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EXECUTIVE SUMMARY

The Partnerships in Rural Health Project was funded by the Australian Government Department of Health and Ageing through the Rural Private Access Program and the WA Country Health Service (WACHS).

The overall aim of the project was the development of a strategic plan to identify appropriate public private partnership models to ensure the long-term viability of privately insurable services in the north west of Western Australia (WA). This project, which has focused on allied health services in the north west, offers a number of significant benefits to the community. The implementation of public and private service provision models in rural and remote Western Australia offers the opportunity to:

- Maximise the capacity of privately insurable health services.
- Increase the sustainability and viability of privately insurable health services.
- Facilitate consumer choice of service providers.
- Provide additional career opportunities to health professionals.

Overall five models were developed and evaluated to illustrate potential partnerships between public and private sectors. A successful pilot service was also introduced to investigate the feasibility of a public private partnership in the far north west.

Enquiries were received from numerous allied health professionals (AHP) during the course of the project regarding establishing private practice in the north west. A need was identified for a resource to assist AHP in how to go about setting up a private practice in a rural or remote area which has led to the development of a ‘How to Become an Allied Health Private Practitioner in Rural WA’ resource.
BACKGROUND

The aim of the Partnerships in Rural Health Project was the development of a strategic plan to identify appropriate public private partnership models to ensure the long-term viability of privately insurable services in the north west of Western Australia. In addition the project focussed specifically on the provision of allied health services. Funding was received in February 2006 through the Australian Government Department of Health and Ageing Rural Private Access Program to assist WA Country Health Service to develop and implement the project.

Communities within WACHS currently have limited access to privately insurable health services. This has generated an over-reliance of the state-funded system and limited consumer choice for health services. The consideration of public private partnerships allows both the state and private providers to establish mutually beneficial relationships and address such barriers.

The allied health professional population in WA is typically very transient. Recruitment and retention difficulties in rural and remote WA have a significant impact on the sustainability of services and act as a barrier to the development of private services. Comprehensive privately insurable health services within many communities in country WA are essentially not viable or sustainable. Factors influencing the establishment of private services include caseload, infrastructure, revenue and workforce. A partnership between public and private health services has been identified as a key opportunity to address such barriers.

This project has focussed on the north west of WA, but has significant opportunity for transfer of outcomes to other rural and remote regions.
POTENTIAL BENEFITS

The implementation of public private service models in rural and remote Western Australia offers the opportunity to:

- Maximise the capacity of privately insurable health services within the WACHS catchment.
- Increase the sustainability and viability of privately insurable health services.
- Facilitate consumer choice of service providers.
- Provide additional career opportunities to health professionals.

This project offers a number of significant benefits to the community. Through the support of privately insurable health services, consumers will have greater choice regarding service providers, especially those with private health insurance. Most consumers in rural WA are required to travel to the metropolitan area (Perth), to access private health services. This may have an impact on the uptake of private insurance in rural and remote areas. By supporting the establishment and sustainability of local private health services, health consumers with private insurance will have the opportunity to use insurance for the purchase of health services. This use of privately funded health services may also have a positive impact on the health status of rural communities by increasing access to primary health programs, which may prevent or delay institutional care.

OBJECTIVES

The objectives of the Partnerships in Rural Health Project as identified in the funding agreement included:

1. An analysis of strategic options for public private service models within WACHS to increase the opportunity for establishment/sustainability of privately insurable health services.
2. Undertaking a needs analysis to determine the private health service needs of the community and the strategic directions of WA Country Health Service.
3. Engaging potential partners in the development of public private service models.
4. Identifying pilot sites, partnerships and public private health service models as a basis for future funding negotiations.
5. Establishing a strategic framework for the implementation of public private health service models within WA Country Health Service.
PROJECT IMPLEMENTATION

The Partnerships in Rural Health Project was conducted between March and October 2006 and included several phases.

**Phase One: Planning and Communication**

A project officer with experience in rural and remote allied health service delivery was appointed to the project. This phase also included project planning, the establishment of a WACHS intranet page on the project, communication to allied health professionals in the north west regarding the project and to allied/primary health managers throughout WACHS.

A project advisory group and terms of reference (Appendix A) were developed. The project advisory group provided advice, consultation and feedback throughout the project via regular meetings and updates to assist in achievement of the project objectives and strategies.

**Phase Two: Needs Analysis and Literature Review**

Phase two involved research relating to private health insurance uptake and coverage, socio-demographic information of the major towns in the north west and mapping of existing public and private allied health services in the north west. A literature review was also undertaken pertaining to public private partnerships and the principles of public private partnerships, allied health issues in rural and remote areas and enablers and barriers to private practice in rural areas.

The literature review can be found in Appendix B.
Phase Three: Regional Consultations

Phase three primarily involved regional visits and consultations with public and private allied health professionals and managers (Appendix C). During this process an outpatient survey was distributed to public allied health clients in the north west regarding private health insurance uptake and access to services (Appendix D).

Phase Four: Model Development

Following research on existing partnerships and issues pertaining to public and private allied health practice in the north west, a series of models was developed and evaluated and feedback sought. In addition to the development of these models, recommendations relating to initiation of public private partnership models were made as a result of research, consultations and feedback throughout the project period.

Phase Five: Pilot Project

Throughout the project period numerous enquiries were received from existing public practitioners and other private practitioners regarding establishment or expansion of private allied health services in the north west. As a result of this a resource¹ was developed to provide assistance to AHP considering private practice in rural WA. A private physiotherapy service pilot was also conducted in the far north west utilising additional funds received from the Australian Government Department of Health and Ageing.
WA COUNTRY HEALTH SERVICE (WACHS)

The WA Country Health Service is the largest country health system in Australia, providing an extensive range of health services across an area of 2.55 million square kilometres to a combined regional population of 454,000 people - almost one third of the state’s population. WACHS delivers acute and primary health services to regional WA, operating within a Regional Network Model and providing an integrated service delivery system that has earned broad community acceptance.

The WA Country Health Service directly employs around 5,700 full time equivalent (FTE) staff, which equates to more than 8,500 individual staff. This includes 2,310 FTE nurses and 180 FTE salaried doctors. Approximately 150 Visiting Medical Officers (general practitioners and specialists) also form a vital part of our clinical workforce. Our services are dispersed across the state and include:

- 6 regional hospitals
- 15 district hospitals (integrated district health services)
- 50 small hospitals (including 29 multi-purpose services)
- 26 mental health services
- 3 multi purpose centres
- 16 gazetted nursing posts
- 21 remote area nursing posts
- 2 state government nursing homes
- Community health services (52 locations)
- Child health services (168 locations)

As at February 2006, full time equivalent staff for specific allied health disciplines included: audiologists (6.0FTE), dietitians (14.0FTE), podiatrists (4.7FTE), occupational therapists (43.0FTE), pharmacists (8.72FTE), physiotherapists (70.5FTE), speech pathologists (44.2FTE), social workers (25.2FTE), clinical psychologists (3.8FTE), and medical imaging technologists including sonography (60.9FTE).

Each year on average, WACHS deals with 325,000 emergency department visits, 96,000 hospital discharges, and 380,000 inpatient bed days across the state.
The population of the north west region of Western Australia (WA), incorporating the Kimberley (35,001 persons) and the Pilbara and Gascoyne (49,260 persons) areas is 84,261 persons. This represents 18.7% of the population of WACHS or 4.26% of the state population. Of the population of the north west, 30% (n=25,321) are estimated to be Aboriginal persons.  

(Note: Population figures are based on the 2004 Australian Bureau of Statistics Estimated Resident Population)

Map of the North West

Appendix E outlines the demographic and population profiles of the major towns in the north west.
SOCIO-ECONOMIC INDEXES FOR AREAS

The Australian Bureau of Statistics (ABS) has produced a number of indexes based on the 2001 Census data that measures the level of ‘disadvantage’ in any given area. These are known as the ‘SEIFA’ indexes (Socio-Economic Indexes For Areas). SEIFA indexes can be used to see whether an area is relatively better or worse off than the Australian average. This can be achieved according to a number of factors identified by the ABS from the census such as household income, education, profession, household and dwelling size.

The ABS has ranked the SEIFA indexes and divided the scores into deciles to provide a picture of the relative ranking of areas. An area that falls into the first decile would indicate the area was amongst the most disadvantaged regions in the country. An area that falls into the tenth decile would indicate an area that was amongst the most advantaged areas in terms of socio-economic advantage/disadvantage.

The Pilbara region (statistical division) falls into the tenth decile and as such is amongst the most advantaged regions in the country. The Kimberley (statistical division) and the towns in it do not appear as affluent with an index of 7, and the Gascoyne (statistical subdivision) has an index of 5.
CONSULTATION PROCESS

REGIONAL VISITS

The needs of a community can be best determined by the people living and working within it. As part of the Partnerships in Rural Health Project, regional consultations were undertaken to gain information from AHP and service providers in the north west, specifically in the towns of Broome, Derby, Kununurra, Karratha, Port Hedland and Carnarvon between May and July 2006. Where practitioners were not able to attend meetings held in the towns, attempts were made to seek feedback from staff from each discipline at each site.

Consultations were conducted with:

- WACHS regional directors and district managers
- WACHS allied health practitioners
- Non WACHS allied health practitioners

Both WACHS and non-WACHS service providers (including Division of General Practitioners, Department of Education and private practitioners) and managers were consulted (Appendix C) across a range of issues relating to rural and remote allied health practice and private practice (Appendix F).
CURRENT STATUS

UPTAKE OF PRIVATE INSURANCE

In June 2006, 46.7% (959,000) of West Australians were covered by private hospital insurance with a registered health benefits organisation. WA had the highest uptake of private hospital insurance of all Australian states. Ancillary cover was held by 56.9% (1,167,000) of the WA population, again higher than any other state.4

The estimated participation rate in private health insurance (PHI) hospital cover in 2002-03 within the Federal electorate of Kalgoorlie was estimated to be 51,100 people (32.5% participation rate).5 The electorate of Kalgoorlie includes WACHS Kimberley, Pilbara, Goldfields and Midwest. Assuming that this participation rate is evenly applied across the regions this would indicate that there are 27,385 people with PHI hospital cover in the Kimberley, Pilbara and Gascoyne areas.

PHI membership is lower outside capital cities. In Western Australia in 2001 there was a regional difference of 5.4% between Perth and the rest of the state in PHI coverage. This may be because regional residents receive less value from PHI membership due to the limited availability of private facilities.6

Information on the extent and importance of each health fund’s business in WA can be seen in Appendix H.
OUTPATIENT SURVEY

An outpatient survey was administered via the allied health public outpatient departments in the major north west towns (Broome, Derby, Kununurra, Carnarvon, Port Hedland and Karratha). The aim of the survey was to gain a snapshot of private health insurance uptake by existing clients and seek information on services that clients would access privately and factors influencing the use of private services. The survey was given to allied health clients attending the outpatient department by the treating therapist. The survey was sealed in an envelope by the client for confidentiality and returned to the AHP for transfer to the project officer for collation.

A copy of the poster displayed and the questionnaire is in Appendix D, along with the data tables.

A total of 94 surveys were returned by September 2006 with the towns of Kununurra (31%, n=29) and Carnarvon (30%, n=28) returning the most surveys. Sixty-seven percent (n=63) of surveys were returned from physiotherapy departments.

Overall 55% (n=52) did not have private health insurance, with the remaining 45% (n=42) indicating they did have private health insurance.

Of the 42 respondents indicating they had private health insurance, 38% (n=16) indicated that their health insurance provider was HBF, 33% (n=14) had another provider (listed in Appendix D) and 26% held insurance with Medibank Private (n=11). In relation to ancillary cover, 86% (n=36) had ancillary cover and 12% (n=4) did not.

Clients highlighted that they would access physiotherapy (60%, n=56), occupational therapy (21%, n=20), speech pathology (19%, n=18) and a number of other allied health services privately if they were available. Twenty-seven percent (n=25) of respondents indicated they would not access any allied health services privately.

Flexibility of appointments (40%, n=38), decreased waiting times (36%, n=34), ability to self refer as required (36%, n=34) and the option of choosing between different service providers (35%, n=33) were rated as the most common factors that would prompt patients to access private health services.

Additional comments from clients indicated that health services were limited in rural and remote areas and the increase in private services within these settings would be beneficial. It was also commented that patients were content and happy with the health services being provided.
ALLIED HEALTH SERVICES PROVIDED WITHIN THE NORTH WEST

Physiotherapy, occupational therapy and speech pathology services are based in all the major towns of the north west (Broome, Derby, Kununurra, Port Hedland, Karratha and Carnarvon). In addition, other allied health services include physiotherapy based in Tom Price, dietetics and social work services based in Carnarvon, Broome and Port Hedland and social work and podiatry based in Karratha. Where services are not based in a major centre, AHP will visit, either from within the region or in some cases from Perth. More information on the WACHS and non-WACHS services provided in each town can be seen in Appendix I.

Practitioners based in the north west generally provide services across a large district including visits to smaller towns in the district and remote locations. Practitioners may be away on a remote visit for up to one week and travel vast distances by road but may also fly to some locations by small plane.

In some cases where a private practitioner is based in the north west, agreements have been made for the practitioner to also provide some public services on behalf of WACHS (as described in model one on page 15). This is a varied approach across regions and some locations may receive services from visiting WACHS practitioners, non WACHS providers (e.g. Division of General Practice) in addition to a private practice based in the town.

The implementation and consideration of the models described in this report may allow for the most efficient use of resources, the redirection of priorities by the state funded service to focus on preventative and primary health programs and may lead to a defining of public and private service priorities in areas where private services are available.
POTENTIAL MODELS

Following extensive review of the literature, research and regional consultations with public and private allied health practitioners and managers, five potential models have been developed which provide a variety of opportunities for public private partnerships. There is no one model that is applicable to all circumstances or locations but there are opportunities for each model or a combination of models to be implemented in rural WA.

Models one and two can be easily implemented with the correct tools and appropriate agreements. Collaborative partnerships and agreements are described in more detail on page 20. Model five relates to the development of partnerships with private services to maximise the use of resources and is a model that could be successfully adopted in all areas, again with appropriate agreements in place.

The diagram on the following page displays each model and the barriers and enablers that consistently arise. There are also a number of tools required that may assist in the implementation of the models or support either health services or practitioners. Each of the models has been described and a SWOT (strengths, weaknesses, opportunities, threats) analysis undertaken on each one. This is described, as are each of the barriers, enablers and tools shown in the diagram.

Within WACHS there are examples of some of the models already in place, particularly models one and two, however these have generally come about through an opportunity presenting itself rather than through the health service initiating or actively seeking to implement these approaches. The development of these models, the identification of the barriers and enablers, the success of the pilot project (page 30) and the awareness of public private partnerships that has occurred during this project provides an opportunity for health services to explore these options in more detail.
PARTNERSHIPS IN RURAL HEALTH POTENTIAL MODELS

**ENABLERS TO PRIVATE PRACTICE**
- Private health funds
- Potential Partnerships e.g. Division of GP (MAHS), aged care facilities, local govt, Dept of Education, local business, existing private practice
- Medicare Allied Health & Dental Care Initiative
- Grants and alternate funding sources e.g. RPA

**MODELS**
1. Existing Private Practitioner contracts to WACHS +/- use of facilities
   - WACHS support to existing and new private practice to facilitate private service delivery and partnerships
2. WACHS employed practitioner with rights to private practice +/- use of WACHS facilities
3. Private entity or existing private practice employing and/or supporting private practitioner
4. Assistance to new private practitioner to establish private practice +/- WACHS contracts

**BARRIERS TO PRIVATE PRACTICE**
- Loss of public/district allowances e.g. accommodation, leave, airfares, salary packaging
- Practice set up costs
- Administrative requirements
- Provider numbers - perceived conflict of interest for practitioners in public/private partnership
- Staff turnover/leave cover

**TOOLS REQUIRED**
- "How To Become a Private Practitioner in Rural WA" resource
- Guidelines for ethical practice public/private mix
- WACHS allied health contract & lease agreement templates
- WACHS policy & procedure guidelines for public/private practice
MODEL ONE

An existing Private Practitioner contracts to WACHS with or without the use of facilities.

Description
This would involve the implementation of contracts with an existing private practitioner in the town to provide public services, possibly on a sessional basis or casual contract to meet unfilled FTE or to provide an additional service. In addition the private practitioner may then treat private or paying clients privately outside of these hours. This may be in his or her private facility or using WACHS premises with a lease agreement.

Example

A private podiatrist in the north west has a contract with WACHS to provide public podiatry services to clients for an agreed number of hours each month. Under this model, the podiatrist is able to receive a guaranteed income through this contract and provide a much needed service to the community.

The strengths of this model are that unfilled or part time FTE for public positions may be covered, there may be flexibility according to periods of demand, the practitioner may be able to use WACHS facilities at little cost and may receive a guaranteed or stable income from the contract hours.

There are also a number of opportunities in this model. The private practitioner may be contracted to perform other duties such as health promotion or other preventative programs, there is the potential to reduce the demands on public services by reducing the need for public practitioners to travel to towns where there is a private practitioner available and there is potential for the development of partnerships between public and private service providers to coordinate services to the advantage of the community.

The weaknesses of this model include the limited number of private practitioners available, the relatively low sessional fee rates and the lack of public/district benefits to the private practitioner as outlined in ‘barriers to private practice’. The practitioner may also encounter difficulties in obtaining provider number if utilising a government-funded facility or receiving government funds.
There may be a lack of strong affiliation with the health service in this model, posing a threat to continuity of care and service planning and a potential for conflict between the public and private service providers if agreements are not clearly defined.

A threat does exist to the public allied health service whereby the reduced demand on public services may lead to a reduction in FTE, which cannot then be filled if the private practitioner leaves.

**MODEL TWO**

WACHS employed practitioner with rights to private practice with or without use of WACHS facilities

*Description*

This model would involve a WACHS employed public practitioner, either full time or part time being provided with rights to private practice with or without the use of WACHS facilities and equipment. If WACHS facilities are not being used the practitioner is free to work privately outside of normal work hours with approval from the health service to undertake other employment outside of their normal working hours. If working from a state (or other government) funded facility a practitioner may face difficulties in obtaining provider numbers from private health funds.

*Example*

A physiotherapist in a remote mining town in the north west conducts pre employment fitness assessments for a mining company. The practitioner invoices the company for each client assessment and is able to use WACHS facilities. Her income is supplemented by this arrangement, which acts as a retention factor for her to remain in the town. Private health fund provider numbers are not required in this instance as the company is paying for the service.

The strengths of this model include that the AHP may still be eligible for the subsidised accommodation and other benefits as a WACHS employee. Also strong ties and partnerships remain with the health service due to their public employment.
This model may create opportunities whereby part time public positions may be recruited to with the option for private work to increase income. There may also be an opportunity for the provision of administrative support from the health service with recoup from practitioner. There is also the potential to develop partnerships with private organisations e.g. aged/residential care or other organisations. A health fund provider number would not required in this example as payment is received from the company and there would be limited administrative requirements.

There is a possibly for conflict in circumstances whereby the practitioner may shift patients from the public sector to their private practice and vice versa and potential conflict between public and private service roles and duties if these are not clearly defined.

**MODEL THREE**

Private entity or existing private practice employing and/or supporting private practitioner.

*Description*

In this model the allied health professional would be employed or supported by a private practice or other private entity and may also provide contract services to WACHS as per model one. The practitioner may be employed by the private practice/entity on a salary or percentage of billable basis. The employing practice/entity would not need to be in the same location as the practitioner, although provider numbers would still need to be obtained for each location worked from. Private entities could include medical or allied health practices, dentists, optometrists, local shires or other services that may be willing to take on this role.

*Example*

*Medical models exist within WA whereby a third party acts as the employer. The third party holds any service delivery contracts and provides the practitioner. The third party provides support and administrative services and either has a salary or profit sharing arrangement with the practitioner.*
The advantages of this model include the reduced administrative requirements for the private practitioner, as billing, salaries and bookkeeping may be undertaken by the private entity. The inexperienced practitioner may also benefit from the experience and support of an experienced employer/entity.

There may be an opportunity for WACHS to work with the private entity to develop a partnership for the provision of allied health and other services across WACHS. There may however, be a loss of autonomy for the private practitioner and reduced income. The direction of the private practitioner’s work may be driven by the demands of a larger corporation/business rather than community needs.

**MODEL FOUR**

Assistance to a new private practitioner to establish private practice with or without WACHS contracts.

*Description*

The new private practitioner would receive assistance from the public sector to establish or develop their practice. There are many ways in which the public sector could provide support including the provision of equipment, assistance in building partnerships, professional development and support, mentorship, advertising or subsidized accommodation. Although there may be a cost to the public sector in providing this support there may in turn be a reduced demand on public services.

*Example*

As part of the Partnerships in Rural Health Project funding was received from the Department of Health and Ageing to establish a pilot physiotherapy service in Kununurra. This involved the purchase of physiotherapy specific equipment, which is maintained by WACHS.

The assistance from the public sector may act as a recruitment and/or retention strategy as there may be an incentive to establish or develop a private practice. This may improve the sustainability of the business, particularly if there is a turnover of practitioners and may allow for a practitioner with little private experience to practise in a more supported environment.
There may however be difficulty in obtaining a private health fund provider number if utilising a government-funded facility or receiving government funding.

As with model one a threat does exist to the public allied health service whereby the reduced demand on public services may lead to a reduction in FTE, which cannot then be filled if the private practitioner leaves and the practice does not continue.

**MODEL FIVE**

WACHS support to existing and new private practitioners to facilitate private service delivery and partnerships.

**Description**

This model would involve WACHS taking a lead role to support private practice and facilitate partnerships. There is potential for improved health service planning to occur to coordinate services and maximise the use of resources from all sectors. Traditionally health service planning involves only the public sector but this model would allow for planning to be undertaken on a broader level and would include private and public service providers.

Again there is the potential for a conflict of interest to occur in this model unless collaborative partnerships and agreements are clearly defined.
CONSIDERATIONS FOR COLLABORATIVE PARTNERSHIPS AND AGREEMENTS

Regardless of the model chosen, underpinning each model is the development of collaborative partnerships and agreements, which must be worked through thoroughly in order to establish an effective relationship.

As part of the development of a public private partnership several principles should be documented and where applicable adhered to. Because a number of clients may be receiving both public and private allied health services, it may be necessary to document the finer details and logistics of a working partnership whereby both parties work in achieving the same desirable outcomes. A collaborative service arrangement or agreement would aid in achieving this.

Collaborative agreements provide a flexible and practical approach to service delivery and minimise the disruption to the continuity of care. They also ensure a wider range of service options and provide services in an effective and timely manner. In addition they have the opportunity for a more responsive and tailored service.

The goals of the collaborative partnership include:

- Promoting specific arrangements between public allied health and private allied health services to allow joint service provision to take place if indicated by the client’s needs and professional assessment.
- Enhancing access for individuals with specific health needs to a wider range of services and opportunities.
- Ensuring continuity of care for patients moving across or between service sector boundaries.
- Increasing the capacity of public and private allied health services to provide responsive, flexible service options to meet the needs of the individual.
- Facilitating joint service provision to meet specific needs.7

In some cases there may be conflict or differing opinions between the public and private sector practitioners and if a collaborative agreement is to be successful practitioners must work together to resolve any issues. A cooperative relationship between both parties is required and is integral for the achievement of successful outcomes.8

In order to gain the maximum benefit from the agreement it is best to define roles and responsibilities for both the public and private practitioner. This ensures that each
practitioner understands their role and responsibility in relation to client service provision and there are no conflicting views. Once the roles and responsibilities are agreed to, it is important that open communication remains evident throughout the agreement. This ensures that the client is receives a high quality service, the use of resources from both sectors is maximised and the potential for conflict or misunderstanding is minimised.

There are a number of substantial benefits, which can be derived from a collaborative agreement for both the public and private sectors and also the patient. The major benefits include offering consumers the option and choice to the advantages of both systems and consumers receiving a more intensive treatment and improved access to health care.\(^8\) The benefits for the public and private sector include improving the continuity of care for consumers, reducing the demand placed on the public sector and increasing the capacity to provide a flexible and responsive service.\(^7\)
FACTORS INFLUENCING MODELS

The models discussed have a number of enablers and barriers that are integral to the success of each one and need to be considered. There are also a number of tools that could be developed and used to facilitate them.

ENABLERS TO PRIVATE PRACTICE

Several enablers exist for private practice. These include the attraction and benefits of private practice, potential partnerships and access to other income streams.

ATTRACTION OF PRIVATE PRACTICE

There are several benefits of establishing and working in private practice. The benefits or attractive aspects include:

- The flexibility of working hours.
- The potential to earn a higher income.
- The ability to control caseloads and improved client compliance.
- Transportability.
- Lack of politics and administration work, compared to the public service.

These aspects were identified throughout the regional consultation process and also identified in the literature. Private practitioners were seen to be more likely to remain in the rural setting, compared to public sector employees due to the added benefits of their practices. This may be due to the additional benefits such as increased financial gains that private practitioner’s receive.9

PRIVATE HEALTH FUNDS

Individuals with private health insurance and ancillary insurance may be able to claim a portion of out of pocket expenses for private allied health services from their health fund. The majority of health funds will pay a benefit for allied health services, depending on the type of cover held. Individuals with private health insurance may choose to access private health services to gain the maximum benefit from their fund and benefit from reduced waiting times.
POTENTIAL PARTNERSHIPS

In rural and remote areas there exist a number of opportunities to develop partnerships with a variety of organisations and sectors. These partnerships may provide income streams to the private practice in addition to the income received from individual clients.

Some examples of potential partners include:

- Local public health services
- Division of General Practitioners
- Schools/child care facilities/playgroups
- Aboriginal health services
- Community organisations e.g. sporting clubs
- Rehabilitation providers
- Other private allied health/complementary health practitioners
- Local government e.g. recreation facilities
- Other government organisations e.g. Department of Sport and Recreation, Disability Services Commission
- Large employers in the area e.g. mining companies
- General Practitioners (GP)

MORE ALLIED HEALTH SERVICES

The More Allied Health Services (MAHS) Program aims to improve the health of people living in rural areas through allied health care. A major outcome of MAHS is to better link the GP with the allied health sector. MAHS funding is managed by eligible rural Divisions of General Practice to provide clinical care by AHP in rural communities.10

In 2003-04, 210.5 FTE AHP were funded through the MAHS Program, covering a range of professions. The key professionals employed were psychologists, registered nurses in specialist roles (such as diabetes and asthma educators) and dieticians.10

Within the north west, the Kimberley Division of General Practice provides podiatry and dietetics services to the community. The Pilbara Division of General Practice provides audiology, podiatry, dietetics, diabetes education and the Midwest Division of General Practice provides physiotherapy to Coral Bay and Exmouth, social work services to Exmouth and podiatry services to Carnarvon.
MEDICARE ALLIED HEALTH AND DENTAL CARE INITIATIVE

The Medicare Allied Health and Dental Care Initiative pays for a selection of services provided by private AHP. It covers patients with a chronic condition and complex care needs who are being managed by their GP under an Enhanced Primary Care (EPC) plan. The patient can benefit for up to five allied health services in a 12 month period from eligible allied health professionals. This can be five of one type of service or a combination of different services.¹¹

GRANTS AND ALTERNATE FUNDING SOURCES

Possibilities may exist for private practitioners to obtain funding or in-kind support to facilitate planning, setting up, or continuing their practice. These may be via government grants, such as the Rural Private Access Program or via community or corporate support, for example funding programs that are available through large mining companies. There are also funding opportunities available from time to time for specific program areas through various grant schemes.
BARRIERS TO PRIVATE PRACTICE

LOSS OF PUBLIC/DISTRICT BENEFITS

There are a number of financial benefits which may be lost if a public AHP decides to move from the public health service into private practice. These include the loss of:

- Four weeks annual leave plus one additional week leave for employees working above the 26th parallel.
- Travel concession of one return flight to Perth per year for employees working above the 26th parallel and their dependants.
- Long service leave of 13 weeks upon completion of 10 years service.
- Air-conditioning subsidy to subside the cost of running air conditioners for employees in specific towns in the north west.
- Subsidised rental accommodation in some regions. In some parts of rural and remote WA private rental accommodation may costs $600-$800 per week for an average house.
- District allowances for employees with the Kimberley, Pilbara, Midwest, Goldfields and Great Southern regions- depending on the location can range from $30 to $129 per week.
- The option to salary package and decrease an individual’s taxable income.
- Leave loading of 17.5%.
- Paid superannuation of 9% of the total annual salary.
- Paid leave for all national and state public holidays.
- Option of taking study, compassionate, sick and parental leave.
- Child allowance of $100.00 per child, per annum for employees who live above 26th parallel and whose children are dependent and school aged and also reside in the north.

PRACTICE SET UP COSTS

Regional consultations with AHP highlighted the costs to establish a private practice as being a major barrier to pursuing private practice. There are a number of costs associated with the necessary equipment, resources and administrative requirements.

The costs associated with the establishment of a private practice vary between disciplines and services provided. Consultations with several AHP identified that some practices such as physiotherapy could be established with minimal equipment and expenditure.
INSURANCE

Private practitioners are strongly recommended to carry professional indemnity insurance. Depending on the policy, this covers breach of professional duty, public liability, goods sold and advice on goods sold, legal fees for disciplinary and coronial inquiries. Different levels of insurance are recommended for different professional groups e.g. $5, $10 or $20 million dollars for physiotherapy or $2, $5 or $10 million dollars for speech pathology. The cost of insurance varies depending on the number of hours worked and discounts for members of professional organisations. For $10 million cover a physiotherapist could expect to pay approximately $1000-$1400 per annum if working more than 15 hours a week in private practice, or $835-$980 per annum if working less than 15 hours per week. The cost to a speech pathologist for the same level of cover would be approximately $540 if working more than 16 hours per week and $380 per annum if working less than 16 hours per week in a private capacity.

The Department of Veteran’s Affairs specifies that a registered provider must have public risk/liability insurance for not less than $10 million per claim and professional indemnity type insurance for not less than $5 million per claim. Worker’s compensation insurance for personnel or appropriate disability income insurance for illness and injury is required for individuals.

MEMBERSHIP TO PROFESSIONAL ORGANISATIONS

AHP are encouraged to obtain membership from their professional organisation for several reasons. The memberships signify a standard of professional and ethical behaviour and the commitment to abide by the organisation’s code of conduct. Memberships provide a number of benefits including professional development, private practice resources, mentoring for new graduates, access to professional journals and other publications, discounts and savings and the recognition of being associated with a professional body. These memberships however do carry an annual fee. Annual fees for selected allied health disciplines are listed in the table below. The Australian Podiatry Association carries the highest membership fee of $800.00 per annum.
Professional Membership Fees (as at 31st July 2006)

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Pathology Australia</td>
<td>$400.00</td>
</tr>
<tr>
<td>Australian Association of Occupational Therapists</td>
<td>$484.00</td>
</tr>
<tr>
<td>Australian Physiotherapy Association</td>
<td>$610.00</td>
</tr>
<tr>
<td>Dietetics Association of Australia</td>
<td>$495.00</td>
</tr>
<tr>
<td>Australian Association of Social Workers</td>
<td>$458.00</td>
</tr>
<tr>
<td>Australian Podiatry Association</td>
<td>$800.00</td>
</tr>
</tbody>
</table>

**ADMINISTRATIVE REQUIREMENTS**

A barrier may exist with the amount of administrative work a private practitioner needs to undertake. Practitioners need to take into account that they will be responsible for their own finances and need to be competent in invoicing, accounting and taxation. Dependent on their level of experience they may be able to complete a number of these tasks themselves, but may require the services of an accountant or bookkeeper.

Information on some of these areas and other factors to consider when establishing a private practice can be found in the ‘How to Become an Allied Health Private Practitioner in Rural WA’ resource.

**PROVIDER NUMBERS**

An allied health practitioner must apply for a provider number in order to receive payments from Medicare, Department of Veterans Affairs and private health funds. A provider number must be issued for each practice location that the practitioner works from. There are a number of conditions or criteria that must be met in order to gain a provider number from a private health fund. The majority of funds require the AHP to provide evidence of qualifications and also registration with their appropriate state or national board, or professional organisation.

There may be some difficulties in obtaining a provider number when a practitioner works from a location that receives local, state or federal funding from the government as there may be a perceived conflict of interest.
STAFF TURNOVER/LEAVE COVER

Many allied health practitioners working in rural and remote areas do not stay for long periods (approximately 13 - 18 months). Therefore many practitioners may not be interested in establishing a private practice and developing a business for this relatively short period of time.

Private practitioners often find it difficult in rural and remote areas to recruit staff or to find locum staff to cover while they are on leave. When they are able to recruit, the costs associated with relocation and accommodation, particularly in the north west can be enormous.
TOOLS TO FACILITATE PUBLIC/PRIVATE PARTNERSHIPS

To support the implementation of the models outlined, resources and tools would need to be made available and include the following:

‘HOW TO BECOME AN ALLIED HEALTH PRIVATE PRACTITIONER IN RURAL WA’ RESOURCE

During the course of the Partnerships in Rural Health Project, enquiries were received from numerous AHP regarding private practice opportunities within the WACHS catchment. From these discussions a need was identified for a resource to assist AHP in undertaking private allied work in rural or remote Western Australia.

Therefore a ‘How to Become an Allied Health Private Practitioner in Rural WA’ resource was created as a tool for AHP to use. This resource outlines information and contact points related to the establishment and planning of a private practice and potential partners and income streams. The resource provides a guide to some of the necessary steps and obligations a practitioner must fulfil in order to establish their own private practice.

GUIDELINES FOR ETHICAL PRACTICE PUBLIC/PRIVATE MIX

In conjunction with the development of collaborative partnership agreements there also needs to be some guidelines relating to ethical practice when practitioners are working in both the public and private sectors. This needs to address issues such as transfer of clients from public to private and vice versa and issues relating to referrals and management of waiting lists.

WACHS ALLIED HEALTH CONTRACT AND LEASE AGREEMENT TEMPLATES

Development of standardised templates for contracts with allied health private practitioners to provide services and standardised templates for lease of premises would be useful for health services and facilitate development of partnerships.

WACHS POLICY AND PROCEDURE GUIDELINES FOR PUBLIC PRIVATE PRACTICE

There are currently several operational instructions pertaining to allied health private practice. The development of standardised policies and procedures that promote public private partnerships would be beneficial.
PRIVATE PRACTICE PILOT SITE

A private physiotherapy pilot service was developed and implemented in Kununurra from August to October 2006. Consultations and regional visits indicated that there was a current lack of private allied health services within Kununurra, with the nearest private services being located in Katherine, NT (510 kilometres) and Broome (1040 kilometres). It was also discovered that there were two physiotherapists residing in the town, not working in physiotherapy and another Perth based physiotherapist interested in establishing a private practice for approximately three months.

The public physiotherapy department in Kununurra is fully staffed with two physiotherapists and a waiting list for outpatient services. Therefore the major aims of the pilot were to establish a private physiotherapy service in Kununurra to increase access to, and choice of physiotherapy services and reduce the overall strain and demand on the public service.

In regional consultations, allied health professionals had highlighted the set up costs of a practice as a major barrier for their establishment. Therefore a successful submission was made to the Commonwealth to purchase basic physiotherapy equipment and provide assistance for the leasing of premises and administrative support for the pilot period. Using these funds WACHS purchased the equipment and consumables required to establish a practice. A lease agreement was also arranged by WACHS with a private facility in Kununurra. The WACHS project officer worked with the Perth based physiotherapist to provide support in establishment of the practice and to develop an agreement with the practitioner who agreed to run the pilot service.

OBJECTIVES

There are a number of objectives that were identified as part of the private practice pilot. These included:

1. To determine the feasibility of a private physiotherapy program in Kununurra.
2. To reduce the demand placed on the public health service.
3. To increase consumer’s choice and alternatives of physiotherapy services.
4. To establish further partnerships with private practitioners to ensure the sustainability of the private physiotherapy service in Kununurra.
5. To determine the effectiveness and sustainability of a public private partnership for introduction to other sites in Western Australia.
TERMS OF AGREEMENT

An agreement was developed between the private practitioner and WA Country Health Service. The main terms of the agreement were:

1. The equipment ownership and maintenance were to remain the responsibility of WACHS, however the private practitioner was responsible for the equipment being maintained in a clean working order.
2. The private practitioner was to be registered with the Physiotherapists' Board of WA and have their own professional indemnity insurance. This is to cover any breach of professional duty, public liability, goods sold and advice on goods sold, legal fees for disciplinary and coronial inquiries.
3. Any additional equipment or consumables required outside of what was initially provided was the responsibility of the practitioner.
4. Support was provided for the term of the agreement to assist with lease of premises and administrative support.
5. The practitioner was required to complete a template each month to assist in evaluation of the pilot and to provide information for prospective practitioners to continue the service.

EVALUATION

In return for support and the provision of equipment, WACHS required the private practitioner to provide monthly reports pertaining to the practice. This included financial information, information relating to referral sources and partnerships developed in the community. The practitioner also provided information relating to barriers and issues identified in establishing the practice, additional costs to the practitioner and potential opportunities that may be pursued in the future. This information was used by WACHS to demonstrate the feasibility of the practice and opportunities available to professionals interested in continuing the service.

Additional information was obtained from the public physiotherapy service, based in Kununurra, to determine the impact of the pilot on their service. As the pilot occurred during the ‘tourist season’ the public physiotherapists identified that being able to refer travellers to an alternative provider was a significant benefit. Often these clients would not receive a service due to waiting lists and the short duration of their stay in the town. The public physiotherapists also experienced a significant decrease in the number of chronic compensation clients attending the service, as they were able to attend the private service. This reduction in time spent on individual client management allowed for the staff
to work on development of preventative health care programs. During the time of the pilot a falls prevention program was developed and implemented and additional ante natal, post natal and hydrotherapy classes were held.

The private physiotherapist was invited to participate in professional development sessions with the public physiotherapists that provided benefits to all as knowledge and skills were shared.

**SUSTAINABILITY**

During the pilot, discussions were held with the two private physiotherapists who had both been living in the town for some time. Information regarding the progress of the pilot was provided to them, including financial information and opportunities that had been identified during the pilot that could be explored further. Both practitioners were provided with information on lease of the premises and requirements for them to commence in private practice, including insurance, provider numbers etc and information regarding the conditions for continued use of the equipment that was purchased for the pilot. As both physiotherapists expressed an interest in working privately part time following the pilot suggestions were made regarding possible options for them to both work from the same premises and a partnership was facilitated.

Following the end of the pilot, the outgoing practitioner was able to provide clients with contact phone numbers for them to continue to see a private physiotherapist. Agreements are being developed for ongoing use of the equipment and continuation of the private service, including ongoing support from WACHS in areas such as professional development in conjunction with the public practitioners.
RECOMMENDATIONS

There are a number of recommendations that can be made following the research and model development undertaken throughout this project. Further work needs to be undertaken in the following areas:

1. Development of specific principles and guidelines for public private partnerships including collaborative agreements.
2. Delineation of the roles of public and private services in rural and remote areas.
3. Further development of tools to support the models including standardised allied health contracts, lease agreement templates and policy and procedures for public private partnerships.
4. Development of a mechanism to provide ongoing support and mentorship to allied health practitioners interested in private practice as has been undertaken during this project.
5. Review the coordination of public and private allied health services to maximise the use of resources and reduce duplication of services and excessive travel.
6. Engage relevant agencies to discuss rural and remote issues with regard to the provision of provider numbers.
APPENDIX A: PROJECT ADVISORY GROUP TERMS OF REFERENCE

PARTNERSHIPS IN RURAL HEALTH

Project Advisory Group

TERMS OF REFERENCE

1.0 Composition:

- WA Country Health Service (WACHS) Head Office representatives (Kim Darby & Suzanne Spitz)
- Project Officer (Anna McDonald)
- WACHS Area Director Population Health (Melissa Vernon)
- Australian Government Department of Health and Ageing representative (Pete Smith)
- WACHS North West Regional Director representative (Kay Atfield)
- WACHS Allied Health Reference Group North West representative (Lynn Harding)

2.0 Modus Operandi

Meetings will be held monthly from May 2006 to September 2006. The objectives of the group will be reviewed at this point. Members will participate via teleconference. The project group will be engaged out of session via telephone and e-mail as required.

An agenda will be set and distributed 1 week prior to the scheduled meeting, with minutes taken and distributed within 1 week of the meeting occurring. The Project Officer will undertake the Secretarial role.

3.0 Purpose

The project advisory group will provide advice, consultation and feedback to assist in achievement of the project objective and strategies.

4.0 Objective

Development of a strategic plan to identify appropriate public/private partnership models to ensure the long-term viability of privately insurable services in the north west of Western Australia.

5.0 Strategies

(i) Undertake an analysis of strategic options for public/private service models within WACHS to increase the opportunity for establishment/sustainability of privately insurable health services;

(ii) Undertake a needs analysis to determine the private health service needs of the community and the strategic directions of WA Country Health Service;
(iii) Undertake an environmental scan to identify and profile local and metropolitan privately insurable health services and partners accessed by the consumers in the north west of Western Australia.
(iv) Identify and assess current privately insurable models utilising a public/private mix (state, national, international);
(v) Identify and profile potential privately insurable models within WACHS;
(vi) Identify and consult with potential partners in the establishment of privately insurable models within WACHS;
(vii) Identify strengths, weaknesses, opportunities and threats (SWOT analysis) for private health service model partnerships within WACHS; and
(viii) Develop a strategic framework for the implementation of public/private health service models within the WA Country Health Service that includes potential pilot sites, partnerships and public/private health service models.

6.0 Reporting

The Partnerships in Rural Health (PRH) Project Advisory Group will report to Kim Darby, Director, Business Enhancement, WA Country Health Service.

General information relating to the Partnerships in Rural Health Project will also appear on the WACHS intranet PRH page.

7.0 Outcome Measures


Monthly reporting to Director, Business Enhancement.

Three monthly stakeholder summaries reporting to WACHS allied health professionals (via Country Allied Health Updates).
APPENDIX B: LITERATURE REVIEW

A database search of Proquest, InfoTrac Onefile and Medline was conducted, along with a general Internet search predominantly using the ‘Google’ search engine. The following key terms were searched: public private partnerships, private public mix, partnerships in health, public sector and private sector partnerships, retention and recruitment, recruitment of allied health, retention of allied health, rural and remote recruitment and retention, allied health practitioners, private health insurance uptake, rural and remote allied health staff and benefits of allied health staff.

PUBLIC PRIVATE PARTNERSHIPS

Currently there are a number of public private models/partnerships evident particularly in rural and remote regions. Public private partnerships aim to increase the availability of and access to health services for community members especially in relation to the provision of allied health services. Public private partnerships also aim to increase the opportunities and service provision within the private sector.13

Several studies have revealed that there is a distinct difference in the health status between those people living in rural and remote areas compared to urban dwellers. People living in rural and remote areas in Australia generally have poorer health then those living in the metropolitan area.14 There are several pertinent reasons including geographical isolation, socioeconomic status, poor access to health services, a greater exposure to risk factors and injury and poorer health among indigenous people.15

There are workforce supply and demand issues that also promote the establishment and continuation of public private partnerships. The Department of Health WA highlighted that health systems and services in developed countries are facing workforce supply pressures that are proposed to escalate as the demand for health services and consumer expectations increase.16 Therefore the establishment of a public private partnership would ease the strain placed on the public sector and increase availability and access to allied health services.

In addition, the current quality allied health services available within rural and remote regions are under pressure due to their geographical location, lack of support services and the lack of health services which “means people are not aware of what should be available and what is possible through allied health”.17

There are a number of significant positives that a public private health partnership can produce. These can include the ability to provide a comprehensive community service,
improving the focus on service delivery, providing an increase in the quality of service provision and overall improved outcomes.\textsuperscript{18}

\begin{center}
\textbf{RETENTION & RECRUITMENT OF ALLIED HEALTH PROFESSIONALS}
\end{center}

A significant number of difficulties exist in relation to the retention and recruitment of allied health professionals. Australia wide it was estimated that the turnover rate within the public sector was approximately 42\% within two years, the annual rural exit rate was approximately 29\% compared to the metropolitan exit rate of 19\%, and the average length of employment in rural areas was approximately 13 - 18 months.\textsuperscript{12} It was also concluded that the high attrition rates were related to family issues and responsibilities, burnout and exhaustion, lack of management support, high stress levels and disillusionment.\textsuperscript{12,19-21}

There are a considerable number of disincentives and negatives for rural practice, which impact on the retention and recruitment of AHP and include:

1. Geographical isolation.\textsuperscript{12}
2. Social and professional isolation.\textsuperscript{17}
3. Lack of management support.\textsuperscript{20}
4. Lack of appreciation of AHP roles and duties.\textsuperscript{17}
5. Lack of locum relief.\textsuperscript{22}
6. Lack of training and professional development.\textsuperscript{17}
7. Poor career pathways.\textsuperscript{17,20}
8. Long hours of work, unpaid overtime and large case loads.\textsuperscript{17}
9. Income and terms of employment.\textsuperscript{12,17}
10. Excessive travel.\textsuperscript{12}
11. Lack of education and employment opportunities for employee’s partner/spouse and children.\textsuperscript{12,17,20}

In addition to the disincentives and negatives of working in a rural and remote area, and despite the acknowledgment that AHP provide an excellent service, the following major issues have been identified as impacting significantly on the work and level of service AHP provide in rural and remote areas:

- Poor quality data and planning for the rural and remote AHP workforce.\textsuperscript{23,24}
- Inequitable access to AHP in rural and remote regions with issues similar to those for the medical profession.\textsuperscript{24,25} The number of AHP per resident ranges from 50\% less (in Western Australia and South Australia) to 20\% less (in Queensland) when rural sites are compared to capital cities in each state.\textsuperscript{24}
- Lack of non-government sector employment of AHP, such as physiotherapists, in rural and remote areas, which reflects limited viability for private services.\textsuperscript{20}
- Long vacancy times for established positions in remote areas.\textsuperscript{20}
- AHP are known to live in rural and remote areas but not be employed in their profession. Therefore there is a large pool of unutilised AHP in rural and remote areas.\textsuperscript{24}
- Lack of awareness of the range of available allied health services/professionals resulting in unrecognised need for services and stress for associated colleagues (other AHP, medical and nursing staff).\textsuperscript{20}

The issues above, along with many other factors, result in well-identified recruitment and retention issues. High staff turnover rates directly impact on allied health service costs, add pressure and stress to remaining staff, and result in a lack of continuous service provision and reduced quality of care during staff shortfalls.\textsuperscript{23} A constant challenge for regional, rural and remote health services is the need to establish equitable access to an adequate and competent workforce.\textsuperscript{24}

A research study conducted by Denham and Shaddock outlined the development of seven main themes affecting the recruitment and retention of AHP to rural and remote regions. These include: lifestyle and personal factors, the support required for professional development and how this could be achieved, team size and the need for a ‘critical mass’ of staff to provide services and allow for leave, management issues, limited and undistributed resources, the requirement for professional supervision and career structure.\textsuperscript{26}

In addition to the barriers to recruit AHP to rural placements, a barrier also exists to recruit general practitioners (GP). GPs rely on AHP to provide specialised support and other services and due to the well-documented shortage of allied health staff in rural areas, this support is not provided adequately. This therefore impacts on the recruitment and retention of GPs, as many are unwilling to work in understaffed departments and hospitals.\textsuperscript{27}

There are a number of factors that attract AHP and other health workers to the rural and remote setting. Research has shown that people are attracted to the rural lifestyle and surroundings, in addition to benefits of farming, cheaper housing and a rural upbringing.\textsuperscript{9} In terms of clinical practice, there are a number of factors and benefits that attract workers rurally. Clinical independence and autonomy were seen as high attractors to rural work as well as specialist support and the opportunity to work within hospitals.\textsuperscript{9}
A recent study highlighted that 98% of AHP working in rural areas identified working with other health professionals of great importance and a motivating factor for retention to their job. The study also concluded that working as a health professional in a rural environment was challenging, rewarding, allowed flexibility and increased management experience, and like other research, highlighted the benefits of autonomy, the lifestyle and being able to gain invaluable clinical experience.

Private practitioners were seen to be more likely to remain within rural settings, and this may be due to financial benefits/gains. An average private physiotherapy consultation can cost between $45 and $55 and could be as high as $130 per consult. An occupational therapist may charge around $100 per hour and dietitians an average of $90 per hour. These rates can be compared to the public sector whereby private practitioners earn a considerable amount more than public practitioners. For example occupational therapists, physiotherapists and dieticians in clinical positions employed in WA may earn between $24 and $35 per hour, dependant on experience.

In light of the extensive research undertaken into the retention and recruitment of rural health workers, there are a variety of strategies that could be implemented to encourage rural recruitment and retention. Financial assistance, locum support and continuing professional development are among the major factors which need to be addressed and highlighted to maintain the retention of staff, and also encourage the recruitment of new workers. Other strategies include promoting the rural lifestyle and the experiences of working rurally, providing support for the worker’s family (including housing and schooling), support from management, clear career pathways and also clear job descriptions.

**ALLIED HEALTH PROFESSIONALS IN RURAL AND REMOTE AREAS**

Utilising allied health professionals increases the overall effectiveness of a quality sustainable partnership where AHP aid in providing a cost effective health care system in both public and private sectors. Rural providers are seen to extend their roles in assessment, health promotion, patient care and disease management in addition to treatment and rehabilitation, as well as improving a person’s overall health thereby minimising hospitalisations.

In Australia, AHP are known to provide 15-20% of patient care services in hospitals and to initiate and implement many population based public health programs. They impact on the efficiency and outcomes of the health and disability sectors across the majority of health and disability conditions, and at all levels of health care. The value and need for allied health services is clearly established and acknowledged. AHP not only provide a
cost effective service in a timely manner but also contribute to the sustainability of the rural health service.\textsuperscript{22}

In WA the rural and remote allied health workforce is under-represented in relation to the population residing in the area.\textsuperscript{31} The Australia Institute of Health and Welfare commented that there were 60% less AHP in rural areas per 100,000 population compared to urban capital cities, and almost twice as many medical workers in the metropolitan area.\textsuperscript{34} This can also be seen where only 24% of AHP are providing services to the 32% of the Australian population living in rural and remote regions.\textsuperscript{17}

The majority of AHP in Australia (75%) are employed within the public health sector, under recurrent state government funding.\textsuperscript{12} In the public sector AHP are expected to perform outreach services travelling to other towns and districts outside their primary employment site, with 81% of staff working unpaid overtime and 75% unable to obtain a locum for periods of leave.\textsuperscript{20,22}

It has been noted that consumers are unaware of the services and quality of services AHP provide.\textsuperscript{17} Adopting a public private partnership between public health services and private practice would increase consumer’s knowledge of the wide range of services available. Usually when consumers are unaware of the services that could be made available to them, they don’t express a need or demand, therefore limiting the services available for their access.\textsuperscript{17} Increasing consumer’s knowledge of the services AHP provide will aid in the demand for the services being requested by consumers and also increase the amount of services available.\textsuperscript{33}

There has been a greater reliance on the public sector for the provision of quality allied health services especially in the rural and remote areas of Australia, with limited expansion of private services. This has resulted from the limited financial resources that are available in rural and remote regions, the lack of incentives, both financial and personal (especially in low socioeconomic areas) and time and travel related issues. Due to the geographic nature of rural and remote areas, clients can be widely dispersed over vast areas of land and therefore private clinicians do not want to travel large distances over poor road surfaces.\textsuperscript{17}

WA experiences very high levels of under usage of its allied health professionals with many qualified AHP not currently employed within their profession.\textsuperscript{33} These AHP are either working in other disciplines, not currently employed, or are studying.\textsuperscript{17,33} The Occupational Therapist’s Registration Board of WA had 1,142 registered occupational therapists in 2002, however only 750 recorded their occupation as an occupational therapist in the 2001 census. Likewise there were 1,788 registered physiotherapists with the Physiotherapist’s
Registration Board of WA in 2002, while only 1,121 reported physiotherapy as their current occupation. This represents 34% of qualified occupational therapists and 37% of qualified physiotherapists not currently employed within their profession.33

In addition to the wastage of AHP, there is also a skills shortage of AHP. The Western Australian Labour Economics Office of the Department of Employment and Workplace Relations conducted a study into the skills shortages of AHP. The results highlighted that there was a skills shortage across six disciplines including pharmacy, occupational therapy, physiotherapy, speech pathology, audiology and medical imaging.33

AHP employed within private practice may be seen to provide a more innovative approach to their work, provide more expertise and a quality service. This can be a result of the financial incentives private practitioners receive and also their commitment to expanding their business and client base.13

Both the literature and research have shown that there has been limited development in the uptake of rural and remote private practice amongst AHP. This in turn produces a greater reliance on the public health sector for the provision of such services.
RURAL VERSUS METROPOLITAN: ACCESS TO ALLIED HEALTH SERVICES

Literature highlights that residents in the metropolitan area (Perth) have double the access to AHP in comparison to residents in inner regional, outer regional and remote areas per 100,000 population. Those residents in the very remote areas of WA have less than a third of the access to AHP when compared to Perth residents (as indicated in the table).33

<table>
<thead>
<tr>
<th>Allied Health Professionals</th>
<th>Major Capital (Metro)</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote</th>
<th>Very Remote</th>
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(Source: Draft NRRHAS Workforce Report for Western Australia, June 2003)

In terms of access to specific disciplines, residents of WA have higher access to physiotherapists, psychologists and social workers in comparison to other selected disciplines across all five regions. When analysing the breakdown of the allied health workforce, orthoptics, hospital pharmacy, podiatry and orthotics have the highest concentrations of staff in Perth (between 88% - 100%) in comparison to rural and remote regions.33
APPENDIX C: PROFESSIONAL GROUPS CONSULTED

A summary of the professional groups consulted within each town is highlighted in the table below.

Summary of Consultations

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Broome</th>
<th>Derby</th>
<th>Kununurra</th>
<th>Karratha</th>
<th>Port Hedland</th>
<th>Carnarvon</th>
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<tr>
<td>Non WACHS Practitioners</td>
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<td>Dietetics</td>
<td>Physio, CEO Div of GP, Podiatry, Speech Pathology</td>
<td>Physio</td>
<td>Physio (Exmouth)</td>
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Dear Client

This week your allied health department is distributing a short survey.

The survey is to look at how we can improve the availability of, and access to private allied health services. Private allied health services may include Physiotherapy, Speech Pathology, Occupational Therapy, Dietetics, Clinical Psychology and Audiology.

Your responses are confidential and anonymous. An envelope is provided with the survey so that you can seal it and return to your health professional. All surveys will then be sent through to Perth for collation.

If you do not feel comfortable completing any question in the survey, leave it and move to the next one.

Thank you for your assistance.

Anna McDonald
Senior Project Officer
WA Country Health Service
OUTPATIENT SURVEY QUESTIONNAIRE

WA Country Health Service
Government of Western Australia

ALLIED HEALTH OUTPATIENT SURVEY
Partnerships in Rural Health Project

Dear Customer

We are looking at how we can improve the availability of, and access to private allied health services. Private allied health services may include Physiotherapy, Speech Pathology, Occupational Therapy, Dietetics, Clinical Psychology and Audiology.

Your responses are totally confidential and anonymous and will in no way affect the current services you are receiving. When you have completed the survey please seal in the envelope provided and return to your health professional. Thank you for your assistance.

Anna McDonald
Senior Project Officer
WA Country Health Service

If you do not feel comfortable completing any question, leave it and move to the next one.

1. Do you have private health insurance?
   □ Yes □ No → Go to Q.4

2. Which health fund are you with?
   □ HBF
different health fund
   □ Other, please state: __________________________
   □ Medibank Private

3. Do you have ancillary cover (may be called extras or essentials; covers things such as dental, physio, chiropractic)?
   □ Yes □ No

4. If they were available, which of the following services would you consider accessing privately (please tick all that apply)?
   □ Physiotherapy  □ Dietetics
   □ Occupational Therapy □ Podiatry
   □ Speech Pathology □ Counselling
   □ Clinical Psychology □ None of the above
   □ Audiology

5. What factors would prompt you to privately access any of the services listed above in question 4 (please tick all that apply)?
   □ Option of choosing between different service providers
   □ Ability to self refer as required
   □ Less waiting times
   □ To get value from my health fund
   □ Flexibility of appointments e.g. after hours, weekend
   □ More frequent appointments available
   □ Any other reason(s) you would wish to seek private services, please state: __________________________

Thank you for your time
OUTPATIENT SURVEY DATA TABLES

Discipline survey received from:

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Location/town survey received from:

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Question 1: Number of clients with private health insurance:

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### Question 2: Health fund patient belonged to:

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### Question 2a: Other health fund patient belonged to:

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### Question 3: Number of patients with ancillary cover:

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Question 4: If available which services would be accessed privately (multiple response)?

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<th>Percent of Cases</th>
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Question 5: Factors that would prompt patients to access private services (multiple response):

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<th>Percent of Cases</th>
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<tr>
<td>Less waiting times</td>
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<td>15.6</td>
<td>36.2</td>
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<tr>
<td>To get value from my health fund</td>
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<td>12.8</td>
<td>29.8</td>
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<tr>
<td>Flexibility of appointments eg. after hours, weekends</td>
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Other reasons/comments from patients included:

- Access to experience and different skill base.
- Consistent service.
- Good service on the whole.
- I’m employed at the hospital, more confidentiality and would rather not access services from co-workers.
- I am happy with the current service.
- Living in the city I am used to paying and going private for these things, so getting it publicly is a luxury.
- Mainly use dental optometrist.
- Private services being available in Derby.
- Public services are limited in rural areas.
- To provide another option when the hospital physiotherapist is unavailable or there is a waiting list.
Additional Analysis: Cross tabulation of location and patients with private health insurance

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Additional Analysis: Cross tabulation of location and discipline

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<td>8</td>
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<td>94</td>
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APPENDIX E: DEMOGRAPHICS BY TOWN

BROOME

Broome is situated in the Kimberley 2,357 kilometres north of Perth via the North West Coastal Highway and 205 kilometres from Derby.\(^3\)\(^5\) Broome is a popular tourist attraction with its array of beaches, 130 million year old dinosaur footprints at Gantheaume Point, its pearling history and relaxed lifestyle.\(^3\)\(^6\)

Broome has a population of 18,507 persons with 4,179 persons identifying as being of indigenous origin, representing 23% of the total population. The median age of residents in Broome in 2001 was 35 years and the median weekly individual income was $400 - $499.\(^3\)\(^7\) Broome has an accessibility/remoteness index of Australia (ARIA+) rating of 86% remote and 14.1% very remote.\(^3\)\(^8\)

The unemployment rate in Broome is 5.8% and the major sources of industry include retail trade, government administration, defence and education.\(^3\)\(^7\) The majority of residents had completed either year 12 or equivalent (33%) or year 10 or equivalent (28%).

Broome’s health care comprises of a hospital that provides emergency, geriatric, hyperbaric medicine, maternity, paediatrics, pathology and pharmacy, general surgery, radiology and other allied health services such as Physiotherapy. Broome also has a Home and Community Care Service.\(^3\)\(^9\)

CARNARVON

Carnarvon has a unique location situated 904 kilometres from Perth on the west coast.\(^3\)\(^5\) Carnarvon is situated in the Gascoyne and is well known for its banana plantations and tropical fruits, as well as the warm climate and coastal situation, making it an exciting tourist attraction.\(^4\)\(^0\) Carnarvon has an ARIA+ rating of 79.5% remote and 20.5% very remote.\(^3\)\(^8\)

Carnarvon has a population of 9,152 persons with 1,141 (12%) identifying themselves as of indigenous origin. The median age of residents in 2001 was 40 years and the median weekly income for an individual was $300 - $399 per week.\(^3\)\(^7\)

The unemployment rate in Carnarvon was 6.0% and the total number of employed persons was 3,513 persons. The major industries of employment were agriculture, forestry and fishing (19%) and retail trade (13%).\(^3\)\(^7\)
Of the 7,213 residents aged 15 years and over, 30% had completed year 10 or equivalent and 25% had completed year 12 or equivalent.\textsuperscript{37}

In terms of health care services, Carnarvon has one hospital with an extensive range of facilities and services ranging from child health, emergency, surgery and theatre. In addition Carnarvon provides allied and community health services and also homes the Gascoyne Population Health Unit, which specialises in health promotion, aboriginal health, nutrition and other health areas.\textsuperscript{41}

**DERBY**

Derby developed as a small rural town serving pastoralists who settled in the area despite the harsh conditions and geographical isolation. In 1880, Derby was known for its sheep stations in surrounding areas and soon become a port necessary for the development of the West Kimberley outback.\textsuperscript{42}

Derby is situated within the Kimberley, 205 kilometres from Broome and 2510 kilometres from Perth via the North West Coastal highway.\textsuperscript{35} According to the ARIA+ ratings, Derby is rated as 100% very remote.\textsuperscript{38}

Derby has a population of 3,688 persons of which 1,554 persons (42%) are employed. The major sources of employment are health and community services (18%), personal and other services (12%) and government administration and defence (11%). The unemployment rate is 6.6%.\textsuperscript{37}

A total of 1,481 persons (40%) identify as being of indigenous origin. The median age of residents in Derby was 32 years in 2001, with 2,936 persons (80%) of the total population being born in Australia. For persons aged 15 years and over, the majority of residents within Derby had completed year 10 or equivalent schooling (n=799) and 765 persons had completed up to year 12 or equivalent.\textsuperscript{37}

In terms of health care, Derby has a local hospital with a variety of services offered such as ante and post natal care, emergency, general practice, pathology, pharmacy, surgery, x-ray services and other allied health services. Derby also provides a community health service.\textsuperscript{39}
KARRATHA

Karratha is situated within the Pilbara of Western Australia, lies 1,538 kilometres from Perth and its name is an Aboriginal word meaning ‘Good Country’. There are 10,796 persons residing in Karratha, with 587 persons (5%) identifying as of indigenous origin. Seventy-eight percent of the population were born within Australia and the median age of residents was 30 years. Karratha has an ARIA+ rating of 100% very remote.

In 2001 there were 5,786 persons employed within Karratha with an unemployment rate of 5.0%. The major employment within the town included retail trade (14%), mining (13%), construction (12%) and property and business services (10%). The majority of residents had completed year 12 or equivalent (34%) or year 10 or equivalent (32%). The median weekly individual income for Karratha was between $500 - $599.

Karratha’s hospital (Nickol Bay Hospital) provides 41 beds for emergency and elective surgery. In addition it also provides allied health services, emergency, home and community care, day surgery, pathology and other specialist services.

KUNUNURRA

Kununurra is situated in the East Kimberley and lies 3,206 kilometres from Perth via the Great Northern Highway and is within the Shire of Wyndham East Kimberley (SWEK). Kununurra was formed in the 1960’s primarily to service the construction and development of the Ord Irrigation Scheme. SWEK has an ARIA+ rating of 100% very remote.

Kununurra has a population of 5,485 persons as of the 2001 census. 789 persons (14%) identified as being of Indigenous origin. The median age of residents in 2001 was 37, with a median individual income of $400 - $499 per week.

In 2001 there were 2,163 employed persons in Kununurra with an unemployment rate of 5.1%. The major employment industries included retail trade (12%), agriculture, forestry and fishing (11%) and health and community services (9%). The majority of residents had either completed year 12 or equivalent schooling (31%) or year 10 or equivalent (25%).

Kununurra has one local hospital with services ranging from emergency, maternity, paediatrics, general surgery, pathology and allied health services such as physiotherapy, speech pathology and occupational therapy. The town provides a community health service in addition to the hospital.
PORT HEDLAND

Port Hedland is situated 224 kilometres from Karratha and 1,765 kilometres from Perth via the North West Coastal Highway, and lies on the coast of Western Australia within the Pilbara. The original inhabitants called Port Hedland ‘Marapikurrinya’, for the evidence of the hand shaped formation of the tidal creeks coming off the natural harbour. Using the ARIA+ rating, Port Hedland is rated as very remote 1.9% and remote 98.1%. Port Hedland has a population of 12,776 persons with 4% of the population aged 65 years and over and 8,731 (68%) identifying as being born within Australia. 1,829 persons (14%) identified as being of indigenous origin. The median age of residents in 2001 was 30.

The major industries in Port Hedland include iron ore processing and export, salt production, shipping of minerals such as magnesium and livestock production. Port Hedland has an unemployment rate of 5.4% and the median weekly individual income was $500 - $599 in 2001. The majority of residents (29%) had completed year 12 or equivalent and year 10 or equivalent (28%).

Port Hedland has one hospital providing a number of services such as computed tomography (CT) scanning, emergency, gynaecology, hospice, immunisation, maternity, medical imaging, radiography, allied health services and a large number of other hospital based services. Port Hedland also homes the Pilbara Community and Aged Care Services, which encompasses the aged care assessment team, home and community care (HACC), community aged care package program and carer respite. In addition to these services Port Hedland also provides community health services and in South Hedland the Population Health Unit and the South Hedland Community Health Service.
APPENDIX F: REGIONAL CONSULTATIONS

IDENTIFIED AREAS OF NEED FOR ALLIED HEALTH SERVICES

Throughout the interview process, AHP, district managers and regional directors were asked what areas of service were lacking or where gaps were evident in allied health service provision.

Clinical psychology, social work and school-based services were seen as the principal gaps in the provision of allied health services to clients within the north west. Additional gaps were also identified with regard to the availability of tradesmen to complete home modifications and wheelchair maintenance and a lack of teacher’s professional development in relation to disabilities in some areas.

Appendix G provides information in relation to the areas of need identified throughout the consultations in each town.

In addition to the gaps identified by AHP, they were also asked to identify if they knew of any AHP living within the region that were not currently employed within their discipline. Staff at Carnarvon identified the highest number of unemployed AHP, with a possible eight people not working within their discipline. AHP were identified in every town including physiotherapists, occupational therapists, dietitians, social workers and speech pathologists that were not working in their allied health discipline for a variety of reasons.

Data collected from the 2001 Census and reported in a symposium paper identified that overall there were twice as many allied health professionals holding qualifications, than there were currently employed within their discipline. Therefore there is a large pool of unutilised AHP in rural and remote areas.

POSITIVES OF WORKING IN THE NORTH WEST

Practitioners were asked to identify the most positive aspects of living and working in their town, with the majority identifying that the lifestyle was the major factor. Other common responses included the diversity of caseloads, working within a close and supportive multidisciplinary allied health team and community spirit.
NEGATIVES OF WORKING IN THE NORTH WEST

AHP were asked about the negatives of working within their region, and the reasons that would most likely make them leave. The distance from family and friends was identified as the major reason practitioners would leave. The lack of professional development opportunities and career progression were also highlighted as a significant factor in each region. High caseloads were reported to cause burnout by a number of respondents in addition to the frustration of no leave cover provided for practitioners when taking annual leave. Other comments included the cost of living, poor management support, lack of incentives to stay (particularly in comparison to nursing and medical staff), high level of administration work and living within a small town with limited facilities.

WAITING LISTS

Public AHP were asked to indicate the current waiting lists within their disciplines. Although there was some variation between sites, on average speech pathology attracted the longest waiting lists with some practitioners indicating waiting lists of up to nine to twelve months. Physiotherapy lists were comparatively short, averaging two to three weeks in most departments.

ATTRACTION OF PRIVATE PRACTICE

Throughout the regional consultation process a number of common themes were evident in relation to the attraction that private practice holds. AHP (both public and private) identified a number of benefits to private practice such as financial gains, flexibility and caseload control as major factors. Other comments included the lack of politics as being an attraction in addition to motivated clients, the availability to work from home and the option to specialise.

BARRIERS TO PRIVATE PRACTICE

Practitioners in the north west identified a number of barriers to working in private practice. The major barriers identified were in relation to the high costs associated with the set up of a practice (equipment, building, insurance etc) and the loss of government based benefits, such as accommodation, air conditioning allowance, district allowance, annual airfares, salary packaging and additional annual leave. Several practitioners (public) also identified long hours as a barrier and the benefit of the public system providing a balanced lifestyle (i.e. no after hour’s service). Existing public practitioners also identified the uncertainty of the number of consumers who would access a private service. Other barriers included administrative duties, a lack of peer/mentor support and potential difficulties in gaining a provider number.
PRIVATE PRACTITIONERS

Overall, the majority of private practitioners identified the flexibility in their practices as one of the major incentives/positives.

Some private practitioners identified that the public allied health services are focussing ‘too much’ on treatment of individual outpatients rather than on preventative work such as developmental, physical activity and obesity programs. This leaves the public service with low waiting lists, which results in fewer incentives for clients to seek private services and these preventative health programs not being prioritised.

Other issues private practitioners had were the difficulties in taking leave and obtaining good locum cover, the cost of housing and the lack of time and incentives to do outreach work.
APPENDIX G: AREAS OF NEED IDENTIFIED

Throughout the interview process AHP, district health managers and regional directors were asked what areas of service were lacking or where gaps were evident in allied health service provision. The table below outlines the areas of need identified throughout the consultation process.

Areas of Need Identified in the North West

<table>
<thead>
<tr>
<th>Service</th>
<th>Broome</th>
<th>Derby</th>
<th>Kununurra</th>
<th>Karratha</th>
<th>Port Hedland</th>
<th>Carnarvon</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Audiology</strong></td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(School based)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech Pathology</strong></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(School based)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td><strong>Clinical Psychology</strong></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic Diseases/Pain</strong></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social Work</strong></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dietetics</strong></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aboriginal Health</strong></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td><strong>Aged Care</strong></td>
<td></td>
<td></td>
<td></td>
<td>✔ (Newman)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continence</strong></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Programs</strong></td>
<td>✔</td>
<td></td>
<td>✔ (Primary care)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry</strong></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td><strong>School Based Services</strong></td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community &amp; Recreation Facilities</strong></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disability Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>

✔ Denotes a gap in service as identified by regional consultations
APPENDIX H: PRIVATE HEALTH FUNDS

The following table provides an indication of the extent and importance of each health fund’s business in Western Australia.\textsuperscript{46} Only those funds with a significant operation in Western Australia are included.

The percentage of the fund’s market share in WA indicates how much of the total health insurance business the fund accounts for in WA. It is an indicator of the size and significance of the fund within WA.

The percentage of the fund’s national market share is an indicator of the number of people (contributors and dependants) covered by that fund’s membership compared to the total national coverage.

The percentage of the fund’s business in WA indicates how much of the fund’s health insurance business is within WA. It is an indicator of how significant WA is to that fund.

Membership indicates if the fund is open to the public or if it is a restricted fund and the eligibility for membership.
### Comparison of Private Health Funds

<table>
<thead>
<tr>
<th>Name of Fund</th>
<th>% Fund’s market share in WA</th>
<th>% Fund’s National Market share</th>
<th>% Fund’s business in WA</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBF*</td>
<td>65.2</td>
<td>7.39</td>
<td>97.6</td>
<td>Open</td>
</tr>
<tr>
<td>Medibank Private*</td>
<td>18.5</td>
<td>28.7</td>
<td>7.1</td>
<td>Open</td>
</tr>
<tr>
<td>Health Insurance Fund* (HIF)</td>
<td>3.4</td>
<td>0.41</td>
<td>100</td>
<td>Open</td>
</tr>
<tr>
<td>Healthguard* (incl GMF, Central West Health Fund)</td>
<td>2.5</td>
<td>0.57</td>
<td>48.7</td>
<td>Open</td>
</tr>
<tr>
<td>MBF Alliances*</td>
<td>2.5</td>
<td>2.18</td>
<td>11.7</td>
<td>Open</td>
</tr>
<tr>
<td>MBF</td>
<td>2</td>
<td>16.72</td>
<td>1.1</td>
<td>Open</td>
</tr>
<tr>
<td>BUPA</td>
<td>1.1</td>
<td>9.85</td>
<td>1</td>
<td>Open</td>
</tr>
<tr>
<td>GMHBA*</td>
<td>1.1</td>
<td>1.46</td>
<td>7.3</td>
<td>Open</td>
</tr>
<tr>
<td>Commonwealth Bank Health Society (CBHS)</td>
<td>0.6</td>
<td>1.08</td>
<td>5.6</td>
<td>Employees of Commonwealth Bank &amp; Assoc. Companies</td>
</tr>
<tr>
<td>Defence Health Limited</td>
<td>0.6</td>
<td>1.37</td>
<td>4.4</td>
<td>Defence Force members, Reserves &amp; those of related orgs</td>
</tr>
<tr>
<td>Hospitals Contribution Fund (HCF)</td>
<td>0.5</td>
<td>8.76</td>
<td>0.5</td>
<td>Open</td>
</tr>
<tr>
<td>NIB Health Funds</td>
<td>0.4</td>
<td>6.18</td>
<td>0.7</td>
<td>Open</td>
</tr>
<tr>
<td>Australian Health Management (AHM)</td>
<td>0.3</td>
<td>2.37</td>
<td>1.8</td>
<td>Open</td>
</tr>
<tr>
<td>GU Corporate</td>
<td>0.3</td>
<td>0.26</td>
<td>9.1</td>
<td>Open</td>
</tr>
<tr>
<td>Australian Unity (AU)</td>
<td>0.2</td>
<td>3.18</td>
<td>0.9</td>
<td>Open</td>
</tr>
<tr>
<td>Manchester Unity (MU)</td>
<td>0.2</td>
<td>1.38</td>
<td>1.7</td>
<td>Open</td>
</tr>
<tr>
<td>Navy Health Ltd</td>
<td>0.2</td>
<td>0.26</td>
<td>9.6</td>
<td>Naval Members, Reserves &amp; Staff &amp; those of related organisations</td>
</tr>
<tr>
<td>Lysaght Peoplecare</td>
<td>0.1</td>
<td>0.33</td>
<td>3.8</td>
<td>Employees of BlueScope Steel, BHP Bilton, Onesteel &amp; related companies.</td>
</tr>
<tr>
<td>Teachers Federation</td>
<td>0.1</td>
<td>1.63</td>
<td>0.4</td>
<td>Teachers belonging to approved unions</td>
</tr>
</tbody>
</table>

(Adapted from: The State of the Health Funds Report 2005)

* Branch/office in WA

It can be seen that two funds hold the bulk of the WA market share. However a large number of other funds, particularly from the eastern states may provide coverage to residents and visitors to the north west. Based on data from the 2001 census there were 7,716 visitors to the Pilbara, Gascoyne and Kimberley statistical areas on the night of the census. This equates to almost 8% of the total persons in those regions at that time.
APPENDIX I: SERVICE PROVISION WITHIN THE NORTH WEST

Both WACHS and non-WACHS allied health services were identified in each major town within the north west.

Service Provision of Allied Health in the North West (as at 31st July 2006)

<table>
<thead>
<tr>
<th>Town</th>
<th>Provider</th>
<th>Physio Avail FTE</th>
<th>OT Avail FTE</th>
<th>SP Avail FTE</th>
<th>Audiol Avail FTE</th>
<th>Podiatry Avail FTE</th>
<th>Dietetics Avail FTE</th>
<th>Clinical Psych Avail FTE</th>
<th>Social Work Avail FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberley</td>
<td>WACHS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td></td>
<td>Non-WACHS</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kununurra</td>
<td>WACHS</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Non-WACHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derby</td>
<td>WACHS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Broome</td>
<td>WACHS</td>
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<td>✓</td>
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<td>✓</td>
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<tr>
<td></td>
<td>Non-WACHS</td>
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<tr>
<td>Pilbara</td>
<td>WACHS</td>
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<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td></td>
<td>Non-WACHS</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Port Hedland</td>
<td>WACHS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
</tr>
<tr>
<td></td>
<td>Non-WACHS</td>
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<tr>
<td>Newman</td>
<td>WACHS</td>
<td>✓</td>
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</tr>
<tr>
<td>Tom Price</td>
<td>WACHS</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Karratha</td>
<td>WACHS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>Non-WACHS</td>
<td></td>
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<td>Gascoyne</td>
<td>WACHS</td>
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<td>✓</td>
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<tr>
<td></td>
<td>Non-WACHS</td>
<td>✓ (Exmouth)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>

* Refers to Division of General Practice Service (MAHS)

The service provision table indicates where a service is available in that town (may be visiting) and possibly servicing surrounding areas. It must be noted that even though there is allocation for a position, in some cases the position may not be filled at any given time and some positions may be part time or shared across several sites e.g. one podiatrist shared across the Kimberley. Also some of the non-WACHS services are visiting services from Perth or other major centres.

Services such as Chiropractic and a visiting Orthotic service are available in most areas but they have not been included as they are not services traditionally provided by WACHS.
## LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied Health Professionals</td>
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<tr>
<td>ARIA</td>
<td>Accessibility Remoteness Index of Australia</td>
</tr>
<tr>
<td>CT</td>
<td>Computerised Tomography</td>
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<td>EPC</td>
<td>Enhanced Primary Care</td>
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<td>FTE</td>
<td>Full Time Equivalent</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>MAHS</td>
<td>More Allied Health Services</td>
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<tr>
<td>Non-WACHS</td>
<td>Services other than provided by WACHS including Division of General Practice, Department of Education &amp; Private Practitioners</td>
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<tr>
<td>PHI</td>
<td>Private Health Insurance</td>
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<td>PRH</td>
<td>Partnerships in Rural Health</td>
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<td>SEIFA</td>
<td>Socio-Economic Indexes For Areas</td>
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<td>SWAHS</td>
<td>South West Area Health Service</td>
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<td>SWEK</td>
<td>Shire of Wyndham East Kimberley</td>
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<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities, Threats</td>
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<td>WA</td>
<td>Western Australia</td>
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<td>WACHS</td>
<td>WA Country Health Service</td>
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</tbody>
</table>
REFERENCES


43. Shire of Roebourne 1999, About Us, viewed 10 July 2006,

44. Shire of Wyndham East Kimberley 2001, About Us, viewed 11 July 2006,

45. Town of Port Hedland 2005, Welcome to your port of discovery, viewed 10 July 2006,

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