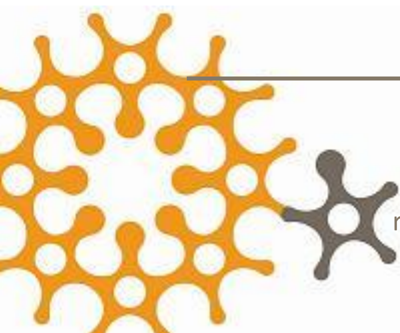
Blueprint objective	3. A health workforce that exists to serve and meet population health needs
Case example	Allied health rural generalist pathway (AHRGP)

What is the community need or problem being addressed?	Rural gradient of health outcomes and a range of health indicators are well known. So the problem definition broadly is well established.
	
	The overall aim of this work is to **support rural and remote communities to improve health outcomes**
	
	More specifically, the objectives for this work are:
	1. Accessible, clinically effective, value for money **multi-professional team-based healthcare**.
	2. **Fit for purpose, sustainable, generalist workforce** in the allied health professions (AHP).
	
	Rationale and drivers:
	
	Just as no one group can own the challenges of health and healthcare in rural and remote areas, no one agency and no one profession can provide the definitive strategy or solution.
	
	There is solid evidence, across healthcare settings, to demonstrate that effective use of a multi-professional team, with all members working to their full scope of practice and delivering well integrated care, provides best practice and optimises outcomes, particularly for complex and chronic conditions.
	
	The issue for implementing this best practice approach in many rural and remote regions is access to allied health services that are integrated into the local community that deliver the range of services required and in a way that is appropriate for rural and remote consumers.
	
	Allied health workforce challenges in rural and remote areas include:
	- Small profession workforces, in particular teams of sole clinicians (or few practitioners of the same profession) resulting in –
	  - Limited profession-specific support, peer learning and supervision opportunities.
	  - Low or no leave cover for training or recreation leave.
	  - Limited clinical governance and allied health leadership.
	  - Limited career progression and succession planning.
	- Primary care funding models that limit the viability of allied health providers in smaller centres.
	- Limited CPD opportunities that meet the diverse learning needs of rural generalist AHPs.
	- Generally lower tenure and higher turnover than metropolitan services.



What is the approach being implemented?	**Rural generalist pathway for seven allied health professions**

The pathway integrates:

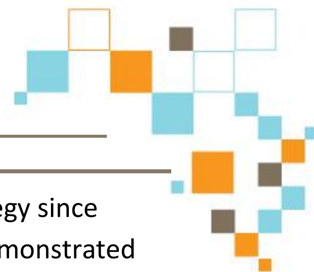
- Rural generalist allied health service delivery strategies and service development priorities that reflect local health needs.
- Rural generalist training positions with embedded training supports and expectations.
- Formal (university) rural generalist education program tailored for rural generalist scope of each profession:
  - Profession-specific skills in a broad (generalist) scope plus, where relevant to the local service model;
  - Advanced practice; and/or
  - Extended scope including skill sharing clinical tasks between professions.

Queensland Health has implemented designated rural generalist training positions since 2014, with positive evaluation findings – see https://www.health.qld.gov.au/ahwac/html/rural-remote.

A collaboration of health sector stakeholders (state/territory health departments/services, Services for Australian Rural and Remote Allied Health) has steered the inter-jurisdictional development of the strategy since 2013.

NOTE: A "rural generalist" possesses a broad range of skills and capabilities in their own profession (across clinical areas, age range, continuum of care). Rural generalists practice under the regulatory instruments of their profession and the policies of their employer.

"Rural generalist" in an allied health (or any other) profession should **NOT** be confused with the concept of a "generic" (allied) health professional, which is a worker without a primary health professional degree. There is no such worker in Australia and this is not the outcome of the rural generalist pathway.



What have been the key enablers to the success of this approach?	■ A strong multi-jurisdictional collaborative steering the strategy since 2013. Commitment to the development of the AHRGP is demonstrated by multiple state/territory health services, PHNs, NGOs and community controlled healthcare providers investing in creating training positions in their own teams and committing to this emerging model of rural and remote service delivery, workforce development, employment and training. ■ Most components of the mature AHRGP model are currently available in some level of development – some have been trialled and evaluated (e.g. early career training positions), some are being trialled and evaluated (e.g. education program) some are in development (e.g. accreditation standards). The early development and trialling work has largely been done – the next step for the health system and education, regulatory and profession group partners is to implement the pathway across the system, make it mainstream and an integral part of rural and remote service and workforce sustainability strategies.

What have been some of the challenges to the success of this approach?	■ Continued awareness raising and development of the concept and profile of rural generalism in allied health professions.
	■ No resourcing to support national coordination and development of the AHRGP. All resourcing is currently contributed by state health department budget allocations and in-kind support.
	■ Existing funding for allied health training is poorly configured for AHPs undertaking the Rural Generalist Program, for example:
	    ■ The Health Workforce Scholarship Program specifically excludes the allied health workforce that are majority or sole providers of primary care services in many rural and remote communities.
	    ■ URDH full funding targets pre-entry clinical education support.
	    ■ Allied health professions have no or restricted access to other Rural Health Multi-disciplinary Training program strategies, limiting capacity to examine the extension of the AHRGP to pre-entry training at this time.
	■ Organisations – HR/Industrial changes are required to fully integrate the pathway, culture changes and support for the existing workforce (leadership, education/training).

What is needed to scale-up the successes?	National coordination of the pathway development is required to progress it beyond its existing multi-jurisdictional trial phase. In particular: ■ Reconfiguring of national rural training funding/support programs is required to integrate the post-graduate rural generalist training. ■ Resourcing to provide a national coordination of the roll out of the AHRGP across rural and remote health services, and in particular, to work with service providers and commissioning agencies to support them to integrate the rural generalist pathway into their business. The majority of trialling and implementation of the AHRGP to date has been managed by large public health services that have larger workforces, leadership roles for allied health and well developed allied health clinical governance systems. These organisations will continue to develop the workforce/employment and service models that embed the components of the AHRGP, and different states are at different points of implementation. However, a national impact for service access, quality and outcomes for rural and remote consumers requires leadership, support and coordination for the portion of primary care services that state/territory health services have limited capacity to directly influence i.e. private (for profit), not-for-profit and community controlled organisations. ■ Health services can pick up this model and implement it now – implementation support materials are available (templates, guides etc), the education program is available, there are emerging supervisor networks and people with expertise in Queensland and other states that can provide advice on practical implementation matters. Most services redesign existing positions to leverage the benefits of the AHRG Pathway, rather than source funding for additional roles so the investment is not excessive and can be weighed against improved retention and attraction to roles.
More information	Ilsa Nielsen: Ilsa.Nielsen@health.qld.gov.au