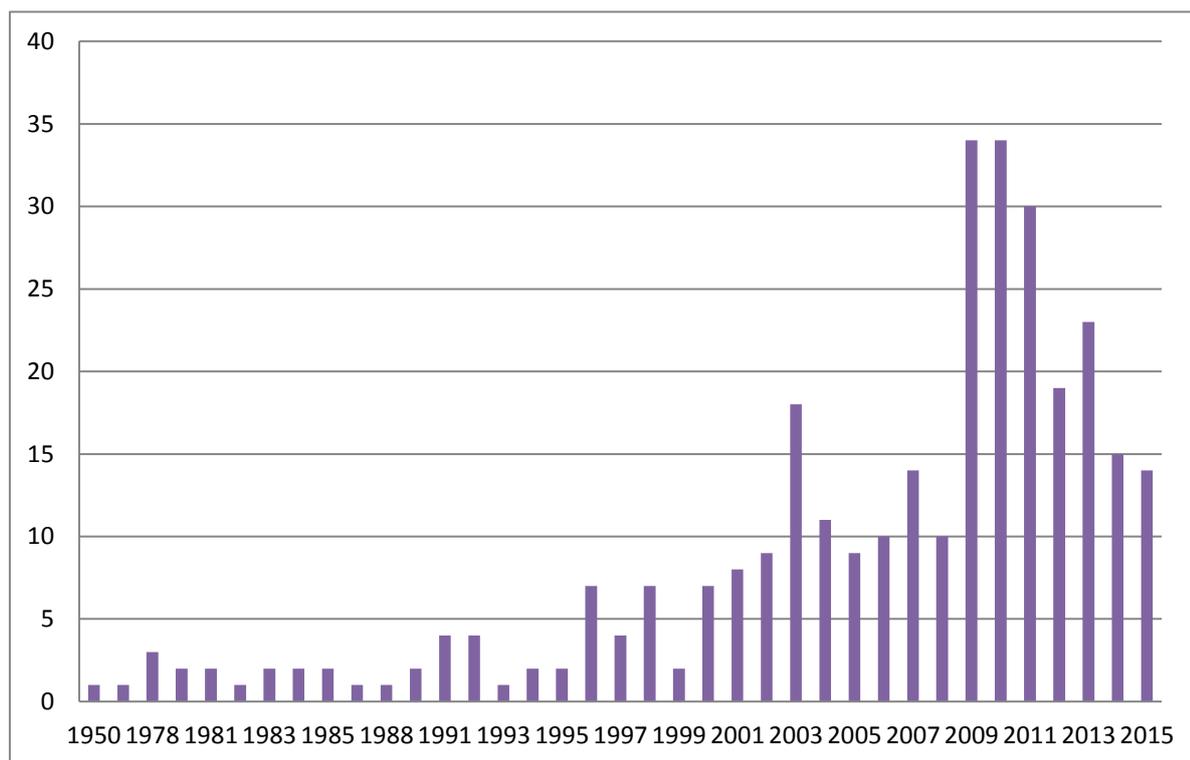
Interestingly, those AHAs who completed the certificate IV after they had started work as an AHA indicated they learnt nothing new from the training and all of their useful learning was on the job. This was further reflected in focus group comments regarding there being only one three week clinical placement as part of the certificate IV; this was viewed as inadequate for AHAs to be work-ready. In response to this, some workplaces required that local requirements be completed before AHAs can work with patients.

*“Every AHA has to meet discipline specific competencies within our workplace before they can see patients, regardless of their qualifications.”*

Most respondents (93%) undertook their education to practise as an AHA in Victoria, with only 3% trained interstate and 4% trained overseas. As AHAs were largely trained ‘in situ’ there was less likelihood of them needing to travel to a metropolitan centre for training, increasing the likelihood of a more geographically stable and locally sourced workforce.

On average, AHAs had been working for 11 years. The majority of respondents (78%) qualified before 2002, with a number attaining their qualifications in 2009 and 2010 (n=32, 31 respectively); the numbers have decreased consistently since then (Figure 19).

**Figure 19: Year of qualification (n=312)**



### Continuing professional development (CPD)

AHAs reported a lack of access to specific training or continuing professional development (CPD), particularly in regional or rural areas. Over three quarters of respondents who indicated they intend to change their employment situation reported that they wanted to do this as their current role was not challenging enough, the position was viewed as low status or they were seeking better employment opportunities.

*“We’re lacking in professional development and are looking at improving this in next 12 months. We have PD [professional development] in the department we are part of but this is generally pitched at a higher level than the AHAs are ready for.”*

*“It would be nice to link in with PD and share in-services with other organisations.”*

*“The lack of PD is an issue here. We don’t have much PD throughout the year and when we do it’s really basic, and usually centred around physiotherapy and OT [occupational therapy]”*

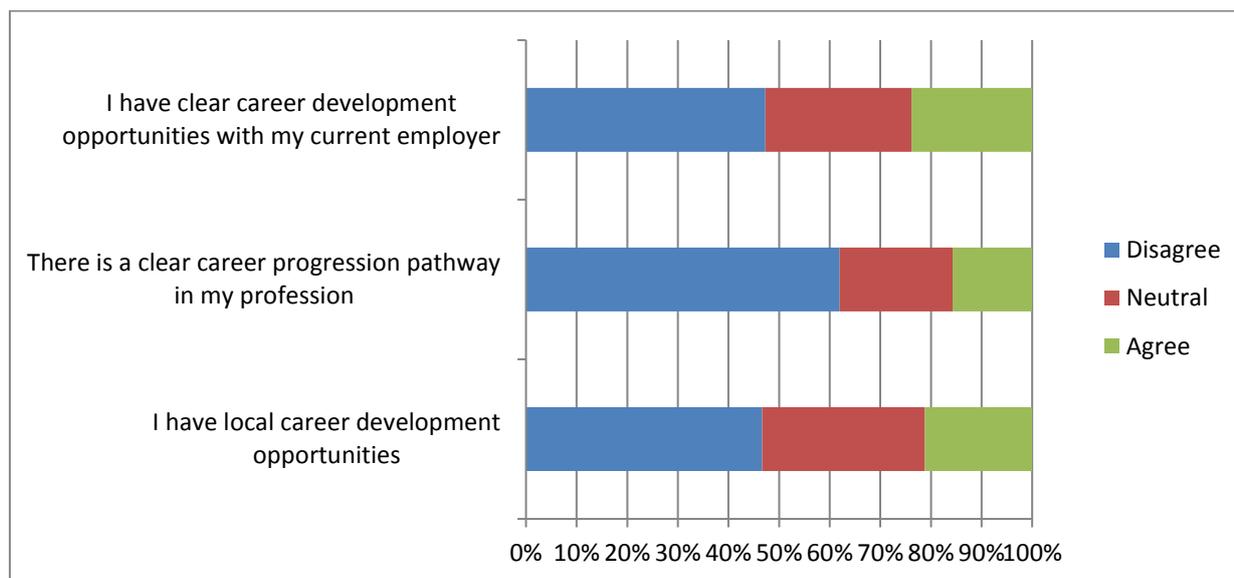
Standardisation of expected competencies may improve the transferability of roles across the sector.

*“What would be fantastic is if we could have some competencies that were standardised across the state so that staff who have completed these competencies at another organisation do not have to repeat this and have transferable skills.”*

### Career development opportunities

AHAs expressed significant dissatisfaction with the lack of career progression opportunities and pay. Over two thirds of respondents reported a general lack of opportunity in the profession to progress their career (Figure 20), this was also rated as very or extremely important to this group. Further, over half of the AHAs were dissatisfied with the opportunities to progress in their current role. This is concerning as over 50% are already employed at the highest grade, grade 3.

**Figure 20: Career development opportunities (n= 255)**



*“As a grade 1 AHA my responsibilities have continued to increase as I’ve got more experience. But there’s never been any discussion about progressing to a different pay level.”*

*“The ability to upgrade skills and qualifications via online and remote training methods while still recognising that some face to face learning is necessary for practical skill sets.”*

*“To get more job satisfaction, I took on an additional role in community health in service coordination. Doing the two roles balances things. I’m really loving it now.”*

*“I’ve had difficulties stepping up from grade 3 into the more co-ordinator and manager roles...I’ve been encouraged to upskill and have completed further study. But you can be a physiotherapist or occupational therapist with no management experience but you’re more employable because you’re a physiotherapist or an occupational therapist... AHAs amass tonnes of knowledge. People who have been in the roles for eight years, or more, their knowledge in the facility they work at, its programs, how it works it, its staff, its strengths, its weaknesses, their knowledge is as strong as any other AHP. So I find it a bit of a barrier in that regard.”*

Challenges to career development included the ceiling effect reached at grade 3 and lack of opportunities for progression beyond grade 3. Some employers were reported to not employ grade 3 AHAs, thus employing more highly qualified staff at lower levels (e.g. grade 3s working as grade 2s). There was a general lack of recognition and remuneration for those practitioners who have progressed their skills by performing managerial, advanced or novel roles.

*“Career structure that allows for progression into leadership / management roles”*

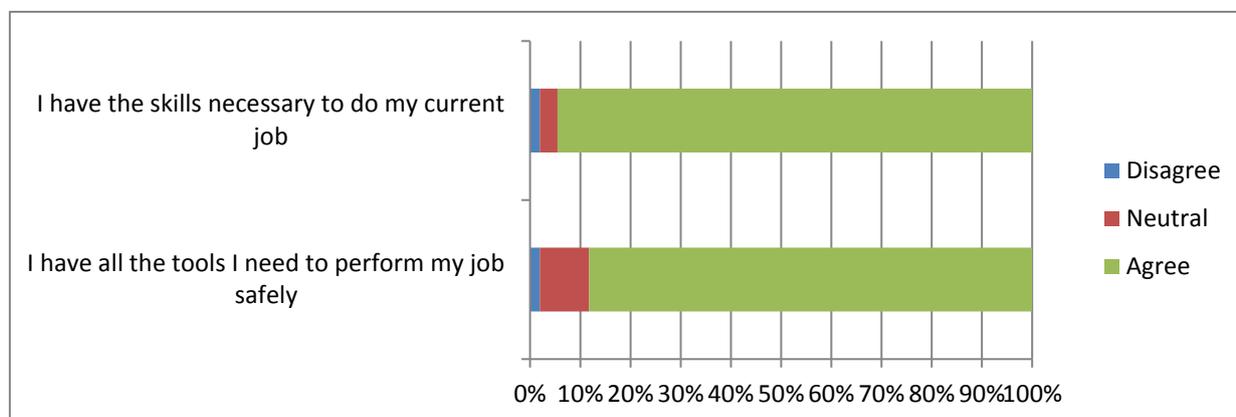
Employment of AHP students in AHA roles was also noted to limit AHA career opportunities.

*“A lot of AHAs are physiotherapy or occupational therapy students who are not qualified AHAs. This blocks AHAs in building their careers. Our organisation has a relationship with TAFE [Technical and Further Education] which we try to support and bring AHA students on. But we’ve got 10 spots and eight of them are taken up with physiotherapy students. It makes it hard for AHAs to move forward.”*

## Clinician knowledge and skills

The vast majority of AHAs perceived they had the tools and skills necessary to safely perform their current job (Figure 21).

**Figure 21: Clinician knowledge and resources (n=255)**



Despite their relatively high levels of qualification, AHAs reported they were being underutilised or inappropriately used by other professionals. As expressed by one participant:

*“Educating AHPs on our scope of practice. We are not just a dumping ground for patients without goals and that don’t really want to be there as I feel underutilised all the time. I enjoy my work place and my allocated scope yet as I’m not utilised to my full potential it does become frustrating at times.”*

### Skill gaps

Organisations employing AHAs identified a small number of skills gaps; however these may reflect local requirements and without more detailed information may not be generalisable to the entire AHA workforce:

- acute and subacute hospital work (as training / education tended to be focused more on aged care)
- communication skills
- interdisciplinary working
- paediatrics
- medical imaging
- dietetics and nutrition
- discharge coordination
- extended roles e.g. massage / fitness qualifications.

*“Course our local students do doesn’t include dietetics. Dietetics plays a big role at our service, so it’s a big gap. If we get a new AHA, they know nothing about dietetics and we have to start from scratch. Speech pathology is starting to be taught, but only one day of training, so this is another gap. Physiotherapy and occupational therapy have been around a lot longer with AHAs, so it’s better.”*

*“The RTOs [registered training organisations] are taking time to catch up with what health organisations are doing with AHAs.”*

*“We’ve been working with TAFE to get podiatry and dietetics units added on, but so far we’ve been unsuccessful.”*

*“AHAs are mainly used by bigger disciplines; therefore there are often gaps from specialist discipline level.”*

*“AHAs usually need lots of support on induction. As an unregulated role, issues of professional conduct (e.g. confidentiality) may be new.”*

These perceived skills gaps suggested a need for flexible, responsive training options that can be introduced at specific sites according to their context and needs.

There was general agreement that there was a need for consistency around core competencies across education providers such that skills and knowledge are transferable across organisations.

The challenge for some AHAs may be having their roles extended too far.

*“I have worked for 8 1/2 years at [name removed] and although I love my job, I have found since the AHA Supervision report, I now have too many disciplines relying on me. There are three AHAs and we all have a lot to do. Can there be more recognition to the discipline AHA and maybe more value to the title rather than assistant. I think ‘Jack of all trades’ would be better title. Sometimes the stress of having so many people to answer to isn’t worth it and sometimes we are valued more than other professionals.”*

The need for improved consistency also extends to understanding the roles of different AHA grade levels within and across organisations and regions. It was noted that the ‘Supervision and Delegation Framework for Allied Health Assistants’ includes some information on this but the information may not be specific enough. As a result, what the different grades can and cannot do is not well understood and were not applied appropriately.

*“Once you’ve been a grade 2 for five or more years AHPs will delegate things that are grade 3 because you’ve built up the experience.”*

*“The main issue is distinguishing what a grade 2 and grade 3 can do. Not many AHPs know about this. Across sites it’s different. A grade 3 OT AHA at one site might do lots of home access visits, but a grade 3 OT AHA at another site isn’t doing that at all. It seems bizarre.”*

*“It’s very dependent on the therapist. One therapist will have you do something another doesn’t want you to do that. We’re having to clarify all the time.”*

*“My grade 3 position was created two years ago but the role still isn’t clearly defined. This year we’re working to sort out the parameters. They’ve created it but aren’t really sure what a grade 3 role can and should do.”*

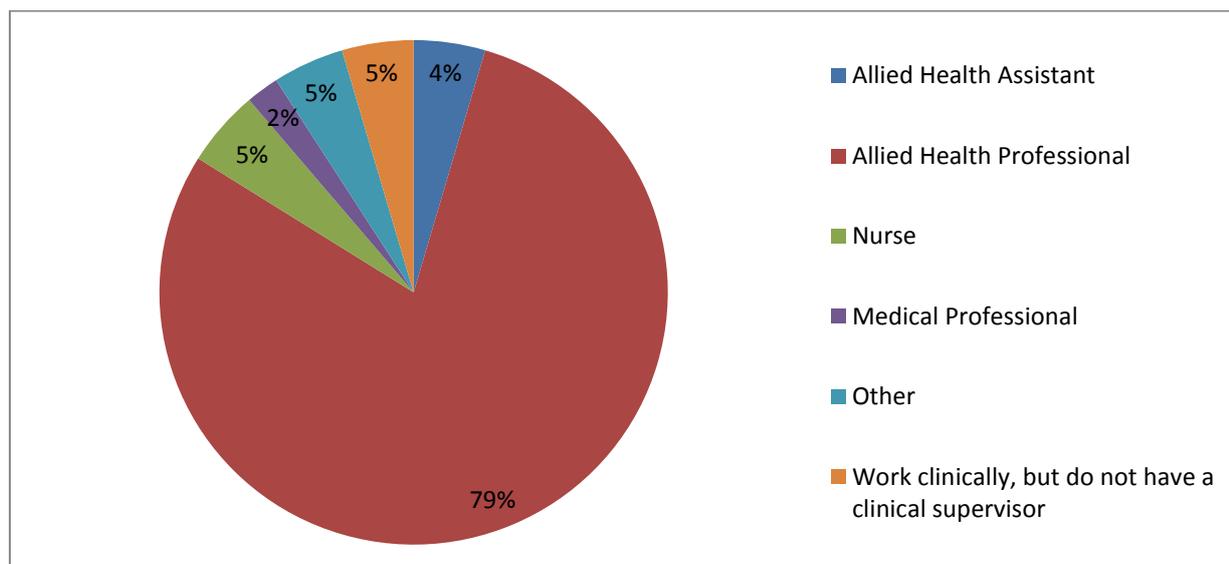
## **Support contexts to enhance capability**

### **Supervision and support**

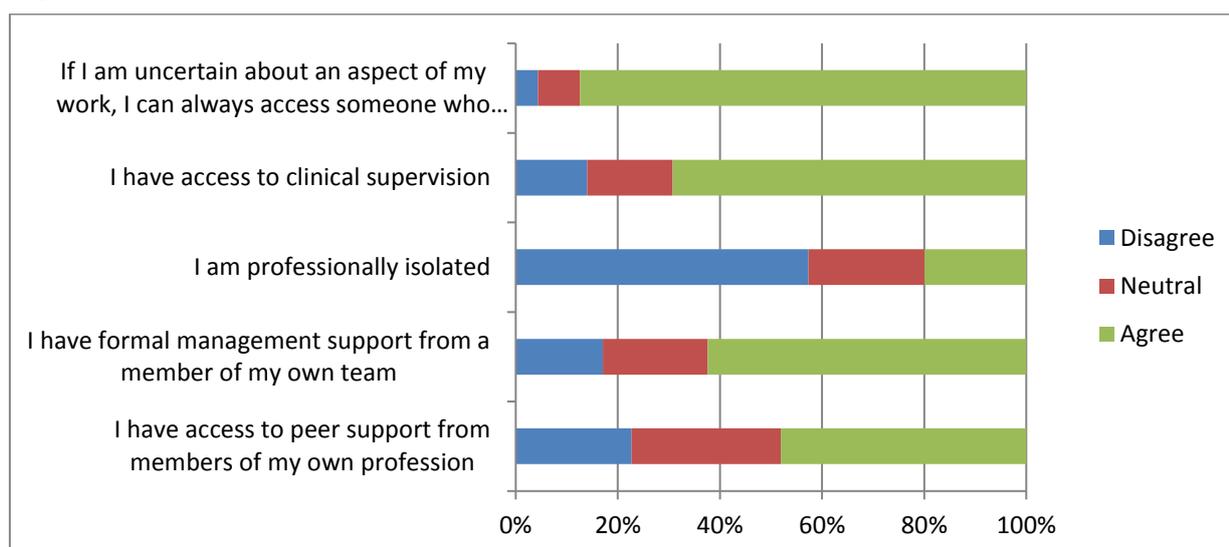
The majority of respondents (70%) reported having access to clinical supervision. However, there were 30% who reported that they do not have access to clinical supervision; including those who do not have someone they can access if they are uncertain about their work (n=11, 4%). Nonetheless, there were very few AHAs who reported they did not feel they have the tools to perform their role safely (2%, n=5) (Figure 21) and almost half of the AHAs felt supported by their own profession 48% (n=123) in terms of peer support (Figure 23).

For the vast majority of respondents (79%), supervision was provided by an AHP (Figure 22).

**Figure 22: Professional background of clinical supervisor (n=286)**



**Figure 23: Access to clinical supervision and support (n=255)**



The focus groups suggested that the adequacy and appropriateness of AHA supervision varied. Some were very well supported through an AHA and AHP structure; others were supervised by AHPs with considerably less experience than themselves.

*“My supervision is a very mixed bag. My clinical supervisor varies as I rotate and my supervisor changes. I can have a grade 2 AHP that’s never worked in the clinical area, or someone who is highly experienced.”*

*“I have monthly supervision with a grade 2 physiotherapist, bimonthly with a grade 3 AHA. We have in-services with the team. I work in a fabulous team. They’re always willing to answer questions and train me in a particular area.”*

*“I’m a grade 3 AHA...We work autonomously a lot. We don’t have anyone mentoring except a physiotherapist. But we have difficulty getting physiotherapists in our area. We don’t get a lot of PD*

*development. At the moment we're down a physiotherapist so they're flat out doing what they're doing. We're fairly much left to our own devices."*

The position of AHAs within organisational structures does not always offer AHAs the level of advocacy and support needed to ensure recognition, professional development and role development. Focus group participants indicated that sitting within AH departments sometimes resulted in AHAs coming second.

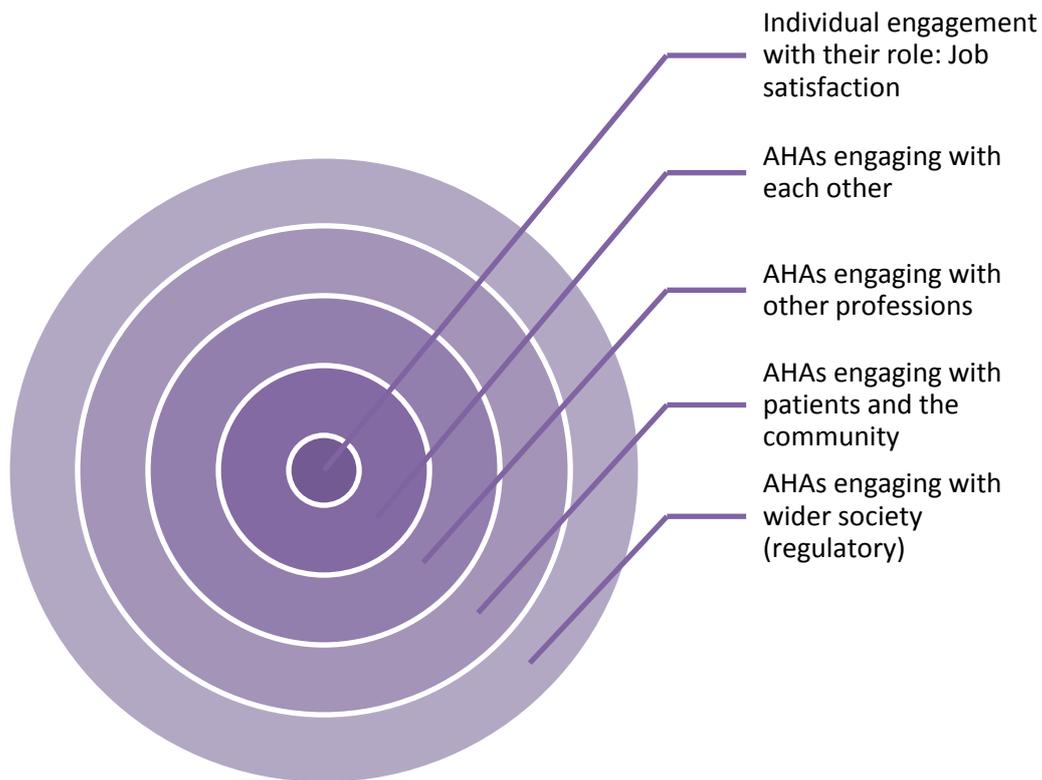
*"My manager is the physiotherapy manager. That person looks after the physiotherapists. They also look after the exercise physiologists and AHAs within physiotherapy. And this is the structure across the whole organisation. So advocating for the AHAs...we sort of come second to the AHPs..."*

*"We're quite lucky...we have an AHA Advisor who works and advocates for AHAs across the organisation, but you can only spread yourself so wide."*

## Engagement

Engagement involves a continuum from the individual practitioner's engagement with their role to the wider engagement of the profession with society through regulatory mechanisms. The path includes engagement with the profession, engagement with other professions, patients and the community (Figure 24).

**Figure 24: Model of engagement**



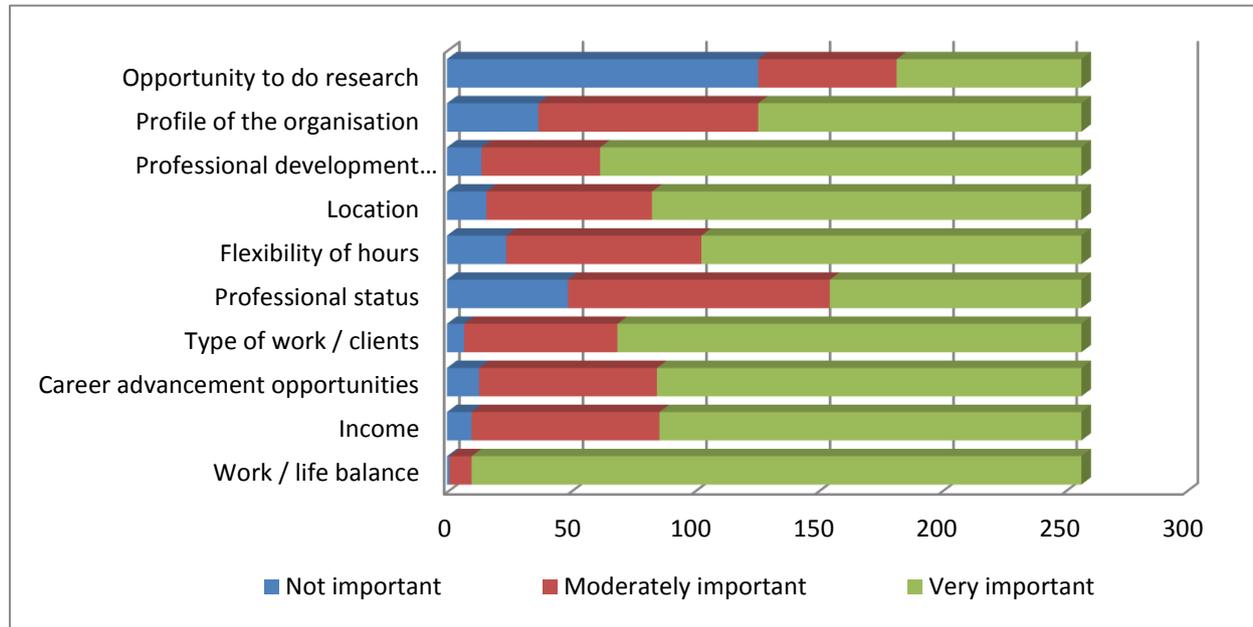
### Key findings

- AHAs were largely satisfied with their work conditions and roles; however the profession is relatively unstable with 4% intending to leave the profession in the next 12 months and 50% intending to leave in the next five years.
- Most AHAs worked with a range of practitioners across different disciplines, settings and services, but have the greatest engagement with and overlap with physiotherapists.
- AHAs perceived that the role is misunderstood or not appropriately recognised by other practitioners and management.
- Respondents reported their current grade or salary was not appropriate for the work they do.
- AHAs lacked a formal organising or advocacy structure which limited their voice as a group, however the workforce are taking a number of steps to organise themselves.

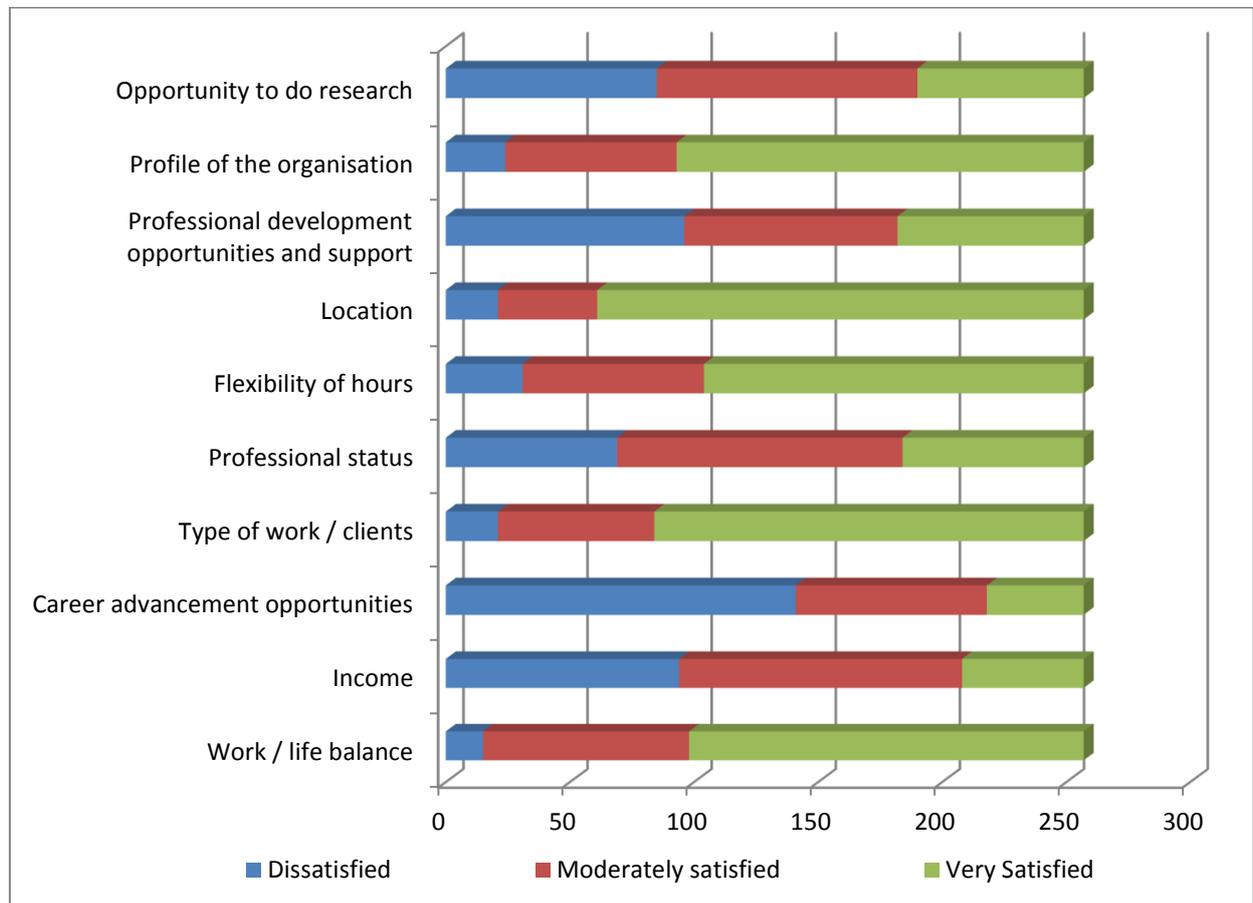


with the location of work, the type of work, and the clients they were currently involved with (Figure 28). This suggests that the AHA role provides a reasonable level of flexibility for staff.

**Figure 27: Importance of factors affecting employment choices**



**Figure 28: Current satisfaction with factors affecting employment choices (n=250)**



Opportunities to do research were neither particularly highly valued, nor were respondents satisfied with it.

However, many respondents were highly dissatisfied with their career advancement opportunities, professional development opportunities and income (Figure 28).

*“We are getting more and more responsibilities and it is not being recognised”*

This is compounded by a lack of professional advocacy for AHAs in the form of an association or organisation that could address issues such as pay and funding for study (which is currently not in the AHA enterprise bargaining agreement).

*“Once you have reached a grade 3 there is no further increase of pay increments – unlike nursing”*

A large proportion of AHAs were not satisfied with career advancement opportunities or the pressure of working across multiple professions and services.

*“Working as a multidisciplinary AHA you can be pulled in all directions. For example, you can have a caseload of up to eight patients and could be seeing these patients for multiple disciplines, i.e. physio and occupational therapy, or occupational therapy and speech pathology.”*

The lack of satisfaction around career progression was reflected in the previously identified high rate of intention to leave the profession with nearly 50% of the AHA workforce intending to leave within five years (Figure 10). This intention to leave may be due to a perceived lack of career structure, unfunded full time positions resulting in a lack of ability to move through the grading system, and AHAs who were qualified in other fields such as exercise physiology. Overqualified practitioners were more likely to be looking for other roles.

*“Many AHAs are overqualified therefore they’re a good match for a short-medium term role only.”*

*“As an exercise physiologist there’s not many jobs in the workforce, so I’ve secured an AHA job in the meantime while looking for an AHP role.”*

*“I’ve been an AHA for eight years, a grade 3 for almost two. I’ve clinically done everything I can do here, rotated across all the wards, so I’m looking at changing up my clinical...or changing my profession...I’m considering teacher and trainer assessment course to teach AHAs at TAFE.”*

*“Not having enough PD is a motivator for people leaving. AHAs feel they’re not upskilled enough. When they move on, some study, some do an AHP a degree, some completely leave health.”*

However, there was a cohort of AHAs who were highly stable.

*“We have a stable workforce here, very few AHAs leave, not a lot of positions get advertised, and there’s been no expansion of new AHA positions for a long time, so people hang on to their jobs. We’re all AHA trained and majority of people have been here five to 10 years.”*

*“In rural settings, jobs are hard to come by so people stay as long as they can. If you’re not satisfied you have to move to a bigger organisation or to Melbourne. Or look within the organisation for other roles.”*

*“I’m a grade 3 AHA, working in rural community health. Unless we move to another organisation we can’t progress.”*

Working with the 'right' client groups and in the 'right' roles was also highly important for meeting AHA satisfaction needs. Over 70% of respondents rated as very or extremely important the type of work or clients at their place of employment. However being spread too thinly across too many roles and service types was not ideal either:

*"My role is too varied. My head spins. In a working week I assist / set-up and get homework packs together for speech language groups for two year olds (2 1/2 hr); lead / assist / set-up and homework packs, write in files for 'Little wrens' – three year olds – speech / occupational therapy group (2 1/2 hr); podiatry routine nail care (3 hours); Podiatry- clean clinic rooms and get instruments to sterilise / put away (1 hr); Walking group - organise, roster, newsletter, paperwork, staffing, other things for group speakers, lunches, birthday vouchers (1 hr but can be up to 6 hours); Lead walking group (1 1/2 hours); Physio client exercise programs 1:1 (6 hours); Active Lorikeets - school readiness - two groups lead / assisted / set-up / write in files / organise (4 hours); Staff meetings / case conferences (2 hours); Ordering / resources / group follow-up / admin (3 hours); Falls balance set up and assistance (1 1/2 hours); Nordic walking lead, group prep, client notes (2 1/2 hours); Tai Chi assisting (1 hour); Aquatic physiotherapy / hydro assist, travel, client files (3 1/2 hours); Occupational therapy assistance with home visits, occupational therapy pack preparation (1 hour); Tai Chi leading, organise group and client notes (3 hours); Physio room preparation (1 hour); ... Plus a lot of other things."*

## **Intra-professional engagement**

AHAs are a relatively newly emerging, unregulated workforce without the representation of a professional body. However there was evidence that AHAs were beginning to formally organise themselves with the establishment of regionally based AH assistance networks, a Victorian AH assistance Facebook page, organisational networks of AHAs, and preliminary discussions regarding a change to be more closely aligned with AHPs.

*"It's been great to watch the development of the AHA role over the last 15 years that I have been working. When I commenced work as a qualified AHA there was no grade system in place so it's been satisfying to see the overall development of the AHA role and the scope of practice."*

*"The interest group for our region meets quarterly – I find that wonderful."*

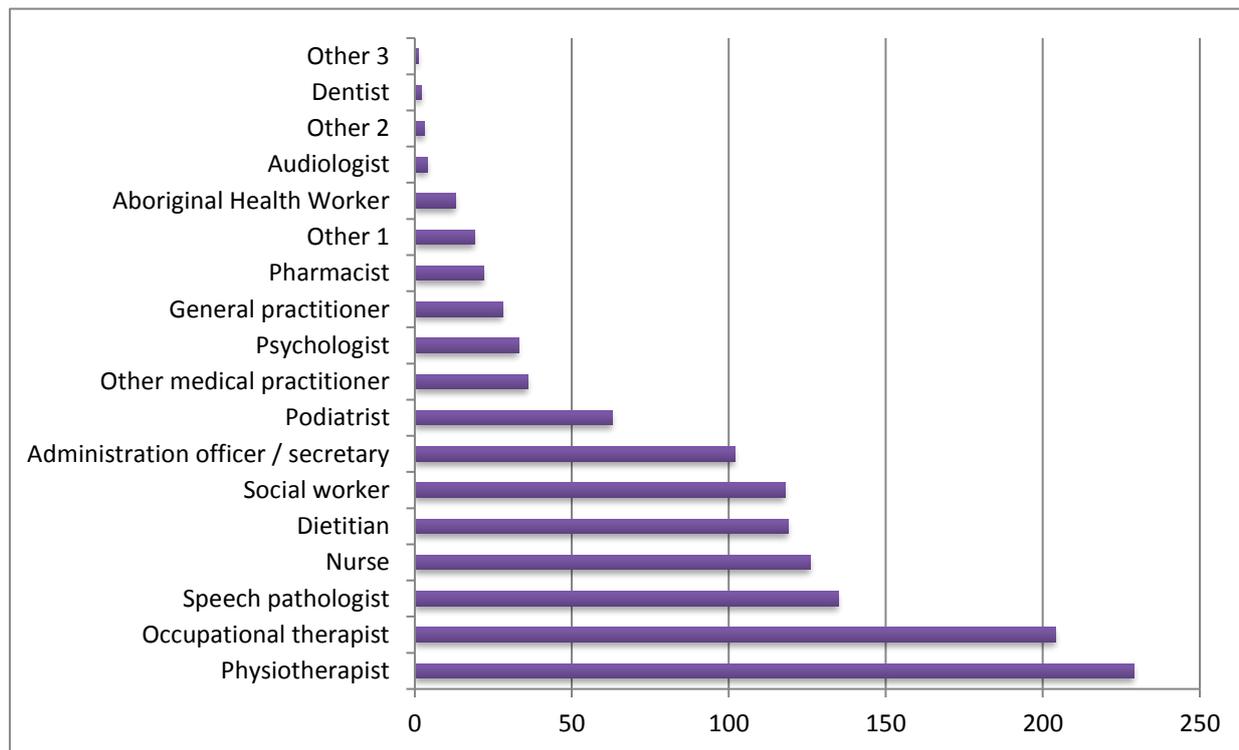
*"I don't meet with AHAs from other organisations, but within our organisation we come together as an AHA leadership group."*

*"That work looking at the union structure and where we fall under is fantastic given the fact that the AHA scope and awareness is rising. Being able to be represented with the rest of allied health would be perfect, it would be absolutely amazing. That's fantastic work."*

## **Inter-professional engagement**

AHAs were asked which professions they worked with. The vast majority of respondents worked with physiotherapists (n=229) followed closely by occupational therapists (n=204). However most AHA respondents reported they worked with a range of practitioners across different disciplines (Figure 29).

**Figure 29: Professions worked with (n=1257) <sup>a</sup>**



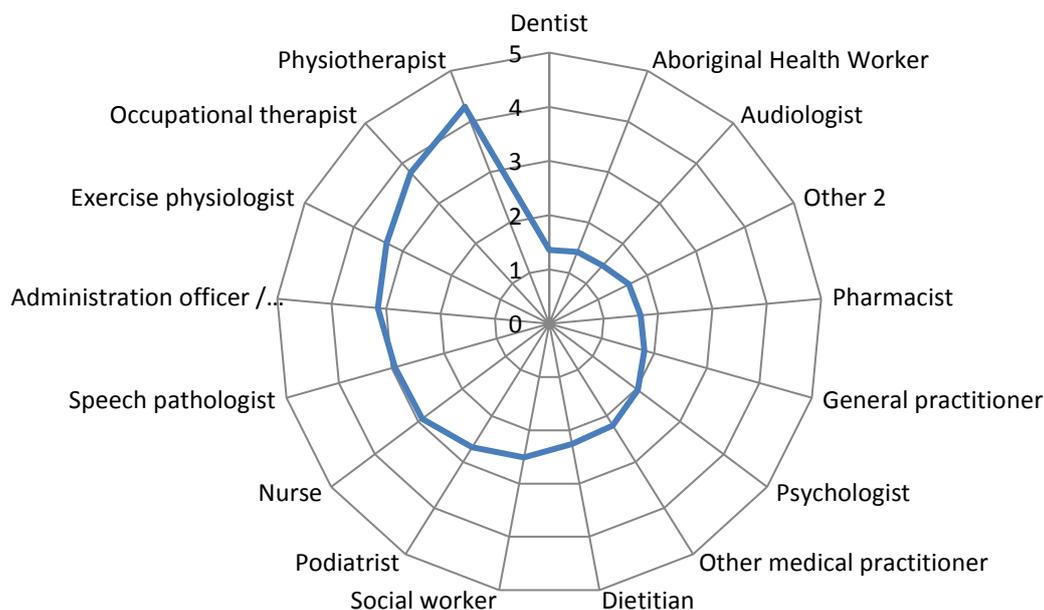
<sup>a</sup> Respondents could select more than one response

Other - included exercise physiology (n=10), specialist nurses (n=3), diabetes educator (n=3), fitness professionals, food service staff, neuropsychologist, orthotists, psychiatrist, radiologist, welfare worker, other AHAs, care coordinators and radiation therapist.

AHAs were also asked how much their role overlapped with other practitioners (Figure 30). Not surprisingly respondents reported the greatest role overlap with those practitioners they reported they worked closely with. Fifty four percent (54%) reported their role overlapped ‘a lot’ and 34% ‘somewhat’ with physiotherapists (n=216), and 33% reported their role overlapped a lot’ and 55% ‘somewhat’ with occupational therapists (n=188).

**Figure 30: Extent of role overlap with other professions**

(Score 0 to 5 where 5 is the maximum amount of overlap)



Despite working closely with speech pathologists, only 20% of respondents reported their role overlapped 'a lot' with this profession (n=25). Sixty seven percent (67%) of respondents reported their role overlapped 'somewhat' with administration and 60% with nursing. Of the respondents who reported they worked closely with general practitioners (n=36), 44% reported their role overlapped at least 'somewhat' with them.

Respondents expressed a need for greater recognition of the AHA role in terms of grading structures and remuneration, but also for the role as a professional role.

*"The perception that people have about AHAs...many consider it a "non-professional" or non-qualified form of employment, e.g.: 'just an AHA'. I am a university graduate and have lots of other qualifications and considerable experience in my field."*

*"With the AHPs I've always been very well supported. But every year we get a new physio, a new grad so I get to train them for a year. This shows what AHAs can achieve. They just don't know what we do."*

AHAs reported that their role was often misunderstood by other professions and by management; therefore they are often underused and often misused.

*"They don't use AHAs enough. There's a lot of areas where they could use us and don't. One is on the acute wards they use the physios but there are times when I know for a fact that the AHAs could be doing some of the work in those areas."*

*"There are only two AHAs here. A lot of people don't understand our role and what we do. Even from management. They don't recognise our profession as such, don't understand our skills."*

*"Not being valued as an AHA because of the perception or lack of understanding of the role. I feel we are looked upon in my work place as 'helpers' that are only there if you are going on holiday's and you have forgotten to complete a task for a client (that an AHA could perform otherwise), the clinician suddenly thinks out of the 'box' and the referrals come flooding in."*

*"We don't just do admin and cleaning. We constantly have to educate people about what we do."*

*“That some of the AHP's would delegate tasks to allow me to grow within my role, and not be threatened that I am going to take their job.”*

*“That clinicians do not appreciate the scope of work that AHAs can do and that they can 'work together' rather than 'for them'”*

Focus group participants spoke of using proactive strategies to increase AHP knowledge of their roles and contributions that AHAs can make, including educating staff about their roles. Such strategies were reported to be valuable, however with ongoing staff turnover it was a constant process.

*“I don't have AHPs onsite but I have to teach the nurses what I do. They're receptive up to a point but I'm only here three days a week so it's very difficult. I've been here a long time (17 years) but it's still a challenge.”*

*“With new AHP staff, we sit down and educate them on what we do, what they can and can't give us. We find this works. Lots of fresh AHP grades 1s have never worked with AHAs. They don't know what we do. It's an ongoing thing; we have to constantly remind people that we are here to help.*

Given the increasing use of AHAs by AHPs, it would be appropriate to embed training around the AHA role, support, supervision and delegation within undergraduate training of AHPs.

## **Engagement with the community and society**

### **Professional recognition**

The lack of formal organising structures for AHAs limited their voice as a group. They are not currently recognised by the Health Services Union which creates further divisions for this workforce with respect to AH professions, although this is currently being negotiated.

*“There is no professional, governing or even support network for AHA's. As such no development pathways like there is in the allied health professions so there is no scope to progress beyond my current position within the organisation I work for.”*

*“I attempted some years ago to become a member of the HSU [Health Services Union] but I was ignored. It would be nice to have a union represent us if we were considered "allied health professionals".*

*“It's difficult seeing AHA as a career due to limited grade structure, income, career opportunities etc.”*

Respondents from other professions were fairly clear that they do not recognise AHAs as a 'profession'.

*“A lot of AHPs don't recognise AHAs as being a profession. It's very frustrating. They don't take us as being as professional as what they are. I find that really downgrading to myself. They think we're not qualified enough for PD.”*

## Conclusion

AHAs are a unique, skilled, and educated group with broad life experience. At the individual level, AHAs have fluid roles that enable them to effectively fill service gaps; however they have nowhere to go once they reach the top of the AHA career pathway, nor are they recognized for their capability to work across numerous roles, disciplines and services. These are not only barriers to career progression but also to further training and PD. This is compounded by a general lack of awareness of the capability of the AHA role and lack of advocacy from a registration body or association.

These frustrations were reflected in the high level of instability of the workforce with high levels of intention to leave the workforce, particularly amongst younger AHAs. Most of those leaving the workforce in the short term were doing so to take on further study. However the need to leave the workforce to take on further study reflects the lack of career pathways available for AHAs.

The research demonstrated that this group of workers were mostly satisfied with their work conditions and roles; yet they have the further capacity in terms of their skills, background and lack of role boundaries to better fill service gaps and meet client or service needs. However being spread too thin across too many professional roles or services was stressful. To gain the most from this group of practitioners, these areas need to be invested in through better advocacy and understanding of the role, improved training opportunities, and a more progressive career structure that recognizes the skills necessary to work across multiple professional groups, roles and services. This is particularly the case for the large number of practitioners working in regional areas.

# References

Victorian Public Sector Commission (2015) *Health Sector Data Collection* Retrieved from:  
<http://vpsc.vic.gov.au/resources/data-collection-health-sector/>

# Appendix

The following section contains additional data, figures and tables referred to in the main report relating to the data collected through the AHWQ AHA survey.

## Responses and respondents

The AHWQ survey consisted of 69 questions or opportunities for the respondent to comment. Completion of the survey was voluntary and respondents had the opportunity to choose if they wished to answer a question or not. Some of the questions were conditional on the response to previous questions. Some questions allowed for multiple answers. As a result, the number of responses for each question varied and is included in the presentation of the data for each question.

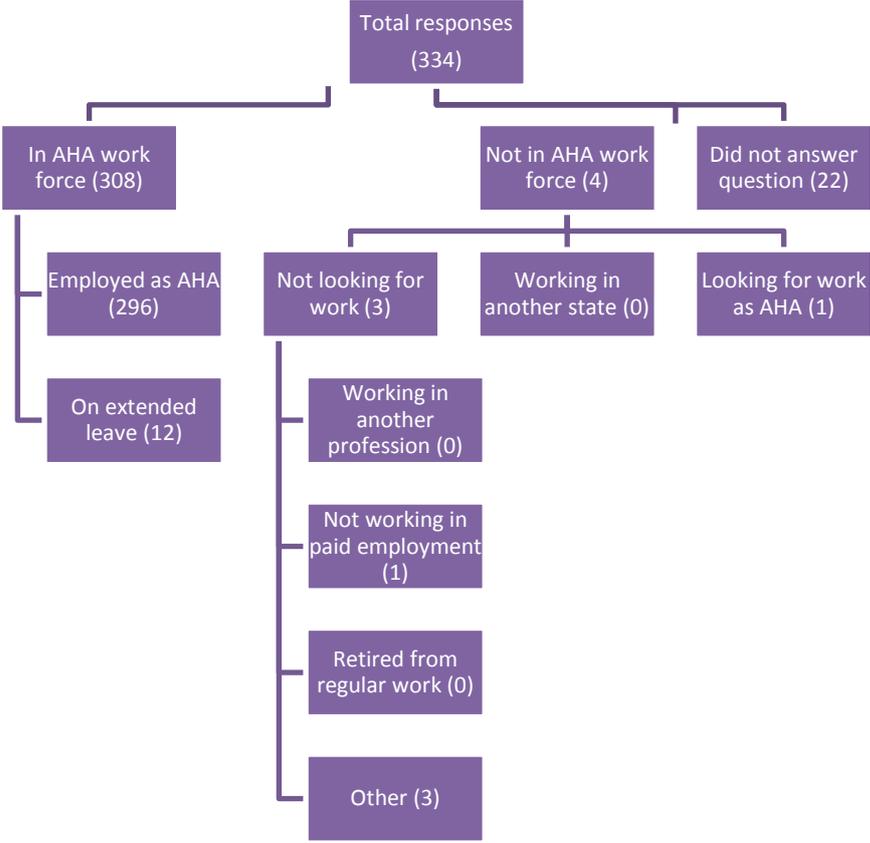
A total of 334 AHAs completed at least one question on the AHWQ survey and submitted their survey. The range of responses to an individual question was from 261 to 1,257. Responses from all persons who answered an individual question have been included, irrespective of whether they completed the entire survey or not.

In order to gather more information about the work that AHAs do on a day to day basis, and the types of clients they work with, an additional qualitative survey involving 11 questions was undertaken. This survey contained predominantly open ended questions where the respondents could provide as much detail as they liked about the work they undertake. Sixty six (66) AHAs completed this second survey.

A total of 108 respondents (32%) provided their email address and agreed to be followed up for future research.

The vast majority of the survey respondents (99%) were employed as an AHA in Victoria at the time of completing the survey. Only one respondent was actively seeking work as an AHA.

**Figure 1: Current employment status<sup>3</sup>**



<sup>3</sup> All data in figures and tables in appendix is from the AHWQ.

**Table 1: Hours worked per week across employers**

Hours per week	Employer 1	Employer 2	Employer 3	Employer 4	Employer 5	Total
0 – 8	7	13	3	3	0	26
8 – 16	32	8	3	1	0	44
16 – 24	48	6	2	1	0	57
24 – 32	58	2	0	0	0	60
32 – 40	131	6	5	3	1	146
>40	19	0	0	0	0	19

**Table 2: Nature of employment**

Question	Employer 1	Employer 2	Employer 3	Employer 4	Employer 5	Total
Permanent	260	24	10	7	1	302
Temporary	9	1	0	0	0	10
Contract	18	4	2	1	0	25
Casual	4	4	1	0	0	9
Locum / other	1	1	0	0	0	2
Other	3	1	0	0	0	4
<b>Total Responses</b>	<b>295</b>	<b>35</b>	<b>13</b>	<b>8</b>	<b>1</b>	<b>352</b>

*There were no responses for voluntary work or self-employed so these columns were removed.*

**Table 3: Hours of work per week in each role**

Role	n	Hours		
		Min	Max	Mean
Clinical	275	0	51	21
Management and administration	238	0	36	10
Teaching or educating	89	0	24	4.
Research	51	0	15	2
Other (please specify)	56	0	30	8
Project work (not involving direct clinical or research)	71	0	32	4

*Other included : Supporting AHP, health promotion, portering, administration (patient contact, driving, non-clinical, stores/equipment maintenance/equipment cleaning/stock, volunteer coordination, professional development, cleaning, community work, 'PAVR' officer, aged care, nursing, studying, quality improvement, exercise groups, resource making for AHP, planned activity group assistant.*

**Table 4: Type of other roles (n=311) (Source: AHWQ)**

Type of role	n	%
Administration	68	21.86
Hospitality	24	7.72
Other health (e.g. nurse, diversional therapist, personal carer etc.)	33	10.61
Banking	3	0.96
Other non-health (business owner, massage therapist, beautician, actor etc.)	75	24.12
Retail	26	8.36
Child care worker	12	3.86
Other allied health (physiotherapist, exercise physiologist)	15	4.82
Lecturer / researcher / university / research assistant	3	0.96
Management	3	0.96
Teacher / teacher's aide	16	5.14
Sports industry (instructor)	27	8.68
<b>Total</b>	<b>311</b>	<b>100.00</b>

**Table 5: Location of study compared to location of childhood (metro vs regional)**

Childhood location	Study location		Total
	Metro	Regional	
Metro	137	32	169
Regional	40	61	101
<b>Total</b>	<b>177</b>	<b>93</b>	<b>270</b>

**Table 6: Location of work compared to location of childhood**

Childhood location	Workplace location		Total
	City	Regional / Rural	
Metro	136	31	167
Regional	29	72	101
<b>Total</b>	<b>165</b>	<b>103</b>	<b>268</b>

**Table 7: Location of work compared to location of study**

Study location	Workplace location		Total
	City	Regional / Rural	
Metro	151	34	185
Regional	25	72	97
<b>Total</b>	<b>176</b>	<b>106</b>	<b>282</b>

**Table 8: Recruitment approaches**

Question	Do not use	Unsuccessful	Moderately successful	Extremely successful	Total
Word of mouth	7	2	11	6	26
Local media (newspaper)	5	5	7	8	25
Professional associations	18	2	5	0	25
Government employment website	16	2	3	2	23
Recruitment consultant	22	1	0	2	25
Employment agency	22	1	0	1	24
Overseas advertising	22	1	0	1	24
Interstate advertising	22	1	0	1	24
Social media (e.g. Linked-in)	21	1	2	1	25
Other strategy	13	1	2	3	19