Identifying the Major Issues of Rural Osteopathic Practice from the Practitioner's Perspective

Sabine Moritz

BSc. Clinical Sciences

Dr. Annie Carter

MBBS, Grad.Dip.Occ.Health, BA (Hons), Grad.Dip.Tert.Ed.

Victoria University

ABSTRACT

Introduction

The lack of appropriate healthcare services in rural areas has been well documented. As osteopaths are primary care practitioners, they can play a significant role in primary health care in geographic areas where there is a shortage of health care practitioners. Until now, there has been no research exploring the background of rural osteopaths in Australia and the specific issues of rural osteopathic practice. The aim of this research was to identify the major issues as described by rural osteopathic practitioners themselves. A subsidiary aim was to explore whether there was an association between a rural background and a rural osteopath's choice to practice in a rural area.

Methods

The RAOPS (Rural Australian Osteopathic Practitioner's Survey) questionnaire used to gain the information was based on issues identified by previous research into other rural health providers. The questionnaire used a number of closed and open-ended questions. The osteopaths addresses were accessed via the Australian Yellow Pages Online. Names and addresses were recorded and then compared to a list of postcodes of regions with a population of less than 100,000. For the purpose of this research, osteopaths were classified as rural if they were practicing in an Australian postcode area with a population of less than 100,000. Two hundred and fifty six questionnaires were sent to rural osteopaths by postal mail, together with an explanation of their purpose, a guarantee of confidentiality, and a reply-paid envelope. The research had received approval from the Victoria University Ethics Committee.

Results

There were only 20% of rural osteopaths in the 20-29 age groups, which was 17% lower than the general osteopathic population, and nearly 20% lower than that of the rural allied health professionals (AHPs). There were 13% more male respondents, and they were on average much older than their female counterparts. Overall, 48% of the rural osteopaths sampled had a rural background before commencing osteopathic studies. Over half (52%) had both a rural primary and rural high school background. Nearly half (48%) of the rural osteopaths based their choice to work in the country on lifestyle factors. Another 25% cited career opportunities, family/social networks, environmental, and financial issues as reasons. Over a third (35%) of the rural osteopathic workforce has worked in rural areas for less than 5 years, with another 22% that have been practising in rural areas for less than 10

years. Over 53.3% had intended to work in a rural area after finishing their osteopathic studies. Overall, 73% of rural osteopaths intend to keep working in a rural area as an osteopath indefinitely, with another 11.7% intending to keep working in a rural area for the next 5-20 years. Over 83% of rural osteopaths believe that there is a greater need for osteopaths in rural areas, with the explanations including that rural areas are underserved by osteopaths, they felt overworked/burnt out, patients travelling long distances due to lack of osteopathic services, and the general shortage of osteopaths in Australia. The five major advantages of rural osteopathic practice were sense of being needed, seeing a variety of issues, cost of living, relying on own skills, and having a personal knowledge of the patient. The availability of locums was seen as a disadvantage by 63% rural osteopaths. There were only two categories, "seeing a variety of conditions" and "using a range of skills", that had no disadvantages recorded.

Conclusion

Findings indicate that rural osteopaths are more likely to be male, and generally older than their counterparts in the urban areas, as well as most other rural AHPs. Female rural osteopaths are on average much younger than their male counterparts, are more likely to be recent graduates, and have a higher rate of having a rural background (58% versus 41%). The rural osteopathic workforce is still relatively inexperienced in rural osteopathy, with over 57% of rural osteopaths having been in rural practice for less than 10 years. Although 48% of rural osteopaths had a rural background, they indicated that it was not a major contributor for their decision to work in a rural area. As 73% of the participants indicated that they intended to stay in rural areas as osteopaths, it can be assumed that they are comfortable and committed to being part of the rural healthcare workforce. Professional satisfaction in the variety of work, autonomy of practice, social and personal satisfaction, the feeling of doing an important job, and the continuity of care given to patients were all seen as benefits of rural practice.

Keywords

Rural, osteopath, osteopathy, osteopathic, allied health, allied health professionals, rural issues, rural background, healthcare, physical therapy, manipulative therapy

Identifying the Major Issues of Rural Osteopathic Practice from the Practitioner's Perspective

INTRODUCTION

The imbalance between rural healthcare needs and the provision of appropriate services is well documented (1,2). The main focus of many national rural health workforce programs has been on the supply of medical practitioners. This has been partly a response to rural communities themselves, who have considered doctors to be their most urgent need, and is partly due to the central role of doctors in primary health care, and is also due to the political influence of the medical profession (1). In recent years the Australian government has turned its attention to rural workforce shortages in allied health professions (AHPs) (1,2).

The total number of AHPs in Australia has increased more rapidly than the numbers of medical or nursing practitioners (3). For example, between 1991 to 1996, the numbers of chiropractors and osteopaths increased by 29.1%, while medical practitioners increased by 13.4% and nurses by 0.5% (3). Overall, according to figures used by Services for Australian Rural and Remote Allied Health (SARRAH) (4), at least 13% of the health workforce consists of AHPs (4). Specific information about rural AHPs is limited (4), and this especially applies to the Osteopathic profession.

Osteopaths are primary care practitioners, and are trained to recognise conditions that require medical referral, so they can play a significant role in primary health care in geographic areas where there is a shortage of practitioners (5). Also Osteopaths have legal registration and are included in government-administered compensation schemes for work-related and traffic accident injuries (5). Furthermore in 2004 the Australian government launched the new Medicare Plus package which among other things, provided some financial support to the public for osteopathic treatment of chronic conditions as determined by their GP (6).

Research about rural issues for AHPs, as well as medical doctors, has shown that some of the positive attributes of rural practice include multi-skilling opportunities, practical skills development, the variety of work, the ability to be creative and flexible, closer professional relationships, reduced living and practice expenses, greater community spirit, and lifestyle (4, 7, 8, 9). While some of the negative

attributes of a rural healthcare practice include professional isolation, lack of practitioner support with complicated problems, poor access to training and education, difficulty in getting associates and locums, and lack of public awareness of health professional roles (4, 7, 8, 9).

Research into rural practice issues from other areas in the world, shows that one way of increasing the numbers of health care practitioners in rural areas, is to preferentially select students with a rural background. Such students are more likely to choose a voluntary rural placement, select small towns in which to train, and practice in rural areas than urban-raised students (10, 11).

So far, there has been no research investigating the background of rural osteopaths in Australia and the issues of rural osteopathic practice. The aim of this research was to 1) identify the major issues of rural osteopathic practice as described by practitioners themselves, and 2) explore whether there was an association between a rural background and a rural osteopath's choice to practice in a rural area. A questionnaire, using a range of closed and open-ended questions, based on issues identified by research into other rural health providers questions was developed (1, 4, 7, 8, 9, 10, 11, 12, 13). The questionnaire also explored the background (rural or urban) of the practitioner.

Where possible, results from the recent census surveys of the general Australian osteopathic profession (14) and those of the rural Australian AHPs (4) were used to compare with results obtained from the rural osteopaths.

METHODOLOGY

The aim of this research was to identify the major issues of rural osteopathic practice and, to explore whether there was an association between a rural background and a rural osteopath's choice to practice in a rural area.

The osteopaths were accessed via the Australian Yellow Pages Online. Names and addresses were recorded and then compared to a list of postcodes of regions with a population of less than 100,000 (15). For the purpose of this research, osteopaths were classified as rural if they were practicing in an Australian postcode area with a population of less than 100,000. Using this criterion, 256 different addresses of rural osteopaths were satisfying the criterion obtained from the 1226 osteopathic addresses found in the Australian Yellow Pages Online. Thus almost 21% of the listed osteopaths were classified as rural. Some osteopaths have multiple addresses listed and it was decided to send a questionnaire to each work place to increase the rate of return.

The questionnaire RAOPS (Rural Australian Osteopathic Practitioner's Survey) (Appendix A) was used for data collection, and was sent to all osteopaths fitting the "rural" criterion. Questionnaires were sent to rural osteopaths by postal mail, together with an explanation of their purpose, a guarantee of confidentiality, and a reply-paid envelope. The research had received approval from the Victoria University Ethics Committee. The questionnaire used an array of closed and open-ended question, as well as tick-a-box method of ratings and then converted to percentages.

The closed-ended questions (tick-a-box/circle-the-answer) investigated:

- General demographics:
    - Age
    - Gender
    - Country of birth
    - Year of qualification
    - Country and state/territory of graduation from osteopathic studies
- Their rural/urban backgrounds
- Their influences to work in rural areas
- How they perceived they obtained most of their rural osteopathic experience
- If they believed that there was a greater need for osteopaths in rural areas

The data from the closed-ended questions were analysed using Microsoft Excel, and converted into percentages where applicable. Many of these questions had "other" as an option with space for comments. These comments were clustered into themes, which were tabulated (Appendix B).

The open-ended questions investigated:

- The amount of time spent in rural areas after high school if they did not commence osteopathic study immediately after leaving school
- What they did during this time
- The length of time spent working as an osteopath in rural areas
- The length of time they intended to keep working as an osteopath in rural areas
- If they had responded in the affirmative to the closed-ended question about a greater need for osteopaths in rural areas what their reasons were

The responses to the open-ended questions were clustered into themes, which were then tabulated (Appendix B).

The issues of rural osteopathic practices were investigated by a tick-a-box method of ratings, and were sub-divided into Important issues, Advantages and Disadvantages on separate pages. The data from these questions were analysed using Microsoft Excel, and converted into percentages (Appendix B).

Important issues were rated as "Very Important", "Important", "Neutral", "Unimportant", and "Very Unimportant". Predominantly, the responses for each of the issues were at one end of the scales, and thus to make the comparisons of the results clearer, the "Very Important" and "Important" were combined, as well as "Unimportant", and "Very Unimportant". The Important issues investigated included:

- Income
- Availability of annual and other leave
- Access and availability to:
    - Community facilities/shopping
    - Social/family networks
    - Health care for their own needs
    - The latest technology
    - Theatre/concerts

    - Other health and human services
    - Continuing osteopathic education
    - Non-osteopathic education
- Opportunities for their:
    - Children (environment, primary and secondary)
    - Spouse/partner
- Professional needs

The Advantages and Disadvantages of rural osteopathic practice were presented in the same format. Advantages were rated as ”Great Advantage”, “Advantage”, “Neutral” and “Not Applicable”. Disadvantages were rated as ”Great Disadvantage”, “Disadvantage”, “Neutral” and “Not Applicable”. Overwhelmingly, responses for each of the issues were at one end of the scales, and thus to make the comparisons of the results clearer, the “Great Advantage” and “Advantage” were combined, as were the “Great Disadvantages” and “Disadvantages”. This part of the questionnaire included issues such as:

- Sense of belonging
- Sense of being needed
- Sense of professional independence
- Sense of Community
- Having a lead role in the Community
- Using a range of skills; relying on their own skill
- Having personal knowledge of the patient
- Seeing a variety of conditions
- Income
- Cost of living
- Number of hours worked
- Availability of locums
- Gaining respect of rural and urban colleagues, other healthcare practitioners (incl. medical)

Results were compared, where possible, with results from the recent census of the general Australian osteopathic profession (14) and those of the rural Australian AHPs (4) (Appendix B).

RESULTS

The most recent comparable data about osteopathic service locations is from the Australian Bureau of Statistics (ABS) survey in the 1997-1998 financial year (16). Four hundred and seventy-five practice locations were surveyed, and 359 (75.6%) were located in capital cities and 116 (24.4%) were located in areas other than capital cities (16). The data of the ABS classification was very similar to the rural osteopath classification data, where almost 21% of the listed osteopaths were classified as rural (24.4% versus 20.9%).

A total of 60 completed surveys were received. This is a response rate of 23.4%. All completed surveys have been analysed and presented.

Demographics of Participants

Ages

Participants were asked to circle their age range. These have been presented in two groups for easier comparison to the general osteopathic population (14) and other rural AHPs (4).

Age Group (in years)	Rural Osteopaths Percent (%)	General Osteopathic Population Percent (%)*
20-24	20	37.1
25-29		
30-34	40	30.9
35-39		
40-44	18.3	19.4
45-49		
50-54	21.7	12.7
55-59		
60-64		
65+		

Table 1 – Ages of Rural Osteopaths compared to the General Osteopathic population *(14)

Age Group (in years)	Rural Osteopaths Percent (%)	Rural& Remote AHPs Percent (%)†
20-24	20	39.4
25-29		
30-34	18.3	13.6
35-39	23.3	26.1
40-44		
45-49	26.7	15.9
50-54		
55-59	10	4.2
60-64		
65+	1.7	0.2

Table 2 – Ages of Rural Osteopaths compared to the Rural and Remote AHPs † (4)

There were only 20% of rural osteopaths in the 20-29 age groups, which was 17.1% lower than the general osteopathic population, and nearly 20% lower than that of the rural AHPs. However, 40% of rural osteopaths were in the 30-39 age group, compared to 30.9% of the general osteopathic population. The numbers of respondents in the 40-49 age groups were very similar between the general and the rural osteopathic population, with only a 1% difference.

The percentage of Osteopaths practicing in rural areas of Australia who were more than 50 years of age was 8.9% higher than the percentage of the same age groups in the general osteopathic profession (21.7% versus 12.7%). Rural osteopaths are generally older when compared to the general osteopathic population. The exception is in the 40-49 year old group, where the results are similar. Over thirty-eight percent (38%) of rural osteopaths were aged above 45 years of age, compared to 20.3% of AHPs aged above 45. Consequently, it appears that rural osteopaths are generally older than their counterparts in the urban areas, as well as being older than the rural and remote AHPs.

Gender

Sex	Rural Osteopaths Percentage (%)	General Osteopathic Population Percentage (%)*	Rural and Remote AHPs Percentage (%)†
Male	56.7	46.2	15.8
Female	43.3	53.8	84.2

Table 3 – Gender of Rural Osteopaths compared to the General Osteopathic Population and Rural and Remote AHPs *(14), † (4)

The percentage of male rural osteopaths was 13.3% higher than their female counterparts, and 10.5% higher than the males in the general osteopathic population, and 40.9% higher than rural and remote AHPs.

Age Range and Gender

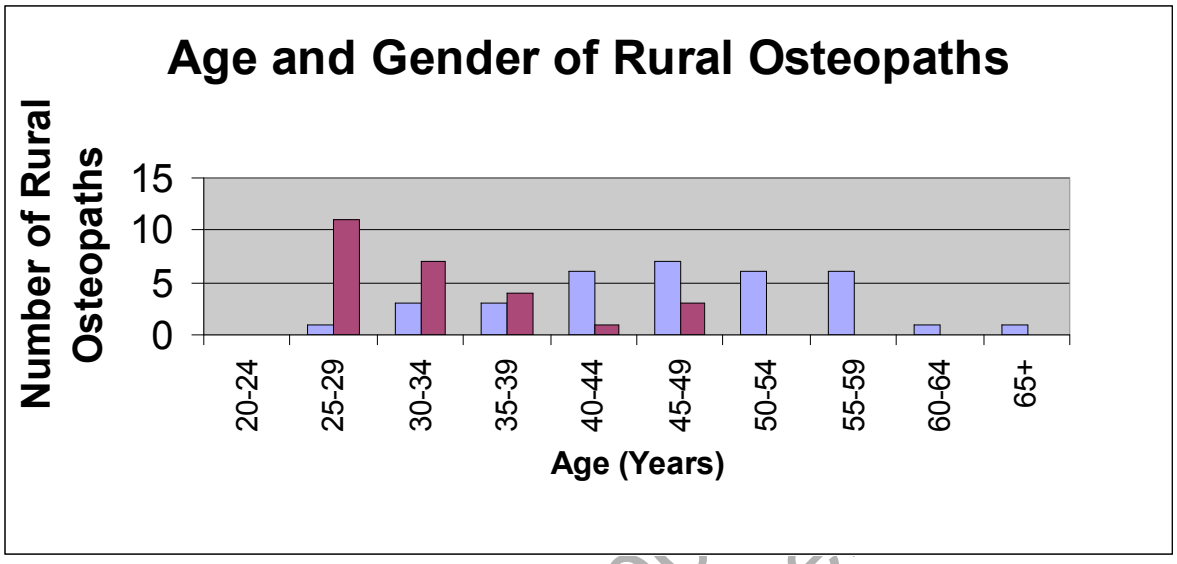

Figure 1 – Age Range and Gender of Rural Male and Female Osteopaths

As the graph above clearly demonstrates, male rural osteopaths are on average much older than their female counterparts. Three percent of males were aged between 25-29 years of age, compared to 42% of females. There were no female rural osteopaths in this sample who were older than 49 years.

Years of graduation of rural osteopaths

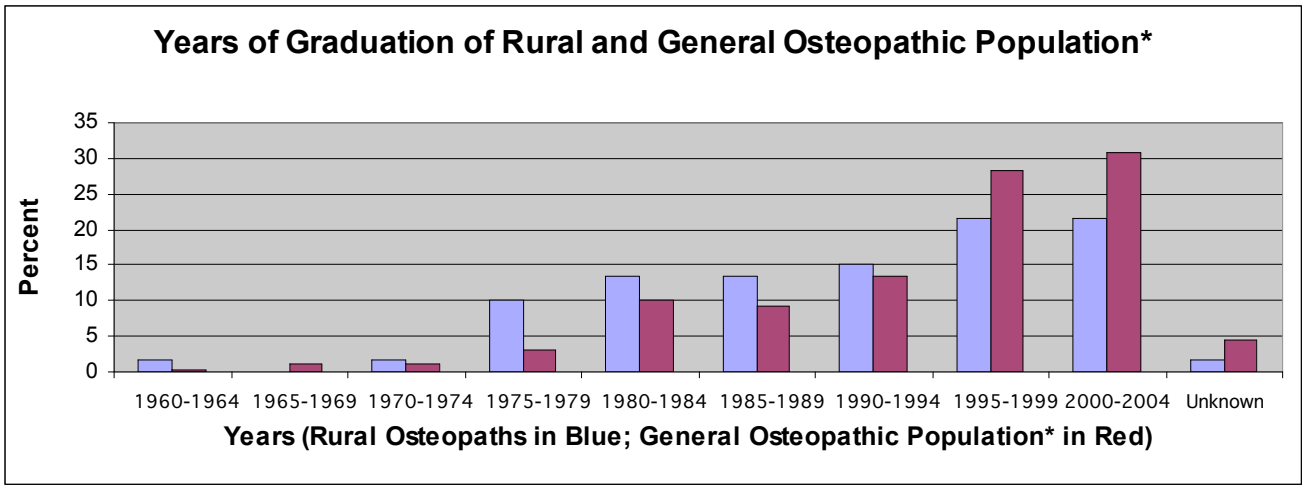

Figure 2 – Years of Graduation of Rural and General Osteopathic Population *(14)

The bar chart shows that overall there have been considerately more osteopaths graduating from 1995 onwards than in the previous years, but a smaller percentage are working in rural practice.

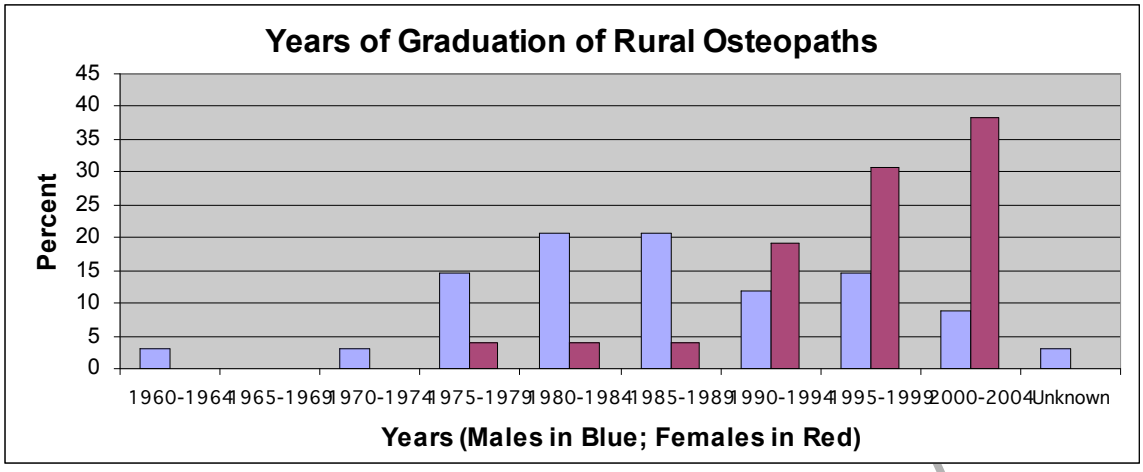

Figure 3 – Years of Graduation of Rural Male and Female Osteopathic Population

In bar chart above, there is a definite trend that in the rural osteopathic population there were more females who were recent graduates compared to the male respondents. It is not possible to compare with the overall general osteopathic population as the data is not available.

Rural background before commencing studies as an osteopathic student

Rural Background	Rural Osteopathic Population		
	Total Percent (%)	Male Percent (%)	Female Percent (%)
Yes	48.3	41.2	57.7
No	51.7	58.8	42.3

Table 4 - Rural Background before commencing Studies as an Osteopathic Student

Overall, 48.3% of the rural osteopaths sampled had a rural background. As there is no comparative data available it is not possible to compare this figure with the urban osteopathic population. The percentage of female rural osteopaths, who have reported a rural background before commencing osteopathic, studies is 17% higher than their male counterparts (58% versus 41%). It is impossible to comment on the general osteopathic population as the gender breakdown is unavailable.

Type of rural background of rural osteopaths

It was found that of the rural osteopaths who reported a rural background, over half (52%) had both a rural primary and rural high school background. Another 17% had a rural primary and rural high school background as well as other experience such as rural higher education and work. Thus, at least 69% of the rural osteopaths with a rural background had gone to both primary and high school in a rural area. A higher percentage of females had a rural primary and rural high school background (60%), when compared to the male rural osteopaths (43%).

Factors that influenced the rural osteopath's decision to work in a rural area

The responses, in decreasing order, were;

- Lifestyle – 48%
- Other (space for comments – see below) – 25%
- Own rural background – 13%
- Spouse's rural background – 9%
- Rural clinical experience – 5%
- Unknown – 1%

Overall, 25% of rural osteopaths said that there were "other" reasons for choosing to live in rural areas, with many respondents mentioning several reasons. When all these responses were grouped, four major categories emerged:

- Work/Career
- Family/Social
- Environmental
- Financial

Most comments fell into the first two categories.

The length of time rural osteopaths worked in a rural area

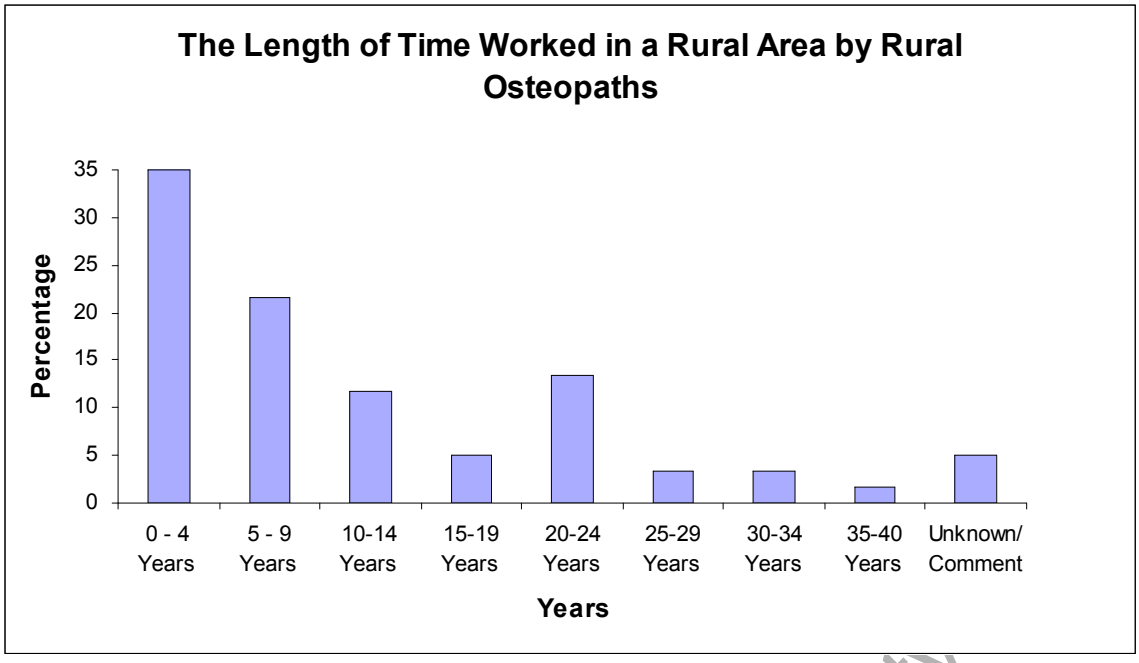

Figure 5 – The Length of Time Spent Working in a Rural Area by Rural Osteopaths

Overall, 57% of respondents have been practising in a rural area for less than 10 years, and another 35% had been in the rural workforce for less than 5 years.

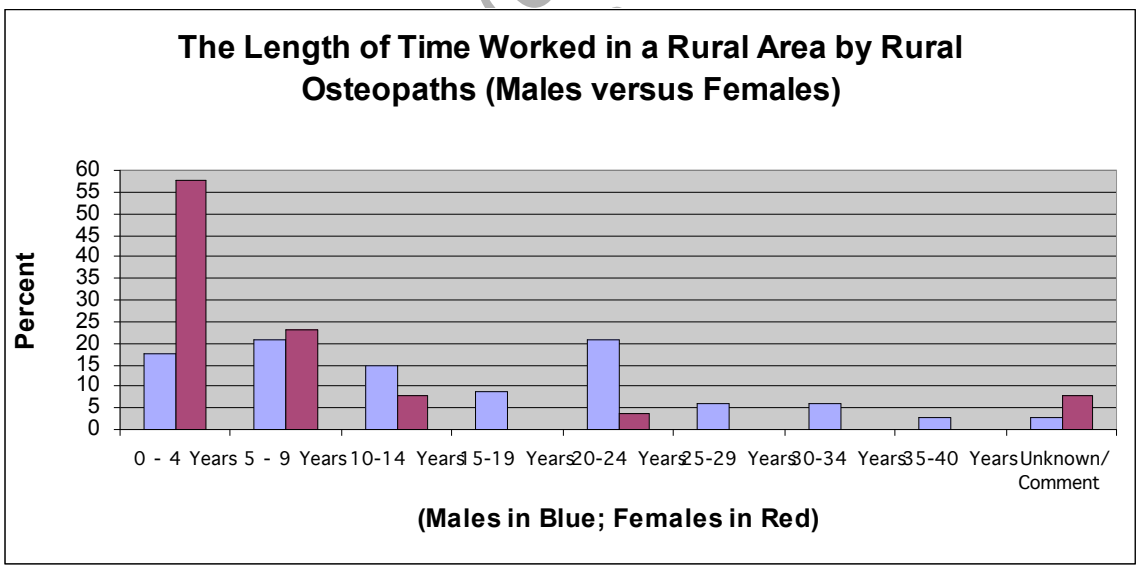

Figure 6 – The Length of Time Spent Working in a Rural Area by Male and Female Rural Osteopaths

More than 80% of female rural osteopaths have been working in rural areas for less than 10 years, with a total of over 88% having worked in rural areas for less than 14 years.

Intention to work in a rural area

Intention to work in a rural area	Percentage (%)	Male %	Female %
Yes	53.3	55.9	50
No	43.3	41.2	46.1
Indifferent	3.3	2.9	3.8

Table 5 – The Intention of Rural Osteopaths to work in a rural area

Over half of the respondent (53.3%) had intended to work in a rural area after finishing their osteopathic studies. A slightly greater percentage of males intended to enter the rural osteopathic workforce than females (55.9% versus 50%).

The amount of time intended to keep working in a rural area as an osteopath

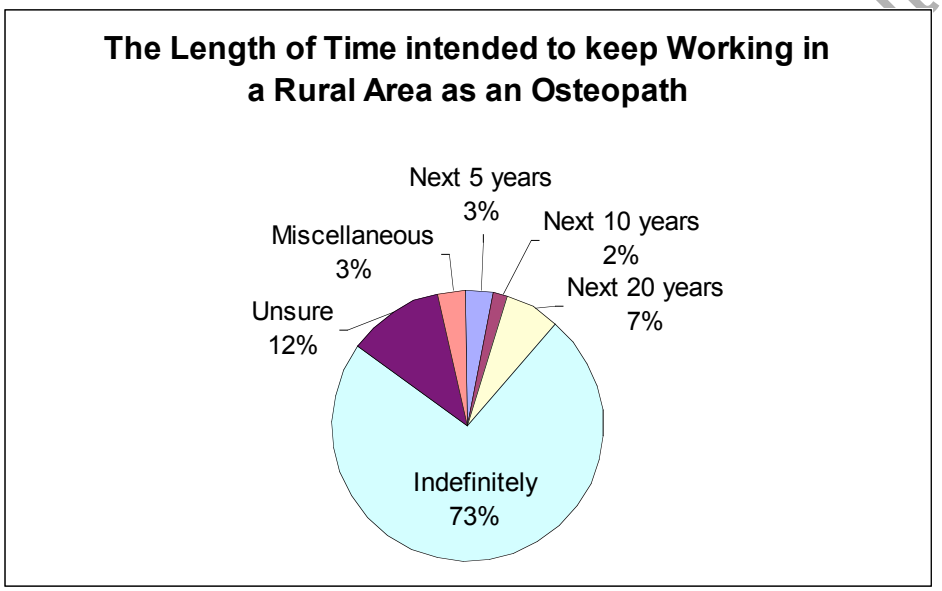

Figure 7 – The Amount of Time Intended to Continue Working in a Rural Area as an Osteopath

Overall, 73% of rural osteopaths intend to keep working in a rural area as an osteopath indefinitely, with another approximately 12% intending to keep working in a rural area for the next 5-20 years. Only 12% were unsure about how long they would continue to work in a rural area.

Need for osteopaths in rural areas

Belief that there is a greater need for Osteopaths in Rural Areas	Total %	Males	Females
Yes	83.3	79.4	88.5
No	11.7	15.7	7.7
Yes and No	1.7	2.9	0
Don't know	1.7	2.9	0
Unknown	1.7	0	3.8

Table 6 - Need for Osteopaths in Rural Areas

Over 83% of rural osteopaths believe that there is a greater need for osteopaths in rural areas. A slightly higher percentage of female rural osteopaths believe that there is a greater need for rural osteopaths when compared to the males (88% versus 79%) (N = 23 versus N = 27).

Why rural osteopaths believe that there is a greater need for osteopaths in rural areas

Participants were asked to comment about why they believed that there was a greater need for osteopaths in rural areas. These open-ended responses were analysed and areas of overlap were grouped together. The following categories emerged:

- The ratio of patient population to osteopaths is high
- Long waiting times for appointments
- Patients travel long distances to see an osteopath
- Insufficient numbers of other primary health care practitioners

How practitioners achieved their rural osteopathic experience

How rural osteopathic experience was achieved	Percentage (%)
Owning your own rural practice	59.7
As an associate	15.6
Own Rural Background	9.1
Other	9.1
As an osteopathic student	2.6
Unknown	2.6
As a locum	1.3

Table 7 – Achievement of Rural Osteopathic Experience

Rural osteopathic experience (60% of respondents) is predominantly obtained once an osteopath owns his/her own practice. Nearly 16% believe that they obtained most of their rural osteopathic experience as an associate. This refers to the business relationship between the principal osteopath and the other osteopaths employed by them. Only 2.6% believe that they received most of their rural osteopathic experience as a student.

The Important Issues in Rural Osteopathic Practice

Predominantly, the responses for each of the issues were at one end of the scales, and thus to make the comparisons of the results clearer, the "Very Important" and "Important" were combined, as well as "Unimportant", and "Very Unimportant". Using this technique, there were eight categories of issues thought to be "Important" by rural osteopaths. These were in decreasing order:

- Access to social/family networks – 82%
- Opportunities for spouse/partner – 76%
- Access and availability of associates – 73%
- Access and availability of continuing osteopathic education – 73%
- Income – 72%
- Availability of annual and other leave – 71%
- Opportunities for children (environmental, primary and secondary schooling) – 71%
- Access to community facilities and/or shopping – 70%

The three lowest of the "Important" issues were the same as the three highest in the "Unimportant" issues:

- Access to latest technology ("Important" – 32%; "Unimportant" – 13%)
- Access to theatre/concerts ("Important" – 33%; "Unimportant" – 17%)
- Availability of childcare services ("Important" – 47%; "Unimportant" – 14%)

All other issues were thought to be Important by more than 55% of rural osteopaths.

Advantages and Disadvantages of rural osteopathic practice

Overwhelmingly, responses for each of the issues were at one end of the scales, and thus to make the comparisons of the results clearer, the "Great Advantage" and "Advantage" were combined, as were the "Great Disadvantages" and "Disadvantages". There were nine issues that were regarded by the participants as "Advantages" in rural practice. These were:

- Sense of being needed – 88.3%
- Seeing a variety of issues – 83.3%
- Cost of living – 73.3%
- Relying on own skills – 71.7%

- Having a personal knowledge of the patient – 70%
- Opportunities for children (environment) – 68.3%
- Using a range of skills – 66.7%
- Opportunities for children (primary) – 61.7%
- Sense of professional independence – 60.7%

The highest category in the "Disadvantages" of rural osteopathic practice was the availability of locums (63.3%). There were only two categories that rural osteopaths thought had no disadvantages. These were "seeing a variety of conditions" and "using a range of skills".

DISCUSSION

In this research, osteopaths were classified as rural if they were practicing in an Australian postcode area with a population of less than 100,000. According to this criterion, 256 addresses were considered to be rural from the 1226 addresses found in the Australian Yellow Pages Online. Consequently, 20.9% of the osteopaths were classified as rural, which is very similar to the ABS classification mentioned in the results section (24.4%).

Of the 256 questionnaires sent out for this research, 60 completed surveys were received. Although the response rate (23.4%) appears to be quite low, it is in fact higher than at first glance. This is due to multiple practice locations being listed in the Yellow Pages Online. The questionnaires were sent to 256 different addresses, not 256 individual osteopaths. It is not possible to determine the exact response rate for reasons of confidentiality.

In comparing rural osteopaths to their metropolitan colleagues, there are some differences. Rural osteopaths are generally older than their urban counterparts, with only 20% of rural osteopaths being in the 20-29 age groups, compared to 37.1% in the general osteopathic population. They were also much older than the rural and remote AHPs, with nearly double the amount of rural AHPs in the 20-29 year age group compared to rural osteopaths. This may be the result of osteopaths feeling more confident to work remotely as they get older. However, as there is no further information available, it is not possible to determine the precise reason why rural osteopaths are older than their urban counterparts as well as other rural AHPs.

The percentage of male rural and remote osteopaths was slightly higher (13.3%) than their female counterparts, and a little higher (10.5%) than the males in the general osteopathic population (14). Women dominate the total AHP workforce, with only 15% being male. There are, however, variations in the different groups of professionals which constitute this group. Radiology and audiology have higher levels of males compared to speech pathology and dietetics (4). Due to the small numbers of participants in this study, it is not possible to identify a definite trend in rural osteopaths compared to urban osteopaths, but there is a much greater male preponderance of osteopaths in the country than other health professionals. This may be related to their age, as will be discussed below.

Female rural osteopaths are on average much younger than their male counterparts. In the 25-29 years of age group, 42% were females, compared to 3% of males. No female rural osteopaths in this sample were older than 49 years. There could be various reasons to explain these differences. There are greater numbers of osteopaths graduating each year, and there are more females than male studying osteopathy. Therefore, females are more recent graduates in the overall osteopathic population.

Female rural osteopaths may also enter the rural workforce at a younger age than male rural osteopaths because they also are more likely to have a rural background (58% versus 41%). Previous research shows that professionals with a rural background are more likely to enter the rural workforce (10, 11, 17). Although women share the same concerns about professional issues as their male colleagues, women did, however, report a greater level of concern about flexible working options, family considerations and the availability of care for their children (18). However, without more specific information, it is not possible to know exactly why female rural osteopaths are so much younger than the males.

Just over 48% of the rural osteopaths sampled had a rural background. At least 69% of them had gone to both primary and high school in a rural area. As a significant amount of their schooling life had been in a rural area, they will have developed a strong social network. Research from various countries, including Australia, has shown that students who were raised in rural communities are more likely to practice in rural areas than urban-raised students (10, 11, 17). Rural students understand better the nuances and intricacies of rural life, and will be more at ease, and willing to live and work, in smaller communities (10, 11). Although it appears that a rural background may predispose health care practitioners to work in rural areas, only 13% of rural osteopaths claim that their rural background had the greatest influence on practising in a rural area. It is very difficult to ascertain whether a rural background is a relevant factor in this sample of rural osteopaths, as there are no comparisons available with the urban osteopathic population. A study by Laven et al. (17) shows that rural GPs were more likely to be male, Australian born, having had a rural home, and rural primary and secondary school education. These statistics are also reflected in the rural osteopathic profession.

Nearly half (48%) of the rural osteopaths based their choice to work in the country on lifestyle factors. In addition, career opportunities, family/social networks, environmental, and financial issues were cited by 25% of rural osteopaths as reasons. These findings were consistent with the experiences of other rural health professionals (12).

Over a third (35%) of the rural osteopathic workforce has worked in rural areas for less than 5 years, with another 22% that have been practising in rural areas for less than 10 years. The most plausible explanation for this relatively short time period, is that there has been a large increase in new graduates in recent years. With two new five-year university courses opening since 1993 in Australia (19), it is no surprise to see that larger numbers of osteopaths have been practising for shorter amounts of time. The results are consistent with the younger age of the rural osteopathic workforce, as over 21% of the rural osteopaths graduated between the years 2000-2004. Limited support, sole therapy positions and professional isolation may be unknown issues experienced by this group of rural osteopaths, but they were not explored in this study.

Over half of the rural osteopaths (53.3%) had intended to work in a rural area after finishing their osteopathic studies. A greater percentage of males intended to enter the rural osteopathic workforce than females (56% versus 50%). However, this questionnaire did not ask what their reasons were for wanting to work in rural area after finishing their osteopathic studies. Overall, 73% of rural osteopaths intend to keep working in a rural area as an osteopath indefinitely, with another 11.7% intending to keep working in a rural area for the next 5-20 years. This suggests that rural osteopaths seem to be content in rural areas, and that they are committed to being part of the rural healthcare workforce.

Over 83% of rural osteopaths believe that there is a greater need for osteopaths in rural areas. When participants were asked to explain this response, the main issues were:

- The ratio of population to osteopaths is high
- Long waiting times for appointments
- Patients travel long distances to see an osteopath
- Insufficient numbers of other primary health care practitioners

It is clear that rural osteopaths feel that as only 20.9% of osteopathic practises are located in rural areas, this is not enough to cope with the demands of rural communities. However, as the numbers of osteopaths are still so small (the Australian Osteopathic Association has just over 1000 members) it is difficult to ascertain if the shortage lies in rural areas or in the numbers of the osteopathic profession (20).

Rural osteopaths believe that rural osteopathic experience is mostly obtained once an osteopath owns his/her own practice (60%). One way to address the specific practice demands of rural osteopathy,

may be to offer osteopathic students the opportunity to experience rural placement/clinical experience. Osteopathy is not the only profession struggling with this issue. Under half (46.2%) of rural AHPs indicated that they did not have any exposure to a rural placement as an undergraduate (4). There is extensive research that demonstrates that both rural and urban students showed at least a slight increase in their desire for rural practice, after rural placement/clinical experience (8, 11). The current "buddy" programme (where osteopathic students are linked with qualified osteopaths in a mentor style relationship), may be one way that this lack of rural education will be improved (20).

It is interesting to note that access to the latest technology was rated as the lowest in important issues (32%) of rural osteopaths, and as unimportant by 13%. Technology has the ability to reduce the effects of distance and isolation, supporting the delivery of healthcare service to rural communities (4). Rural osteopaths were either not concerned about their access to the latest technology, or, other issues were seen as much more important.

The five major categories of advantages of rural osteopathic practice were:

- Sense of being needed – 88.3%
- Seeing a variety of issues – 83.3%
- Cost of living – 73.3%
- Relying on own skills – 71.7%
- Having a personal knowledge of the patient – 70%

These were very similar to the issues found by other research, where professional satisfaction in the variety of work, autonomy of practice and social and personal satisfaction were seen as benefits of rural practice, as well as the feeling of doing an important job, and the continuity of care given to patients (4,12).

In the study of AHPs in rural and remote Australia by SARRAH (4), the major factors identified as deterrents for taking up, or remaining in, rural practice are professional and social isolation. This does not appear to be the case with rural osteopaths. While they did identify professional and social support as important issues, they did not consider them to be disadvantages of rural practice.

The availability of locums is obviously an area of concern to many rural osteopaths (63.3%), but they are not the only profession struggling with this issue. Access to locum services for rural AHPs all over Australia is surprisingly low, with only 26% indicating that they had access to locum services (4).

There were only two categories, of the 22 provided, that rural osteopaths thought had no disadvantages. These were "seeing a variety of conditions" and "using a range of skills". This indicates that osteopaths do not believe that multi-skilling is a disadvantage in their rural practice. The uses of diverse clinical skills, and the requirement to be flexible in service delivery and management, are considered to be essential to practice by a wide range of rural AHPs (4).

LIMITATIONS OF THE STUDY

As the sample size was not large (60 participants; 34 males and 26 Females), the findings are not easily generalised. As anonymity was assured for the respondents and there is no information available about the non-responders, it is not possible to know that the respondent-group is representative of the entire rural osteopathic population. It is also not possible to compare many of the issues of rural osteopathic practice with the urban osteopathic practice, as the data about the latter is not available. It is hoped that similar research will be conducted in the future to ascertain the diverse issues of osteopathic practice and compare rural to urban osteopathic practice. An outcome of this research was the young age of the rural osteopathic workforce, with many being new graduates (especially females). The various issues that new graduates experience, such as limited clinical experience and self-confidence of working in rural areas, have not been explored.

There were also several deficiencies in the design of the questionnaire. The questionnaire itself was quite long (6 pages), and thus potential participants may have been deterred from answering due to time constraints. There were also ambiguities in the instructions regarding the tick-a-box arrangement of the advantages and disadvantages of rural practice.

CONCLUSION

This study aimed to explore the major issues and backgrounds of rural osteopathic practice as described by the practitioners themselves. Findings indicate that rural osteopaths are more likely to be male, and generally older than their counterparts in the urban areas, as well as most other rural AHPs. Female rural osteopaths are on average much younger than their male counterparts, are more likely to be recent graduates, and have a higher rate of having a rural background (58% versus 41%). The rural osteopathic workforce is still reasonably inexperienced in rural osteopathy, with over 57% of rural osteopaths having been in rural practice for less than 10 years.

Although 48% of rural osteopaths had a rural background, they indicated that it was not a major contributor for their decision to work in a rural area. Other factors including lifestyle were reasons given by rural osteopaths for making their choice towards living in a rural area. It is recommended that further research, particularly into this area, be undertaken.

As 73% of the participants indicated that they intended to stay in rural areas as osteopaths, it can be assumed that they are comfortable and committed to being part of the rural healthcare workforce. They did, however, identify the need for more osteopaths in rural areas.

Professional satisfaction in the variety of work, autonomy of practice, social and personal satisfaction, the feeling of doing an important job, and the continuity of care given to patients were seen as benefits of rural practice. These are well supported by numerous other studies about healthcare practitioners. The lack of locums does not only concern rural osteopaths. Recommendations for further research include investigating the factors that would encourage locums to fill these positions.

REFERENCES

1. Humphreys J., Hegney D., Lipscombe J., Gregory G. & Chater B.; Whither rural health? Reviewing a decade of progress in rural health; *Australian Journal of Rural Health*, 2002, 10, pg 2-14
2. Lowe S. & Lawrance R.; Allied health and the medical workforce – Teamwork integration and sustainability; 8th National Health Conference; 10-13 March 2005 (Alice Springs); *National Rural Health Alliance Inc.*
3. National Rural Health Alliance (NRHA) Submission to the National Review of Nursing Education, August 2001
4. Services for Australian Rural and Remote Allied Health (SARRAH); A study of allied health professionals in rural and remote Australia; 2000
5. Australian Osteopathic Association (AOA) – www.osteopathic.com.au/about.htm; - Date accessed: 13/10/2005
6. Australian Osteopathic Association (AOA) – www.osteopathic.com.au/index.htm - Date accessed: 13/10/2005
7. Baker J.; Why start a clinic in the country? *Ostium (The News Magazine of the Australian Osteopathic Association)*; Autumn Edition 2002, pg 8
8. McDonald J., Bibby L. & Carrol S.; Recruiting and retaining general practitioners in rural areas: Improving outcomes through evidence-based research and community capacity-building (Evidence-Based Review; Final Report); *University of Ballarat Victoria, Victorian Universities Rural Health Consortium (VURHC), The Department of Human Services Victoria and The Rural Workforce Agency Victoria*; October 2002
9. Thompson C.; A country practice; *Ostium (The News Magazine of the Australian Osteopathic Association)*; Winter Edition 2001, pg 7
10. Peach H.G. & Bath N.E.; Comparison of rural and non-rural students undertaking a voluntary rural placement in the early years of a medical course; *Medical Education*, 2002, Volume 36, pgs 231-233
11. Woloschuk W. & Tarrant M.; Does a rural educational experience influence students' likelihood of rural practice? Impact of student background and gender; *Medical Education*, 2002, Volume 36, pgs 241-247
12. Kamien M.; Staying in or leaving rural practice: 1996 Outcomes of rural doctors' 1986 intentions; *Medical Journal of Australia (MJA)*; Vol. 169; 21 September 1998; pg 318-321

13. Wilkinson D., Beilby J.J., Thompson D.J., Laven G.A., Chamberlain N.L. & Laurence C.O.M.; Associations between rural background and where south Australian general practitioners work; *Medical Journal of Australia*, Vol. 173, 7 August 2000, pg 137-140
14. Orrock P.J.; Osteopathic Census 2004. Unpublished Data, Australian Osteopathic Association (AOA)
15. Australian Reinsurance Pool Corporation - arpc.treasury.gov.au/content/tier_postcode.asp?NavID=7 – Date accessed: 4/11/2004

This was the only source available for the obtainment of population by postcode

16. Australian Bureau of Statistics (ABS) – AusStats 8550.0Chiropractic and Osteopathic Services, Australia.htm – Date accessed: 27/6/2005
17. Laven G., Laurence C., Wilkinson D.; Using the Australian rural background study to inform rural and remote multi-disciplinary health workforce planning research; *National Rural Health Alliance; 8th National Rural Health Conference*; Alice Springs, 10-13 March 2005
18. Richards H.M., Farmer J., Selvaraj S.; Sustaining the rural primary healthcare workforce: Survey of healthcare professionals in the Scottish Highlands; *The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy*; http://rrh.deakin.edu.au/; 2005
19. Carnell L., Nicholls B. & Gibbons P.; A study of the referral patterns of general practitioners to Osteopaths, Chiropractors, and Physiotherapists in Victoria; *British Osteopathic Journal*, Vol. XXIV 2002, pg 6-12
20. Australian Osteopathic Association (AOA) – www.osteopathic.com.au/members_executive.htm – Date accessed: 13/10/2005

APPENDIX A

INFORMATION FOR PARTICIPANTS INVOLVED IN RESEARCH OF OSTEOPATHIC RURAL PRACTICE

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study investigating possible issues of rural osteopathic practice as perceived by rural Osteopathic Practitioners. This study will involve a short questionnaire (approximately 10-15 minutes completion time), which will be examining factors such as the influences of an Osteopaths choice to practice in rural area, and if there is a need for greater numbers of Osteopaths in rural areas as perceived by rural Osteopaths.

The outcome of this survey will identify possible issues of rural osteopathic practice, as well as identifying the major influences that affect an Osteopaths choice to practice in a rural area. It will identify current gaps in the general knowledge of the rural osteopathic profession. The data from this research will be published. The adoption of an alphanumeric coding system will preserve confidentiality and will exclude any possibility of personal identification.

In addition to this information sheet, you will find attached a survey questionnaire about the issues surrounding rural osteopathic practice, which should be filled out in pen, and returned in the reply paid envelope provided. Completion of this survey implies consent to participation in this study. The Questionnaires are anonymous. After receiving completed surveys, each response will be numerically coded according to date of return by the researchers, thus identification of the participant will NOT be possible. Participation in this study is voluntary.

Procedures:

A survey of opinions and perceptions of rural Osteopaths of the Australian Osteopathic Association (AOA) about the possible issues of rural practice is to be undertaken. Each potential participant has been mailed a package consisting of an information sheet, and a questionnaire regarding the research project. Completion of the questionnaire is regarded as being equivalent to a signed consent form. The objectives of the study are outlined in this information sheet. The questionnaire comprises questions regarding Osteopaths and the experience and possible issues of rural practice.

All participants are asked to return the questionnaires via the reply paid postage envelope by the **15th December 2004**.

There is a very small risk that answering the questionnaire honestly could discomfort some respondents, due to reflecting on professional practice in rural and metropolitan settings. Participants will be referred to a psychologist, Dr Mark Andersen, in the highly unlikely event that they feel anxious. If participants have any queries regarding the study, or are interested in the results, then they can forward any questions to the researchers at Victoria University City Flinders Campus on (03) 9248 1111 or to Dr. Annie Carter (Principal Investigator), on (03) 9248 1081.

Any queries about your participation in this project may be directed to the researcher Dr. Annie Carter (Principal Investigator) on (03) 9248 1081 and Sabine Moritz (Student Investigator - BSc–Clinical Sciences).
If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MC, Melbourne, 8001 (telephone no: 03-9688 4710).

Rural Australian Osteopathic Practitioner's Survey

Issues of Rural Osteopathic Practice

Note: By completing and returning this survey, you are implying consent to your participation in the project & subsequent publication of the collated anonymous results.

Please CIRCLE your answers:

Age:

20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65+

Sex: Male Female

Country of Birth:_____

If other than Australia, please specify year of migration to Australia:_____

Practice Location:_____

What was the year of your graduation from your Osteopathic studies?_____

In which country did you complete your Osteopathic studies?

Australia

Other (please specify country and state)_____

Did you have a rural background before commencing your studies as an Osteopathic student?

Yes No

If yes, was this background:

- A rural primary school background? Yes No
- A rural high school background? Yes No
- Other _____

_____

_____

If you did not commence osteopathic study straight after leaving school, did you spend some time after high school in a rural area?

Yes No

If yes, how long?_____

If yes, doing what?_____

_____

_____

_____

Following the completion of your studies, was it your intention to work in a rural area?

Yes No

How long have you worked in a rural area as an Osteopath?_____

_____

_____

_____

How long do you intend to keep working in a rural area as an Osteopath?_____

_____

_____

_____

What had the most influence on your decision to practice in a rural area?

- Rural Background
- Spouse's Rural Background
- Rural clinical experience
- Lifestyle
- Other (please specify)_____

_____

_____

Do you believe that there is a greater need for Osteopaths in rural areas?

Yes No

If yes, why?_____

_____

_____

_____

_____

_____

_____

Where do you feel you got the most rural Osteopathic experience from?

- Rural background
- As an Osteopathic student
- As a Locum
- As an Associate
- Owning your own rural practice
- Other (please specify)_____

_____

_____

_____

_____

Do you consider any of the following to be <u>IMPORTANT</u> issues in rural practice?
(Please answer <u>EVERY</u> question with a cross)

	Very Important	Important	Neutral	Unimportant	Very Unimportant
Availability of annual & other leave					
Income					
Access to community facilities &/or shopping					
Access to social/family networks					
Access to health care for your own needs					
Access to latest technology					
Availability of annual & other leave					
Access to theatre/concerts					
Access and availability to other health & human services					
Access and availability of continuing osteopathic education					
Access & availability to non-osteopathic education					
Access & availability of Associates					
Opportunities for children (environment)					
Opportunities for children (primary)					
Opportunities for children (secondary)					
Opportunities for children (tertiary)					
Availability of childcare facilities					
Opportunities for spouse/partner					

Which of the following do you consider to be <u>BENEFITS</u> of rural practice?
(Please answer <u>EVERY</u> question with a cross)

	Great Advantage	Advantage	Neutral	Not Applicable
Sense of belonging				
Sense of being needed				
Sense of professional Independence				
Sense of Community				
A supportive Community				
Having a lead role in the Community				
Continuity of care				
Using a range of skills				
Relying on own skills				
Having personal knowledge of the patient				
Seeing a variety of conditions				
Rural Lifestyle				
Physical attractiveness of the area				
Access to social/family networks				
Income				
Cost of living				
Number of hours worked each week				
Availability of locums				
Gaining respect of urban colleagues				
Gaining respect of rural colleagues				
Gaining respect of other health care practitioners (incl. Medical)				
Opportunities for children (environment)				
Opportunities for children (primary)				
Opportunities for children (secondary)				
Opportunities for children (tertiary)				
Opportunities for spouse/partner				

Which of the following do you consider to be <u>DISADVANTAGES</u> of rural practice?
(Please answer <u>EVERY</u> question with a cross)

	Great Disadvantage	Disadvantage	Neutral	Not Applicable
Sense of being needed				
Sense of professional Independence				
Having a lead role in the Community				
Loss of privacy & anonymity				
Access to social/family networks				
Using a range of skills				
Relying on own skill				
Having personal knowledge of the patient				
Seeing a variety of conditions				
Income				
Cost of living				
Number of hours worked each week				
Availability of Locums				
Availability of Associates				
Lack of respect from urban colleagues				
Negative attitude from urban colleagues toward rural practice				
Opportunities for children (environment)				
Opportunities for children (primary)				
Opportunities for children (secondary)				
Opportunities for children (tertiary)				
Availability of childcare facilities				
Opportunities for spouse/partner				

Thank-you for your participation in this Questionnaire.