

Allied Health in Australia and its Role in Palliative Care



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Summary

As the Australian population ages and the prevalence of chronic, sometimes life-limiting diseases increases, so to does the demand for palliative care with its emphasis on quality of life. Allied health (AH) professionals are expected to have a key role in meeting this demand. Representing more than a quarter of the Australian health workforce and delivering approximately 200 million health services annually, allied health is an important and major contributor to the Australian system of care.

This review aimed to understand the context of allied health practice in the Australian setting and hence how they might be supported to increasingly engage with palliative care.

1.1 Key findings

In general, important considerations when engaging with allied health include:


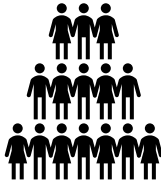

- With little or no consensus on member disciplines, utility of the term 'allied health' in discussions of care provision is uncertain and potentially hinders useful data collection
- Being representative of one quarter of the Australian health workforce, allied health collectively have the potential for a strong voice in healthcare policy
- Individual professions are well represented by independent peak bodies and these represent major opportunities to engage with large numbers of allied health professionals
- Collective peak bodies vary in terms of included member disciplines but are also active contributors and promoters of service and skills development
- Access to subsidised allied health services for people with palliative care needs is often limited to hospitals or GP referral via the Chronic Disease Management (CDM) program funded under the Medicare benefits Schedule (MBS)
- AH professionals engage in core activities related to their area of expertise as well as a broad range of overlapping peripheral activities
- Access to allied health practitioners is more limited in regional and rural areas

- Allied health is a minor workforce component in residential aged care; estimated 5% in 2016
- Allied Health Assistants are a major component of allied health in residential aged care
- Data is lacking for allied health services not subsidised through Medicare or private health insurance.

Efforts to support allied health in palliative care are likely to be influenced by many factors including:

- Although the roles of allied health in palliative care are recognised in the Palliative Care Australia Service Development Guidelines, data on supply and demand is limited
- Allied health palliative care workforce is broad and may include but is not limited to art and music therapy, grief and bereavement counselling, occupational therapy, pastoral care work, pharmacy, physiotherapy, psychology, social work, speech pathology, and spiritual care practice
- Occupational therapy is the only allied health profession to have a position paper on palliative care
- In common with general practice, there are no MBS items specific to delivery of palliative care related services by allied health professionals in the community
- Although most residential aged care clients are approaching end of life, only 4% of allied health professionals working in aged care hold specialised qualifications in palliative care
- There are limited positions for allied health professionals within specialist palliative care
- Palliative care education in allied health is growing but remains limited and support for upskilling qualified professionals is needed

Specialist areas of research are emerging and will inform palliative care practice. (e.g. bereavement practices, swallowing and routes of medication administration, breathlessness and functional decline).

Allied Health in Australia		
		
Deliver 200 million services annually	26% of registered health professionals in Australia	Are recognised by Palliative Care Australia and in the National Palliative Care Strategy 2018

Introduction

The following overview of allied health in Australia was developed to inform future engagement between CareSearch/palliAGED and the allied health sector in relation to supporting their role in palliative care services. In recognition of the diversity across allied health professions, this was considered an important step towards better understanding of the needs and roles of allied health professionals in providing palliative care and care for people approaching the end of their life.

Palliative care is defined as care that supports people with a life-limiting illness to live their life as fully and comfortably as possible. The [World Health Organization \(WHO\) definition](#) of palliative care has been broadly adopted internationally as well as within Australia including the [Australian Government National Palliative Care Strategy 2018](#).

The Australian Institute of Health and Welfare notes an ageing population and an increase in the population of people living with chronic disease. [1,2] This means people are living longer with impaired function, and decreased ability to participate in everyday activities. [3,4] Information is not readily available on the number of people living with a life-limiting illness who might benefit from palliative care, but the demand for services is growing. [3-6]

The rate at which demand for palliative care services is growing has prompted concerns that specialist palliative care teams will not be able to satisfy future demand. [4-6] Not all people at the end of life have complex needs requiring specialist palliative care. Many people can be cared for by their usual doctor, family and others including allied health professionals. [5] However, suitable, and timely palliative care should be available to meet their needs. It is therefore becoming critical that palliative care becomes the remit of all health professionals including allied health. [6]

The role of allied health in palliative care is recognised but still emerging. With little or no consensus on member professions it is difficult to capture the involvement and potential of these services in palliative care as a group.

Aim: By bringing together information on allied health in Australia and its role in palliative care, we aim to improve understanding of the current context and to identify relevant approaches to supporting future involvement. In the following, a broad overview of allied health in the Australian context is followed by more specific information on the role of allied health in the delivery of palliative care.

1.2 Methods

The primary aim of this report was to provide insights into the current role of allied health in the Australian context. A horizon scan of available literature and resources was undertaken. To identify grey literature resources, keyword scans of Google and the CareSearch section were conducted with a check of all references of relevant articles. Based on the palliAGED evidence protocol, the PubMed database was also searched for the period 2013–2018 using keywords relevant to the specific question. Search terms used were 'allied health', 'art therap*', 'counsell*', 'dietician', 'dietitian', 'dietetics', 'music therap*', 'nutrition*', 'occupational therap*', 'paramedic*', 'pharmacist*', 'physiotherap*', 'psychology', 'psychologist', 'social work*', 'speech therap*', 'speech patholog*', 'speech-language', 'palliative care', 'terminally ill', 'death', 'palliat*', 'hospice*', 'terminal care', 'advanced disease', 'rehabilitation', 'functional decline'.

Professional experience of the main author (qualified physiotherapist) was invaluable with respect to identifying information sources, specific organisations, and practice-related knowledge. Familiarity with the allied health professions, peak bodies, regulatory bodies, and settings of care within Australia also supported sourcing of relevant data.

Allied Health in Australia

Allied health is a relatively new term and, nationally or internationally, there is still no universally accepted definition. [7-11] Allied health describes a group which comprises health professions that are not medicine, nursing, dentistry, or Aboriginal health workers¹. [8-10,12-15] Another description of allied health is as partners, or allies, to the doctors and nurses in a healthcare team. [8,14] The term allied health is also explained in terms of the inter-disciplinary relationship and the multi-disciplinary, collaborative approach in the provision of care to their clients and the communities they serve, sometimes summed up as 'an inter-professional alliance or alignment'. [13,14,16-18]

Allied health professionals or practitioners (AHPs) have a university qualification and expertise in preventing, diagnosing and treating a range of health conditions and illnesses. Often working within a multidisciplinary health team, they provide specialised support for different patient needs affecting physical, sensory, psychological, cognitive, social, emotional, and cultural wellbeing of their clients. [8,10,12,14,16-18]

These professions provide direct patient or therapy services, diagnostic or technical services and education. [9,19] Allied health contributes across acute, subacute, and primary care sectors from diagnosis to direct provision of specialist treatment and rehabilitation services and including health promotion and community development work. [9,11,12] However, there is not at present a comprehensive national source of allied health workforce data. This has implications for current and future health workforce planning and policy development for the health sector. [20]

¹ However, Aboriginal health workers and Aboriginal and Torres Strait Islander Health Practitioners are considered eligible allied health providers in the Medicare Chronic Disease Management (CDM) scheme.

The allied health workforce is extremely diverse with significant variation across and within professions with complex and interrelated roles, responsibilities, skills, and scopes of practice. [9,13,19,21] Allied health is usually described by discipline lists and/or tasks, which can vary between countries, government bodies, industry, healthcare settings, and training institutions. [8,9] The types of activities undertaken by common allied health disciplines often overlap but each has a specific core focus related to expertise in treatment, assessment, diagnosis, or counselling as shown in Table 1.

Table 1 Activities commonly undertaken by selected allied health disciplines, adapted from [9]

Discipline	Therapy Treatment	Assessment	Diagnosis	Counselling	Education	Preparation/ prescription	Organisation
Dietetics and nutrition	Core	Peripheral		Peripheral	Peripheral		Peripheral
Occupational therapy	Core	Peripheral		Peripheral	Peripheral	Peripheral	Peripheral
Pharmacy				Peripheral	Core	Core	Peripheral
Physiotherapy	Core	Peripheral	Peripheral	Peripheral	Peripheral	Peripheral	Peripheral
Psychology	Core	Peripheral	Peripheral	Peripheral			
Speech pathology	Core	Peripheral	Peripheral	Peripheral	Peripheral		
Social work		Peripheral		Core	Peripheral		Core

In Table 2, the allied health professions recognised by 1) Allied Health Professions Australia (AHPA), 2) Australian Health Practitioner Regulation Agency (AHPRA), 3) Palliative Care Australia (PCA) Service Development Guidelines 4) Commonwealth workforce policy documents, and 5) in international literature are juxtaposed to demonstrate the variation in recognised allied health professions.

From this it is apparent that the list of allied health professions registered under the National Registration and Accreditation Scheme (NRAS) for health practitioners and maintained by the AHPRA is more restrictive than those considered in the

Commonwealth's health workforce policy planning report. [7,22] Comparison with professions listed by Medicare Benefits Schedule (MBS) for Chronic Disease Management Plans or in international literature further illustrates wide variation across settings. [23]

This approach has been criticised for its focus on 'who's in and who's out' with an alternative grouping based on activity being proposed [24] as follows:

- therapy
- diagnostic and technical/manufacturing,
- scientific
- complementary services.

Unfortunately, few details are available about this proposed grouping or its application.

Table 2 Comparison of recognised or included allied health disciplines across selected organisations

Allied health disciplines	AHPA members	AHPRA (NRAS)	AIHW [11,25]	MBS Chronic Disease Management	PCA [3]	CHWPP [7]	International literature
Aboriginal & Torres Strait Islander health practice	○	●	●	●	○	●	○
Art therapy	●	○	○	○	●	○	○
Audiology	●	○	○	●	○	●	●
Bereavement counselling	○	○	○	○	●	○	○
Chinese medicine	○	●	●	○	○	●	○
Chiropractic	●	●	●	●	○	●	○
Counselling	○	○	○	○	●	●	○

Allied health disciplines	AHPA members	AHPRA (NRAS)	AIHW [11,25]	MBS Chronic Disease Management	PCA [3]	CHWPP [7]	International literature
Dental practitioners	○	○	●	○	○	○	○
Diabetes education	○	○	○	●	○	○	○
Dietetics	●	○	○	●	●	●	●
Exercise physiology	●	○	○	●	○	●	○
Genetic counselling	●	○	○	○	○	●	○
Medical radiation practice	●	●	●	○	○	●	●
Mental health work	○	○	○	●	○	○	○
Music therapy	●	○	○	○	●	●	○
Nutrition	○	○	○	○	○	●	○
Occupational therapy	●	●	●	●	●	●	●
Optometry	●	●	●	○	○	●	○
Oral health	○	○	●	○	○	○	○
Orthoptics	●	○	○	○	○	○	●
Orthotics & prosthetics	●	○	○	○	○	●	●
Osteopathy	●	●	●	●	○	●	○
Paramedicine	○	●	●	○	○	●	○
Pastoral care	○	○	○	○	●	○	○
Perfusion therapy	●	○	○	○	○	○	○
Pharmacy	○	●	●	○	●	●	○
Physiotherapy	●	●	●	●	●	●	●
Podiatry	●	●	●	●	○	●	●
Psychology	●	●	●	●	●	●	●
Rehabilitation counselling	●	○	○	○	○	○	○
Social work	●	○	○	●*	●	●	●
Sonography	○	○	○	○	○	●	○
Speech pathology	●	○	○	●	●	●	●
Spiritual care	○	○	○	○	●	○	○

○ not included, ● included; Allied Health Professionals Australia (AHPA); Australian Health Practitioner Regulation Authority (AHPRA); Australian Health Practitioner Regulation Authority (AHPRA); National Registration and Accreditation Scheme (NRAS); Australian Institute of Health and Welfare (AIHW); Medicare Benefits Schedule (MBS); Palliative Care Australia (PCA) Service Development Guidelines; Commonwealth Health Workforce Participation Program (CHWPP); *appropriately trained in mental health.

1.3 Allied health regulation in Australia

In 2008, the National Registration and Accreditation Scheme (NRAS) for registered health practitioners was endorsed by The Council of Australian Governments (COAG) with the aim of regulating health practitioners to protect the public and facilitate access to safer healthcare. [26]

Since July 2010, the Australian Health Practitioner Regulation Agency (AHPRA) has supported the National Boards of several health professions to implement the National Registration and Accreditation Scheme (NRAS). [15,26-28]

Each National Board sets the registration standards that practitioners must meet in order to register. Once registered, practitioners must continue to meet the standards and renew their registration yearly with the National Board. [26]

The twelve allied health professions included in the NRAS [15,25,26,28] are:

- [Aboriginal and Torres Strait Islander Health Practice Board of Australia](#)
- [Chinese Medicine Board of Australia](#)
- [Chiropractic Board of Australia](#)
- [Medical Radiation Practice Board of Australia](#)
- [Occupational Therapy Board of Australia](#)
- [Optometry Board of Australia](#)
- [Osteopathy Board of Australia](#)
- [Paramedicine Board of Australia](#)
- [Pharmacy Board of Australia](#)
- [Physiotherapy Board of Australia](#)
- [Podiatry Board of Australia](#)
- [Psychology Board of Australia](#)

These boards are responsible for registering allied health practitioners and students; developing standards, codes, and guidelines; assessing overseas-trained allied health practitioners who wish to practise in Australia; and approving accreditation standards and accredited courses of study.

Participation in continuing education programs is important for continued provision of safe, effective, and good quality services by allied health practitioners and a requirement of registration. [29,30] This is monitored through Continuous Professional Development (CPD) programs with allocation of CPD points for additional education and development undertaken by individuals.

While the allied health professions have a requirement of a university qualification, there are different processes and requirements around accreditation for practitioners practising their professions. The major division in the accreditation of allied health professionals is between those professions that are accredited through the National Registration and Accreditation Scheme (NRAS) and those professions that are self-regulated. Allied health profession members of either scheme have a system in place to ensure that registered practitioner members are appropriately qualified, engage in ongoing professional development, and adheres to professional standards.

Accreditation is a key part of the National Registration and Accreditation Scheme. Accreditation authorities (external authorities or a committee established by a National Board) exercise the accreditation functions under the National Law. Accreditation standards are used to assess whether a program of study, and the education provider that provides the program, provide graduates with the knowledge, skills and professional attributes to practise the profession in Australia.

The following allied health professions registered with AHPRA have current accreditation standards and processes developed and monitored by a Council or National Board:

- Aboriginal and Torres Strait Islander Health Practice
- Chiropractic
- Medical Radiation Practice
- Occupational Therapy
- Optometry
- Osteopathy
- Paramedicine²
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology.

National Alliance of Self Regulating Health Professionals (NASRHP) supports member organisations of self-regulating health professions. NASRHP has the following membership:

- Audiology Australia
- Dietitians Association of Australia
- Exercise and Sports Science Australia
- Speech Pathology Australia.

1.4 Peak bodies and support entities

Representational or peak bodies for allied health professions can provide leadership; and/or promote the discipline, its members, and the patients; and/or enhance best practice through professional development, support, and access to profession-specific information; and/or host special interest groups. As shown in Table 3, many

² Accreditation Standards for Paramedicine are currently under development
<https://www.paramedicineboard.gov.au/Accreditation.aspx> (accessed 2019 Nov 8)

of the profession-specific peak bodies have achieved significant membership numbers, as have those representing multiple professions.

Table 3 Representational or peak bodies for individual allied health professions in Australia.

Peak Body	Number of members
<u>Australian Association of Social Workers (AASW)</u>	>12,000
<u>Australian Centre for Grief and Bereavement</u>	NK
<u>Australian Counselling Association (ACA)</u>	>5,000
<u>Australian New Zealand and Asia Creative Arts Therapies Association (ANZACATA)</u>	600
<u>Australian Music Therapy Association (AMTA)</u>	700
<u>Australian Physiotherapy Association (APA)</u>	26,000
<u>Australian Podiatry Association</u>	2,500
<u>Australian Psychological Society</u>	24,000
<u>Australian Society of Medical Imaging and Radiation Therapy (ASMIRT)</u>	>8,000
<u>Chiropractors' Association of Australia (National) Limited (CAA)</u>	>3,000
<u>Dietitians Association of Australia (DAA)</u>	7,000
<u>Diversional & Recreation Therapy Australia (DRTA)</u>	NK
<u>Exercise & Sports Science Australia (ESSA)</u>	7,700
<u>Federation of Chinese Medicine & Acupuncture Societies of Australia</u>	NK
<u>National Aboriginal Community Controlled Health Organisation (NACCHO)</u>	NK
<u>Occupational Therapy Australia</u>	6,000
<u>Osteopathy Australia</u>	NA
<u>Optometry Australia</u>	>4,000
<u>Paramedics Australasia</u>	NK
<u>Pharmaceutical Society of Australia</u>	31,000
<u>Speech Pathology Australia</u>	8,000
<u>Spiritual Care Australia</u>	NK

NK = membership number not available

Representational or peak bodies for allied health in Australia outside of the distinct professional peak bodies are:

[Allied Health Professions Australia \(AHPA\)](#) as the peak national organisation for allied health professions is the recognised national voice for allied health professions in Australia. AHPA has 20 allied health association members and 5 affiliate members. Collectively, organisations within AHPA represent about 130,000 health professionals. [7,21] To see the list of AHPA's membership of twenty allied health professional associations see Table 2.

[Indigenous Allied Health Australia \(IAHA\)](#) provides support and advocacy on behalf of indigenous allied health professionals and builds leadership capacity across the allied health and indigenous health sectors. IAHA works with organisations and individuals to improve access to allied health services and ensure that allied health professions and services are kept in the forefront of policy development and the decisions which affect allied health professionals and Australia's First Peoples. [14,31,32]

[Services for Australian Rural and Remote Allied Health \(SARRAH\)](#) is the peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector. Membership of SARRAH comprises nine universities, four private health care organisations, two public health care organisations, four Primary Health Networks (PHNs), and one health workforce agency.

The [Australasian Allied Health Benchmarking Consortium \(AAHBC\)](#) is a network of allied health representatives from tertiary teaching hospitals across Australia and New Zealand. AAHBC develops and maintains a standardised approach to benchmarking of allied health activity as well as evaluating processes and outcomes. AAHBC is involved in project work that enhances and validates benchmarking processes. [33]

[CRANaplus](#), the peak professional body for the remote and isolated health workforce, provides education, support and professional services, and represents the

remote health sector Australia-wide. [34] Initially, CRANA served remote area nurses, now CRANApplus includes allied health and medicine. [34]

1.4.1 Supporting allied health knowledge and translation of evidence

[International Centre for Allied Health Evidence](#) (iCAHE) works locally, nationally, and globally to create new knowledge and translate evidence into safe, quality health care. Partnering with researchers, clinicians, educators, policy makers, government, industry, professional and consumer groups and the broader community, iCAHE provides a wide range of tools, services and resources to support health practitioners, service managers, policy makers, consumer representatives and researchers translate evidence into policy and practice. [35]

1.5 Allied health services in Australia

Allied health services represent a significant part of the Australian health workforce. [9] According to Australian Institute of Health and Welfare (AIHW) data, *'In 2012, the total number of allied health practitioners registered in Australia was 126,788 ...'* [11] Health Workforce Data reports that in 2017, allied health represented 26% of all registered and employed professionals in the Australian health workforce (147,549 allied health practitioners). [36] In 2011, allied health made up 5% to 11% of the global health workforce. [9]

Australia's 195,000 allied health professionals deliver an estimated 200 million health services annually. [21,25] The discrepancy between estimates of number of professionals likely reflects differences in the professions included under the term 'allied health' as demonstrated in the Table 2. AIHW estimates that on an average day in Australia there are 27,000 allied health services provided which compares to 381,000 visits to a general practitioner (GP). [28]

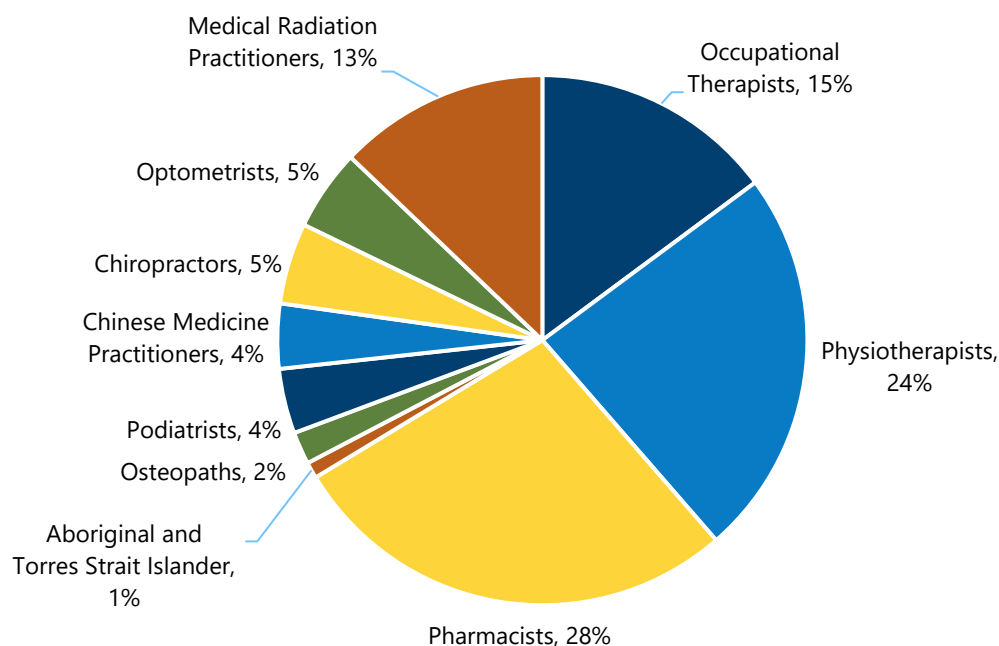


Figure 1 Australian Allied Health Workforce 2012 [11]

Australian Bureau of Statistics (ABS) data reveals 71.2 million allied health services (subsidised by Medicare or by private health insurance) were delivered in Australia in 2016-2017. [15] At present, we do not have national data on allied health services accessed outside of private health insurance or Medicare. [15] Although AIHW acknowledges that there is limited comprehensive national information on allied health services, [15,28] available data reveals that on an average day in Australia 27,000 allied health services are provided. [28] There has been a marked increase in the use of allied health in the decade 2007/2008 - 2016/2017: an increase of almost 30% of allied health services subsidised by general health insurance and 91% increase in Medicare-subsidised allied health services. [15]

Allied health is considered to be a core element of indigenous-specific primary health care services that improves access for Indigenous people to health care, including addressing barriers such as cost and cultural appropriateness. [28]

Indigenous-specific primary health care services are administered and run by a combination of Aboriginal Community Controlled Health Organisations (ACCHOs), Primary Health Network services, other non-government organisations, and state or territory local health services. [15,28]

Allied health has an important role to play in supporting Australians to live safely and independently in the community with optimum quality of life. This is becoming increasingly important given the rising costs of acute hospital beds and residential places. [12] Allied health interventions may reduce or remove the need for medical interventions. [21] Allied health professionals are taking on a more advanced and extended scope of practice in response to healthcare workforce reforms in Australia. [19,37-39] The breadth of service delivery contexts and settings in which allied health services are provided have necessitated the development of flexible and robust clinical governance systems and processes to underpin allied health services. [39,40]

1.6 Access to allied health services

The use of allied health services is increasing. [15] Allied health services can usually be accessed directly and without a referral by a person paying privately. The National Disability Insurance Scheme (NDIS) provides funding for allied health and other therapy needed by people with permanent and significant disability. [41] Australians can access subsidised allied health services in the community (commonly in private practice) through their private health insurance if they have 'ancillary' or 'extras' cover, or through Medicare where eligible (most commonly through Enhanced Primary Care (EPC) services). If the need for allied health services arises from treatment received in hospital, most or all of those allied health services are likely to be provided by allied health professionals employed by that hospital. [42]

A limited range of national and state-based funding schemes and programs are available to help people access allied health services by meeting some or all of the cost. In these cases, a referral, typically from a GP, is needed. These schemes are

community health services (particularly for people experiencing disadvantage and poor health due to their economic and social situation), aboriginal health services, Department of Veterans Affairs (DVA), Medicare-funded services and allied health services provided by aged care or disability. [42] These community health services vary between and within States and Territories. [42]

Access to Medicare funding for most services, apart from optometry and audiology, requires a referral from a general practitioner. [42] Specialised funding for optometric, audiological and diagnostic services is available through Medicare as well as access to services for children with autism, people experiencing mental ill health and people living with chronic disease. [42] For people living with chronic conditions and complex care needs managed by a GP, Medicare benefits are available for certain services provided by allied health professionals through Chronic Disease Management (CDM) plans (Table 4). A chronic medical condition is one that has been or is likely to be present for at least six months, e.g. asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions, and stroke. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers. [23] The allied health service(s) must be recommended in the person's plan as part of the management of their chronic condition. [23] Medicare benefits are available for a maximum of five allied health services per eligible patient, per calendar year. [23] The five allied health services can be made up of one type of service or a combination of different types of services. [23]

Table 4 Medicare Benefits schedule item numbers for allied health services eligible as part of a Chronic Disease Management Plan or Team Care Arrangements

Allied Health profession	MBS item number	Rebate as of 4/11/2019 ³ [23]
Aboriginal Health Workers	10950	Fee: \$63.25 Benefit: 85% = \$53.80
Aboriginal and Torres Strait Islander Health Practitioners	10950	
Audiologists	10952	
Chiropractors	10964	
Diabetes educators	10951	
Dietitians	10954	
Exercise physiologists	10953	
Mental health workers	10956	
Occupational therapists	10958	
Osteopaths	10966	
Physiotherapists	10960	
Podiatrists	10962	
Psychologists	10968	
Speech pathologists	10970	

The [referral form for individual AH services](#) is available from the Department of Health, and corresponding Medicare benefit schedule (MBS) item numbers are shown in Table 4.

1.7 Practice settings

Allied health professionals provide services to enhance and maintain function of their patients (clients) within a range of settings including clinics, hospitals, private practice, rehabilitation centres, community health centres, Aboriginal health services, schools and universities, residential care facilities, and in-home care. [11] The allied health workforce works across the spectrum from acute to primary care and paediatric to aged care. Allied health professions also have a major role in the management of people with disabilities from childhood to adulthood to old age. [7,11,14]

³ If a provider accepts the Medicare benefit as full payment for the service, there will be no out-of-pocket cost. If not, the patient will have to pay the difference between the fee charged and the Medicare rebate.

From the National Health Workforce Data Set, pharmacists and physiotherapists are more likely to work in the private sector but psychologists and occupational therapists are more evenly distributed across private and public. [11] Social workers, occupational therapists, physiotherapists, speech pathologists, dietitians, pharmacists are allied health professions which commonly work in the hospital environment. [43] However, as with distribution across private and public sectors, participation within the hospital and community sector differs between individual professions and data for some professions is lacking.

Distribution of allied health practitioners in Australia also varies according to geography (Figure 2). Based on 2012 data, for all professions except Aboriginal and Torres Strait Islander health practitioners, the number of registered practitioners per 100,000 population was highest in major cities. [11] The number of registered psychologists, pharmacists, physiotherapy practitioners and occupational therapists (OTs) per 100,000 population ranged from 68-151 in major cities to 23-60 in remote/very remote regions and 48-92 for inner regional areas. [11]

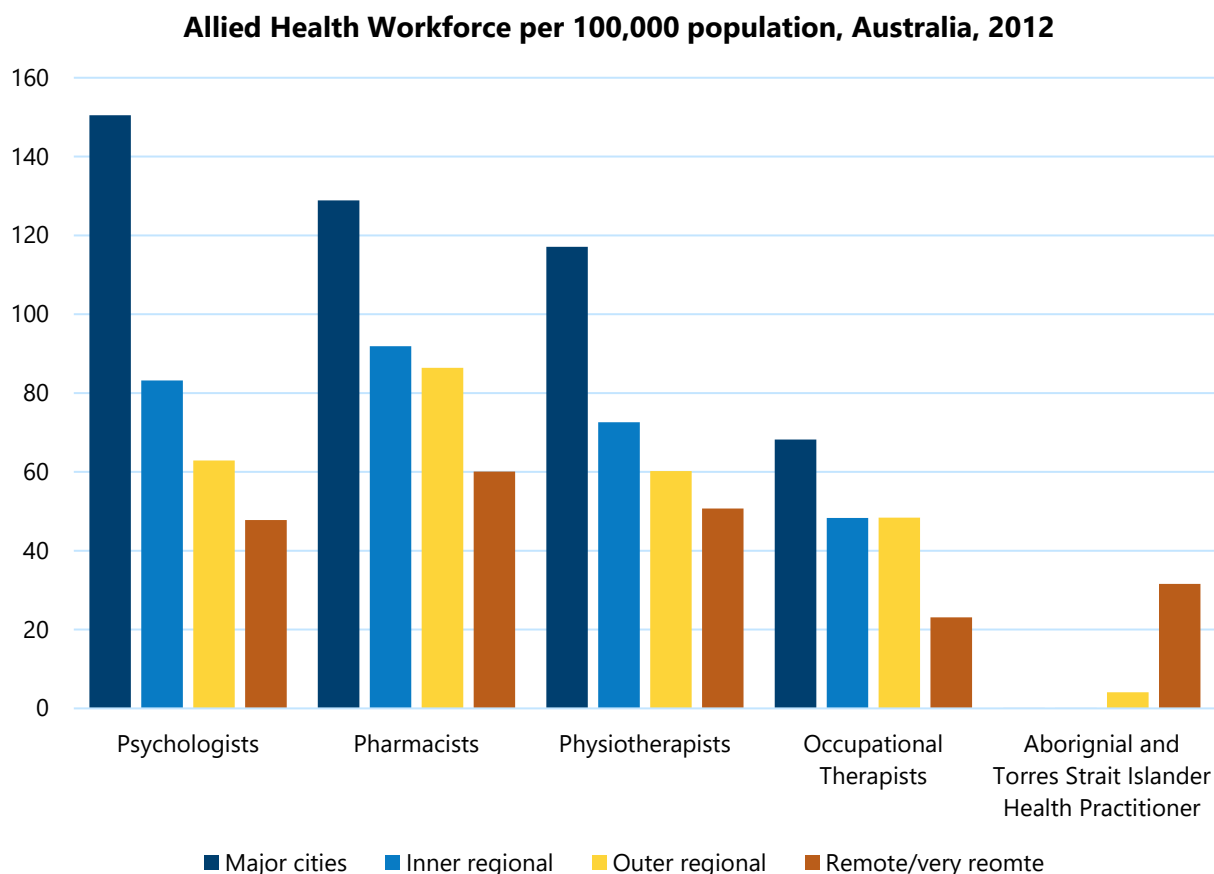


Figure 2 Geographic distribution of selected allied health professional groups in Australia for 2012 [11]

The role of allied health assistants (AHAs) has emerged in recent years, particularly in the community and in rural settings. [37,44-46] Within residential aged care, data from 2016 shows that the number of AHAs employed was more than double that of allied health professionals. [47] In contrast, there are four times more allied health professionals providing in-home care and home support for older people compared to AHAs

Based on 2017 data, the [Australian Government Department of Health](#) has developed a series of factsheets providing an overview of workforce participation, demographics, and distribution for selected allied health disciplines including the following:

- [Aboriginal and Torres Strait Islander Health Practitioners \(pdf 231 KB\)](#)

- [Aboriginal and Torres Strait Islander Allied Health Practitioners \(pdf 399 KB\)](#)
- [Occupational therapists \(pdf 648 KB\)](#)
- [Pharmacists \(pdf 254 KB\)](#)
- [Physiotherapists \(pdf 268 KB\)](#)
- [Psychologists \(pdf 277 KB\)](#)

These insights show that the number of OTs principally working in residential aged care facilities more than doubled between 2014 and 2017 from 363 up to 885 people. In contrast, the number of physiotherapists has only moderately increased from 1,525 to 1,749 in residential aged care over the same period. With aged care residents increasingly entering facilities at an older age and with more complex needs [48], the role of allied health is likely to increase.

Role of allied health in palliative care

A recent Australian study of Australian allied health clinicians showed they play an active role in physical, social, and psycho-spiritual care of palliative care patients and carers. The participants noted that given increasing numbers of palliative care patients in non-specialist palliative care settings, this care within a palliative care context is likely to be an increasing responsibility. [6] In a survey of 169 allied health practitioners, more than one-third of respondents felt that allied health could have a real impact if a more conservative approach to end of life was implemented across the health system. [12] Many people approaching the end of life without a life-limiting illness might also benefit from palliative care; this is particularly relevant to care of older people.

The Palliative Care Australia Service Delivery Guidelines [3] acknowledges the role of allied health professionals in meeting the needs of people living with a life-limiting illness:

- providing support to manage physical symptoms including support related to medication, nutrition, communication, and mobility;
- assisting people with a life-limiting illness to maintain function and independence;
- providing a wide range of psychological support, social support, pastoral care, and bereavement support;
- providing therapies that focus on improving the quality of life that support people, families, and carers to achieve their goals; and
- sharing information about disease progression and providing education for people living with a life limiting illness, their families, and carers.

The medical management and coordination of care for people living with a life-limiting illness may be undertaken by a wide range of health professionals including

GPs, geriatricians, physicians, oncologists, paediatricians, renal specialists, cardiologists, endocrinologists, and other specialists, nurses and allied health workers. [3,4,49]

Palliative Care Australia suggests that every palliative care provider should be able to identify a full network of specialist palliative care service providers including allied health for support, advice and consultation, even if not in close geographical proximity. [3] They have also endorsed international expert opinion that interdisciplinary palliative care teams comprising allied health personnel are an essential component of comprehensive quality palliative care for all. [3]

Palliative Care Australia describes three levels of palliative care: palliative care for people with straightforward and predictable needs; specialist palliative care for people with straightforward and predictable to intermediate and fluctuating needs; and specialist palliative care for people with straight forward and predictable, intermediate and fluctuating, or complex and persistent needs. [3,49] Allied health has a role in palliative care and in care for these three groups. [3,12,49-51]

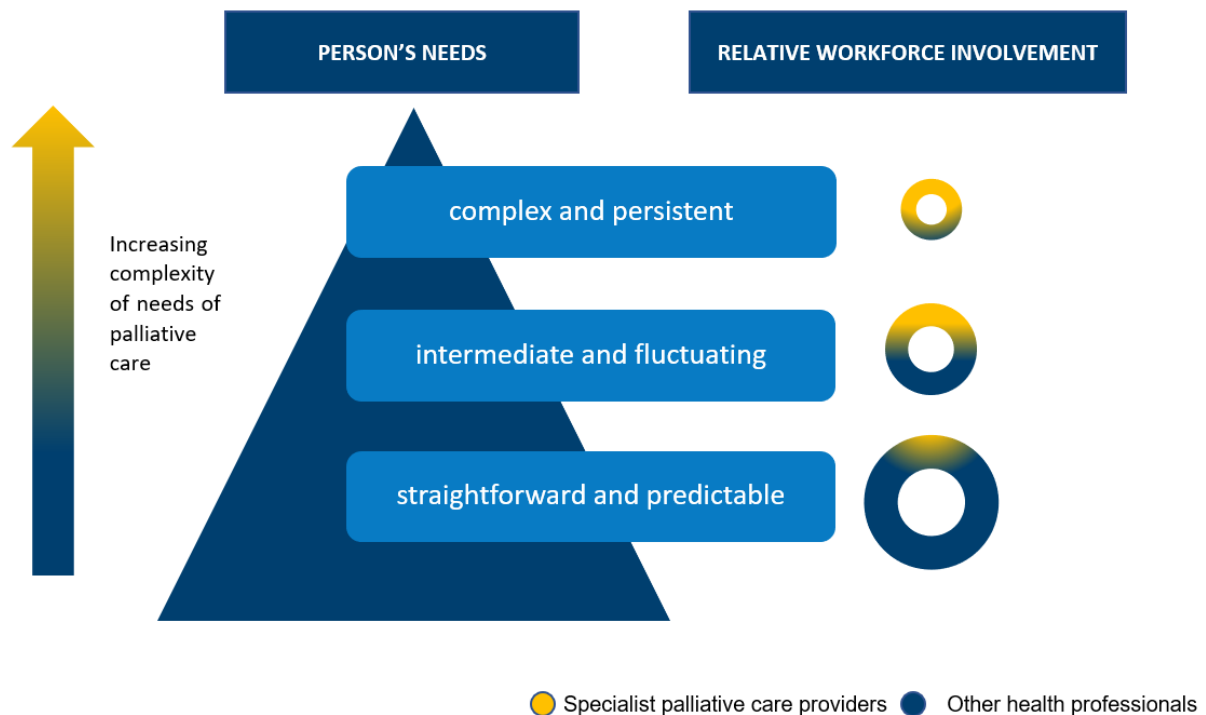
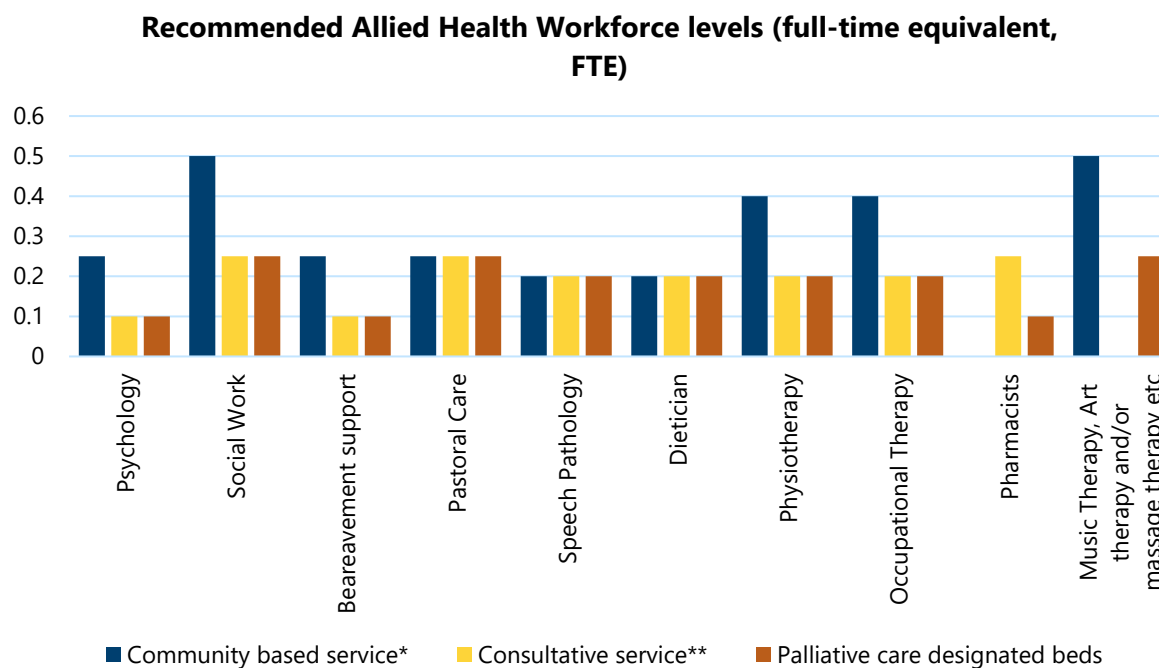


Figure 3 Alignment of need for palliative care against workforce capability
(Adapted from Palliative Care Development Guidelines, 2018, Palliative Care Australia [3])

With respect to specialist palliative care services, the Palliative Care Australia Service Delivery Guidelines includes suggested allied health workforce levels across three settings; community-based services, consultative service, and palliative care designated beds. [3] However, it should be noted that in the absence of national benchmarks or adequate data on supply and demand these recommendations are based on expert panel consensus.



* Full-time equivalent per 100,000 population ** Full-time equivalent per 125 beds *** Full-time equivalents per 6.7 beds (within acute hospital)

Figure 4 Palliative Care Australia recommended workforce levels in specialist palliative care services. [3]

While data is generally lacking, it is known that allied health professionals can play an important role in palliative care, particularly around the physical, psychological, social, and spiritual needs of patients as they reach the terminal stage of their condition. By addressing functional limitations, allied health professionals, particularly a multi-disciplinary team, can offer support and/or resources to help people to stay at home for as long as possible and ultimately, continue living whilst dying. [6,12,52] This can include support and training for families and carers to help make home-based palliative care a viable option. [12] The inclusion of allied health in palliative care delivery is reflected in the Australian Government [National Palliative Care Strategy 2018](#). It has been suggested that referrals from nurses and allied health professionals can be helpful in overcoming late referrals to specialist palliative care. [50]

1.8 Allied health palliative care practice activity

Activities undertaken by allied health professionals involved in palliative care are highlighted in Table 1. This shows both overlapping common areas of activity across the individual professions and core profession-specific areas of expertise. In the following we consider those activities in more detail when caring for people with palliative care needs. People with cancer are more likely to receive palliative care support than people with other non-cancer life limiting conditions. Cancer Council NSW [53] suggests specific roles for allied health practitioners as part of a palliative care team.

The following are examples of allied health professionals and others who may work in palliative care as part of their role.

Art therapist [54,55]

- assesses a person's need to express strong feelings and through art, provides permission and support to express these feelings and psychologically adjust to their changed health through multifaceted communication
- usually works with the help and support of counselling or psychological teams and as part of a wider multidisciplinary palliative care team.

Chaplain [54,56]

- can set up a screening process and educate staff about the use and importance of the screening questions and how to make referrals
- takes a spiritual history including an assessment of spiritual symptoms
- helps a person identify and articulate their beliefs and values
- helps a healthcare team accommodate cultural beliefs and practices of patients or clients and their family
- knows and shares religious resources in the community which may be helpful
- may facilitate
 - goals of care discussions or family meetings

- palliative care meetings
- communication when bad news is being delivered
- coordination of activities such as memorial services or spiritual groups for staff
- may provide spiritual care to the clinical team, debriefing sessions, or individual counselling
- educates staff on spiritual and religious issues
- supports family members after a death.

Dietitian [53,54,57,58]

- recognises that eating has an emotional, social and cultural significance and that changes in food intake may be distressing for the person, family and carers
- assesses the person's symptoms which may interfere with appetite or eating and their sense of what is important
- creates with the person realistic goals and expectations to enhance quality of life in the face of decline and impending death within the context of a therapeutic relationship
- assesses the person's
 - diet or changes in diet
 - understanding of nutrition and relevance for quality of life
 - need for nutritional supplements
 - help or lack of help from a carer or carer network
- supports the multidisciplinary team with the nutritional management of symptom-related problems such as loss of appetite, altered taste and smell, dysphagia or cachexia
- can facilitate discussions on the potential benefits and burdens of supplemented oral, enteral and parenteral nutrition

- advises on preparation / fortification / supplementation / relaxation of previous dietary restrictions as appropriate for the person
- helps with the management of digestive issues, such as poor appetite, nausea or constipation
- educates the person and carers about safe eating and changes with deterioration
- works closely with the interdisciplinary team to ensure psychological and emotional support is provided, as required
- works closely with a speech pathologist, who will assess and address eating and swallowing problems.

Music therapist [54,59-62]

- is led by the person's symptoms and their sense of what is important to them to co-create realistic goals and expectations with the person in the face of impending death within the context of a therapeutic relationship
- engages actively with the person and/or family and friends in singing, song writing, improvisation, music imagery, music-based relaxation or life review, as well as listening to music, according to a person's musical preferences
- assists with management of symptoms such as pain, fatigue, anxiety, delirium, depression, spiritual needs, and ability to cope through assessment, music therapy methods, counselling, and instrument borrowing
- assists to help maintain function or with adaptation to decreasing function
- create recordings and songs to be left as a legacy for family and friends
- can use improvisations and familiar music to support emotional well-being and quality of life for people with living with dementia
- can assist connectedness between patients and those significant to them through shared music experiences and music-based legacy creation
- liaises within the care team to promote best outcomes

- can collaborate with other professionals such as physiotherapists in music and movement, spiritual care practitioners in planning memorial services, occupational therapists in music playing/performing
- provides support to family and carers, including bereavement support.

Occupational therapist [53,54,63-67]

- assesses a person's functional ability within practical everyday contexts in order to enable occupational engagement⁴ wherever possible as function declines
- is led by the person's symptoms and their sense of what is important to them to co-create realistic goals and expectations with the person in the face of impending death within the context of a therapeutic relationship
- assists with the management of symptoms such as anxiety, fatigue, breathlessness and pain through assessment, education, relaxation techniques, counselling, task redesign and equipment prescription
- assesses and treats dyspnoea (difficulty breathing) with supported body positioning and other strategies such as breathing techniques, energy conservation techniques and use of handheld fans within the context of everyday function
- assesses for and prescribes complex seating and wheelchairs as required, as well as prescribing pressure relieving devices such as cushions and mattresses where required
- assesses and develops strategies to help people manage cognitive changes that impact participation in everyday activities; these changes may be due to ageing, medical treatment or disease specific changes such as cerebral metastases or frontotemporal dementia (MND)

⁴ here occupation/occupational engagement refers to self-care or personal care or activities that are work-related, domestic activities or leisure

- assists the person to maintain or improve independence within their own home or place of care of their choice through assessment, education, environmental modifications and planning for future needs
- encourages and facilitates engagement in purposeful or pleasurable activities such as hobbies or leisure pursuits to enhance quality of life
- may retrain the person in personal or domestic activities using either a change of technique or appropriate equipment
- supports the person's capacity to attend to affairs and develop a legacy
- liaises within the care team to promote best outcomes
- provides support, education and training to informal carers about manual handling within the home context in order to reduce risk of injury
- may be involved in lymphoedema management, additional qualifications required.

Pharmacist [53,54,68]

- trained in medication action and management
- assesses the appropriateness of prescriptions and ensures the timely provision of effective prescription and over-the-counter medications for symptom control
- communicates with the prescribing doctor or nurse practitioner if necessary
- ensures that patients and carers understand and follow the directions provided with medications or medication delivery
- assists the person or their carer with keeping track of medicines, including the costs on the Pharmaceutical Benefits Scheme (PBS)
- may conduct a medication management review including Home Medication Reviews (HMRs) and Residential Medication Management Reviews (RMMRs)
- provides a reliable supply of stock drugs to palliative care services with a system for reviewing and updating agreed stock supply

- counsels and educates the palliative care team about safe use of drugs of relevance to palliative care, for example, syringe driver compatibility
- provides efficient way of compounding non-standard drugs or dosage
- ensures safe and legal disposal of all medications after death.

Physiotherapist [53,54,69-73]

- is led by the person's symptoms and their sense of what is important to them to co-create realistic goals and expectations in the face of decline and impending death within the context of a therapeutic relationship
- assesses therapy needs and appropriate therapeutic interventions
- reassesses the person's changing care needs as their condition changes
- uses massage, range of motion or strengthening exercises, or balance training and falls prevention education to help the person manage the physical aspects of daily activities, such as walking and transfers
- provides advice on physical aids to improve mobility and management of fatigue
- educates the person, their carers and family on how to use to exercise, massage, supported positioning to reduce pain and stiffness, conserve energy and increase mobility
- teaches carers and family ways to best position, move or transfer the person
- may assist with relief of pain using techniques such as supported body positioning, hot and cold packs, massage, relaxation techniques, dry needling (additional qualifications required) and transcutaneous nerve stimulation (TENS) where clinically appropriate
- assists with pain relief for people living with dementia
- assesses and treats dyspnoea (difficulty breathing) with supported body positioning and other strategies such as breathing techniques, energy conservation techniques and use of handheld fans

- may assist the person with relaxed breathing techniques and techniques to help clear lung secretions
- assists with oedema management through positioning, exercise, compression and massage
- may be involved in lymphoedema management, additional qualifications required
- helps prevent pressure injuries through positioning and movement
- liaises within the care team to promote best outcomes
- provides support, education and training to informal carers about manual handling within the home context in order to reduce risk of injury.

Psychologist [53,54,74]

- supports and reinforces the psychological work of other team members
- is led by the person's symptoms and their sense of what is important to them to co-create realistic goals and expectations with the person in the face of impending death within the context of a therapeutic relationship
- understands the interrelationship between physical symptom distress and psychological distress
- is trained in listening and counselling
- assesses or screens a person for distress, inability to cope, or anxiety or depression
- allows a person to talk about any fears, worries or conflicting emotions
- can clarify misunderstandings or mis-expectations
- helps a person identify and talk about loss or grief
- helps a person with existential concerns such as the search for meaning in life, hope, sense of purpose, dignity, grief, and spirituality
- assists a person and their family to communicate and to explore relationship or emotional issues

- can help mobilise individual or family resources, to reduce feelings of isolation and loneliness
- might suggest strategies, techniques, and ways of lessening the distress, anxiety, or sadness the person and others are feeling
- helps explore the issues a person is facing so that they can find more pleasure in life, adjust to changing relations and social roles, and to changing impaired function and dependency
- acknowledges strength and achievements in the life of the person
- assists with verbal or written life review
- may introduce meditation or relaxation exercises to help ease physical and emotional pain
- provides bereavement care and support to family and carers
- contributes to the preparation of legacies and eulogies either with the person and/or the family.

Social worker [53,54,75-77]

- is led by the person's situation and sense of what is important to them to co-create realistic goals and expectations in the face of decline and impending death within the context of a therapeutic relationship
- enables the person to make decisions and exercise choice in their care and decision-making around this
- strengthens people in managing the emotional, psychological and social consequences of what is happening to them
- helps friends, families and partners to feel involved in care and decision-making as appropriate
- enables people to make the best possible use of relevant and available community resources that will help them

- connects the person, family or carers with financial support services to assist with management of financial issues
- can help the person to identify others who are important to them and highlight relationship issues
- can empower the person and those close to them to work towards completion of any unfinished business and say their goodbyes
- along with the pastoral carer, may help to address spiritual pain by recognising concerns, providing comfort and helping to relieve isolation
- provides the person with information and support during advance care planning
- may help the person address issues of sexuality or sexual health and resolve sexual problems
- may advocate for the person's wishes to the palliative care or healthcare team
- liaises within the care team to promote best outcomes
- can provide grief counselling of pre-bereaved or bereaved family members including those experiencing complex bereavement
- can assist with accommodation or placement such as residential aged care, respite care and supported accommodation.

Speech pathologist [54,78-83]

- is led by the person's symptoms and their sense of what is important to them to co-create realistic goals and expectations in the face of decline and impending death within the context of a therapeutic relationship
- optimises the person's ability to eat and drink in the safest, most comfortable way
- helps the person to enjoy eating, drinking and participating in mealtimes
- educates the person, their carers and family on safe swallowing techniques and expected decline in oral intake and ability to swallow
- advises on risk and benefits of feeding modes in cases of dysphagia
- educates the multidisciplinary team as to the swallowing status of the person

- may work with a pharmacist to assess and modify medication administration routes
- utilises a variety of methods to communicate meaningful and relationship sustaining conversations at different stages of life
- helps to optimise the person's ability to communicate which may involve the use of communication strategies, communication tools, and alternative and augmentative communication systems
- assists the family, carers and treating clinicians to use strategies that optimise communication
- uses cognitive stimulation to improve or maintain communication function in people living with moderate to severe dementia
- assesses and supports strategies to manage oral care including excessive saliva production (drooling) and dry mouth
- may advocate for the person's wishes to the palliative care or healthcare team
- liaises within the care team to promote best outcomes.

Spiritual care practitioner [53,54]

- may also be known as a spiritual adviser or pastoral carer
- supports the person and their family in talking about spiritual matters
- reflects with the person about their life and helps them search for its meaning, if appropriate
- helps a person to feel hopeful and develop ways to enjoy your life despite the illness
- may organise special prayer services and religious rituals, if appropriate
- connects a person with other members of your faith
- may discuss emotional issues, as many are trained counsellors.

Roles for other allied health professions are emerging as services respond to client needs and the evidence base for involvement of allied health in palliative care expands. New roles in support of palliative care needs are also emerging in the area of complementary and alternative therapies. Complementary therapies are widely used in the Australian community and they are often adopted by palliative care patients. Several specialist palliative care services now offer a range of complementary therapies for their patients, and for their patients' families and carers. Most commonly these can include massage, aromatherapy, relaxation, meditation, and acupressure.

1.9 Formalised scope of allied health practice in palliative care

In Australia, occupational therapy is the only allied health profession to have a position paper relative to the profession and palliative care. [63] Therefore Occupational Therapy Australia might be instrumental in future efforts to expand understanding of palliative care among allied health professions.

APA has published a [Position Statement on the scope of practice](#) of physiotherapists which does not refer explicitly to palliative care. It does, however, emphasise that physiotherapy is concerned with maximising quality of life and developing, maintaining, and restoring movement and functional ability through the lifespan.

'This includes providing services in circumstances where movement and function are threatened by ageing, injury, pain, diseases, disorders, conditions or environmental factors. Functional movement is central to what it means to be healthy. (Physiotherapy) is concerned with identifying and maximizing quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation. This encompasses physical, psychological, emotional, and social wellbeing.' (page 2) [84]

Emerging areas of practice in the field of speech-language pathology are communication and dysphagia management as patients approach end of life. [78-83]

Potential challenges for speech pathologists becoming involved in palliative care include the impact of working with people who are dying, limited professional preparation, ongoing education constraints, and legal and ethical considerations. [78,80,82,83] These challenges are likely to be shared by other allied health professions.

1.10 The palliative care team

Allied health professionals work with people with life-limiting illnesses in a wide variety of settings, including; community health, aged care, community rehabilitation, outpatient clinics, acute care, tertiary rehabilitation centres, day hospice, hospice and inpatient palliative care units. [9-12,18,63]

Palliative Care Australia and the Cancer Council include the following professions as part of the allied health palliative care workforce: art and music therapists, grief and bereavement counsellors, occupational therapists, pastoral care workers, personal care workers, pharmacists, physiotherapists, psychologists, social workers, speech pathologists, and spiritual care practitioners. [3,49,85] In the acute hospital setting, it is preferable for allied health staff to be specifically designated as part of the palliative care team, rather than a rotation. [86] The professional mix of a multidisciplinary palliative care team may vary depending on the skills and training of individual team members and resources.

If patients with terminal conditions have access to allied health services, they are more likely to maintain their function, wellbeing, and quality of life for longer, with less need for costly admissions and interventions from the health system. [12]

Evidence for the value of physiotherapy in palliative patients is emerging, [87,88] yet not all patients are referred. [71,88] Referrals to allied health for end-of-life or palliative care may depend on GP, nurse, or specialist palliative care knowledge of or experience with allied health. [88] Rehabilitation-in-reverse, where a person patient is

rehabilitated through every step of his/her physical decline towards death, features in the literature. [88]

A Queensland study of the role that AHPs play in the care of complex conditions in older people, found that older people appreciated access to allied health services particularly if Medicare funding was available. [89] The community nurse was pivotal to the coordination of allied health service provision highlighting the importance of coordination of care for this population. Although allied health and GP co-location was not essential to good multidisciplinary care, the capacity for care coordination and mechanisms for timely referral and professional communication were.

A network mapping study of palliative care delivery in a remote region of NSW found specialist palliative care services and residential aged care facilities had the most practice connections and allied health the least. [90] Allied health involvement was defined by their discipline and in response to needs. This suggests potential for improved integration of allied health through enhanced relationships with existing care networks in rural settings.

1.11 Settings of allied health practice in palliative care

Allied health professionals may care for people approaching the end of their life in a variety of settings. These include the person's home; in hospitals (inpatient, outpatient and sub-acute services); hospices; private practices; specialist clinics; aged care facilities; and residential organisations for people living with severe mental illness or severe disabilities. [3,9,11,12]

1.12 Funding of allied health services in palliative care

There are no direct Medicare benefit schedule items specifically for palliative care in the community setting except for specialist palliative care. [23,91] For people with complex needs allied health services are frequently accessed through the Chronic Disease Management Medicare items.

1.13 Allied health education in palliative care

Recognition of the importance of allied health in palliative care has led to an increased emphasis on specific education to support their involvement.

1.13.1 Formal education in palliative care

In 2013, the European Association for Palliative Care (EAPC) [92] outlined agreed levels of education for palliative care health professionals :

- **Palliative care approach**

A way to integrate palliative care methods and procedures in settings not specialised in palliative care. Should be made available to general practitioners and staff in general hospitals, as well as to nursing services and nursing home staff. May be taught through undergraduate learning or through continuing professional development.

- **General palliative care**

Provided by primary care professionals and specialists treating patients with life-threatening diseases who have good basic palliative care skills and knowledge. Should be made available to professionals who are involved more frequently in palliative care, such as oncologists or geriatric specialists, but do not provide palliative care as the focus of their work. Depending on profession, may be taught at an undergraduate or postgraduate level or through continuing professional development.

- **Specialist palliative care**

Provided in services whose main activity is the provision of palliative care. These services generally care for patients with complex and difficult needs and therefore require a higher level of education, staff, and other resources. Specialist palliative care is provided by specialised services for patients with complex problems not adequately covered by other treatment options. Usually taught at a postgraduate level and reinforced through continuing professional development.

Few allied health courses in Australia include palliative care concepts to any major degree, with little standardisation in the content or the teaching methods. [63]

Available courses intended for allied health and other professions include:

- The [Palliative Care Curriculum for Undergraduates \(PCC4U\)](#) Project. PCC4U provides evidence-based student and facilitator learning resources: online learning modules, online learning and teaching resources, learning and teaching support, and guidance for including palliative care in undergraduate curricula.
- A free online program for undergraduates - [Interprofessional Education in Aged Care \(IPEAC\)](#) Developed by aged care providers Brightwater Care Group from Western Australia and Helping Hand in South Australia this program includes the IPEAC Toolkit to guide residential aged care staff in conducting an interprofessional student placement at their facility. It uses learnings and experience from a research project specifically designed to evaluate their benefit in these settings. Students from all health disciplines can be involved.
- Face-to-face unit of study offered by James Cook University '[Allied Health Interventions for Palliative Care](#)'. Available only to students enrolled in the Postgraduate Certificate of Allied Health Sciences and Master of Occupational Therapy.
- An [Online Learning Module for Nurses and Allied Health Professionals](#) (2012) and [Learning Guide for Nurses and Allied Health Professionals](#) (2015) developed by PEPA. PEPA also offers [clinical workforce placements](#) of up to four days with a specialist palliative care service.
- [Advance Care planning Australia offers educational programs](#) (online modules, webinars, educational workshops) which range from an introduction to advance care planning to more specialised courses for professionals.

1.13.2 Self-directed or informal education

Without postgraduate training, allied health professionals may feel unprepared for deterioration and death of patients approaching the end of their life. Peer support from multidisciplinary team members and self-directed learning can foster a better understanding of disease processes and clinical presentations and the development of new skill sets to help allied health professionals to work more confidently with palliative care patients.

A number of tertiary-level courses and eLearning education resources in palliative care are available, and many of these can be used to contribute to CPD requirements. Access to a range of courses is facilitated by [CareSearch](#) and [palliAGED](#).

1.13.3 International education

The European Association of Palliative Care (EAPC) has established the [EAPC taskforce on education for physiotherapists in palliative care](#) which is working towards a 'global' definition of physiotherapy in palliative care. The EAPC Task Force on Education for Psychologists in Palliative Care was initiated in 2010. [93] In 2018, it was suggested that palliative psychology is an emerging specialty. [94]

1.13.4 Allied health palliative care support groups/special interest groups

A growing number of initiatives support the growing interest of allied health professionals in palliative care. Establishment of these groups also suggests a growing recognition of the value of allied health within palliative care and a potential for further contribution not only in care provision but in palliative care policy and research.

- Australian Allied Health in Palliative Care (AAHPC) is a group developed to facilitate and promote research and to be a voice to promote and raise the profile of allied health in palliative care.
- Australian Physiotherapy Association (APA) members can join the national or state branch of [Cancer, Palliative Care and Lymphoedema Special Interest Group](#) for peer support, educational events and information, and access to a [Facebook group](#).
- The World Confederation for Physical Therapy (WCPT) hosts a subgroup - [International Physical Therapists for HIV/AIDS, Oncology, Hospice and Palliative Care \(IPT-HOPE\)](#).
- Occupational Therapy Australia: Victorian Oncology & Palliative Care Interest Group aims to support OTs working in Oncology & Palliative Care, through maintaining and further developing a group that provides a range of professional development, research and networking opportunities.
- The [Palliative Care Social Workers Practice Group](#) is a group established to provide mentoring, support, information and resource sharing for social workers working in hospices or palliative care situations.
- [Oncology Social Workers Australia](#) is committed to fostering the professional development of social workers in end-of-life care (subscription required).
- The Australian Psychological Society (APS) [Psychologists in Oncology](#) group is open to APS members and non-members.
- Speech Pathology Australia website hosts information about [special interest groups](#) such as SPECS, Speech Pathology Head and Neck Cancer Google Group and state-based dysphagia interest groups.
- The [Palliative Rehabilitation Facebook page](#) allows sharing of information amongst people with an interest in palliative rehabilitation.

1.14 Allied health and policy and research

Recognition of the role of allied health in palliative care by peak organisations such as Palliative Care Australia (PCA) [3] suggest the potential for allied health to contribute to policy development in this area. The Position Paper of the Occupational Therapy Australia [63] might be regarded as an important step towards such involvement. With many allied health training courses including the role of evidence and evidence-based practice in the formal curriculum, allied health professionals are likely to be well skilled to contribute in this area.

Research in palliative care is emerging as an activity in allied health practice. Research can be used for evaluation or assessing resources and inform the creation of new programs, practice frameworks and policies. To deliver best care that responds to an evolving context within available resources, research can indicate the interventions that are effective and cost-effective, how they work and which models of care are best. Hospice UK's publication 'Research in palliative care: Can hospices afford not to be involved?' [95] recommends a three-level framework for research activity i.e. 1) research awareness amongst staff, 2) engagement in external research projects, and 3) undertaking research. Ways to achieve this and useful tools to help those wanting to conduct research on palliative care have been outlined in UK hospice research and an article for occupational therapists. [96,97]

The Australian Association of Social Workers, Australian Physiotherapy Association, Australian Psychological Society, Occupational Therapy Australia, Speech Pathology Australia support their members participating in evidence-based research from which the profession can draw insights. [98-102] Research specific to the palliative care context is sparse.

Specialist areas of research are emerging and will inform palliative care practice. (e.g. bereavement practices, swallowing and routes of medication administration, breathlessness and functional decline). [54,66,78-80,82,103-110]

Conclusion

Allied health professionals comprise a significant proportion of the Australian and global health workforces. While peak organisations have been established to represent allied health professionals, terminology within available literature suggests that many identify with an individual profession rather than the collective 'allied health' term. Lack of consensus with respect to professions recognised under the term allied health and variation in core skills are likely contributing factors to this. Application of varied definitions of allied health also renders comparison of available data collections difficult and affects data usefulness. With respect to engagement, this likely means that efforts to collaborate will need to target individual disciplines and respond to specific skill sets, and where possible include data collection.

The role of allied health in palliative care is recognised by the national peak body Palliative Care Australia and has been described in the literature for individual professions. However, inclusion of palliative care in undergraduate curriculums and support for upskilling of qualified allied health professionals is needed. This support should include consideration of the role of AHAs within residential aged care facilities. Improved data collection on supply and demand for allied health services across settings and in the palliative care context is also needed to inform future planning. The limited availability of MBS funding streams for the large number of allied health professionals operating in the private sector may be a barrier to greater involvement. Finally, support for improved integration of allied health professionals into palliative care teams and earlier referral for services is also likely to encourage increased engagement with palliative care. Many of these findings represent opportunities to increase awareness and support upskilling and networking among allied health professionals specifically and across palliative care teams more generally.

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