Building the Evidence Base for Allied Health in the 'real world'

Kristine Battye[1], Cath Sefton[1], Scott Davis[2], Rob Curry[3]

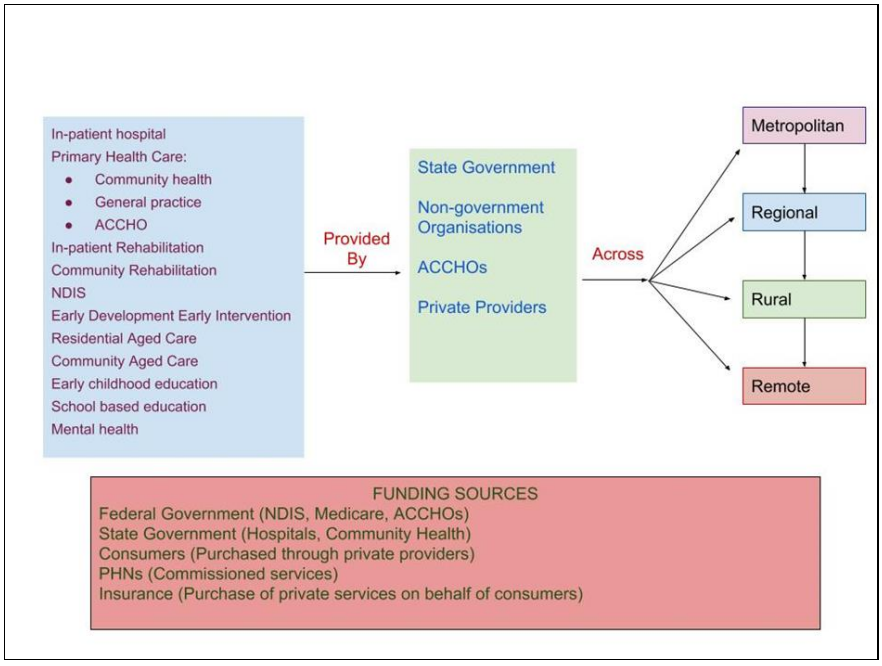
[1] KBC Australia; [2] James Cook University; [3] Services for Rural and Remote Allied Health

The published evidence for allied health interventions and services is limited, particularly in relation to service models and models of care in rural and remote Australia. Furthermore, there is limited published research or evidence of the effectiveness of various workforce strategies, including cost effectiveness for rural and remote Allied Health. It is likely that much of the evidence, particularly around workforce and service models sits in the grey literature and/or in "local intelligence" of what works (or not). A recent report by *The International Centre for Allied Health Evidence*, *June 2018*, prepared in response to the review of MBS items highlights a similar paucity of evidence of the impact of allied health services across the sector, not just in relation to rural and remote service delivery.

Traditional notions of evidence hinge on scientifically controlled research studies with a focus on measurement of intervention effect, reliability and replicability. Such studies have been and continue to be undertaken in relation to allied health interventions, predominantly in acute settings.

However most allied health services in Australia are provided outside acute clinical settings and increasingly the evidence being sought is not about specific interventions per se, but rather about the impact of allied health services in "real world" environments in recognition of the complexity of the allied health service industry. This industry has multiple funding sources with providers delivering services across a wide range of services types, including not only health but also aged care, education and early development and a wide variety of settings in metropolitan, regional, rural and remote Australia, (Figure 1).

Figure 1. Allied health industry in Australia



In 2018, Services for Rural and Remote Allied Health (SARRAH) convened a forum of researchers, education providers, allied health professionals, service providers and policy makers, to identify opportunities to build the evidence base. Examples include:

- Linking with PHNs to co-design and evaluate models of care and service delivery strategies where allied health is a component of the multidisciplinary team
- Identifying and evaluating emergent models of allied health intervention including delegation to allied health assistants, telehealth applications and skill sharing
- Establishing partnerships with rural and remote NDIS service providers to analyse models and workforce requirements
- Identifying private practice models in rural and regional areas and determining key ingredients for viability to overcome market failure
- Documenting case studies of service providers around Communities of Practice for priority areas e.g. NDIS, aged care, solo practitioner models
- Establishing and evaluating service learning models in rural and remote locations to determine impact on service capacity, learning outcomes for allied health students and early career health professionals, perceptions of remote practice.

Evidence about allied health interventions, services, workforce, models of care, and funding mechanisms is generated by both researchers and a wide variety of people within the service industry. Yet much of this evidence remains unpublished and inaccessible and hence not effectively utilised by peak bodies or others, including government, in developing policy and programs to meet the health and educational needs of the community. Furthermore, the haphazard approach to the collection, sharing and translation of the grey literature impedes the contribution of this body of work to inform future policy and service delivery.

Improving evidence translation and dissemination

A key challenge in the current allied health environment is the capacity of any individual or organisation to effectively access, assess and disseminate relevant evidence. Similarly, there is no coordinated approach to translating evidence from across the allied health sector to meet the needs of different audiences including peak bodies, government, policy makers, politicians, service planners, commissioners, service providers and consumers.

Improving evidence collection, analysis and dissemination is a common problem across the allied health sector and lends itself to a coordinated and collaborative approach. The key areas of focus are on:

- **Collation of evidence** around topic areas of interest through systematic reviews of published literature and grey literature drawing together existing knowledge and evidence, and identifying evidence gaps to inform future research and evaluation priorities.
- **Reviewing the evidence** recognising variation in the level of rigour or relevance and instituting a filtering process to understand how different pieces of evidence contribute to an understanding of each issue, including making judgements about the quality of that evidence.

- **Communication and dissemination** of appropriately translated evidence and key messages targeted to a wide variety of audiences using different platforms and approaches.

While the key components of an allied health evidence translation strategy are relatively easy to define, the challenge to the sector is how to bring key parties together with the requisite skills, industry knowledge and resources to establish the collective evidence base, maintain its currency and advocate effectively for necessary changes to the health system.

Recommendation:

Establish and resource an allied health evidence translation collective inclusive of Universities, University Departments of Rural Health, Allied Health peak bodies, state and territory health and education departments and commissioners to build the evidence base for priority topic areas including but not limited to workforce development, workforce planning, allied health interventions and models of care.