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Diverse and vulnerable: experiences of private allied health practices managing through the coronavirus (COVID-19) pandemic. Implications for the financial viability of Australian primary care

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ABSTRACT

Background. The majority of allied health services are delivered by small, private practices in the primary care setting with limited government funding. During the coronavirus disease 2019 (COVID-19) lockdowns these practices were subject to the same health orders as any other private business with only 'essential services' permitted to remain open. **Research aim.** We set out to understand the impact of the COVID-19 pandemic, and associated public health measures, on the financial viability of private allied health practices. **Methods.** Thirteen semi-structured interviews were conducted with primary care allied health practice owners and managers in Sydney. Data were analysed thematically. **Findings.** All of the interviewees reported experiencing the stress of balancing precarious finances caused by reduced and/or fluctuating patient demand. Patients' reluctance to seek care was compounded by ambiguity around whether allied health services were 'essential'. Manual therapies were particularly vulnerable to financial stress because their capacity to transition to telehealth and access to government funding were limited. Conversely, psychologists reported demand for their services exceeded what they could provide. **Study implications.** The findings are indicative of primary care allied health's peripheral status in Australia's primary care landscape. Greater priority to the funding and integration of primary care allied health is needed in primary care policy.

Keywords: allied health, health economics, health funding and financing, health system resilience, pandemic, primary health care, public policy, qualitative.

Introduction

There are approximately 218 000 allied health workers (regulated and self-regulated) in Australia, comprising more than 25 professions delivering manual and/or counselling-based interventions for a range of acute and chronic health conditions.[1,2] Many allied health professionals are employed by large healthcare institutions, but the majority work in private primary care practice as sole practitioners, small business owners, employees, or contractors.[3] Income for these practices is based on fee-for-service payments, with patients paying the fee in full or partially subsidised through Medicare and/or private health insurance. Only a small proportion of allied health services are fully funded by Department of Veteran's Affairs, National Disability Insurance Scheme (NDIS), or State-based compensation schemes.

During the coronavirus disease 2019 (COVID-19) lockdowns of 2020 and 2021, allied health practices were subject to the same health orders as other private businesses. Only 'essential services' could remain open, within imposed density limits and infection control measures.[4] The Australian Government also introduced Medicare items to subsidise video and telephone ('telehealth') consultations in March 2020 and increased maximum Medicare eligible psychologist sessions from 10 to 20 sessions in October 2020.

Previous research has highlighted the impact of pandemics on primary care,[5] and the role of general practice specifically in maintaining safe access to healthcare, and vaccines.[6,7] Little is known about the impact of the COVID-19 pandemic, and associated public health measures, on private allied health practices. The aim of this study was to address that gap by exploring the experiences of sole practitioners and small businesses managing their practice through the pandemic, and the challenges for maintaining financial viability.

Methods

The data presented in this paper draws on in-depth interviews with owners and managers of private allied health practices, exploring how they managed the unpredictable conditions of the COVID-19 pandemic and its impact on their practice's income and operations.

Participants

Private allied health practices in Greater Sydney were recruited by emailing practices on the Central and Eastern Sydney Primary Health Network (CESPHN) database and promotion by allied health peak bodies. Purposive sampling was used to include practices providing both manual and counselling treatments across a range of practice sizes and ownership types. Participants were offered AUD100 as compensation for participation. Signed consent was obtained online.

Data collection

Interviews were conducted between June and August 2021, with the majority occurring during lockdown conditions. A flexible interview guide (Appendix 1) was developed in consultation with allied health professionals and piloted with two practice owners. Questions included observed changes in patient demand over the previous 18 months, adaptations to services including telehealth, and experiences of responding to public health orders.

Interviews lasted between 30 and 60 min (mean 40 min), were digitally recorded, and transcribed and de-identified through a confidential transcription service, and checked for accuracy by interviewers. Summary notes were made after each interview regarding broad discussion points and any extraneous factors relating to interviewer/interviewee rapport and reactivity. Sample adequacy was achieved through data saturation, signalled by replication or redundancy in the insights provided by interviewees.[8]

Data analysis

Analysis and reporting of data follow the Consolidated Criteria for Reporting Qualitative research[9] (Appendix 2). Thematic analysis systematically identified patterns within the data without a predetermined theoretical framework or template. Transcripts were coded iteratively to reflect participants' meanings. These codes were discussed and scrutinised by the research team to identify significant broader patterns of meaning and grouped into categories and used to generate potential themes. Potential themes were checked against the transcripts to determine that they accurately reflected the data and answered the research question. The team reached agreement on the final themes by rigorously discussing the findings and potential themes, encouraging different interpretations of the data that strengthened the analysis, before finally agreeing on the final themes.

Ethics

Ethics approval was obtained from the University Technology Sydney Human Research Ethics Committee (ETH18-2507).

Results

Thirteen allied health practices participated in an interview. The majority of practices were well-established, clinician-owned and small in size (Table 1). There were five psychologists in total, one speech pathologist, an optometrist and an occupational therapist. The remaining six allied health professionals provided manual therapies including physiotherapists, chiropractors and exercise physiologists. Five practices were sole-practitioners, four of whom were psychologists.

Table 1. Profile of participating practices.

	n
Total	13
Interviewee role	
Clinician-owner	12
Practice manager	1
Years in current location	
Less than 1 year	1
1–3 years	1
3–5 years	2
5–10 years	4
10–20 years	2
Over 20 years	4
Staff size	
Sole practitioner	5
2–9 staff	5
10–19 staff	2
20+ staff	1
Mean staff size	6.4 staff

Four themes emerged that illuminate allied health practices' experience of managing their practice through the pandemic: (1) fluctuating demand for services; (2) ambiguity of 'essential' services; (3) the feasibility and effectiveness of telehealth; and (4) balancing precarious finances.

Fluctuating demand for services

A major challenge for allied health practices was managing sharp declines, followed by prolonged periods of fluctuating demand for their services. Universally, interviewees reported a sharp drop in patient demand following the initial lockdown in March 2020, which recurred with the onset of the June 2021 lockdown.

> The first thing was [patients] rang me and said, "I won't come in this week". (AC03-psychologist)

> Through March, April, May, June [2020] our practice numbers dropped by about 90% on average per day. (AP01-occupational therapist)

For physiotherapists and chiropractors, whose patients often undertake time-limited courses of treatment, this caused a drastic slowing in the pipeline of new patients:

> … we look at new patient numbers each week, because that gives us an indication of our business going forward. It was our new patients that completely died… We were seeing two or three new patients [per week] compared to maybe 20… That was a really big thing that dropped, which caused us a fair amount of anxiety. (AP03-physiotherapist)

Interviewees attributed this sharp drop in demand to a number of factors including patient fear of contracting the virus and patients adjusting to life in lockdown (especially those homeschooling children). It was also clear that allied health services were vulnerable to reduced discretionary spending among patients experiencing pandemic-related financial disruption. Some interviewees observed that patients whose services were fully funded by government schemes (e.g. NDIS) were more likely to continue treatment, whereas '…private patients disappeared into thin air' (AP03).

The majority of practices experienced a 'bounce-back' in patient demand between the 2020 and 2021 lockdowns. Psychologists reported their practices were 'busier than ever' (AC04) and were turning away new patients. They attributed this to the pandemic 'exacerbating pre-existing issues that were otherwise lying dormant' (AC06) including anxiety, relationship problems and substance misuse.

Practices offering manual therapies also reported a bounce-back, as people presented with lockdown-related conditions such as suboptimal working-from-home set-ups and injuries from new physical activities (e.g. running). However, this bounce-back was less marked than for psychologists and practices operated below pre-pandemic capacity.

Ambiguity of 'essential' services

A contributing factor to fluctuating demand was a perceived ambiguity around whether their service was deemed 'essential' under the public health orders that governed lockdowns. Many reported that patients, already hesitant to seek care, were often not aware that allied health could continue to provide face-to-face care.

> We get calls daily being like, "Am I allowed to come? Because I'm in a lot of pain", but people don't view us as medical. So there has been a bit of confusion there, because [public health authorities] have never really specifically said physiotherapy is okay. (AP07-physiotherapist)

As AP07's comment reveals, public health orders left the definition of 'essential' to the judgement of individual businesses. This ambiguity was compounded by contradictory interpretations provided in media releases, and professional governing bodies. Practice owners therefore had to interpret information from multiple sources to make crucial operational and clinical decisions. For some, it was clear:

> I decided to consider myself an essential service and to continue going to work, not to close. I wasn't expecting to see anyone. Instead, the very next day, I received so many phone calls. (AP02-optometrist)

Others worried whether they were doing the 'right thing' for patients and staff by staying open for face-to-face consultations, and the potential legal penalties of making the 'wrong' decision.

> But, it's been difficult to keep on top of the evolving rules. I'm someone that reads the actual public health orders and, unfortunately, what's written is often conflicting with what's being stated in press conferences, and what police advice is… The general advice is, if you can provide the service by telehealth then do so, unless there's an urgent need. And, that's open to interpretation. (AC06-psychologist)

All interviewees described similar deliberations over whether substitution of face-to-face with telehealth consultations was mandatory, coming to different conclusions depending on their interpretation of official advice. However, telehealth options were limited for many.

The feasibility and effectiveness of telehealth

The pandemic saw the rapid adoption of telehealth which helped maintain patient access (and therefore practice income) during lockdowns. All reported the technology costs incurred were relatively low, and software to support telehealth consultations were relatively easy to implement and use. However, the feasibility of transitioning to telehealth varied.

Compounding reduced patient demand, there was limited scope for manual therapies to replace, or supplement face-

to-face care with telehealth. Some provided one-to-one video consultations for patients nervous to attend the practice, or introduced online group exercise classes. However, all perceived these were a poor substitute for hands-on care.

> There's a whole lot of information as a physio that you just can't get when you can't touch people… There were a few existing patients who asked if we could do it and we did, but we didn't push that as an important part of our business. (AP03-physiotherapist)

In contrast, telehealth was a more feasible substitute for face-to-face care in counselling-based practices. Psychologists, occupational therapists, and speech pathologists used video (and to a lesser extent, telephone) to continue their services remotely. Some also used telehealth to expand their geographical reach. That said, all retained a strong preference for face-to-face and reported a higher level of burn-out in delivering telehealth services. Moreover, effective treatment was difficult for new patients in the absence of an established therapeutic relationship, and a safe clinical space.

> Initially it was fine [for new patients], but I found … that after about maybe four sessions, it was harder to get to the depths of stuff… it's also just people being in a space where they're feeling safe and relaxed. Sometimes people are in their car doing this. (AC04-psychologist)

Psychologists welcomed the introduction of Medicare subsidies for telehealth services and also the expansion in Medicare subsidised sessions. However, an initial requirement to provide consultations with no out-of-pocket cost led one to stop offering Medicare-subsidised services because the remuneration was so low 'I would probably have gone under' (AC03). Such significant business decisions needed to maintain practice viability were common across the interviews.

Balancing precarious finances

All of the interviewees experienced the stress of balancing precarious finances caused by reduced and/or fluctuating patient demand. Some had reduced the number of staff, or the hours they worked. The majority accessed JobKeeper in 2020, which was valued highly by practice owners. One stated that without it 'we would've closed' (AP04). Others commented it prevented them from paying wages out of their personal savings. One business owner stated that their central Sydney practice had only stayed viable through 2020 with various forms of government financial support, and by renegotiating their business and personal finances.

> If we hadn't had [JobKeeper] and New South Wales and the City of Sydney council grants we would have gone bankrupt within that period. We had no means of supporting loans and leases, especially with the rapid onset of the decline of our business. (AP05-chiropractor)

Paying high Sydney rental rates from a declining income was the biggest financial stress reported by all interviewees. Most had received no financial assistance or even temporary rent relief, with landlords refusing to negotiate on rates or reluctantly granting a short 'holiday', to be paid back later.

Six out of 13 interviewees reported that, overall, the pandemic had a negative financial impact on practice finances. In mid-2021, the Federal government had ruled out extending JobKeeper payments. Consequently, five practices expressed very low levels of optimism about the future viability of their practice.

Discussion

The experiences of managing through the COVID-19 pandemic described by allied health practices in our study were highly variable, and contingent on the type of service provided. Services with greater access to Medicare and other government income, and those where telehealth was a reasonable substitute for face-to-face care (at least in the short term), generally fared better. Notably, all of the psychologists in the study said demand for their services exceeded what they could provide, in line with national trends.[10,11] In contrast, practices providing manual therapies, such as chiropractors and physiotherapists, struggled with sharper declines in demand and were less able to transition to telehealth to maintain income during lockdowns. Confirming the findings of other studies,[12–14] the manual therapists in our study did not regard telehealth as an effective substitute for hands-on care.

The ambiguity surrounding allied health's 'essential service' status made it even more challenging to maintain a viable income during the pandemic, especially for those unable to transition to telehealth. Most practices in the study described stressful deliberations in interpreting conflicting advice between and within various government and professional bodies. Wright *et al.*[15] found a similar lack of clarity, consistency and timeliness in government communication around the COVID-19 vaccination program, causing financial and emotional stress for general practice. There is a clear need for a source of relevant, consistent and timely information for primary care practices during times of crisis and beyond, where Primary Health Networks could play a more central role.

The 'essential service' debate, a precarious reliance on patients' discretionary spending, and the overstretched psychology services identified by this study all reflect allied health's peripheral status in Australia's primary care landscape. The former Federal government's 10 year plan (2022–2023)[16] for primary care reform offers little to address these problems.

Limitations

The experiences of these Sydney practices may not reflect those of allied health practices elsewhere in Australia where

the duration and rules surrounding COVID-19 lockdowns, and government support differed. Interviews were restricted to owners/managers, all but one of whom were allied health professionals themselves. We did not have the opportunity to explore patients' attitudes to accessing allied health services during the pandemic.

Conclusion

The COVID-19 pandemic revealed the financial vulnerability of these private allied health practices, especially those not underpinned by government funding and/or could not transition to telehealth. This disproportionately impacted manual therapies. Greater priority to the funding and integration of allied health will be needed to meet the biggest challenges facing the Australian health system, of an aging population and rising chronic disease.

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Data availability. The data that support this study cannot be publicly shared due to ethical or privacy reasons and may be shared upon reasonable request to the corresponding author if appropriate.

Conflicts of interest. Dr Petrozzi is board director and chair of Central and Eastern Sydney Allied Health Network. Dr Wright is Deputy Chair of RACGP NSW/ACT Faculty Council; Board Chair of Central and Eastern Sydney Primary Health Network; Chief Medical Officer, Avant Mutual. All other authors declare no conflicts of interest.

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Appendix 1. Consolidated Criteria for Reporting Qualitative research (COREQ)

Domain 1: research team and reflexivity	
Personal characteristics	
1. Interviewers	SW, JH
2. Credentials	MW, SW, JP and BG have PhD in health science or health services research. RH has masters health qualifications
3. Occupation	MW – General Practitioner (GP)/researcher; SW – academic researcher; JP – chiropractor/researcher; RH – GP/researcher, BG – health executive/researcher
4. Gender	Three male, two female
5. Experience and training	The lead interviewer (SW) is an experienced qualitative researcher with a deep knowledge of the Australian health care system. JP and RH have completed PhDs using qualitative research methods. MW and BG are experienced health services researchers
Relationship with participants	
6. Relationship established	The interviewers had no prior relationship with participants
7. Participant knowledge of the interviewer	Participants knew interviewers' professional affiliations and were informed about the purpose of the research. They did not know them personally
8. Interviewer characteristics	SW is a non-clinician and provided a systems perspective. She sought clarification on any clinical or primary care practice matters from the clinician researchers on the team. JP also conducted interviews. As practicing clinicians and researchers living in Sydney the clinician researchers have 'insider' knowledge of the research topics
Domain 2: study design	
Theoretical framework	
9. Methodological orientation and theory	The interviews are the second stage of a larger explanatory sequential mixed-methods study that pragmatically adopted quantitative (survey) and qualitative (interview) methods. Thematic analysis of the interviews uncovered underlying patterns in the data and elucidated their meaning
Participant selection	
10. Sampling	Purposive sampling method was used to capture different manual and mental health therapies, as well as a range of practice sizes and ownership types
11. Method of approach	A combination of recruitment methods were used: through an expression of interest at the end of the survey; Central and Eastern Sydney Primary Health Network (CESPHN) and professional association newsletters; and posts on relevant social media
12. Sample size	$n = 13$
13. Non-participation	N/A
14. Setting of data collection	Telephone interviews were conducted privately by telephone or videoconferencing at a mutually convenient time
15. Presence of non-participants	None.
16. Description of sample	13 allied health practices (see Table 1)
Data collection	
17. Interview guide	A semi-structured interview guide was informed by the survey findings and designed in collaboration with practitioners and CESPHN. It was piloted with a GP and allied health practitioner (not included in final sample) and minor adjustments made for clarity and fluency. The guide included open ended questions enabling participants to freely discuss their experience, as well as more specific questions regarding their practices' adaptations to the COVID pandemic 2020–2021
18. Repeat interviews	None
19. Audio/visual recording	Interviews were digitally recorded and professionally transcribed
20. Field notes	Field notes were recorded during and immediately after the interview, taking particular attention of possible key points, emotional intonations/emphasis that was embedded into the transcript for contextual detail
21. Duration	Interviews lasted between 30 and 60 min, mean 40 min
22. Data saturation	Sample adequacy was achieved through data saturation, signaled by replication or redundancy in the insights provided by interviewees
23. Transcripts returned	None (not offered to participants)

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Domain 3: analysis and findings	
Data analysis	
24. Number of data coders	JP and SW coded the data
25. Description of the coding tree	The report structure (sections and subsections) follows the structure of the coding tree
26. Derivation of themes	Themes were derived from the data thematically without a predetermined theoretical framework or template
27. Software	NVIVO
28. Participant checking	None offered
Reporting	
29. Quotations presented	Illustrative quotations that have been edited for readability and confidentiality. Missing words have been replaced with '…' and any words changed or added from the original verbatim transcript are indicated by square parentheses. Quotations are attributed according to the identification codes used to anonymise participants
30. Data and findings consistent	Reflexivity and rigor was jointly upheld by the research team
31. Clarity of major themes	The results section is structured by the four major themes
32. Clarity of minor themes	None

Appendix 2. Interview guide

Practice background	– Job title/role – Main business – Other services? e.g. pathology – Staff number and type – Practice ownership (clinicians, corporate entity, other) – Practice location (suburban/CBD), socio-economic patient cohort – Time in business
Adaptations to the COVID-19 pandemic	– How did the volume of services change at the practice? Why do you think that is? (2020 lockdown/in between/this lockdown). – Can you tell me about how the practice implemented telehealth in the 2020 lockdown and why? Who was seen face-to-face? Investment in technology, patient/clinician attitudes. – Did services return to 'normal' in-between? (What has happened this time? Lessons learnt?) – Did you make any other changes to services? – Infrastructure and equipment (a) What investment did you have to make in infrastructure and equipment during the pandemic to support service changes or infection control? (b) Did you receive any financial or other support for these investments? – Staffing (a) Did you have to make changes to staffing during 2020 lockdowns? (b) Did you access Jobkeeper? If not, why not? (c) Did staffing returned to 'normal'? How is it now? (d) Did you have challenges managing other outgoings/expenses? – What is the usual billing practice? (private billing with health fund con-payment, Medicare bulk-billed, other e.g. NDIS, worker's compensation) – How did billing practices change during 2020 lockdown? (were there any challenges in changing billing practices?) How familiar were you with the new Medicare Items introduced during the pandemic? (e.g., new Medicare items for telehealth) (a) Has billing returned to 'normal'? Why? (b) Other than JobKeeper, did the practice receive any other financial support? e.g. tax relief, PIP (Practice Incentives Program) payments, rent relief
Practice viability and resilience	– Overall, what impact has the pandemic had on the financial viability of this practice and why? – Were there changes to profitability – income and outgoings? Initially and now? – Were there any changes to the practice you were planning to make, but couldn't because of the pressures of the pandemic? – How optimistic are you about the future of the practice? – How did responding to the pandemic impact you and your colleagues? – Could you comment on personal finances, stress, uncertainty – What was your experience of managing the information and advice in relation to your practice and business? Is there anything else you would like to say to about practice viability and resilience throughout the pandemic?