COMMENTARIES

What the participants in this study demonstrate is that retention of Allied Health Professionals (AHPs) in rural areas is a complex issue. The difference between what professionals need at work and what they actually receive can lead to an assessment of options that are available to them which, at times, may lead them to resign. Whereas lifestyle, career and family ties (and in this instance some financial incentives) may have attracted professionals to rural employment, reasons for leaving may also relate to personal factors, social and professional isolation, poor access to continuing professional development (CPD) and lack of career paths (Belcher et al, 2005; Stagnitti et al, 2005a; b). Furthermore, there may be poor organisational commitment and management that lead to health workforce retention problems (Denham and Shaddock, 2004; US Department of Health and Human Services, 2004).

> **"There is little recognition given to rethinking models that help to integrate the private sector into the policy mix."**

The AHP Scheme

The Allied Health Professions (AHP) Support and Development Scheme in Scotland under discussion in this article appears to have made some headway to counter some of the problems associated with a lack of retention (e.g., financial incentives, CPD, etc.). This adds to the literature that proposes a greater emphasises on flexible funding models for rural health (Humphreys, 2002; Larson, 2002), alternative models of management (Southon, 1996) or funding to establish clinical leadership and improved rural career options. However, the focus is still very much about restructuring the funding and management models for the public sector only. There is little recognition given to rethinking models that help to integrate the private sector into the policy mix.

The responses of the participants in this study provide some further data for improvements to public sector retention programmes, but there is also a need to create broader policies for rural health that include private AHPs. Research has shown that, in Australia, private Allied Health Professionals generally remain longer in rural areas than those working in the public sector (O'Toole et al, 2008). At present there is little incentive or policy commitment for attracting private AHPs, or for offering rural practitioners options for mixing private and public service. This does not mean privatisation of the system but rather the scope for policy

makers to broaden the range of options available for practice in rural areas by: 1) increasing the critical mass of AHPs available to rural areas; 2) embedding professionals in local communities through investment into multiple capitals; and 3) extending local investment in health infrastructure. This can only make the system more efficient by making better use of resources, increasing local resource allocation and service provision, and increasing the sustainability of AHP practice. It is not about 'handing over' to the private sector, but a means of incorporating a range of service delivery types into broader cooperative processes and hopefully extending the retention of AHPs in rural areas.

Conclusions

Nevertheless programmes such as the Allied Health Professions (AHP) Support and Development Scheme in Scotland are indicative of the fact that AHPs do form an important segment of the rural health services. The challenge now is to maintain and create more innovative approaches to make practice in rural areas a normal part of national health services.

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