



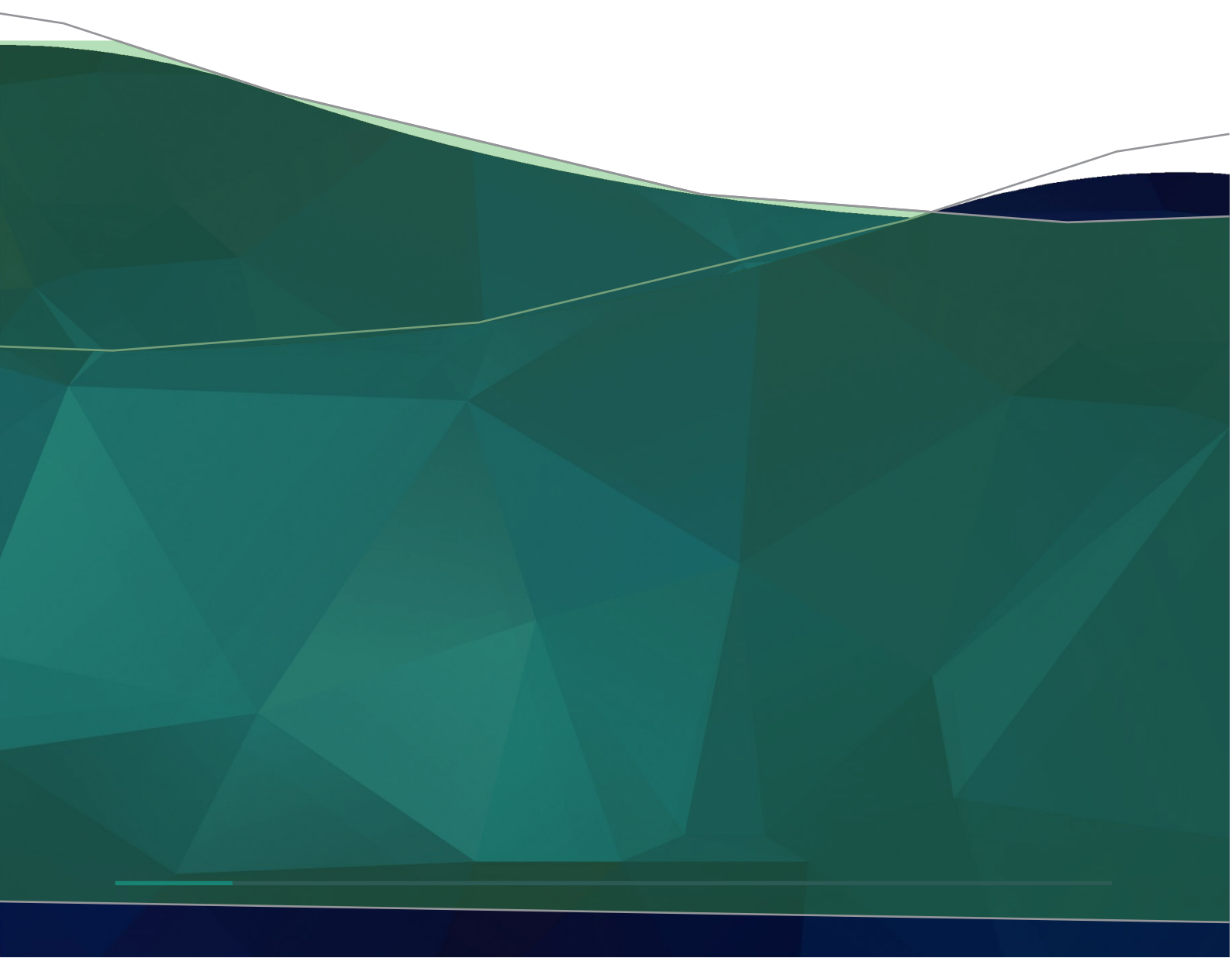
Australian Government

National Rural Health Commissioner

National Rural Health Commissioner

Final Report

June 2020



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This Report has been prepared by Professor Paul Worley, National Rural Health Commissioner.
Lead Researcher: Dr Rose Ellis, Director of Jurisdictional Engagement

Enquiries

Enquiries regarding any other use of this publication should be addressed to the

**National Rural Health Commissioner
Department of Health
GPO Box 9848
Canberra, ACT 2601**

or via e-mail to

nrhc@health.gov.au

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Acknowledgement of Country

The National Rural Health Commissioner acknowledges the Traditional Owners and Custodians of Country throughout Australia. The Commissioner recognises the strength and resilience of Aboriginal and Torres Strait Islander people and acknowledges and respects their continuing connections and relationships to country, rivers, land and sea. The Commissioner acknowledges and respects the Traditional Custodians upon whose ancestral lands our health services are located and the ongoing contribution Aboriginal and Torres Strait Islander people make across the health system and wider community. He also pays his respects to Elders past, present and emerging and extends that respect to all Traditional Custodians of this land.

In developing this Report the Commissioner has been guided by learnings from Aboriginal and Torres Strait Islander people’s concepts of health and wellbeing, in the importance of community control and connection to country, and with respect and consideration for the wisdom of Elders and local decision-making.

**The Hon Mark Coulton
Minister for Regional Health,
Regional Communications and Local Government**

**Parliament House
Canberra ACT 2600**

Dear Minister

In accordance with section 79AC of the Health Insurance Act 1973, I present to you the Final Report of the National Rural Health Commissioner covering the Commissioner's activities during the period of appointment from November 11, 2017 to June 30, 2020.

Yours sincerely

**Emeritus Professor Paul Worley
National Rural Health Commissioner**

June 30, 2020.

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Executive Summary

It has been my great privilege to serve as the inaugural National Rural Health Commissioner. This Australian and world-first position, with its independent status enshrined in legislation, has placed a national and international focus on rural and remote communities, their health, wellbeing and development. These three interlocking elements are the barometers of how we function, as individuals, as communities and as a nation.

Improvements to Australia's health system over the next decade will be framed by *Australia's Long Term National Health Plan* and the target set by the Minister for Health, the Hon Greg Hunt MP, to make Australia's health system the world's best. As a nation, our health system performs extremely well. We are currently ranked number two in the world. However, in the areas of access and equity, our performance is less optimal. As we enter a new decade our challenge is clear – the benefits of our progress must be available to all. Access and equity must be increased for Australians who live outside urban centres and in particular for Aboriginal and Torres Strait Islander populations.

Since commencing my role, my activities have focused on improving access and equity through improvements to the supply of a sustainable, high quality, rural and remote health workforce. I have approached this work with a clear and lived understanding of the capacity of rural networks to develop the means of production that will create self-sustaining systems of workforce training and service delivery. However, in order to realise this, we need to move away from current models that rely on a workforce that is primarily developed for and by market-driven, metropolitan training systems and a dwindling cohort of solo practitioners working in isolation in small towns. We must move to a system of integrated, place-based, regional health networks that train and support a rural and remote workforce – working in collaborative teams across defined geographical areas. The foundations for this system have already been established through several decades of rural health education development, and, more recently, the National Rural Generalist Pathway for medicine and the allied health Service and Learning Consortia – two models I have developed over the last two years and presented to the government on behalf of the rural and remote sector.

Consultation has been a key component in ensuring that the reforms I recommended were community designed and led. In-depth engagement across such a diverse and broad terrain as Australia is challenging but vital to the integrity and veracity of the resulting recommendations. My approach was to be as strategic and efficient as possible, utilising the natural gathering places of rural stakeholders - meetings and conferences - where I was both a speaker and a participant in discussions. I was also supported through the establishment of expert reference groups who provided a high quality evidence base for policy recommendations at various stages of their development. I am profoundly grateful to the thousands of rural and remote Australians – consumers, local councils, students, trainees, clinicians, educators, supervisors, health and service delivery organisations and professional groups - who have contributed so generously to the work I have been engaged in during my term and who support the recommendations it produced.

I also recognise the leadership and commitment of the Ministers, Members and Senators I have worked with during my term and the Departmental staff who have supported me as an Independent Statutory Officer. The independent nature of my role has allowed me to listen to, learn from, and be a voice for all representatives of the rural and remote health sector, and reflect these learnings in all aspects of the advice I have produced.

This Final Report of the National Rural Health Commissioner is a summary of the work undertaken during my term: the development of advice regarding a *National Rural Generalist Pathway*; and the provision of recommendations on the *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia*. The Report outlines the scope of both pieces of work, their development, consultation processes and final recommendations. This Report also contains recommendations for areas of future development that can be supported through the office of the National Rural Health Commissioner.

In the aftermath of a devastating cycle of fire and flood that swept through many already drought-stricken rural and remote communities in the latter half of 2019, we now face a new crisis – COVID-19. While the pandemic is a threat to the health and livelihood of every Australian, its potential ramifications in rural and remote communities, where the health system is reliant on fragile workforce supply chains from other countries and our major cities, are arguably far more severe. Rural and remote Australians have risen to meet these challenges, but the need to establish a self-sustaining, integrated system of local workforce supply and service delivery that ensures continuity of care for rural and remote patients has never been more urgent.

Thankfully there is a way forward. The work I have undertaken over the last two years, the strong evidence base that has supported it, and the wisdom and experience of Indigenous and non-Indigenous leaders in this field, have demonstrated that the solutions to many of the challenges that rural communities face lie within rural communities themselves. I thank all the clinicians who serve rural Australia so well, in particular those who have come from overseas or through locum agencies to help our rural communities in times of need. Now is the time for them to become the supervisors of the next generation of rural and remotely trained health professionals. Through targeted investment and an urgent realignment of funding priorities towards smaller rural and remote communities, we can create the local means of production for a world class rural and remote training and service delivery system, starting with those where our nation's food, fibre and mineral resources are produced, far from major cities. In doing so we will increase access and equity for the health and wellbeing of those populations and develop the productivity and prosperity of their communities and of our nation as a whole. If we can achieve that, then we will become the world's best health system.

Report Structure

The National Rural Health Commissioner's Final Report covers the period from November 11, 2017 to June 30, 2020 and summarises the outcomes of two specific areas of activity: the development of the National Rural Generalist Pathway and improvements to the access, quality and distribution of allied health services in regional, rural and remote Australia. Both of these sets of activities have been undertaken within the broader framework of rural health reform. The report also contains recommendations for areas of future development that can be supported through the Office of the Rural Health Commissioner. The Statements of Expectations for each activity can be found at Appendix One.

I would like to acknowledge the foundational work of the Hon Dr David Gillespie MP, and the support of Senator the Hon Bridget McKenzie MP and the Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton, MP.

Support from the Minister's office and staff from the Australian Department of Health has been invaluable in assisting me in the role.

Stakeholder engagement has been integral to the activities undertaken during the reporting period and has underpinned all aspects of my work.

A summary of stakeholder consultations is included in this Report at Appendix Two.

Functions

The *Health Insurance Act 1973* (the Act) provides the legislative basis for the appointment and the functions of the National Rural Health Commissioner (the Commissioner).

In accordance with the Act, the functions of the Commissioner are to provide advice in relation to rural health to the Minister responsible for rural health, including:

- defining what it means to be a rural generalist;
- developing a National Rural Generalist Pathway; and
- providing advice to the Minister on the development and distribution of the rural workforce and on matters relating to rural health reform.
- In performing these functions, the National Rural Health Commissioner must:
 - consult with health professionals in regional, rural and remote areas;
 - consult with States and Territories, and with other rural health stakeholders as the Commissioner considers appropriate;
 - consider appropriate remuneration, and ways to improve access to training for rural generalists; and
 - consider advice of the Rural Health Stakeholder Roundtable and the Rural Health Workforce Distribution Working Group.

Office

Vision

Equitable access to high quality, locally delivered healthcare for all Australians.

Role

To work with regional, rural and remote communities, the health sector, universities, and specialist training colleges and across all levels of government to improve rural health policies, champion the cause of rural practice, and to create frameworks for a sustainable locally trained health workforce to meet the needs of regional, rural and remote communities across Australia.

Final Report

The Final Report is a formal accountability document that summarises the activities of the Commissioner during the statutory reporting period – November 11, 2017 to June 30, 2020 as per section 79AM of the *Health Insurance Act, 1973*.

Financial Management

The Department of Health received an appropriation of \$4.4 million over four years until June 2020 to support the work of the National Rural Health Commissioner.

Chapter One: The Role of the National Rural Health Commissioner

Introduction

The National Rural Health Commissioner's (the Commissioner) role was established through an amendment to the *Health Insurance Act, 1973*. The Bill to amend the Act was introduced by the then Assistant Minister for Rural Health, the Hon Dr David Gillespie MP, and received bipartisan support from both Houses of Parliament. Its passing was seen as a watershed moment in the history of rural health both in Australia and internationally, and represented the cumulative efforts of a broad range of rural health advocates and rural health leadership for over three decades.

History, as Emeritus Professor Max Kamien once observed, is everywhere.¹ In Australia, in the context of health and clinical care, it begins with the roles Traditional Healers developed over millennia to protect the wellbeing of their communities and teach others to do the same. This ancient trajectory has been followed in more recent times by other rural health practitioners: medical doctors, nurses and midwives, dentists, allied health professionals and Aboriginal and Torres Strait Islander health workers and practitioners, as both healthcare providers and advocates for their communities.

There are also particular individuals who have worked tirelessly at the jurisdictional and national levels for policy reform in the areas of health and medical education, training and clinical care. Their longstanding advocacy has, at various times, been carried forward in important policy and program initiatives through the commitment of Ministers such as the Hon Michael Wooldridge, the Hon John Anderson and the Hon Brian Howe. These early policy reforms, framed by the first *National Rural Health Strategy* in 1994 and the *Regional Health Strategy: More Doctors, Better Services* in 2000, shaped many of the programs that continue to benefit rural communities, students and rural practitioners today. In more recent years, the former Minister for Rural Health, Senator the Hon Fiona Nash, was instrumental in laying the foundations for the establishment of the Commissioner's role, which was carried through by the energy and commitment of the Hon David Gillespie, MP. Since commencing the role, my activities have received enthusiastic support from Senator the Hon Bridget McKenzie and more recently, the current Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton, MP.

The Commissioner's role was established through, "A deep-lying principle that every Australian should have the right to access a high-quality standard of healthcare, no matter where they live".² This principle, and a number of others listed below, have guided my approach to the role of Commissioner and the important work I have been entrusted to undertake on behalf of rural and remote communities.

A holistic view

Throughout the period of my appointment, my work has been framed by Aboriginal and Torres Strait Islander concepts of a comprehensive approach to community health, wellbeing and development:

*Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.*³

¹ National Rural Health Alliance. *4th National Rural Health Conference Proceedings*. NRHA; Perth: 1997.

² D. Gillespie. "Second Reading Speech, Health Insurance Amendment (National Rural Health Commissioner) Bill, 2017", House of Representatives. Hansard Debate. February 9, 2017; p.242.

³ National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. Canberra: 1989.

Rather than focusing on a compartmentalised view of healthcare provision, I have taken a similar holistic approach in developing the concept of integrated networks of primary, secondary and tertiary care, delivered by a locally trained generalist health workforce with appropriate skills that place community wellbeing and development at the centre. My work has focused on the importance of place – of *locus* – for training, working and living and the psychological, social and spiritual bonds that connection brings.

An independent voice

The Commissioner's status as an Independent Statutory Officer is highly important and has been central to my work in advising Government on reforms. Since my appointment to the role in November 2017, this independence has been crucial in enabling my activities to reach across all tiers of government and create a focal point for the issues impacting on the health of Australians living in diverse settings outside metropolitan centres. My independent position has allowed me the opportunity to reflect on the important, rather than be caught within tyranny of the urgent: the familiar constraint faced by those working within an organisation – government, professional or educational. The independent status of my role as Commissioner has allowed me to bring together the evidence from across the sector and develop consensus from a non-partisan position. I acknowledge the foresight of the Government in designing the role in this way and enshrining it in legislation.

Strategic engagement

From the commencement of my role I have placed immeasurable value on being able to listen and learn from rural and remote communities and from those who provide their care. I have chosen to engage with people where they live and work, making strategic use of meetings and conferences where people gather to discuss, to listen and to be heard. I have observed, first hand, innovative models of practice that are improving access to services for local communities. Equally, I have witnessed the pressures on communities and providers when training and service models designed for urban, market-driven health systems are overlaid onto rural and remote geographies. The wide-range of stakeholders I have engaged with reflects the complexity of the health system. I have held productive discussions with consumers, students, educators, supervisors, postgraduate trainees, practice owners, clinicians across the specialities, professional organisations, health services, non-government organisations, colleges and representatives from all levels of government; constantly truth testing concepts as they were developing, seeking feedback and making constructive use of their input. I have also harnessed expertise through the formation of strategic groups such as the National Rural Generalist Taskforce, the Rural Consumer Group and the Jurisdictional Forum, while working closely with existing representative groups in rural medicine, nursing and allied health. I have been consistent in this approach across the two pieces of work I have undertaken during the reporting period to ensure that outcomes are community-led and consensus-driven.

At the same time, I have chosen, from the commencement of my role, to continue to work as a rural clinician. This has allowed me to retain my contact with rural patients and colleagues and has helped to keep me grounded during my term as Commissioner.

The National Rural Health Stakeholder Roundtable

Part of my role as National Rural Health Commissioner was to work with the Rural Health Stakeholder Roundtable, chaired by the Minister responsible for rural health. Over the reporting period I attended five National Rural Health Stakeholder Roundtables, where I updated members on the work I was engaged in and sought feedback. This was a very valuable process and the expert advice I received from Roundtable members made a positive contribution to the various programs of work my office has undertaken.

A strength-based approach

The health system is, by its nature, complex and multifaceted. In rural and remote settings where there are variations in population distribution and geography, and often considerable distance between services, there is additional complexity. One of the main policy levers to ensure that the Australian health system works to produce better health outcomes for its citizens is the supply of a highly trained and appropriately skilled workforce: a further challenge in rural and remote locations.

Despite, or perhaps because of these challenges, rural health has always been a site for innovation – often born of necessity - and carried forward with commitment and vision. Throughout my activities over the last two years, including broad and in-depth consultations across the sector, it is clear that the potential for collaborative, cohesive, interconnected networks of training and service provision exists across regional, rural and remote Australia. We need to recognise this potential and take a strength-based approach to policy development.

Yet comprehensive, locally-based training pathways in rural and remote locations are still described in terms of deficits – including a misconception about the detriments of rural training on future career choices for trainees.⁴ We have more than enough evidence now to show that the reverse is true. The deficits lie, not in rural settings, but in the current training models that are primarily based in metropolitan universities and are well designed to produce metropolitan health providers. The reality that must be overcome is one of urban privilege rather than urban superiority. Training in rural settings can be different to training in urban settings but they are at the very least equivalent in quality of outcome. In fact, it can be argued that there are distinct advantages to rural training.⁵

My work over the last two years has involved flipping the current model on its head and identifying regional, rural and remote settings as the locus for training a sustainable health workforce that meets the needs of populations living outside metropolitan centres. The model I have been developing in consultation with consumers, students, educators, supervisors, clinicians and sector leaders seeks to build rural and remote networks of training, research and development, and service delivery. These networks will connect with their urban counterparts but will not depend on them for the supply of students, trainees and providers. They will perform as centres of excellence for rural and remote health service provision and in doing so will make a significant contribution to the growth and development of the communities where they are based.

⁴ Bourke L, et al. From 'problem-describing' to 'problem-solving': Challenging the 'deficit' view of remote and rural health. *Aust J Rural Health*. 2010;18:205-209.

⁵ Worley P, Murray R. Social Accountability in Medical Education: an Australian Rural and Remote Perspective. *Med Teach*. 2011;33(8):654-8.

Progress to date

The purpose of this report is to describe my activities and the recommendations produced as a result, over the period of my appointment. These have been presented chronologically. The report also includes recommendations for further much needed areas of development to improve the health and wellbeing of rural and remote communities.

One of the first steps in achieving the required legislated outcomes of the Commissioner's role, was the development of the *Collingrove Agreement* (see chapter two), an agreed definition of the skills and training required by Rural Generalists and a commitment by the two General Practice Colleges to work collaboratively towards specialist recognition for Rural Generalists. The second step was the development of a National Rural Generalist Pathway – a framework for developing, supporting and training a sustainable Rural Generalist workforce to meet the needs of regional, rural and remote Australia (see chapter two). The third step has been to develop a series of recommendations to improve the access, quality and distribution of allied health services – a fundamental component of holistic care for people living in regional, rural and remote communities at all stages of their lives (see chapter three). The reporting period's final six months were concerned with various activities to support the implementation of both the Pathway and the allied health reforms. This period was also concerned with supporting the national response to the COVID-19 pandemic (see chapter four).

Conclusion

The independent nature of my role as Commissioner has enabled me to act as a conduit and bring together an often-fragmented sector to work collaboratively towards a collective objective: health reforms that increase access to services and lead to more equitable health outcomes for people living in rural and remote Australia. This independent status has allowed me to bridge divisions and competing interests and develop a consensus-driven approach, supported by comprehensive research and a deep and broad knowledge of rural and remote workforce. The result has been the development of evidence-based, decentralised, community-focused, national policy frameworks that provide consistency and at the same time, flexibility for implementation in diverse settings.

Australia has led the way in creating this world-first rural and remote-focused, independent role and there is much international interest in our progress. The following chapters provide an overview of the areas of activity I have undertaken in the reporting period and recommendations for further development.

Chapter Two: 2018 - Rural Generalism in Medicine

Introduction

Approximately 30% of Australians live outside metropolitan centres in regional, rural and remote settings. Of those, nearly half (44.7%) lives in towns with less than 15,000 people.⁶ Within these settings access to appropriate health services can vary dramatically. Recent data from the Australian Institute of Health and Welfare indicates that the distribution of medical doctors in metropolitan centres is 4.1 per 1000 population compared to 2.5 per 1000 in non-metropolitan areas, while only 12% of non-General Practice specialists currently live outside major cities.⁷ The further away from larger population centres people live, the less likely they are to receive services from resident teams of specialist healthcare providers. This results in patients often having to travel, sometimes long distances, to access healthcare and creates significant impacts personally, socially and economically.

The bulk of medical services in rural and remote areas is delivered by General Practitioners (GPs), however the number of GPs with procedural skills in these same locations has declined significantly over the last fifteen years. In the same way, the number of GPs providing hospital services in smaller communities (sometimes known as Visiting Medical Officers) has also declined and many rural Local Health Networks have been forced to rely on locums to provide emergency and in-hospital services. As a career choice, General Practice has been overtaken by other specialist areas.⁸

Commonwealth and state and territory governments have made significant investments in programs to address maldistribution including a combination of incentives and restrictions to direct medical practitioners into areas of need. In the university setting there has been longstanding support for Rural Clinical Schools and University Departments of Rural Health that offer some undergraduate training in non-metropolitan settings. More recently, the Commonwealth Government announced the introduction of the Murray Darling Medical School Network Program which will expand end-to-end training for medical students in a number of regional locations. This program is part of a suite of measures contained in the *Stronger Rural Health Strategy* to address education, training and service provision. Yet despite these measures, the gap in access to services for smaller rural and remote communities persists.

Decades of research have confirmed that early and prolonged exposure to rural environments during training has a positive influence on career decision-making for those considering rural practice.

Yet despite this evidence and the many initiatives established by both the Commonwealth and jurisdictional governments to increase opportunities to train outside metropolitan centres, rural and especially remote training pathways remain limited and disjointed. While it is possible to undertake some undergraduate and postgraduate training rurally, there are many obstacles to being able to complete the entirety of postgraduate vocational training in rural areas. Many graduates who are committed to rural careers struggle to find junior doctor positions and, even in larger regional locations, training posts in their chosen speciality. Many return to the city to complete their training and remain there. When, at this foundational life-stage, the vast majority of training, and therefore living and socialising, occurs in capital and regional cities, the loss of potential rural workforce increases.

At the same time there has been growing recognition, both in Australia and internationally, that Rural Generalist medicine – a discipline that combines General Practice, emergency and an additional skill appropriate to needs of rural and remote communities – is a viable alternative to the current pattern of maldistribution, patient upheaval and reliance on temporary workforce supply.

⁶ National Rural Generalist Pathway Taskforce. *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*. Canberra; National Rural Health Commissioner; 2018, p. 18.

⁷ Ibid, p. 15; Australian Institute of Health and Welfare. *Medical Practitioners Workforce 2015*. Canberra; Australian Government: 2016.

⁸ Australian Medical Association. *A Plan for Better Health Care for Regional, Rural and Remote Australia*. Canberra: 2016.

Several jurisdictions have supported this by introducing Rural Generalist programs. The Queensland Government led this reform through a substantial investment in the Queensland Rural Generalist Pathway which was introduced in 2007 through the leadership of Professor Dennis Lennox. Subsequently NSW, Victoria and Tasmania also commenced Rural Generalist Programs, each varying in design. It was in the context of these developments and the maturing debate on Rural Generalism that the task of establishing a nationally consistent framework for Rural Generalist training commenced. And it began by finding a common language.

Rural Generalist – a definition

As the concept of Rural Generalism has gained currency, multiple ways of describing the Rural Generalist role have developed as well. One of my first tasks – as directed by the responsible Minister – was to develop a definition of a Rural Generalist that would be accepted and used consistently by the sector and form the basis of the development of the National Rural Generalist Pathway (the Pathway).

In January 2018, senior representatives of the two General Practice Colleges travelled to a rural homestead in South Australia at my invitation. Their task was to develop a definition for Rural Generalism that would be the foundation for our work going forward. I would like to acknowledge the leadership and commitment of Associate Professor Ruth Stewart, then president of the Australian College of Rural and Remote Medicine (ACRRM); Associate Professor David Campbell, Chief Censor of ACRRM; Associate Professor Ayman Shenouda, Vice President of the Royal Australian College of General Practitioners (RACGP) and Chair of RACGP Rural Faculty; and Dr Melanie Considine, Deputy Chair, RACGP Rural Faculty.

Over a three-day period, the leaders of each College worked with me to develop what has come to be known as the *Collingrove Agreement*. It was finalised via teleconference with the two College presidents during my visit to the St George practice of Dr Adam Coltzau, then president of RDAA, in rural Queensland.

This historic document provides the following definition of a Rural Generalist:

A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.⁹

The *Collingrove Agreement* has given the sector an agreed language to describe the role of the Rural Generalist and in doing so has placed community need at the centre of workforce design. It combines General Practice with emergency care and the additional skills required in primary and secondary care that would usually be delegated to other specialists in urban or larger regional centres. Those additional skills could be anaesthetics or obstetrics but could also be palliative care, Aboriginal and Torres Strait Islander health, mental health, internal medicine or a number of other specialities. The setting for the Rural Generalist is primarily in smaller towns without the critical mass to support larger medical specialist teams, where they provide additional skills but are still part of regional networks of providers:

Different communities and their doctors need different models of accessible high-quality sustainable care. Some rural and remote communities rely on doctors working in General Practice. Some communities are of significant critical mass to support other specialists working in different fields. But there are a multitude of communities that need Rural Generalists who span both worlds of General Practice and additional specialist services. One rural doctor is not better than the other, but their skills and practice models are likely to be different depending on where they work. All are needed in their appropriate contexts, as matched to community need and working in highly complementary regionally networked teams.¹⁰

⁹ National Rural Generalist Taskforce, p. 5.

¹⁰ Ibid, p.4

The *Collingrove Agreement* was not just a definition. It also included a commitment by the two General Practice Colleges to work together on the development of the Pathway and the recognition of Rural Generalism as a specialised field within the discipline of General Practice.

The *Collingrove Agreement* was formally announced at the Rural Health Stakeholder Roundtable on 9 February 2018 by Senator the Hon Bridget McKenzie and was enthusiastically endorsed by members of the Rural Health Stakeholder Roundtable who recognised its historic significance. It became the cornerstone for the next important piece of my work: the development of a structured and sustainable national training pathway framework.

The National Rural Generalist Taskforce

In May 2018, I established the National Rural Generalist Taskforce (the Taskforce) to guide the development of the Pathway and ensure that the essential Pathway components were robust and evidence-based. The Taskforce comprised experts from across rural health, including consumers, workforce, planning, research, service delivery and clinical care, and provided oversight of a number of Working Groups and Expert Reference Groups. These Groups were responsible for developing individually themed papers on topics including Pathway structure, curricula and standards, professional recognition, support and co-ordination, remuneration and evaluation. The papers were circulated for broader comment and feedback at different stages of development. At the conclusion of this extensive development and consultation process, the papers were combined as *The Advice to the Rural Health Commissioner on the Development of the National Rural Generalist Pathway (The Advice Paper)*.

The National Rural Health Workforce Jurisdictional Forum

The role of jurisdictional governments is central to the training and employment of the prevocational medical workforce and vocational training for the majority of specialities. Many jurisdictions have introduced Rural Generalist training programs and had established a Rural Generalist forum prior to my appointment.

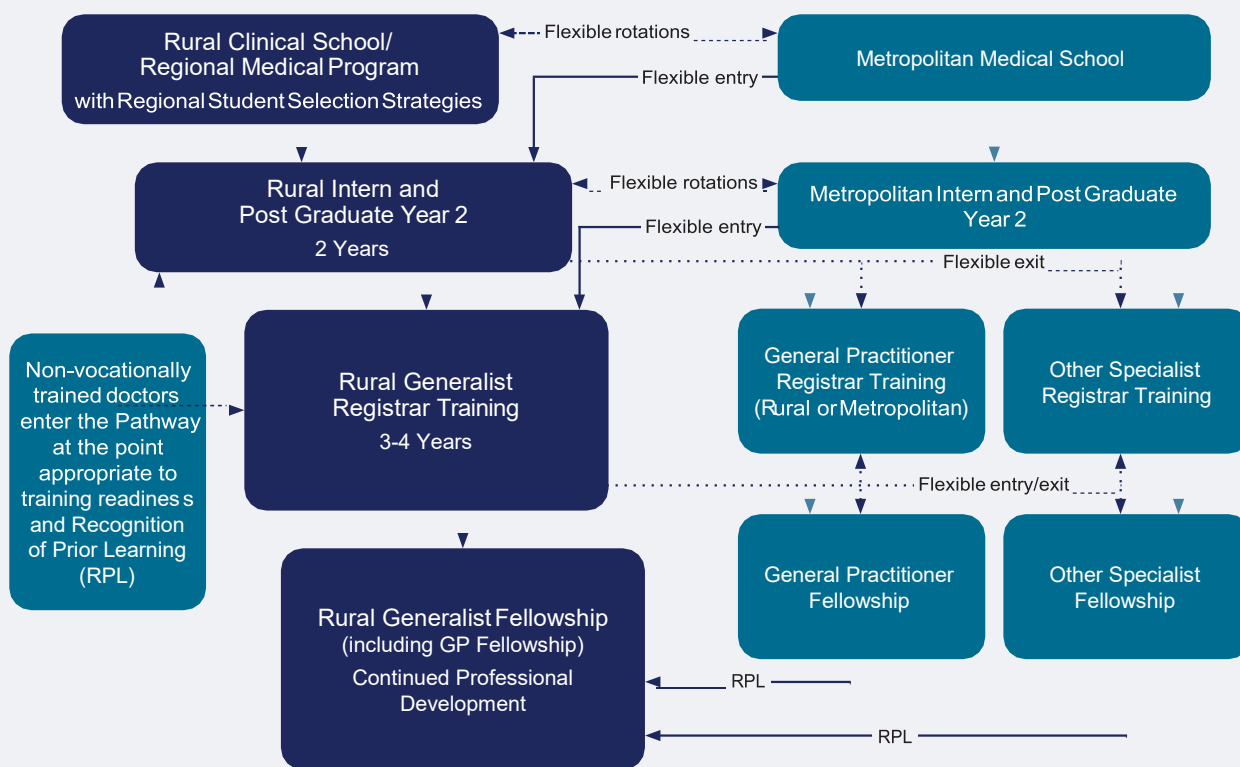
At the beginning of 2018, in collaboration with jurisdictional stakeholders, I reconstituted this forum as the National Rural Health Workforce Jurisdictional Forum (the Forum). The Forum's role was to provide strategic advice on rural health workforce and facilitate inter-jurisdictional collaboration. During 2018, the Forum had a particular focus on the Pathway. Members brought high levels of expertise and knowledge to discussions on the challenges unique to their geographies and service structures and worked towards a framework for the Pathway that would be nationally consistent but flexible enough to accommodate different jurisdictional contexts. The Forum was extremely valuable in informing my work and key to developing a successful Pathway model for multiple settings.

The Pathway Model

The Taskforce consultations identified the essential components to create a sustainable Rural Generalist training Pathway. In essence, the Pathway had to be attractive to students and trainees by offering a structured, co-ordinated and supported learning program at each stage of training. It had to be regionally-driven and adaptable to different jurisdictions and existing models; and it had to provide training in a range of skills required in rural and remote communities.

As the model below illustrates, the Pathway is a framework for end-to-end training in regional, rural and remote locations. It includes a flexible format that allows lateral entry and exit points; a requirement for at least one additional skill that matches community need; recognition of prior learning for existing rural GPs; and a sustainable workforce in primary care, inpatient and emergency care.

National Rural Generalist Training Pathway*



* Dark boxes depict the four Stages of the National Rural Generalist Pathway. Timeframes vary by full or part time training and achievement of Entrustable Professional Activities.

The Pathway allows for flexible entry/exit and rotations to metropolitan sites for training as required. Current rural training capacity varies by jurisdiction and more rural training capacity will be built over time. Prospective Rural Generalists may join the Pathway at any Stage, appropriate to training readiness and recognition of prior learning.

The structure of the Pathway is five to six years of postgraduate training delivered through integrated teaching and training health service networks across regional, rural and remote Australia. These networks will align with existing health service networks and education and training organisations. Ideally trainees should be able to train in smaller settings matched to community need and aligned with workforce planning, as well as larger regional centres for different components of the curricula.

As a result, Rural Generalists will be equipped to work across multi-town networks, providing high quality, culturally safe, community and population-based General Practice, along with emergency/trauma services and inpatient care. They will train in an additional skill that is required by rural and remote communities. Optimal patient safety will be maintained through a robust continuing education program.

In many ways, the MBS represents a judgement on the relative value placed on the work of different types of doctors and other health professionals. Using this 'value judgement' proactively is a key feature of the *Advice Paper*, which recommended that:

Rural Generalists are given access to Medical Benefits Scheme specialist item numbers when providing clinical care in areas of accredited Additional Skills, including access to telehealth item numbers.

A key component of the fairness of the package is to recognise equal pay for equal services. In relation to the MBS this means that Rural Generalists should have access to General Practice item numbers when providing General Practice services and access to relevant specialist item numbers when using their Additional Skills.¹¹

¹¹ National Rural Generalist Taskforce, *op cit*, p.45.

The MBS is a central vehicle to increase access to services in smaller rural and more remote communities through incentives that support the Rural Generalist workforce and make it attractive to a new generation of doctors. This will make a significant contribution to reversing the current trends of limited access and corresponding poorer health outcomes and higher mortality rates.

The MBS can also support the delivery of telehealth as an augmentation to healthcare delivery where appropriate. The recent expansion of telehealth rebates is a step in the right direction and should be maintained for rural and remote communities to ensure that telehealth has the maximum impact in increasing services and supporting integrated regional health service networks.

The *Advice Paper* also identified structured support as an important element that will underpin the successful implementation of the Pathway. Trainees should be able to retain their work entitlements for the duration of their training. A single employer or 'duration of training' contract is an important incentive for rural trainees who are significantly disadvantaged in the current General Practice training system that does not allow for the accumulation of parental and other types of leave entitlements. Another important distinguishing feature of the Pathway is the inclusion of a case management faculty that will provide mentoring and support for trainees as they progress through the various stages of training and employment.

Specialist Recognition

A key recommendation of the *Advice Paper* was for the two General Practice Colleges to promote the national recognition of "Rural Generalist" as a protected title as a Specialised Field within the Specialty of General Practice.

This recommendation was the subject of detailed discussion and close scrutiny across the sector and received broad support. There are very practical benefits to be gained from specialist recognition that include greater public transparency of skills and training and greater patient safety; more streamlined credentialing processes for health services; the transferability of additional skills across jurisdictions; improved data collection for workforce planning; and an attractive career pathway for future and existing rural doctors.

Conclusion

In December 2018, I presented the Advice paper and its 19 recommendations to the then Minister for Regional Services, Decentralisation and Local Government, Senator the Hon Bridget McKenzie, who accepted the Report and its recommendations and directed me to support the General Practice Colleges to progress the application for national recognition. In response to submitting the Advice paper, the Australian Government announced \$62.2m in the 2019-20 Budget to implement the first stage of the National Rural Generalist Pathway. Funding covered three key measures commencing in 2020:

- Support for the GP Colleges to provide an application to the Medical Board of Australia for recognition of Rural Generalist Medicine as a specialised field within the specialty of General Practice.
- Coordination units within each jurisdiction to support rural generalists trainees to navigate their five to six years of postgraduate training, in particular the intersection between hospital and primary care settings.
- Increased early exposure to rural primary care through expanding Commonwealth supported rural junior doctor training rotation placements.

More recently, a trial of a single employer model for Rural Generalist trainees has been established in NSW. These are important foundation steps for the establishment of the National Pathway and respond directly to recommendations in the *Advice Paper*.

The Minister also directed the Department of Health to ‘take responsibility for progressing the remaining elements’ of the *Advice Paper*.¹² The Department is continuing discussions with state and territory governments in 2020 to support the rollout and discuss next steps, which will require joint commitments.

Why is the National Rural Generalist Pathway beneficial to rural communities? It will attract a new generation of graduates to live, learn and work in rural Australia. The Pathway will also provide, for the first time, a sustainable workforce of Rural Generalists who are specifically trained to work and thrive in rural and remote communities. It will revitalise rural health services as places of learning and innovation. Finally, it will ensure that community need is at the centre of workforce design, contributing to better health outcomes for rural and remote communities through appropriate, place-based, continuous care. An investment in the Pathway is an investment in the future growth and prosperity of rural and remote communities. When rural and remote communities grow and prosper, every Australian benefits – no matter where they live.

¹² B McKenzie. Statement of Expectations – National Rural Health Commissioner. Jan 2019. Available from: www.health.gov.au/nationalruralhealthcommissioner/publications

Chapter Three:

2019 - Allied Health Services in Regional, Rural and Remote Communities

Introduction

My next task, as directed by the responsible Minister, was to develop recommendations to improve the quality, access and distribution of allied health services for people living in regional, rural and remote communities. The full Statement of Expectations for this activity is available at Appendix One

The diverse range of services that fall under the banner of allied health are not confined to healthcare. In fact, they are integral to all aspects of social care and include aged care, disability, justice, early childhood and education. They comprise both regulated and self-regulated professionals working in a variety of employment arrangements, often in multiple settings. Along with this diversity in roles, settings, regulatory frameworks and specialisation, there are numerous definitions that describe allied health professionals. In order to provide consistency in discussions, consultation and policy development, the following definition from the Australian Allied Health Leadership Forum (AAHLF) was used:

Allied health professionals are qualified to apply their skills to retain, restore or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations. Allied Health Professionals hold nationally accredited tertiary qualifications (of at least Australian Qualifications Framework Level 7 or equivalent), enabling eligibility for membership of their national self-regulating professional association or registration with their national board. The identity of allied health has emerged from these allied health professions' client focused, inter-professional and collaborative approach that aligns them to their clients, the community, each other and their health professional colleagues.¹³

Although allied health professionals make up approximately 25% of the overall health workforce, they are largely concentrated in cities. Of an estimated 195,000 allied health professionals, less than 15,000 (7.7%) work in rural and remote locations.¹⁴ Funding models such as private health insurance, the Medical Benefits Scheme, My Aged Care and the National Disability Insurance Scheme are designed to be market-driven. However, outside of metropolitan centres, there is both a maldistribution and a shortage of workforce, resulting in thin markets, or areas of market failure. This is particularly the case in smaller rural and remote communities, where providers are forced to rely on temporary, short-term or part time funding arrangements, which diminish workforce attraction and retention and lead to high turnover.

Literature Review

In order to provide a sound evidence base to underpin the development of policy options, a comprehensive literature review was undertaken. The literature review provided a detailed analysis of 119 peer-reviewed articles published over the last two decades, examining issues concerned with training, recruitment, retention, models of service and scope of practice. The findings confirmed that, although there are increasing numbers of allied health graduates, this does not translate into increased access to services for those living outside metropolitan centres, where demand continues to exceed supply. While it is well established that rural origin students are more likely to choose and remain in rural practice, the review identified significant structural and economic barriers for rural candidates to gain entry into allied health undergraduate courses. In addition, there was limited scope for allied health students to complete their studies in rural areas. In regard to differences between urban and rural and remote practice, the review found that rural and remote allied health professionals have less resources and infrastructure and higher patient ratios across wider geographical areas than those practising in cities. In addition, allied health professionals in rural and remote areas require broader skills sets and the ability to provide services in a variety of modes including telehealth. The review highlighted a number of strategies to increase the

¹³ Australian Allied Health Leadership Forum (2019) *What is Allied Health?* [Accessed 12 Sep, 2019] Retrieved from: <https://aahlf.com/what-is-allied-health>.

¹⁴ [www.ahpa.com.au/AHPA membership](http://www.ahpa.com.au/AHPA_membership) [Accessed 17 Dec, 2019]

access, quality and distribution of allied health services which formed the basis of the options paper and the consultation that followed.

The literature review is a valuable resource for future research and is available at Appendix Three.

Consultation with the sector

The support I received from the allied health sector during the course of my work has been invaluable. In particular, I am grateful for the guidance and expertise of the Australian Allied Health Leadership Forum (AAHLF). AAHLF comprises representatives from Allied Health Professions Australia (AHPA), Australian Council of Deans of Health Sciences (ACDHS), Indigenous Allied Health Australia (IAHA), National Allied Health Advisors and Chief Officers Committee (NAHAC), and Services for Australian Rural and Remote Allied Health (SARRAH). In addition, I have received valuable feedback and advice from the Australian Healthcare and Hospitals Association (AHHA), the National Aboriginal Community Controlled Health Organisation (NACCHO), the National Rural Health Alliance (NRHA), the Australian Rural Health Education Network (ARHEN), jurisdictional health departments and individual professional associations and guilds representing different allied health professions and students.

These broad-based consultations and the results from the literature review formed the basis of an options paper which outlined policy options to improve the access, quality and distribution of allied health services for regional, rural and remote communities. The options paper was released for public feedback and was broadly circulated using a variety of methods to ensure saturation.

At the same time, I liaised extensively with the Commonwealth Government across a number of portfolios. My work was also informed by a number of current strategies and reforms including *Australia's Long Term National Health Plan*, *the Stronger Rural Health Strategy*, *the Medicare Benefits Schedule Review*, *the National Aboriginal and Torres Strait Islander Health Workforce Plan*, *the 10-Year Primary Health Care Plan*, *The National Preventative Health Strategy*, *the Evaluation of the Rural Health Multidisciplinary Training Program* and *the National Health Reform Agreement*. In addition, I have been cognisant of the important work being undertaken by the Royal Commission into Aged Care and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, both of which have relevance for the rural and remote allied health workforce.

The options paper received 116 written feedback submissions from a wide variety of stakeholders including individuals, the university sector, public, private and not for profit organisations, consumers, student organisations, peak bodies, professional associations and relevant representation from every state and territory. The feedback was comprehensive and constructive and provided a platform to further develop and nuance the options as recommendations for the final report, which fell into four main categories: access, quality, distribution and leadership.

Recommendations

Access

Rural allied health professionals often work with multiple funding sources that can be short-term in nature, while access to other sources of funding including the NDIS and My Aged Care require substantial administration that is often beyond the capacity of many clinicians, particularly those working in solo or dual practices. Alternatively, where organisations and clinicians have worked together in partnership to share resources and streamline service delivery, there is a demonstrable increase in access to appropriate care for communities across a geographical area.

The literature review also identified that the health professional education system is a key modifiable determinant of rural health workforce distribution but significant barriers exist for end-to-end or longer term service learning opportunities in rural and remote areas. In addition, the majority of short-term student placements take place in Modified Monash Model (MMM) 2 and 3, and not in areas of the most acute workforce shortages.

In order to ensure a sustainable supply of appropriate workforce, I have called for a greater focus on increasing pathways into allied health courses for rural origin students through structured pathways between secondary school, the VET sector and universities. At the tertiary level I have called for an increase in end-to-end training and longer-term 12 month placements. These placements will require flexible distance modes of delivery for course work requirements.

At the same time, there is global recognition that where high quality clinical services, teaching and training are combined, there are considerable benefits for both patient outcomes and workforce sustainability.

Based on this evidence and consistent feedback from the sector I have recommended a system that combines learning, postgraduate training and service delivery with a particular focus on areas of workforce shortage in MMM4-7.

In developing this recommendation, it was not my intention to reinvent the wheel but rather to capitalise and build on existing structures and programs that have demonstrated successful outcomes. More than two decades of consistent Commonwealth support for rural education infrastructure provides the ideal platform for an integrated approach to workforce sustainability and increased access to allied health services through the development of Service and Learning Consortia.

Service and Learning Consortia should be established progressively in a small selection of MMM4-7 locations and more isolated MMM3 locations. Service and Learning Consortia comprised of existing rural training and service organisations and allied health professionals would design and deliver health services and training opportunities across multi-town and multisector networks. This would enable the development of full time positions, additional supervision and longer term student placements. Additional support for 'back of house' administration would enable Service and Learning Consortia to identify and secure available funding streams, reduce the potential for duplication, deepen rural markets, co-ordinate and increase service provision in areas of need.

While improving access to services for rural and remote communities, the Service and Learning Consortia Program offers structured support for an education and training pathway through placement, supervision and mentoring capability at both student and postgraduate levels.

By combining sub-regional services models with allied health VET, graduate and postgraduate programs, workforce sustainability would be built into the Service and Learning Consortia program design. Sustainability would be strengthened in two ways: through incentivising service integration and combining it with local, high value, service-based training opportunities for allied health students and new graduates – the emerging health workforce.

Quality

Improving access to healthcare includes designing high quality services that are appropriate for the communities who use them. This is particularly important for Aboriginal and Torres Strait Islander populations for whom cultural safety and cultural responsiveness in service delivery are fundamental to comprehensive healthcare. In my consultations and the options paper feedback, it was made clear that cultural safety and cultural responsiveness need to be embedded across all allied health training curricula. One of the key recommendations of the report was the universal application of the *Aboriginal and Torres Strait Islander Health Curriculum* across all allied health courses.

A second and important factor in ensuring cultural safety and cultural responsiveness, is the participation of Aboriginal and Torres Strait Islander people in allied health service delivery. Currently this cohort is 0.5% of the allied health professional workforce. This is despite the fact that the burden of disease for rural and remote Aboriginal and Torres Strait Islander populations is significantly higher and exacerbated by limited access to culturally safe and appropriate health services. Aboriginal and Torres Strait Islander men in rural and remote areas have a life expectancy that is 6.2 years less than the same populations in urban areas. For Aboriginal and Torres Strait Islander women in rural and remote areas the difference in life expectancy is 6.9 years. My recommendations sought to identify practical ways to address the current undersupply through increased pathways into tertiary training for Aboriginal and Torres Strait Islander people.

At the community level – and particularly in rural and remote areas - there are significant barriers for Aboriginal and Torres Strait Islander students to gain entry into tertiary training. A key component of my consultations was examining current models that demonstrated successful outcomes in community-led, local pathways into health professions. The National Aboriginal and Torres Strait Islander Health Academy is a successful model that works with Indigenous high school students and graduates to mentor and support them into health careers. A key recommendation in the report was for the expansion of this model into every jurisdiction in Australia.

At the tertiary level, there is uneven approach to increasing and retaining the number of Aboriginal and Torres Strait Islander allied health students. Stakeholders emphasised a lack of consistency in admissions targets and the implementation of the *National Aboriginal and Torres Strait Islander Health Curriculum* across all courses. A successful model has already been established in medicine through the Leaders in Medical Education (LIME) Network which works to ensure excellence in Indigenous health teaching and training in medical education and attraction and retention of Indigenous students, trainees and educators. I have proposed a similar model – a Leaders in Indigenous Allied Health Training and Education Network (LIAHTEN) to be led by Indigenous Allied Health Australia, which will work with academic institutions to increase and retain Aboriginal and Torres Strait Islander allied health students and ensure that cultural safety and cultural responsiveness is embedded in all allied health curricula.

Distribution – National Allied Health Workforce Data Strategy

Effective workforce and service planning is dependent upon comprehensive and reliable data. The wide-ranging nature of allied health practice with its multiple, cross-sectional workforce settings and mixture of regulated and self-regulated disciplines has created significant challenges for workforce planning, research and policy development.

The report has recommended the establishment of a national allied health data strategy to overcome the current obstacles created by disparate systems and fragmented data collections. The strategy would oversee the creation of a centralised repository for allied health workforce information. A foundational element will be the development of a National Allied Health Workforce Minimum Dataset (NAHWMDS) that combines national and jurisdictional workforce data for multiple allied health professions across health, justice, education, aged care and early childhood in both hospital and community settings. The NAHWMDS would include data about both regulated and self-regulated allied health professions. I have recommended that the data strategy be led by the Chief Allied Health Officer (see section below).

Leadership

Without exception, stakeholders agreed that strong leadership and representation – along with an ongoing commitment to the principle of building on existing and emerging knowledge, structures and practices – are critical to successful and appropriate implementation of improvements to quality, access and distribution of allied health services. Stakeholders agreed that the Commonwealth should appoint a dedicated full-time Chief Allied Health Officer with an allied health background and extensive knowledge of rural and remote health, services and systems to provide a conduit for the allied health sector into government policy development by working closely with rural and remote allied health stakeholders. The report recommended that the Chief Allied Health Officer work across the relevant government departments and sectors to ensure a holistic, intersectorial approach to allied health policy and to develop an overarching national regional, rural and remote allied health strategy.

Conclusion

In December 2019, I presented the *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* report and its four recommendations to the Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton MP.

The four recommendations are designed to work in harmony with each other and with existing programs and plans. The recommendations aim to unite rural and remote allied health services to form a productive and efficient whole. Scale, through the Service and Learning Consortia, will create jobs and deepen economies and enhance health service integration across rural and remote communities. Rural training and support for rural students, including enhancing opportunities for Aboriginal and Torres Strait Islander participation in allied health professions, will build sustainability and attract the emerging workforce to rural allied health careers. Training a culturally responsive allied health workforce will result in improved quality of care for all communities. National leadership will connect government sectors and ensure there is rural and allied health representation where policy decisions are made. Importantly, rural communities will become healthier and self-sustaining as training and employment opportunities and access to essential health services increase.

Chapter Four: 2020 – Challenge and Response

Introduction

In December 2019, I was issued with a new Statement of Expectations by the responsible Minister for the period January to June, 2020. (See Appendix One.) The Statement of Expectations listed three main tasks:

To further refine the recommendations contained in the *2019 Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* and develop an implementation plan;

To continue to assist the General Practice Colleges with the process for recognising Rural Generalist Medicine as a specialised field within the discipline of General Practice; and

To support and champion the \$62.2 million roll out of the National Rural Generalist Pathway.

This chapter will describe the activities undertaken in response to the Statement of Expectations, along with the Commissioner's role in supporting the national response to the COVID-19 pandemic.

Rural and Remote Allied Health Reforms

During 2019, I worked with a broad range of stakeholders to develop a set of policy reforms designed to improve the access, quality and distribution of the rural and remote allied health workforce. As described in chapter three, consultation was broad and in-depth and was supported by a literature review that examined two decades of peer reviewed research. The result of this research and consultation was set out in the Report I provided to the responsible Minister at the conclusion of 2019. In 2020, I returned to consult further with stakeholders to refine the recommendations in the Report, identify potential barriers for implementation and align the outcomes with intersecting Commonwealth programs and strategies. This was a productive process and confirmed that the direction of policy reforms the Report had taken complemented current Government strategies, while still reflecting the views and aspirations of the rural and remote allied health sector. An interim report outlining the further refinement of the recommendations, was released publically in March, 2020. The architecture of the reforms I have recommended remains firmly built on existing Government investments and the advancements made by the sector over the last twenty years in the areas of education, training and service delivery. The revised Report was accompanied by an Implementation Plan to further inform the Government's consideration of the recommendations and was presented to the Minister for Regional Health, Regional Communications and Local Government on June 19, 2020.

The National Rural Generalist Pathway

As part of my role in supporting the rollout of the \$62.2 million Pathway elements I was requested to provide advice on timelines for implementation; provide advice on the role and function of the co-ordination units; and assist the Commonwealth to convene governance committees including the Rural Generalist Jurisdictional Forum and National Rural Generalist Pathway Advisory Forum. These two groups would be central to the overall co-ordination of the Pathway implementation.

My first action was to bring together key representatives on an interim basis to discuss the roll out of the Pathway. I am grateful to the RACGP, ACRRM, RDAA and the AMA for their input and advice in identifying key steps, outcomes and timelines for the Pathway implementation.

Rural Generalist Specialist Recognition

Chapter two described the work I undertook with the two General Practice Colleges during 2019 to develop a joint application for Rural Generalism to be recognised as a speciality within the discipline of General Practice. The first stage of this process was to develop and submit an application to the Medical Board of Australia. This process was completed in December 2019. The Recognition Taskforce, which I chaired during 2019, met in January 2020 to map out activities while the first stage of the application process was being considered by the Medical Board of Australia. A communication strategy was developed and subsequently media releases were produced to update the sector on the application process. A comprehensive stakeholder engagement plan was also developed for immediate application, however, due to the onset of the COVID-19 pandemic, the Taskforce was unable to meet during the February to April period. Meetings resumed in May 2020.

COVID-19 and the Rural Response

The emergence of COVID-19 as a global pandemic and the requirement for a rapid response to minimise its impact, necessitated a reprioritising of activities and commitments across governments and the health sector. As Commissioner, I worked alongside my many rural and remote colleagues to advocate for the needs of rural patients and practitioners. As a rural doctor, I continued to practise and witnessed firsthand the very real and urgent need for resources in communities already vulnerable through a lack of access to healthcare.

Throughout this period, as Commissioner my role has been to act as a resource and a unifying voice for rural and remote communities by providing clarity to stakeholders faced with an increasingly large volume of information and messaging – all with competing importance.

In the initial stages of the national COVID-19 response I wrote to Primary Health Networks and Local Health Networks recommending that they develop sub-regional practice networks within their regions to develop collaborative practice plans to facilitate such issues as shared on-call, record sharing, enhanced transition between primary and secondary care for patients and increased use of extended scope of practice to improve surge capacity and continuity of care. The increased availability of telehealth was an invaluable tool in establishing these systems.

Judicious use of social media enabled me to provide regular health messages succinctly, identify and circulate innovative responses by rural clinicians and garner support for Government initiatives such as the COVIDSafe Application as an effective use of technology to further contain the virus spread. I also participated in multiple webinars as both a panellist and a co-ordinator and provided responsible commentary to the national media when called upon for comment. At the same time I responded to hundreds of individual communications from practitioners and other stakeholders who had particular concerns or questions.

Throughout the COVID-19 response I remained a regular participant in teleconferences established by the Commonwealth including the Rural Health Stakeholder Group, chaired by the Minister for Regional Health, Regional Communications and Local Government, the Hon Mark Coulton, MP and the Primary Healthcare COVID-19 Response Updates, chaired by Professor Michael Kidd, helping to ensure rural and remote stakeholder participation.

Another important activity during the period was the establishment of the Rural General Practice Respiratory Clinic National Leaders Network, which I initiated and led. Having Rural Generalists on the ground in these regions able to respond so quickly in establishing the Respiratory Clinics has proved to be an important resource for local healthcare providers and regional health services, keeping communities safe and freeing up hospital staff to manage acute care and general practice to continue to look after patients safely. I am extremely grateful to those doctors and practices who participate in the program. The Respiratory Clinics are a vital resource for rural communities both during the COVID-19 pandemic response and their potential role going forward is discussed in the following chapter.

Conclusion

The onset of the COVID-19 pandemic in the early months of 2020 required a reprioritisation of work for all of us across the rural and remote sector. At the same time the underlying issues of workforce maldistribution and high levels of chronic illness became starkly apparent and necessitated holistic, innovative yet also rapid responses.

As a result, many of the initiatives developed by the Commonwealth and jurisdictional governments in response to the pandemic have been instrumental in containing the spread and have had direct benefits for rural and remote communities. In particular, the expansion of telehealth across medicine and several disciplines within allied health has been extremely beneficial. Telehealth is an important tool but it will not in itself address the very pernicious workforce shortages and access problems experienced by rural and remote communities for decades. Now is the time to learn from the actions we took as a nation in responding so rapidly and to-date so successfully to this major public health emergency. We have shown what can be achieved by thinking and acting laterally, by acting on evidence and expert advice, and by moving nimbly over the barriers of distance and geography that have traditionally placed rural and remote populations at the periphery. Going forward it will be vital to maintain our sense of urgency to push forward with initiatives that will ensure that communities across the country remain resilient through the recovery stage and into the future. The way that we approach this in the context of the new normal of a post COVID-19 regional Australia is discussed in the following chapter.

Chapter Five:

An investment in equitable health and economic growth

Introduction

Rural and Remote Health in the New Normal

I began this Report by describing health, wellbeing and economic development as three interlocking elements that underpin social functioning. The COVID-19 pandemic and the Government's rapid response has also focused largely on these same three areas, recognising the need to act with urgency to protect the basic fabric of our society.¹⁵ Our ability to prioritise, adapt and respond has meant that we have managed to contain a very real public health emergency and can now move into a recovery phase. However that does not mean that we can afford to return to previous systems and behaviours – particularly in the context of rural and remote health. The gaps and vulnerabilities that the COVID-19 pandemic revealed must be addressed with the same sense of urgency we have witnessed over the last six months. The priorities in workforce shortages, supply chains and underlying health inequities that make rural and remote communities particularly susceptible must be addressed as priorities as we plan our approach to recovery. As a nation, our reliance on global supply chains for basic commodities became apparent in recent months. In the context of rural and remote access to healthcare, we have experienced a similar vulnerability because of our long-term reliance on a predominantly global supply chain for rural and remote health workforce. In a similar way, the closing of external and internal borders and the sealing off of rural communities during the pandemic highlighted our secondary reliance on an urban supply chain of health students, trainees and locum workforce. At the same time our ability to adapt rapidly to digital application in remote learning and health service delivery has strengthened the capacity for a self-sufficient, locally trained health workforce for rural and remote communities.

My work over the last two years and the sound evidence base it has drawn upon, has demonstrated that a self-sustaining workforce can be produced at a regional level and that this mechanism will increase the development and prosperity of communities outside major urban centres. With the adaptation of digital technology and the expansion of telehealth, remote education can be an important enabler for future remote and rural health workforce to learn and train where they want to work and where the gaps in workforce supply are the most acute.

Economic Recovery and Investment

A significant part of the new normal of post COVID-19 recovery will be the rebuilding of the nation's economy. Safeguarding the production and supply of rural food supply chains for domestic and international markets is paramount. Safeguarding the health of rural and remote populations is fundamental to that and increasing access to health services through improvements to health workforce supply and distribution should be seen as an investment in economic productivity rather than a cost.

There is ample evidence internationally to demonstrate that an investment in the health of populations leads to improved economic outcomes. Improved economic outcomes in turn produce benefits at the local, regional and national level though what is often called an 'economic dividend'. While the definition below refers to developing economies, it is relevant to rural and remote communities in Australia where income, resources, access to health services and health outcomes are demonstrably less than those for populations living in high income metropolitan centres:

Economic growth and development depend on a healthy population. Around one quarter of economic growth between 2000 and 2011 in low- and middle-income countries is estimated to result from the value of improvements to health. The returns on investment in health are estimated to be 9 to 1. One extra year of life expectancy has been shown to raise GDP per capita by about 4%. In countries with high fertility rates, a reduced likelihood of child mortality can also positively influence household decisions on family planning. This contributes to a faster demographic transition and its associated economic benefits, often called the demographic dividend.¹⁶

¹⁵ See The Hon Josh Frydenberg, MP. Address to the National Press Club: Covid19 – Australia's Path to Recovery and Reform: May 5, 2020.

¹⁶ High-Level Commission on Health, Employment and Economic Development. *Working for health and growth: investing in the health workforce*. Geneva; World Health Organization: 2016.

By investing in regional communities as a means of production for a self-sustaining workforce we will not only be able to stimulate local economies, we will ensure that rural communities receive the healthcare they need to participate fully in the workforce and maintain the supply chains of food production and mineral extraction that the nation depends upon. We will create a demographic dividend.

A self-sustaining workforce supply that is developed specifically to address the needs of rural and remote communities will also address many of the issues that have come to the surface so acutely during the pandemic. Increased levels of family violence and mental health issues, exacerbated by isolation, unemployment and financial pressures are not temporary phenomena and are very real contributors to poorer health outcomes and higher levels of morbidity and mortality, along with chronic disease. A recent AIHW report has shown that Australians living in remote communities are 24 times more likely to be hospitalised from violence compared to urban populations.¹⁷ A Rural Generalist workforce with additional skills in public health, mental health and chronic disease management, trained and working as part of integrated regional networks can meet the needs of rural and remote communities in a way that creates a self-sustainable, holistic system of workforce supply and service provision. This chapter identifies specific areas that require an immediate and urgent focus within the broader prioritisation of rural and remote workforce reform.

Smaller remote and rural communities - a priority

We live in a federated nation, where different levels of government provide multiple funding streams to support the health system. Despite these complicated financing arrangements, the Australian health system has been ranked number two in the world by the Commonwealth Fund in a comparison of eleven advanced economies. Our strengths in administering complex systems have been recognised. Yet in the areas of access and equity, Australia's ranking was lower than other comparable countries.¹⁸ I agree with both these assessments. We have an excellent health system but it is not available to everyone.

A central part of *Australia's Long Term National Health Plan (National Health Plan)* is the aim 'to make Australia's health system the world's number one': a goal set by the Federal Minister for Health, the Hon Greg Hunt, MP.¹⁹ If this goal is to be achieved, then considerable focus must be placed on the areas with the least access and equity - smaller rural and remote and Aboriginal and Torres Strait Islander communities.

As we enter the next decade, guided by the *National Health Plan* and the Minister's overarching goal, we need to take a solutions-based approach and realign our concepts of what the best models of workforce and service provision are for these smaller scale and more remote communities.²⁰ However, that does not mean that we ignore the challenges – and there are many.

My work over the last two years has placed a particular focus on the smaller communities in rural, remote and very remote settings, where the historic deficits in investment and outcomes have been greatest and where the impact of climate change, natural disasters and fluctuating international trade environments are often most keenly felt. The gradual rationalisation of health services into regional centres through the closure of smaller procedural services, despite evidence of their safety,²¹ has been accompanied by population and workforce drift from many of these towns, where economic inequality is coupled with health inequality.²² Health service access and equity barriers are exacerbated by workforce shortages and a complex mix of health workforce training and employment models, which are often siloed and frequently disjointed. Resident populations face significantly higher levels of morbidity, preventable hospital admissions and mortality.²³

¹⁷ Australian Institute of Health and Welfare. *Family, Domestic and Sexual Violence in Australia: Continuing the National Story*. AIHW; Canberra; 2019.

¹⁸ Schneider E, et al. *Mirror, Mirror: 2017*. The Commonwealth Fund. [accessed 12 Dec, 2019]

¹⁹ Hunt, G. 'Minister's Foreword'. *Australia's Long-term National Health Plan*. Commonwealth Government: Canberra: August 14, 2019.

²⁰ Wakeman J, et al. Is remote health different to rural health? *Rural and Remote Health*. 2017;17:3832.

²¹ Tennant D, Kearney L, Klynn M. Access and outcomes of General Practitioner Obstetrician (Rural Generalist)-supported birthing units in Queensland. *Australian Journal of Rural Health*. 2020;28(1):42-50.

²² Wakeman J, Humphreys J. Sustainable Workforce and Sustainable Health Systems for Rural and Remote Australia. *Med J Aust*. 2013;199(5):S14-S17.

²³ Australian Institute of Health and Welfare. *Rural and Remote Health*. Canberra: Australian Government; 2019.

A postcode should not be a prognosis. Disadvantage and demography should not determine your destiny.

It is my view that these are the communities that need particular and urgent focus, yet they are often the areas that receive the least attention. We need to reverse that trend if we are to realise the Minister's goal to make Australia's health system the best in the world and meet the Prime Minister's increased regional migration targets in our Government's Population Plan.²⁴ There are challenges, but as the work I have led over the last two years has demonstrated, challenges can be overcome. An equitable level of investment and a community-led redesign of current workforce, training and service models, built on a strong evidence base, will meet those challenges and lead to stronger, healthier and more prosperous remote and small rural communities.

Recommendations

In order to achieve these aims I have identified three main domains for development: structural, therapeutic and translational and recommend the following areas for further investigation.

Workforce policy

The prevailing model that supplies the medical workforce for smaller rural and remote towns is dependent on two major policy levers.

The first lever is a regulatory framework that directs the flow of workforce into areas of need. This is a time-limited measure that relies primarily on overseas trained doctors (a fragile global supply chain) and bonded Australian graduates and has few mechanisms to link it to workforce planning in a comprehensive manner. This measure also has the effect of positioning remote and rural practice as inherently unattractive for domestic graduates, thus requiring a legislative 'stick'.

The second lever is urban-based medical school programs that produce Australian graduates who are increasingly choosing subspecialisation as a career choice.²⁵ In remote, very remote and smaller rural towns, access to specialists reduces according to distance from metropolitan centres.²⁶ Relying on urban-based training models that continue to produce subspecialists does not, and will not in the future, result in the type of workforce smaller rural and remote towns require.

The outcomes of these two policy levers are not meeting remote and rural Australia's needs. Currently 30 to 58 per cent of people living in outer regional and remote communities lack access to non-GP specialist services compared to six per cent of people living in metropolitan areas. The same cohorts are 2.5 times and six times less likely to have access to GP services respectively. Potentially preventable hospital admissions in very remote areas are 2.5 times higher than in major cities. Women living in very remote areas of Australia have a mortality rate for potentially avoidable deaths that is 3.3 times higher than their counterparts living in cities, while male mortality rates in similar geographies are 2.3 higher than in urban settings.²⁷ For rural and remote Indigenous populations, the rates of avoidable deaths and burden of disease are also greater than the rates for urban Indigenous populations which are already unacceptably high.

As the extensive work carried out in the development of the National Rural Generalist Pathway has demonstrated, Rural Generalists with additional skills can reduce this gap in access by providing a variety of specialist services required by smaller rural and remote communities along with comprehensive General Practice and Emergency care.

We have already seen some positive changes with the initial Commonwealth investment in various components of the National Rural Generalist Pathway including the trial of a single employer model in the Murrumbidgee area of NSW. It is vital that the remainder of the Pathway recommendations be implemented now, so that smaller rural towns and more remote communities can recover and thrive. If our goal is to reduce the gap in access and equity in the nation's health system, then the National Rural Generalist Pathway must be implemented in remote Australia as a priority.

²⁴ www.pm.gov.au/media/morrison-government-increases-regional-migration-target

²⁵ Australian Government. *Scoping Framework for the National Medical Workforce Strategy*. Canberra: Australian Government; 2019.

²⁶ AIHW. *Rural and Remote Health*, op cit.

²⁷ Australian Institute of Health and Welfare. *Medical Practitioners Workforce 2015*. Canberra: Australian Government; 2016.

Integrated Health Service Networks

If we are to provide cost effective, appropriate and sustainable health services for rural and remote communities that align with *Australia's Long Term Health Plan's* goals of “integrated, efficient, patient-focused and equitable” systems, then we require a paradigm shift away from the current model that is based on professional hierarchies radiating out from urban centres in ever diminishing circles.

There are still many communities that are dependent on solo practitioners; often a cohort of older professionals who will retire in the next decade. Where these practitioners are absent or have scaled back their working hours, the communities are reliant on locum services – particularly in the staffing of smaller hospitals - which places an unsustainable pressure on the health budgets of Local Health Networks and reduces continuity and the patient-centredness of care.

Instead, we need to move towards a system that attracts, supports and sustains a locally-based, rural generalist primary healthcare workforce. Our systems need to invest in and support integrated networks of training, service provision and research that can vary in size and configuration depending on the communities they service. These Integrated Health Service Networks can and should combine resources, funding streams and administrative functions when required, to offer the full scope of primary and secondary healthcare needed by their cluster of communities. They should offer flexible employment models to attract newer cohorts of healthcare providers and support entrepreneurship and innovation. Much of the infrastructure for these networks is already in place but requires a governance structure and financial incentives that support integration and ensure flexibility and community leadership. There is a key role for rural and remote Local Health Networks, supported by Primary Health Networks, Aboriginal Community Controlled Health Services, (ACCHS) local Universities and Rural Workforce Agencies, to develop the means of production locally, training their own workforce, and acting as academic institutions by collecting data to inform and improve clinical practice in the same way that urban hospitals have done.

A recent successful example of integration can be found in the establishment of the General Practice Respiratory Clinics (GPRC). The GPRCs were set up as part of the Commonwealth Government's response to the COVID-19 pandemic and they have been particularly valuable in rural and remote communities where they have provided a mechanism for safe testing and isolating potentially infectious patients. In doing so they have changed people's perceptions and behaviour in a positive way and maintained the continuity of general practice and in-hospital care, increasing the safety of the whole network. Where GPRCs have been embedded as part of local disaster response and clinical care pathways, they have demonstrated the efficacy of integrated health services in producing better health outcomes for the community. The Commonwealth should now work with the sector to investigate how it can leverage the current GPRC infrastructure it has funded and maximise its investment, so that this approach to infection control can become an explicit and ongoing part of the general practice contribution to a patient-centred, integrated rural and remote healthcare system.

It is likely that different models will be best for different typologies of remote and rural regions. However, fundamental building blocks for integrated regional health networks have been articulated through the National Rural Generalist Pathway and the recommended reforms to regional, rural and remote allied health services, along with the recent initiatives introduced during the pandemic by the Commonwealth – the expansion of telehealth and the GPRCs. These building blocks provide the foundation for a nationally consistent approach with flexibility for local application. These innovative networks, combined with comprehensive benchmarking for service delivery models in rural and remote health clusters, will provide a rationale for a realignment of current financing and incentive programs with long term benefits for rural communities and their clinicians.

Rural and Remote Indigenous Training Units

Barriers to accessing appropriate health services can take many forms – workforce shortage, geographical isolation, financial and service type. Barriers can also be cultural: built over time by past decades of racism and neglect. ACCHSs have made a significant contribution to reducing access barriers to safe and appropriate care for Aboriginal and Torres Strait Islander people, with the number of ACCHSs growing steadily over the last five decades through Commonwealth investment. However, it is incumbent on the health system to ensure that *all* services are culturally safe and culturally responsive to Aboriginal and Torres Strait Islander people.

One of the most effective mechanisms for improving cultural safety and cultural responsiveness and reducing access barriers, is to increase the number of Aboriginal and Torres Strait Islander health professionals. This has been recognised by the Council of Australian Governments Health Council (COAG Health Council) in the development of a *National Aboriginal and Torres Strait Islander Health Workforce Plan* and is central to the overarching national goal to close the gap in Aboriginal and Torres Strait Islander health outcomes. While the current gap in life expectancy between Indigenous and non-Indigenous populations receives broad focus, there is an additional gap within Indigenous populations that also requires scrutiny and redress: the gap between urban and remote Indigenous life expectancy, referred to in chapter three of this Report.

The Rural Health Multidisciplinary Training (RHMT) Program, which has recently undergone an extensive evaluation, has been successful in creating the infrastructure to increase training opportunities outside of metropolitan settings for student placements of short and longer-term through Rural Clinical Schools (RCS), University Departments of Rural Health (UDRH) and some regional universities. There is, however, a lack of consistency and accountability in improving health outcomes for Aboriginal and Torres Strait Islander populations. Individual universities and rural schools that have established reciprocal partnerships with Aboriginal and Torres Strait Islander organisations and communities and enabled a place-based flexibility that ensures a cultural match to the surrounding region, have achieved successful outcomes. Unfortunately this approach is not replicated consistently across the rural and remote landscape.

The RHMT Program is now of sufficient maturity to accommodate dedicated, Indigenous-led Rural and Remote Indigenous Training Units as a new, autonomous, initiative of equal weight and status to the existing RCS and UDRH initiatives. These Units would have a leadership role in supporting universities to increase the number of Aboriginal and Torres Strait Islander enrolments and graduations and ensuring that cultural safety and cultural responsiveness are a core component of health and medical training for all students and staff. Along with training and building the capability and career development of Indigenous academic staff and students, these units will be central to the capacity building of universities to develop a critical mass of Indigenous academic staff across schools and faculties and to ensuring culturally safe learning and teaching environments. The process for establishing the Units should be co-led by the National Indigenous Health Leadership Forum which should oversee the development of KPIs and the criteria universities need to meet in order to be eligible for funding. The Forum's work should be supported by the Indigenous Health Division within the Department of Health. With targeted investment, Indigenous leadership and a commitment by the university sector, these Units could shift the health paradigm across rural and remote Australia.

Priorities in therapeutic intervention

The specific health challenges that many people living in remote and smaller rural communities face are significant and three emerge as interlinked priorities: mental health, obesity and family violence. These three issues have also emerged as critical in our response to COVID-19: the mental health sequelae of isolation and income insecurity, the vulnerability to increased mortality for those with obesity, excess refined sugar intake, and their related diabetes and heart disease, and the unmasking of family violence with the closing of schools and more men confined to home. The implications of these conditions for children are very serious. While these conditions are problematic across both cities and regions, they are particularly emblematic of the current health status of many rural and remote populations, where they are complicated by economic and environmental factors and the reality of historical disenfranchisement.

Therapeutic intervention and preventative treatments are innately intertwined with the social determinants of health. Therefore, even though the way we design therapeutic interventions to address these three priorities will vary depending on different contexts, as a fundamental basis they must be holistic and consider the impact of multigenerational racism and urban-centrism, and the role of trauma-informed care and cultural safety. In order to be effective, therapeutic interventions should be developed and led by rural and remote communities and have meaningful intersections with justice, disability, early childhood, aged care and education using a cross-sector, place-based, integrated approach. In this way therapeutic interventions will be cognisant of the bio-psycho-social and spiritual relationship individuals and families have to place and history, along with their aspirations and fears for the future – their own and their communities. Rural and remote Australian communities need to be supported to debate and develop their own plans to address these three health priorities together, rather than separately. This will require significant investment, a networked system of leadership, support, data and evidence, and an appropriately skilled workforce.

Research data and evaluation

The last two decades have seen a growth in evidenced-based research to improve access to services for rural and remote communities, evaluating the effectiveness of current service models, programs and policies and providing valuable recommendations for further improvements.²⁸ This research has been central to the development of the Commission's work over the last two years. Comprehensive data, however, is still incomplete and this continues to be a serious impediment to the ability to measure the impact of models of care and service delivery. A greater investment in rurally-based, translational research is vital if we are to continue to measure the impact of policy and program reform on the health outcomes of rural and remote communities. In particular, an investigation into the lessons we have learned in regional Australia from the recent bushfires and floods and the management of COVID-19 would be extremely valuable to any recovery process. This is an area where Australia could lead the world and with sufficient investment – potentially through the Medical Research Futures Fund - could develop into a commercially successful export enterprise, adding to the development and prosperity of local rural and remote communities.

²⁸ Walters L, et al. Where to from here for rural general practice policy and research in Australia. *Med J Aust.* 2017;207(2); Wakerman J, Humphreys J. Sustainable primary health care services in rural and remote areas: innovation and evidence. *Aust J Health.* May 2011; <https://doi.org/10.1111/j.1440-1584.2010.01180.x>; Lyle D, Saurman E, Kirby S, Jones D, Humphreys J, Wakerman J. What do evaluations tell us about implementing new models in rural and remote primary health care? Findings from a narrative analysis of seven service evaluations conducted by an Australian Centre of Research Excellence. *Rural and Remote Health* 2017;17:3926.

Conclusion

The work I have undertaken over the last two years, the strong evidence base that has supported it and the wisdom and experience of Indigenous and non-Indigenous leaders in this field, have demonstrated that the solutions to many of the challenges that rural communities face lie within rural communities themselves if they are supported by the appropriate policy and investment supports.

We have the knowledge and the capability to train the future workforce *in situ*, in a way that will meet demand and work best for the communities it will serve. We have a current workforce of both Australian and overseas trained professionals who can and do train this workforce to the highest levels of excellence in healthcare. Foundation programs such as the Rural Undergraduate Support and Co-ordination (RUSC) program and later initiatives such as the RHMT Program have provided the infrastructure that complements existing regional universities: Rural Clinical Schools, University Departments of Rural Health and more recently, Rural Training Hubs. In addition, we have Local Health Networks, Primary Health Networks, Aboriginal Community Controlled Health Services and Rural Workforce Agencies. We have a National Pathway framework for the training of the future Rural Generalist medical workforce along with a burgeoning national Allied Health Rural Generalist Pathway. Most recently, we have witnessed the very real benefits of digital adaptation and collaboration between jurisdictional and federal governments. What is needed is an investment in an integrated, networked, benchmarked, evidence-based system that will bring all these elements together in a comprehensive and consistent manner that will benefit populations across rural and remote Australia.

As our nation rises to the challenge of making Australia's health system 'the world's number one', within the new normal of a post COVID-19 recovery, there has never been a more important time to ensure equitable access to health, wellbeing and economic development for all Australians 'no matter where they live'.

Appendix One: Statements of Expectations

Amended Statement of Expectations for the National Rural Health Commissioner 2018

1. Introduction

This Statement outlines the Australian Government's expectations about the role and responsibilities of the National Rural Health Commissioner (the Commissioner), the Commissioner's relationship with the Government, issues of transparency and accountability and operational matters.

The Commissioner is a statutory appointment, independent from the Department of Health (the Department) and the responsible Minister. This position has been established to independently and impartially improve rural health policies and champion the cause of rural practice.

The Government recognises and respects the statutory independence of the Commissioner. It is imperative that, as Commissioner, you act independently and objectively in performing functions and exercising powers as set out in Schedule 1 of the Part VA of the *Health Insurance Act 1973* (the Act). However, the Government expects that you take into account the Government's broad policy framework, including its agenda to reform the health workforce and improve the health outcomes of rural, regional and remote Australians, in performing your role and functions.

The Commissioner will work with rural, regional and remote communities, the health sector, universities, specialist training colleges and across all levels of Government to meet its statutory objectives. In addition, the Commissioner will assist to better target Australian Government interventions to support access to services and quality of services.

The rural health workforce and communities living in rural and remote areas will benefit from the introduction of the Commissioner by placing rural and remote issues at the forefront of government decision making.

The responsible Minister with oversight of rural health expects to be fully informed in a timely manner about the activities of the Commissioner and any emerging trends, problems or issues in respect of its functions. If requested by the Minister, the Commissioner may also provide advice to the Minister on matters relating to rural health reform.

2. Priorities for the Rural Health Commissioner

As Commissioner, you will:

1. *Work with rural, regional and remote communities, the health sector, universities, specialist training colleges and across all levels of government to improve rural health policies.*
2. *Assist the Australian Government to better target interventions in regional, rural and remote areas to support access to services and quality of services, as well as champion the cause of rural practice.*
3. *Develop and define new National Rural Generalist Pathway.*
4. *Work with the health sector and training providers to define what it is to be a Rural Generalist. This includes developing options for increased access to training and appropriate remuneration for Rural Generalists, recognising their extra skills and workload.*

5. *Consult with stakeholders to give consideration to the needs of the entire rural health workforce, including but not limited to nursing, dental health, pharmacy, Indigenous health, mental health, midwifery, occupational therapy, physical therapy and allied health.*
6. *If requested by the Minister, consult with state and territory governments to identify, assess and develop policy options to address current or emerging regional, rural and remote health reform opportunities on a national level, and to ensure effective information exchange across jurisdictions.*
7. *Liaise with national peak professional organisations, consumer organisations, rural health stakeholders and other advisory committees in developing solutions that reflect community needs.*
8. *Provide national leadership for regional, rural and remote health, and work with the Government to progress nationally agreed goals in regional, rural and remote health, including: flexible models of service delivery and workforce development, best practice approaches, and future national policy responses.*

The first priority for you as the Commissioner is to work with health professionals and other rural stakeholders, and with the state and territory governments, to define what it means to be a Rural Generalist and develop the National Rural Generalist Pathway.

While the development of the National Rural Generalist Pathway is the first priority for your role as Commissioner, the role is much broader than the medical workforce alone, and will include consultation with stakeholders to give consideration to the entire health workforce needs in rural and remote Australia.

3. Stakeholder relationships

Your role as Commissioner will require you to work closely with a number of stakeholders and the Government expects that you will engage professionally and collaboratively with relevant stakeholders throughout your appointment. These stakeholders include rural, regional and remote communities, the health sector, universities, specialist training colleges and state and territory governments.

A key stakeholder group is the Rural Health Stakeholder Roundtable (the Roundtable), which was established to promote rural health strategic discussion and to bring together key rural health stakeholders to assist the Government with informing and developing national rural health policy. The Government expects that you will engage closely with members of the Roundtable and take part in meetings, which are held biannually.

As the Commissioner you will be a member of the Distribution Working Group, which has been established to: investigate and consider ways to modify or update the existing district of workforce shortage classification system; to consider the implementation and design of the Modified Monash Model; and to consider mechanisms to encourage equitable distribution of the health workforce.

The Government expects that you will work collaboratively and closely with the Department and the Minister, and that you are aware of the Government's agenda on rural health reform. Conducive to an effective working relationship, the Department will continue to consult with you on any issues that may impact on you fulfilling your statutory objective or compliance with the law.

In your role as Commissioner, you should maintain professional and collaborative working relationships with other key stakeholders, particularly the broader rural health sector.

4. Organisational Governance and Financial Management

As Commissioner, you do not hold any financial delegation powers, or have any specific employment powers. The Secretary of the Department of Health may enter into an arrangement with you for the services of Australia Public Service (APS) employees in the department to be made available. This is intended as assistance for the position whilst you undertake your duties. Further, it is requested that you continue to manage the affairs as National Rural Health Commissioner in a way that promotes the efficient, effective and ethical use of resources. In support of this and in line with the allocated budget for the position, the Department will continue to provide you with the necessary corporate support, policies and systems to fulfil the functions of your role.

Where you are assisted by staff employed by the Department of Health under the *Public Service Act 1999* you should ensure you uphold and promote the APS Values and ensure that all APS employees adhere to the APS Code of Conduct.

5. Reporting

As part of your legislative requirements under 79AC of the Act, you must prepare and present to the Minister a draft report about your functions that includes advice and recommendations before 1 January 2020, or earlier if specified by the Minister.

You must also prepare and present to the Minister a Final Report about your functions that includes advice and recommendations before 1 July 2020, which will be tabled in the House of the Parliament, within five sitting days of the Minister receiving the final report. Reporting requirements may continue beyond 30 June 2020, should the Commissioner's position be extended beyond that date.

Additionally, you must, within three months after the end of each calendar year, prepare and give to the Minister, for presentation to the Parliament, a report on your activities during the previous calendar year, which also includes any other matters that the Minister may direct you to include in the report.

In addition to the reports that you prepare as part of your legislative requirements, it is expected that you provide input to the Department's annual report and other publications as requested from time to time.

6. Conclusion

The Government expects that the appointment of the Commissioner will benefit the rural health workforce and communities living in rural and remote areas by placing rural and remote issues at the forefront of government decision making. In your role as Commissioner, the Government expects that you will help improve rural health policies and champion the cause of rural practice in Australia. As Commissioner, you will also assist to better target Australian Government interventions to support access to services and quality of services. The Government expects that you will work cooperatively and collaboratively with the Department, rural health stakeholders, and all levels of government to develop the National Rural Generalist Pathway and progress rural health reform.

Statement of Expectations for the National Rural Health Commissioner 2019

1. Introduction

This Statement provides the Australian Government's expectations about the role and responsibilities of the National Rural Health Commissioner (the Commissioner) from receipt of this document until 30 December 2019, including the Commissioner's relationship with the Government, issues of transparency and accountability and operational matters.

The Commissioner is a statutory appointment, independent from the Department of Health (the Department) and the responsible Minister. This position has been established to independently and impartially improve rural health policies and champion the cause of rural practice.

The Government recognises and respects the statutory independence of the Commissioner. It is imperative that, as Commissioner, you act independently and objectively in performing functions and exercising powers as set out in Schedule 1 of the Part VA of the *Health Insurance Act 1973* (the Act). However, the Government expects that you take into account the Government's broad policy framework, including its agenda to reform the health workforce and improve the health outcomes of rural, regional and remote Australians, in performing your role and functions.

You have met your legislated obligations to define rural generalism and to provide advice to Government on the development of a National Rural Generalist Pathway. As per Section 79AC (1C), your advice is now sought on rural allied health workforce reform.

The responsible Minister with oversight of rural health expects to be fully informed in a timely manner about the activities of the Commissioner and any emerging trends, problems or issues in respect of its functions. If requested by the Minister, the Commissioner may also provide advice to the Minister on matters relating to rural health reform.

2. Priorities for the Rural Health Commissioner

The Commissioner will develop recommendations to Government on effective and efficient strategies that will improve access to allied health services and quality of services, and to improve the distribution of the rural allied health workforce in regional, rural and remote Australia. The final advice is due to Government no later than 30 December 2019, with consultation with the sector complete by 1 October 2019. The October-December period will be used to refine the report and consult within government.

As Commissioner, to achieve this you will:

1. *Conduct a literature review to: explore the means by which allied health services are delivered in rural, regional and remote areas; identify existing or developing issues; identify potential duplication of services provided by the Commonwealth and jurisdictions; and provide an evidence base for advice to Government.*
2. *Work with the Australian Allied Health Leadership Forum (which includes Allied Health Professions Australia, Indigenous Allied Health Australia, and Services for Australian Rural and Remote Allied Health Australia), Australian Healthcare and Hospitals Association and the National Rural Health Alliance to:*
 - a. *Prepare a discussion paper on policy options, within the Commonwealth's remit, to improve the quality, accessibility and distribution of allied health services in regional, rural and remote Australia;*
 - b. *Deliver a final report with evidence-based recommendations for consideration by the Minister;*
 - c. *Consult on policy concepts in the discussion paper. The above organisations can consult independently, on your behalf via their membership, and report back to you.*

3. *Provide advice on rural allied health matters at the request of the minister responsible for rural health.*

Separate to allied health you are also required to provide assistance to the two GP Colleges (the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine) to collaboratively pursue recognition of Rural Generalists through a protected title and specialised field within General Practice.

3. Stakeholder Relationships

Your role as Commissioner will require you to work closely with key professional allied health bodies and the Government expects that you will engage professionally and collaboratively with these stakeholders throughout your appointment.

These key bodies will in turn liaise with regional, rural and remote communities, the health sector, universities and allied health training organisations. You may also be required to work closely with state and territory governments.

A key stakeholder group is the Australian Allied Health Leadership Forum, which was established to provide a collective view for allied health by bringing together key aspects and stakeholders of the Australian allied health sector and services.

Another key stakeholder group is the Rural Health Stakeholder Roundtable (the Roundtable), which was established to promote rural health strategic discussion and to bring together key rural health stakeholders to assist the Government with informing and developing national rural health policy. The Government expects that you will engage closely with members of the Roundtable where appropriate and take part in meetings, which are held biannually.

The Government expects that you will work collaboratively and closely with the Department of Health and the Minister responsible for rural health, and that you are aware of the Government's agenda on rural health reform. Conducive to an effective working relationship, the Department will continue to consult with you on any issues that may impact on you fulfilling your statutory objective or compliance with the law.

4. Organisational Governance and Financial Management

As Commissioner, you do not hold any financial delegation powers, or have any specific employment powers. The Secretary of the Department of Health may enter into an arrangement with you for the services of APS employees in the department to be made available. This is intended as assistance for the position whilst you undertake your duties.

Further, it is requested that you continue to manage the affairs as National Rural Health Commissioner in a way that promotes the efficient, effective and ethical use of resources. In support of this and in line with the allocated budget for the position, the Department will continue to provide you with the necessary corporate support, policies and systems to fulfil the functions of your role.

Where you are assisted by staff employed by the Department of Health under the *Public Service Act 1999* you should ensure that all parties uphold and promote the Australia Public Service (APS) Values and ensure that all APS employees adhere to the APS Code of Conduct.

5. Reporting

You are expected to provide final advice to Government on the priorities outlined in this Statement of Expectations by no later than 30 December 2019, or earlier if specified by the Minister.

As part of your legislative requirements under 79AC of the Act, the Office of the Commissioner must prepare and present to the Minister a draft report about the Commissioner's functions that includes advice and recommendations before 1 January 2020, or earlier if specified by the Minister.

The Office of the Commissioner must also prepare and present to the Minister a Final Report about the Commissioner's functions that includes advice and recommendations before 1 July 2020, which will be tabled in the House of the Parliament, within five sitting days of the Minister receiving the final report. Reporting requirements may continue beyond 30 June 2020, should the Commissioner's position be extended beyond that date.

Additionally, the Office of the Commissioner must, within three months after the end of each calendar year, prepare and give to the Minister, for presentation to the Parliament, a report on the Commissioner's activities during the previous calendar year, which also includes any other matters that the Minister may direct you to include in the report.

In addition to the reports that you prepare as part of your legislative requirements, it is expected that you provide input to the department's annual report and other publications as requested from time to time.

6. Conclusion

The Government expects that the appointment of the Commissioner will benefit the rural health workforce and communities living in rural and remote areas by placing rural and remote issues at the forefront of Government decision making. In your role as Commissioner, the Government expects that you will help improve rural health policies and champion the cause of rural practice in Australia. The Government expects that you will work cooperatively and collaboratively with the Department, rural health stakeholders, and all levels of government to fulfil your legislative obligations and Government expectations of the role the National Rural Health Commission.

Statement of Expectations for the National Rural Health Commissioner 2020

Introduction

This Statement provides the Australian Government's expectations about the role and responsibilities of the National Rural Health Commissioner (the Commissioner) for the period 1 January 2020 until 30 June 2020, including the Commissioner's relationship with the Government, issues of transparency and accountability and operational matters.

The Commissioner is a statutory appointment, independent from the Department of Health (the Department) and the responsible Minister. This position has been established to independently and impartially improve rural health policies and champion the cause of rural practice.

The Government recognises and respects the statutory independence of the Commissioner. It is imperative that, as Commissioner, you act independently and objectively in performing functions and exercising powers as set out in Schedule 1 of the Part VA of the *Health Insurance Act 1973* (the Act). However, the Government expects that you take into account the Government's broad policy framework, including its agenda to reform the health workforce and improve the health outcomes of rural, regional and remote Australians, in performing your role and functions.

1. Priorities for the Rural Health Commissioner

Three areas of rural health reform have been identified for you to focus on in the first six months of 2020:

Your first priority is to refine your advice to Government on effective and efficient strategies to improve the access, quality and distribution of allied health services in regional, rural and remote Australia. Due to the significant reforms that you are suggesting, it is important that the report outlines priorities for implementation; potential barriers; and other practical implementation considerations.

Your second priority will be to provide assistance as required to the GP Colleges, regarding the Rural Generalist Medicine specialist recognition application to the Medical Board of Australia. Support only need be provided if requested by the GP Colleges, noting that a large part of this work is already underway. It is expected that this will be a secondary role for you in 2020.

Your third and final priority, as part of your existing consultative work, is to identify strategic opportunities to champion the \$62.2 million roll out of the National Rural Generalist Pathway (the Pathway). Noting the significant contribution you have made in providing advice on the development of the Pathway, your role will involve:

- Provide clear advice on timelines for implementation;
- advising on the role and function of jurisdictional coordination units; and
- assisting the Commonwealth to convene a Rural Generalist Jurisdictional Forum and a separate Steering committee to oversee and coordinate the ongoing work of the Pathway.

It is expected that you will work closely with the Department in relation to the above priorities, particularly Health Workforce Division, Primary Care Division and Indigenous Health Division.

The responsible Minister with oversight of rural health expects to be fully informed in a timely manner about the activities of the Commissioner and any emerging trends, problems or issues in respect of its functions. If requested by the Minister, the Commissioner may also provide advice to the Minister on matters relating to rural health reform.

2. Stakeholder Relationships

The three areas of rural health reform will require you to work closely with a variety of stakeholders including: professional allied health bodies; the two GP colleges; LHDs, PHNs, ACCHOs, the Rural Doctors Association of Australia, Services for Australian Rural and Remote Allied Health, the Australian Health and Hospital Association, the National Rural Health Alliance, the Australian Medical Association, the Australian Allied Health Leadership Forum and the university sector. The Government expects that you will engage professionally and collaboratively with these stakeholders throughout your appointment.

Another key stakeholder group is the Rural Health Stakeholder Roundtable (the Roundtable), which was established to promote rural health strategic discussion and to bring together key rural health stakeholders to assist the Government with informing and developing national rural health policy. The Government expects that you will engage closely with members of the Roundtable where appropriate and take part in meetings, which are held biannually.

The Government expects that you will work collaboratively and closely with the Department of Health and the Minister responsible for rural health, and that you are aware of the Government's agenda on rural health reform. Conducive to an effective working relationship, the Department will continue to consult with you on any issues that may impact on you fulfilling your statutory objective or compliance with the law.

3. Organisational Governance and Financial Management

As Commissioner, you do not hold any financial delegation powers, or have any specific employment powers. The Secretary of the Department of Health may enter into an arrangement with you for the services of APS employees in the department to be made available. This is intended as assistance for the position whilst you undertake your duties.

Further, it is requested that you continue to manage the affairs as National Rural Health Commissioner in a way that promotes the efficient, effective and ethical use of resources. In support of this and in line with the allocated budget for the position, the Department will continue to provide you with the necessary corporate support, policies and systems to fulfil the functions of your role.

Where you are assisted by staff employed by the Department of Health under the *Public Service Act 1999* you should ensure that all parties uphold and promote the Australia Public Service (APS) Values and ensure that all APS employees adhere to the APS Code of Conduct.

4. Reporting

You are expected to provide drafts of the implementation plan and updated allied health report by 15 April 2020, with the final versions due on 30 June 2020. You are also required to submit a stakeholder engagement plan for Ministerial approval by 1 February 2019, which will outline key stakeholders and opportunities to communicate with them to market the \$62.2 million National Rural Generalist Pathway.

As noted in your previous Statement of Expectations (dated July 2019) as part of your legislative requirements under 79AC of the Act, the Office of the Commissioner must prepare and present to the Minister a draft report about the Commissioner's functions that includes advice and recommendations before 1 January 2020, or earlier if specified by the Minister.

The Office of the Commissioner must also prepare and present to the Minister a Final Report about the Commissioner's functions that includes advice and recommendations before 30 June 2020, which will be tabled in the House of the Parliament, within five sitting days of the Minister receiving the final report.

Additionally, the Office of the Commissioner must, within three months after the end of each calendar year, prepare and give to the Minister, for presentation to the Parliament, a report on the Commissioner's activities during the previous calendar year, which also includes any other matters that the Minister may direct you to include in the report.

In addition to the reports that you prepare as part of your legislative requirements, it is expected that you provide input to the department's annual report and other publications as requested from time to time.

5. Conclusion

The Government expects that the appointment of the Commissioner will benefit the rural health workforce and communities living in rural and remote areas by placing rural and remote issues at the forefront of Government decision making. In your role as Commissioner, the Government expects that you will help improve rural health policies and champion the cause of rural practice in Australia. The Government expects that you will work cooperatively and collaboratively with the Department, rural health stakeholders, and all levels of government to fulfil your legislative obligations and Government expectations of the role the National Rural Health Commission.

Appendix Two: List of Consultations

Australian Government Ministers

The Hon Mark Coulton MP, Minister for Regional Health, Regional Communications and Local Government

The Hon Greg Hunt MP, Minister for Health

The Hon Dan Tehan MP, Minister for Education

The Hon Ken Wyatt MP, Minister for Indigenous Affairs

Senator the Hon Bridget McKenzie, former Minister for Regional Services, Minister for Sport, Minister for Local Government and Decentralisation

The Hon Dr David Gillespie MP, former Assistant Minister for Health

Senator the Hon Matt Canavan, Chair of the Northern Australia Advisory Council

Federal Parliament

Standing Committee on Community Affairs – *Inquiry into the accessibility and quality of mental health services in rural and remote Australia*

The Hon Rowan Ramsay MP, Member for Grey

The Hon Tony Zappia MP, Member for Makin

Former Senator the Hon John Williams

Senator the Hon David Fawcett

Commonwealth Department of Health

Ms Glenys Beauchamp PSM, Secretary

Professor Brendan Murphy, Chief Medical Officer

A/Professor Debra Thoms, Chief Nursing and Midwifery Officer

Ms Caroline Edwards, Deputy Secretary, Health Systems Policy and Primary Care Group

Mr David Hallinan, First Assistant Secretary, Health Workforce Division

Ms Chris Jeacle, Assistant Secretary, Rural Access Branch

Ms Fay Holden, Assistant Secretary, Health Training Branch

Ms Lynne Gillam, First Assistant Secretary, Health Workforce Reform Branch

Ms Maria Jolly, First Assistant Secretary, Indigenous Health Division

Mr Chris Bedford, Assistant Secretary, Primary Health Networks Branch

Mr Simon Cotterell, First Assistant Secretary Primary Care and Mental Health Division

Mr Mark Cormack, Previous CEO, Health Workforce Australia

A/Professor Andrew Singer, Principal Medical Advisor, Health Workforce Division

A/Professor Susan Wearne, Senior Medical Advisor, Health Workforce Division

Ms Rosalind Knox, Allied Health Advisor, Primary Care, Dental and Palliative Care Branch

Ms Maureen Lewis, Deputy CEO, National Mental Health Commission

Ms Lucinda Brogden, Commissioner, National Mental Health Commission

Dr Lucas De Toca, Principal Medical Advisor, Office of Health Protection and Acting First Assistant Secretary, Primary Care and Mental Health Division

Dr Chris Carslile, Assistant Secretary, Office of Health Protection

Branches and Divisions

Health Training Branch, Health Workforce Division
Health Workforce Reform Branch, Health Workforce Division
Rural Access Branch, Health Workforce Division
Diagnostic Imaging and Pathology Branch, Medical Benefits Division
Strategy and Evidence Branch, Indigenous Health Division
Primary Health Networks Branch, Primary Care and Mental Health Division
Primary Care, Dental and Palliative Care Branch, Primary Care and Mental Health Division
Pharmacy Branch, Technology Assessment and Access Division

Department of Social Services

National Disability Insurance Scheme, Market Reform Branch
National Disability Insurance Agency, Thin Market Strategy Group – Mr Thomas Abhayaratna, Ms Corin Moffat, Ms Alice Tickner, Greg Perrett, Aleisja Henry

National and International Committees and Expert Groups

Australian Allied Health Leadership Forum
Distribution Working Group
Distribution Advisory Group
Primary Health Care COVID Response
Rural GP Respiratory Clinic National Leaders Network - Chair
Rural Generalist Recognition Taskforce - Chair
Rural Health Stakeholder Roundtable
World Health Organisation – Rural Health Workforce Attraction, Recruitment and Retention Guideline Development Group

National Organisations

Allied Health Professions Australia – Ms Claire Hewat CEO; Ms Lin Oke, EO
Allied Health Professions Australia Rural and Remote – Ms Nicole O'Reilly, Convenor
Australia and New Zealand College of Anaesthetists – Dr Rod Mitchell, President
Australian College of Emergency Medicine - Dr Simon Judkins, President; Dr Peter White, CEO
Australian College of Rural and Remote Medicine – A/Professor Ruth Stewart and A/Professor Ewen McPhee, Presidents; Ms Marita Cowie, CEO
Australian College of Rural and Remote Medicine – Council
Australian Council of Deans of Health Sciences – Council
Australian Dental Association - Ms Eithne Irving, Deputy CEO
Australian Health and Hospitals Association – Ms Deborah Cole Chair; Ms Alison Verhoeven, CEO; Ms Kylie Woolcock, Policy Director
Australian Hearing Services – Ms Sarah Vaughan, Board Director
Australian Indigenous Doctors Association - Dr Kali Haywood, President; Mr Craig Dukes and Dr Monica Barolits-McCabe, CEOs
Australian Institute of Health and Welfare – Health Systems Group – Mr Jason Thompson
Australian Medical Association – Dr Michael Gannon and Dr Tony Bartone, Presidents; Dr Warwick Hough, Director - General Practice and Workplace Policy; Dr Martin Laverty – Secretary General

Australian Medical Association Council of Doctors in Training

Australian Medical Association Council of Rural Doctors

Australian Medical Association Federal Council

Australian Medical Students Association - Ms Alex Farrell, President

Australian Medical Students Association Rural Health Committee - Ms Nicole Batten; Ms Gaby Bolton; Ms Candice Day; Ms Sarah Clark; Ms Jasmine Elliott

Australian Medical Council

Australian Psychological Association – Ms Frances Mirabelli, CEO

Australian Physiotherapy Association – Mr Phil Calvert, National President; Ms Anja Nikolic, CEO

Australian Rural Health Education Network - Dr Lesley Fitzpatrick, CEO; Ms Janine Ramsay, National Director

Australian Society of Anaesthetists – Prof David Scott

Australasian College of Paramedic Practitioners – Mr Andrew McDonnell, President

Coalition of National Nursing and Midwifery Organisations

Council of Aboriginal and Torres Strait Islander Nurses and Midwives – Ms Janine Mohammed, CEO

Council of Presidents of Medical Colleges - Dr Phil Truskett, President; Ms Angela Magarry, CEO

CRANaplus - Mr Christopher Cliffe, CEO

Cultural Fusion – Dr Shane Houston, Director; Mr Shane Perdue

Federation of Rural Australian Medical Educators – National Executive

GP Registrars Association – Dr Andrew Gosbell, CEO

GP Supervisors Association – Dr Steve Holmes, President; Mr Glen Wallace, CEO

Healius Institute – Mr Mark Priddle; Dr Shirley Fung

Health Professions Accreditation Councils' Forum

Indigenous Allied Health Australia - Ms Donna Murray, CEO; Allan Groth, COO

KBC Consulting – Dr Kristine Battye, Director; Dr Cath Sefton, Senior Consultant

Medical Board of Australia - Dr Joanna Flynn, Chair

Medical Deans Australia and New Zealand – Ms Helen Craig, CEO; Professor Richard Murray, President; Executive

Medical Travel Companions – Mr Ben Wilson, CEO

National Aboriginal Community Controlled Health Organisation – Dr Dawn Casey, Deputy CEO

National Aboriginal and Torres Strait Islander Health Worker Association – Mr Karl Briscoe, CEO

National Disability Insurance Agency

National Medical Training Advisory Network (NNMTAN)

National Rural Health Alliance - Mr Mark Diamond, Dr Gabrielle O'Kane, CEOs/ Ms Tanya Lehmann, Chair

National Rural Health Student Network – Ms Ashley Brown, Mr Harry Jude, Presidents; Mr Krishn Parmer, Allied Health Officer

Optometry Australia, Rural Optometry Group – Mr Phillip Anderton, Convenor; Simon Hanna, Clinical Consultant; Libby Boshchen, Special Advisor; Sarah Davies, Policy and Advocacy Manager; Simon Hanna, Professional Development and Clinical Development Manager

Osler Technology – Mr Todd Fraser, Director

Pharmaceutical Society of Australia - Mr Shane Jackson, National President

Pharmacy Guild of Australia – Ms Suzanne Greenwood, Executive Director.

Procedural Medicine Collaboration – Dr Bruce Chater, Chair
Regional Training Organisations Network
Remote Vocational Training Scheme - Dr Pat Giddings, CEO; Dr Tom Doolan, Chair
Royal Australian College of General Practitioners - Dr Bastian Seidel, Dr Harry Nespolon, Presidents;
Dr Zena Burgess, Mr Nick Williamson, CEOs
Royal Australian College of General Practitioners – Council
Royal Australian College of General Practitioners Rural Faculty – A/Professor Ayman Shenouda, Chair
Royal Australia and New Zealand College of Obstetricians and Gynaecologists – Dr Vijay Roach,
President; Ms Vase Jovoska, CEO; Rural Council Forum
Royal Australia and New Zealand College of Ophthalmology – Dr Cathy Green, Dean of Education,
and Policy team
Royal Australasian College of Physicians - Professor Donald Campbell
Royal Australasian College of Surgeons – Mr John Batten, President
Royal Flying Doctors Service – Dr Martin Laverty, CEO;
Mr Frank Quinlan, Federation Executive Director
RFDS Federation Board of Directors, RFDS Vic Board of Directors; Dr Tony Vaughan, CEO RFDS
Central; Dr Mardi Steere; Dr Clive Hume, RFDS Central
Rural Doctors Association of Australia – Dr Adam Coltzau, President; Ms Peta Rutherford, CEO
Rural Doctors Association of Australia Junior Doctors Forum
Rural Doctors Association of Australia Specialists Group
Rural Workforce Agency Network – Ms Lyn Poole and Ms Megan Cahill, Chairs
Rural Health Workforce Australia – Mr Edward Swan, Executive Officer
Services for Australian Rural and Remote Allied Health – Mr Rob Curry President; Mr Jeff House and
Ms Cath Maloney, CEOs
Stroke Foundation – Ms Sharon McGowan, CEO
Universities Australia – Ms Rachel Yates
University of the Sunshine Coast – Dr Lucas Litewka, Director Clinical Trials

Australian Capital Territory

The Hon Meegan Fitzharris, ACT Minister for Health and Wellbeing, Higher Education, Medical and
Health Research, Transport and Vocational Education and Skills
ACT Health – Ms Helen Matthews, CEO
Aspen Medical - Mr Andrew Parnell, Government and Strategic Relationship Director
National Health Co-op - Mr Blake Wilson, General Manager; Adrian Watts, CEO

Northern Territory

The Hon Natasha Fyles, Attorney-General and Minister for Justice; Minister for Health
Central Australian Health Service – Dr Samuel Goodwin, Executive Director Medical and
Clinical Services
FCD Health – Ms Robyn Cahill, CEO
Flinders University – A/Prof Tina Noutsos; Dr Sam Heard
Northern Territory General Practice Education (NTGPE) - Mr Stephen Pincus, CEO
Northern Territory Medical Program – Prof John Wakerman, Associate Dean
Northern Territory Primary Health Network – Ms Nicki Herriot, CEO
Territory Health Services – Dr Hugh Heggie, NT Chief Health Officer and Executive Director Public

Health and Clinical Excellence; Dr Len Notaras and Ms Catherine Stoddart, CEOs
Territory Health Services – Heather Malcolm, Principal Allied Health Officer

Western Australia

Office of the Minister for Health - Neil Fergus, Chief of Staff; Julie Armstrong, Senior Policy Advisor
WA Department of Health - Dr DJ Russell-Weisz, Director General
Broome Aboriginal Medical Service – Dr David Atkinson and staff
Broome Health Campus - Dr Sue Phillips, Senior Medical Officer
Broome Regional Hospital Junior Doctors – Meeting
Curtin Medical School - Prof William Hart, Dean of Medicine
Dr Kim Pedlow -Geraldton
Fitzroy Crossing Hospital and Renal Dialysis Unit - staff
Healthfix Consulting - Mr Kim Snowball, Director
Kimberley Aboriginal Medical Service Executive – Ms Vicki O’Donnell CEO and staff -
Nindilingarri Cultural Health Service – Ms Maureen Carter, CEO and staff, Fitzroy Crossing
Rural Health West – Mr Tim Shakleton, CEO; Ms Kelli Porter, General Manager Workforce; RHW Board
Rural Clinical School of WA – Dr Andrew Kirke, Director, Bunbury; Prof David Atkinson, Former Director,
Broome Staff and Students
University of Western Australia – Ms Vivienne Duggin, Ms June Foulds, Regional Training Hub
WA Country Health Service - Mr Jeff Moffet, CEO; Dr Tony Robins, EDMS; Dr David Gaskell, DMS
Kimberley Region; Dr David Oldham, Director of Postgraduate Medical Education
WA Department of Health – Dr James Williamson, A/g Chief Medical Officer; Dr Paul Myhill, Senior
Medical Advisor, Medical Workforce and Strategic Planning
WA Department of Health – Jenny Campbell, Chief Health Professions Officer
WA Primary Health Alliance – Ms Linda Richardson, General Manager
WAGPET - Prof Janice Bell, CEO; Dr Chris Buck
Western Australia Health Translation Network - Assistant Director, Dr James Williamson

Queensland

Apunipima Cape York Health Council – Dr Mark Wenitong; Dr Paul Stephenson
Central Queensland HHS – Mr Steve Williamson, CEO; Ms Kerrie-Anne Frakes, Executive Director
Strategy, Transformation and Allied Health,
Central Queensland University - Professor Fiona Coulson, Deputy Vice Chancellor, Strategic
Development and Growth
Central West Health Service- Dr David Rimmer, DMS and Executive members
Central West PHN - Ms Sandy Gillies, Manager and staff
Condamine Medical Centre – Dr Lynton Hudson and Dr Brendon Evans
Darling Downs Health and Hospital Service – Dr Peter Gillies, CEO
Darling Downs HHS, Queensland Country Practice – Dr Hwee Sin Chong, Executive Director;
Dr Dilip Duplelia, Director Medical and Clinical Services, Rural and Remote Medical Support;
Dr Denis Lennox, Previous Director
Dr Col Owen - Past President RDAA and RACGP, Inglewood
Gidgee Healing – Ms Renee Blackman, CEO
Goondiwindi Hospital – Dr Sue Masel DMS; Lorraine McMurtrie DON; and staff

Goondiwindi Medical Centre – Dr Matt Masel, staff, registrars and students
Health Workforce Queensland – Mr Chris Mitchell, CEO
Institute of Health Biomedical Innovation - Professor Julie Hepworth
James Cook University – Centre for Rural and Remote Health, Mt Isa, Prof Sabina Knight, Director
James Cook University - Centre for Rural and Remote Health, Longreach, Rural Generalist trainees
James Cook University – College of Healthcare Services, A/Prof Rebecca Sealey, Dean;
Prof Lee Stewart, Dean
James Cook University – College of Medicine and Dentistry, Prof Richard Murray, Dean;
James Cook University – College of Nursing and Midwifery, Prof John Smithson, A/Academic Head
James Cook University – Dr Trish Wielandt, Academic Head, Occupational Therapy and Speech
Pathology
James Cook University – Lisa Vandommele, A/Director, Academic Quality and Strategy
James Cook University – Prof Ian Wronski, Deputy Vice Chancellor
Longreach Family Medical Practice – Dr John Douyere and staff
Longreach Hospital - Dr Clare Walker and staff – Meeting and Multi-Disciplinary Ward Round
North West Health and Hospital Service – Ms Lisa Davies-Jones, CEO
Northern Beaches GP Superclinic – Dr Kevin Gillespie
Queensland Health – Ms Ilsa Nielsen, A/Director Allied Health Professions’ Office of Queensland
Queensland Health - Ms Kathleen Forrester, Deputy Director General Strategy, Policy and Planning
Division
Queensland Health – Ms Liza-Jane McBride, Chief Allied Health Officer
St George Hospital – Dr Adam Coltzou, DMS, GP staff, junior doctors and students
Stanthorpe Hospital – Dr Dan Manahan, DMS; Dr Dan Halliday, ACRRM Board Member,
Ms Vickie Batterham, A/DON and staff
Stanthorpe Medical Practitioners – GPs, Junior Doctors and Hospital Staff – Meeting
Torres and Cape Health and Hospital Service Executive, Thursday Island
University of Queensland Regional Training Hub - Dr Ewen McPhee, Director, Rockhampton
University of Queensland Rural Clinical School – Dr Belinda O’Sullivan, Research Fellow
Warwick Hospital - Dr Blair Koppen, Medical Superintendent; Anita Bolton DON; and RG trainees
Western Queensland Primary Health Network – Mr Stuart Gordon, CEO

New South Wales

The Hon Brad Hazzard, MP, Minister for Health
The Hon Kevin Anderson, MP, Member for Tamworth
Broken Hill Public School – Mr Michael Fisher, Principal
Charles Sturt University – Ms Fiona Nash, Strategic Advisor Regional Development; Prof Megan Smith
Deputy Dean
Clinical Excellence Commission – Ms Carrie Marr, CE
Dr Louise Baker - Cowra
Forbes Medical Centre – Dr Neale Somes, Dr Glenn Pereira, Dr Herment Mahagaonkar
Glenrock Country Practice, Wagga Wagga - Dr Ayman Shenouda, Dr Samiha Azab, Ms Tania Cotterill,
Practice Manager; Dr Annie Woodhouse, psychologist
GP Synergy – Dr John Oldfield, CEO; Dr Vanessa Moran, Director of Education and Training
Hunter New England Local Health District – Mr Michael Dirienzo, Chief Executive; Dr Kim Nguyen,

Executive Director, Workforce and Allied Health
Inverell Medical Centre - Dr Cheryl McIntyre
Inverell Town Rural Doctors – Meeting
Maari Ma Aboriginal Health Service – Mr Bob Davis, CEO
Molong Health Service and District Hospital – Dr Robyn Williams
Murrumbidgee Local Health District – Ms Jill Ludford, Chief Executive; Dr Wendy Cox, Executive Director of Medical Services
Murwillumbah District Hospital and University Centre for Rural Health, King St Medical Centre - Dr John Moran
National Party Room Meeting, NSW Parliament, Sydney
North Coast Allied Health Association – Jacqui Yoxall, Director
Northern Rivers University Department of Rural Health – Dr John Moran
NSW Ministerial Advisory Committee for Rural Health
NSW Ministry of Health – Andrew Davidson, Chief Allied Health Officer
NSW Ministry of Health - Dr Linda McPherson, Medical Advisor Workforce and Planning
NSW Ministry of Health - Dr Nigel Lyons, Deputy Secretary, Strategy and Resources
NSW Ministry of Health – Hassan Kadous, Principal Allied Health Advisor
NSW Ministry of Health – Health Education and Training Institute - A/Prof Kathleen Atkinson, NSW Statewide Director
NSW Ministry of Health – Mr Richard Griffiths, Executive Director, Workforce Planning and Talent Development Branch
NSW Regional Health Partners – Prof Christine Jorm
NSW Rural Doctors Network – Mr Richard Colbran, CEO and Executive
Parkes District Hospital – Staff and junior doctors meeting
Royal Far West - Ms Lindsay Cane, CEO
Royal Flying Doctors Service – Mr Greg Sam, CEO, South Eastern Division; Dr Justin Gladman, RFDS South-Eastern
University Centre for Rural Health, Lismore – Professor Ross Bailie, Director
University of New England - Professor Rod McClure, Dean, Faculty of Medicine
University of Newcastle Rural Clinical School, Tamworth – Prof Jenny May, Director; Dr Luke Wakely, Dr Rebecca Wolfgang, Dr Katrina Wakely, Allied Health Academics
University of Notre Dame Rural Clinical School, Wagga Wagga – Professor Joe McGirr, Director and staff
University of NSW Rural Clinical School, Wagga Wagga – student, junior doctor and consultant meeting
University of Sydney - Professor Arthur Conigrave, Dean, Faculty of Medicine
University of Sydney Rural Clinical School, Dubbo – Medical Student and Early Career Doctors Meeting
University of Western Sydney, Bathurst – Rural Mental Health Roundtable, Dr Robyn Vines
University of Western Sydney Rural Clinical School – Ms Jane Thompson, Rural Program Co-Ordinator; Dr Ross Wilson; Dr Sandra Mendel
University of Wollongong – Professor Andrew Bonney; A/Professor David Garne
Western NSW Local Health District - Dr Shannon Nott, Rural DMS – Dubbo
Western NSW Local Health District – GP Proceduralist meeting - Dubbo
Western NSW Local Health District – Mr Richard Cheney – Director, Allied Health
Western NSW Local Health District – Mr Scott McLaughlin, CE and Executive

Western NSW Primary Health Network – Dr Tim Smyth Chair; Dr Robyn Williams Chair;
Mr Andrew Harvey, CEO

Westmead Hospital – Prof Ada Guastella, Brain and Mind Centre

South Australia

The Hon Stephen Wade MP, Minister for Health and Wellbeing

The Hon Peter Treloar MP, Member for Flinders, South Australia

Department of Health and Wellbeing - Christopher McGowan, Chief Executive

Country Health SA – Ms Maree Geraghty, CEO; Dr Hendrika Meyer, Executive Director Medical Services; Dr Robyn Anderson Principal Clinical Policy Officer

Doctors Health SA – Dr Roger Sexton, Medical Director

Dr Ben Abbott, Rural Generalist Surgeon, Jamestown

Dr John Williams, Port Lincoln

Dr Peter Clements, Rural Generalist Educator, Adelaide

Flinders University - Professor Jonathan Craig, Vice President and Executive Dean

Flinders University - Professor Lambert Schuwirth, Strategic Professor in Medical Education,

Flinders University – College of Nursing and Health Sciences – Mr Chris Brenber, Dean of Education

Flinders University Department of Rural Health - Professor Jennene Greenhill, Director;
Professor Lucie Walters

GPEX - Ms Chris Cook, CEO

Health Transition – Ms Wendy Keech

Royal Flying Doctors Service Central Operations – Dr Mardi Steere, Executive General Manager

Rural Doctors Workforce Agency - Ms Lyn Poole, CEO

Rural Generalist Pathway Steering Committee

Rural Health Workforce Strategy Steering Committee

SA Health – Catherine Turnbull, Chief Allied Health and Scientific Officer

SA Health – Ms Julianne O'Connor, Principal Consultant Allied Health

University of Adelaide – Professor Benjamin Kile, Executive Dean, Faculty of Health Sciences;
Professor Ian Symonds, Dean of Medicine; A/Prof Hakan Muyderman; Prof Lucie Walters, Director
Adelaide University Rural Clinical School

University of South Australia – College of Health Sciences - Prof Esther May, Dean

University of South Australia – Department of Rural Health – A/Prof Martin Jones, Director

Victoria

The Hon Jill Hennessy MP, Minister for Health

Allied Health and Community Services Workforce – Ms Kate Boucher, Principal Policy Advisor

Attend Anywhere Video Consulting Programs – Mr Chris Ryan, Director, Melbourne

Ballarat Health Services – Allied Health Leadership team

Bendigo Health – Mr Peter Faulkner CEO, Bendigo

Bendigo Hospital – junior doctor and student meeting, Bendigo

Border Medical Association - Dr Scott Giltrap, Chair and members

Echuca Regional Health – Mr Nick Bush, CEO

Gippsland Primary Health Network – Ms Theresa Tierney, Chair; Ms Amanda Proposch, CEO

Glenelg Shire Workforce Group, Meeting, Portland

Goulburn Valley Regional Training Hub – Ms Mimi Zilliacus, Manager
Hayfield Medical Centre – Dr Peter Stephen; Dr Sarah Christenson
Western District Health Service, Hamilton – Rohan Fitzgerald, CEO
La Trobe University – Prof John Dewar, Vice Chancellor; Prof Timothy Skinner, University Department of Rural Health
Latrobe Community Health Service – Ms Judi Walker, Director
Latrobe Health Advocate – Ms Jane Anderson
Monash University, School of Rural Health – Professor Robyn Langham and staff; Emeritus Prof John Humphreys; Dr Deborah Russell, Adjunct Senior Research Fellow
Murray Primary Health Network – Mr Matt Jones, CEO
Murray to Mountains Intern Program – Mr Shane Boyer; Dr Jack Best, Shepparton
Portland District Hospital – Christine Giles, CEO
Royal Flying Doctors Service – Mr Denis Henry, Chair; Rural Health Sustainability Project staff, Mildura
Rural and Regional CEO Forum, Melbourne
Rural Health Forum - La Trobe University and Murray PHN, Mildura
Rural Workforce Agency Victoria - Ms Megan Cahill, CEO
Safer Care Victoria – Ms Donna Markham, Chief Allied Health Officer
Safer Care Victoria - Professor Euan Wallace, CEO
Victorian Department of Health and Human Services - Mr Dean Raven, Director, Dr Claire Langdon A/ Director Workforce Strategy and Planning; Ms Tarah Tsakonas, Senior Policy Advisor
Western Victoria Health Accord – Meeting, Portland
Western Victoria Primary Health Network – Ms Leanne Beagley, CEO

Tasmania

The Hon. Michael Ferguson MP, Minister for Health
Department of Health - Dr Allison Turnock, Medical Director GP and Primary Care; Ms Lorraine Wright, Senior Consultant, Strategic Workforce
Department of Health – Ms Kendra Strong, Chief Allied Health Officer
Dr Brian Bowring, Dr Tim Mooney, Rural Generalists, Georgetown
Dr Rohan Kerr
HR+ Rural Workforce Agency – Mr Peter Barns CEO, Launceston
North West Health Service - Dr Rob Pegram, Executive Director of Medical Services
Professor Richard Hays, Rural Medical Generalist, Hobart

New Zealand

The Hon Dr David Clarke, Health Minister – New Zealand
Rural General Practice Network New Zealand – Dr Dalton Kelly, CEO
University of Waikato – A/Prof Kirstin Petrie

Presentations and Meetings

“Are You Remotely Interested?” Conference; Realising Remote Possibilities, Centre for Rural and Remote Health, Mount Isa, Qld
10th Anniversary of the Joint Medical Program, Armidale, NSW
AMSA Rural Health Summit Albury, Vic

Association for Medical Education Europe 2018 Annual Conference, Basel, Switzerland
Association for Medical Education Europe 2019 Annual Conference, Vienna, Austria
Australian and New Zealand Society of Palliative Medicine Annual Conference, Melbourne, Vic
Australian College of Health Service Managers Congress, Darwin, NT
Australian College of Health Service Managers National Podcast
Australian Colleges of Health Service Managers Graduation, Brisbane, Qld
Australian Medical Council AGM 2018, Launceston, Tas
Australian Primary Health Care Research Conference, Melbourne, Vic
Australian Rural Health Education Network Board Meeting, Canberra, ACT
Barossa Medical Practitioners Meeting, Angaston, SA
Bowen and Collinsville Health Action Group Meeting
Central Queensland HHS Clinical Senate, Rockhampton, Qld
Central West Hospital and Health Service Board and Medical Staff Meeting, Longreach, Qld
Coalition of National Nursing and Midwifery Organisations Meeting, Sydney, NSW
Consortium of Longitudinal Integrated Clerkships International Meeting, Vancouver, Canada
Council of the Presidents of Medical Colleges – Council Meeting
CRANaplus 36th Annual Conference, Think Global Act Local, Cairns, Qld
Flinders University Regional Training Hub Launch, Mt Gambier, SA
General Practice Supervisors Liaison Officer Network, Brisbane, Qld
General Practice Training and Education Conference, Melbourne 2019
Griffith Rural Medicine Retreat, Griffith, NSW
Gippsland PHN Combined Clinical and Advisory Council Meeting, Sale, Vic
GP Synergy, Farm Safety Workshop, Dubbo NSW
Health Professions Accreditation Collaborative Forum, Melbourne, Vic
Hills Mallee Fleurieu Student Welcome Dinner, Angaston, SA
Hunter New England Professional Development Program for Doctors, Pt Stephens, NSW
Indigenous Allied Health Australia Conference, Darwin, NT
Innovations in Health Professions Education Workshop, Institute of Medicine, Washington, USA
International Medical Muster, Mount Gambier, SA
La Trobe University Rural Health Forum, Mildura, Vic
Medical Deans ANZ Annual Mid-Year Meeting, Canberra, ACT
Medical Oncology Group of Australia Annual Scientific Meeting, Adelaide, SA
Ministerial Advisory Committee for Rural Health, Queanbeyan, NSW
Murray to Mountains Rural Intern Training Program Annual Dinner, Shepparton, Vic
Murrumbidgee PHN Board Meeting, Griffith, NSW
NAHAC/ACDHS Joint Meeting, Melbourne, Vic
National Association of Field Experience Administrators 2019 Annual Conference, Toowoomba, Qld
National GP Training Advisory Council, Melbourne, Vic
National Primary Care Strategy Allied Health Roundtable, Melbourne, Vic
National Regional Training Hubs Forum, Canberra, ACT
National Rural Health Alliance Conference, Hobart, Tasmania
National Rural Health Alliance Council Meeting

National Rural Health Conference, Hobart, Tas
National Rural Health Student Network Council Meeting, Adelaide, SA
National Rural Training Hubs Conference, Sydney, NSW
New Zealand Rural Health 2019 Conference, Blenheim, NZ
NSW Bilateral Regional Health Reform Meeting, Wagga Wagga, NSW
NSW Local Health Districts and Regional Training Hubs Meeting, Sydney, NSW
NSW Agency for Clinical Innovation Rural Health Network Executive Meeting, Queanbeyan, NSW
NT PHN Board Meeting, Darwin, NT
PHN North and Central West Queensland Health Forum, Mt Isa, Qld
Prevocational Medical Education Forum 2018, Melbourne, Vic
Primary Health Networks Rural CEOs Annual Meeting, Canberra, ACT
Primary Health Networks National Forum 2019, Canberra, ACT
Primary Care Reform Consultation Group Meeting, Melbourne, Vic
Procedural Medicine Collaboration national meeting
Prideaux Centre for Research in Health Professions Education, Adelaide, SA
Queensland Health Improving Healthcare through Integration Forum, Brisbane, Qld
RACGP Annual Convention 2017, Sydney, NSW
RACGP Annual Convention 2018, Gold Coast, Qld
RACGP Annual Convention 2019, Adelaide, SA
RDAA/ACRRM Rural COVID-19 National Webinar
RDASA 2018 Annual Meeting, Adelaide, SA
Regional Workforce Forum “*Who will look after me?* A future Medical Workforce for Central Queensland”, Rockhampton, Qld
Royal Australasian College of Physicians (SA), Annual Scientific Meeting 2018, Adelaide, SA
Royal Australasian College of Physicians SA, Annual Scientific Meeting, Adelaide, SA
Royal Australasian College of Surgeons – Rural Surgical Workforce Summit, Melbourne, Vic
Royal Australasian College of Surgeons Tristate Annual Scientific Meeting, Pt Lincoln, SA
Royal Australia and New Zealand College of Obstetrics and Gynaecology Council, Melbourne, Vic
Rural Doctors Association of Australia - Council Meeting
Rural Doctors’ Association of South Australia Annual Conference, Adelaide, SA
RDAQ Annual Meeting, Brisbane, Qld
Rural Doctors Workforce Agency Annual Conference, Adelaide, SA
Rural Health Workforce Agencies Network, Adelaide, SA
Rural Health Workforce Strategy Steering Committee, Adelaide, SA
Rural Medical Specialist Training Summit, Sydney, NSW
Rural Medicine Australia 2017, Melbourne, Vic
Rural Medicine Australia 2018, Darwin, NT
Rural Medicine Australia 2019, Gold Coast, Qld
Rural Mental Health Roundtable, Bathurst, NSW
Rural and Remote Primary Health Care Strategy Roundtable, Adelaide, SA
6th Rural and Remote Health Scientific Symposium, Canberra, ACT
Rural Workforce Forum, NSW Health in conjunction with Local Health Districts & the Regional Training

Hubs, Sydney, NSW

SARRAH Webinar – The Fragile Forgotten: Providing and Receiving NDIS Services in Rural Areas

SA/WA Health and Grants Network, Adelaide, SA

Services for Australian Rural and Remote Allied Health (SARRAH) 2018 Conference, Darwin, NT

Seventh Rural Health and Research Conference, Tamworth, NSW

South Australia Allied Health Research Forum, Adelaide, SA

South Australian Digital Showcase, Adelaide, SA

Stanthorpe Health Service Clinical Staff Meeting, Stanthorpe, Qld

Sustainable Rural Generalist Employment Models Forum, Pt Augusta, SA

Tasmanian Rural Health Conference, Launceston, Tas

Third Annual Vietnam National Medical Education Conference, Haiphong, Vietnam

Towards Unity in Health International Conference, Darwin, NT

Universities Australia Health Professionals Education Standing Group Meeting

University of Adelaide Medical Graduation Ceremony, Adelaide, SA

Victorian Health Accord Clinical Council Conference, Melbourne, Vic

Victorian Rural and Regional Public Health Service CEO Forum, Melbourne, Vic

WA Rural Health Conference 2019, Perth, WA

Western Victoria PHN Board and Clinical and Community Advisory Forum, Ballarat, Vic

Western NSW Innovation Symposium, Dubbo, NSW

Western NSW Primary Health Workforce Planning Forum, Dubbo, NSW

Western NSW Virtual Rural Generalist Network Launch, Dubbo, NSW

WONCA World Rural Health Conference 2019, New Delhi, India

WONCA World Rural Health Conference 2019, Albuquerque, USA

World Health Organisation Fourth Global Forum on Human Resources for Health, Dublin, Ireland

World Health Organisation Rural Health Workforce Attraction, Recruitment and Retention Guidelines Development Group, Dalaman, Turkey

National Rural Generalist Pathway Advisory and Reference Groups

National Rural Generalist Taskforce

Professor Paul Worley - Chair

Dr Kaye Atkinson

Dr Adam Coltzau

Ms Marita Cowie

Mr Jeff Moffet

A/Professor Ayman Shenouda

A/ Professor Ruth Stewart

Dr Yousuf H. Ahmad

Professor David Atkinson

Professor Amanda Barnard

Dr Mike Beckoff

Mr George Beltchev

A/ Professor David Campbell

Dr Hwee Sin Chong

Dr Dawn Casey

Dr Melanie Considine

Ms Candice Day

Mr Mark Diamond

Dr Rose Ellis

Mr David Hallinan

Dr Kali Hayward

Dr Sandra Hirowatari

Dr Tessa Kennedy

Dr Martin Lavery

Dr Belinda O'Sullivan

Ms Carolyn Reimann

Dr Mark Rowe

Dr Kari Sims

Professor Ian Symonds

Dr Allison Turnock

Dr Kristopher Rallah-Baker

National Rural Health Workforce Jurisdictional Forum

Emeritus Professor Paul Worley - Chair

A/Professor Kathleen Atkinson

Dr Hwee Sin Chong

Dr Dilip Dhupelia

Dr John Douyere

Dr Rose Ellis

Ms Maree Geraghty

Dr Hugh Heggie

Dr Claire Langdon

Dr Linda MacPherson

Dr Hendrika Meyer

Mr Jeff Moffet

Dr David Oldham

Ms Tarah Tsakonas

Dr Allison Turnock

Ms Lorraine Wright

Postgraduate Standards, Curriculum and Assessment Frameworks Working Group

A/Professor David Campbell – Co-Chair

Dr Mark Rowe – Co-Chair

Dr Claire Arundell

Ms Gaby Bolton

Dr John Douyere

Dr Teena Downton

Dr Catherine Engelke

Professor Liz Farmer

Dr Pat Giddings

Dr Emma Kennedy

Dr Steven Lambert

Dr Olivia O'Donoghue

Ms Carolyn Reimann

Professor Tarun Sen Gupta

Dr Kari Sims

Professor Ian Symonds

Dr Kenan Wanguhu

Professor Paul Worley

Student and Junior Doctor Expert Reference Group

Dr Kari Sims – Chair
Ms Carolyn Reiman – Deputy Chair
Dr Claire Arundell
Ms Ashley Brown
Ms Gaby Bolton
Ms Candice Day
Dr Amran Dhillion
Dr Benjamin Dodds
Dr Tessa Kennedy
Ms Georgie Macdonald
Ms Davina Oates
Dr Carolyn Siddel
Ms Georgina Taylor
Mr David Trench
Professor Paul Worley

Aboriginal and Torres Strait Islander Rural Health Expert Reference Group

Professor Paul Worley – Chair
Mr Karl Briscoe
Dr Tammy Kimpton
Ms Janine Mohammed
Ms Donna Murray

Rural Consumer Expert Reference Group

Mr Mark Diamond - Chair
Dr Martin Lavery – Deputy Chair
Mr George Beltchev
Ms Katherine Burchfield
Dr Dawn Casey
Ms Dorothy Coombe
Dr Chris Moorhouse
Ms Lynne Strathie
Ms Sally Sullivan
Ms Leanne Wells
Prof Paul Worley

Recognition Working Group

Dr Mike Beckoff – Co-Chair
Dr Melanie Considine - Co-Chair
Dr Yousuf Ahmad
A/Professor Kathleen Atkinson
Dr Ian Cameron
Dr Hwee Sin Chong
Mr Amran Dhillon
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Ms Georgina Macdonald
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Ms Maureen McCarty
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Professor Roger Strasser
Ms Michelle Taitz
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Professor Lucie Walters
Professor Paul Worley

Rural Local Health Network Expert Reference Group

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Ms Lisa Davies Jones
Mr Steve Rodwell
Mr Scott McLachlan
Mr Shane Boyer
Mr Andrew Freeman
Ms Chris Giles
Mr Stewart Dowrick
Ms Jill Ludford
Dr Nicki Murdock
Dr Danielle Allan
Ms Linda Patat
Dr John Elcock
Mr Wayne Jones
Dr Chun Yee Tan
Mr Michael Di Rienzo
Dr Dale Seierup
Dr Shannon Nott
Dr Ka Chun Tse
Dr David Rimmer
Ms Jo Whitehead
Dr Hendrika Meyer
Ms Maree Geraghty

Rural PHN Expert Reference Group

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Ms Pattie Hudson
Ms Melissa Neal
Dr Leanne Beagley
Mr John Gregg
Ms Suzanne Mann
Mr Nik Todorovski

Vertical Integration Expert Reference Group

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A/Professor. Katrina Anderson
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Professor Jennene Greenhill
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Dr Bek Ledingham
Professor Jenny May
Dr Laurie McArthur
Professor Richard Murray
Dr Sue Page
Mr Steven Pincus
Dr Simon Quilty
Dr Richard Tarala
Dr Phillip Truskett
Professor Deb Wilson
Professor Paul Worley

Appendix Three: Literature Review

Review of rural allied health evidence to inform policy development for addressing access, distribution and quality

Prepared by the National Rural Health Commissioner

Lead Researcher Dr Belinda O'Sullivan, Director of Research and Evidence

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Executive summary

In December 2018, the Rural Health Minister Hon Bridget McKenzie requested the National Rural Health Commissioner to work with the allied health sector to develop Advice about improving the access, distribution and quality of rural and remote allied health services. The Commissioner's Office has prepared this literature review to inform policy advice.

This document summarises the results of a scoping review of the published peer review literature (1999-2019). Included were 119 studies, 19 of which were other reviews and 100 empirical studies. Broad themes identified were: rural allied health workforce and scope of practice; rural pathways to train and support; recruitment and retention and; models of service.

Snapshot of findings

Workforce and scope of practice

More than half of rural allied health professionals work publicly; although those more privately based include optometrists, podiatrists, pharmacists, physiotherapists and psychologists.

Rural allied health workers commonly service large catchments, visiting multiple communities. They work across an extended scope using generalist and specialist skills to meet diverse community needs with limited infrastructure.

Particular skills used are in paediatrics, Indigenous health, chronic diseases, health promotion and prevention, primary health and health service management. In rural and remote communities, training local workers including Indigenous Health Workers and allied health assistants is important for increasing early intervention, prevention, service coordination and enabling culturally-safe care.

Rural pathways to train and support

Based on a range of surveys, around half to two-thirds of rural allied health workers have a rural origin and half have some rural training experience.

Accessing tertiary allied health training is challenging for rural youth. Rural training opportunities have increased over time through University Departments of Rural Health (UDRH) (some disciplines of 12 months' duration), with signs that quality rural training impacts early career supply, after controlling for rural background.

Tertiary scholarships with rural return of service requirements and professional support could improve uptake of rural work. Intention to stay and turnover have the potential to vary between public and private sectors warranting tailored approaches.

Recruitment and retention

Reduced turnover is predicted by commencing employment at a higher grade (2/3 compared with 1) or being aged >35 years (compared with <35).

Factors considered important for retention are having strong rural career pathways, access to relevant professional development and local colleagues, working in a supportive practice environment and the nature of work (independence in role, variety of work, its community focus and a feasible workload).

Models of service

Available professionals (public and private), skills, infrastructure and the community need determine the allied health service platform for a regional catchment.

Patient-centred planning and partnerships between public hospitals and private providers (shared care) in regions can optimise use of the available workforce and promote access and quality.

Coordinated patient care depends on health service networks having strong leadership/coordination, patient information, clear referral processes and staff training.

Outreach and telehealth, along with viable business models, are important for increasing service distribution. They require an adequate staff base, strong community engagement and training for local staff who manage ongoing care between allied health service points.

Summary

Australia is leading the evidence base with respect to rural allied health workforce and services. Findings suggest that allied health providers are working as generalists and need particular skills.

Access and quality depend on a critical mass of skilled providers, working in complementary teams to address needs of regional catchments. This can be aided by selecting rural background students, providing more rural-based training, rural curriculum, supported rural jobs and rural career pathways including addressing job satisfaction.

At the regional level, patient-centred service planning and coordination of public and private providers underpins access to more comprehensive and high quality services.

For smaller communities, outreach and virtual consultations are critical for early intervention and continuity of care, but viable business models and an adequate staff base are essential to improve service distribution.

Introduction

There are around 195,000 allied health professionals and allied health workers make up 25% of Australia's registered health workforce, however, they remain poorly distributed in rural and remote areas (1, 2). In December 2018, the Rural Health Minister Hon Bridget McKenzie requested that the National Rural Health Commissioner (the Commissioner) consult with the allied health sector to develop advice about the current priorities for rural and remote allied health services by October 2019. To support this, the Commissioner's Office has prepared a literature review and policy options paper. This document describes the literature review. Section 1 outlines the scope of the review. Section 2 describes the collection of evidence. Section 3 describes the results and Section 4 discusses the policy implications.

Section 1: Defining the scope of the review

1.1 Defining allied health

"Allied Health" describes a range of health professional groups involved in health service provision who are important for achieving comprehensive health and well-being outcomes outside of the boundaries of emergency, medical, dental and nursing care.(2, 3) In Australia, allied health professionals are trained in universities (faculties of health science, medicine, education, social sciences and University Departments of Rural Health (UDRH). Allied health assistants are trained by vocational training providers.

There are a range of allied health professions registered through the National Registration and Accreditation Scheme including psychologists, pharmacists, physiotherapists, occupational therapists, medical radiation practitioners, chiropractors, optometrists, podiatrists and osteopaths (Table 1).(1) In addition to the registered allied health professions, a large number of allied

health professions operate under self-regulation. These include speech pathologists, dietitians, social workers, audiologists, exercise scientists/physiologists, orthoptists, orthotists, prosthetists and sonographers. Allied health assistants work under supervision of allied health professionals in single or multi-disciplinary roles.

A number of stakeholders are involved in allied health policy development. In February 2018, AHMAC formally recognised the Australian Allied Health Leadership Forum (AAHLF) as the appropriate allied health forum for AHMAC and Health Service Principle Committee (HSPC) to seek allied health workforce specific advice. The Forum includes members of Allied Health Professions Australia (AHPA), Deans of Universities that have allied health courses, Chief Allied Health Advisers, Indigenous Allied Health Australia and rural and remote representation via Services for Rural and Remote Allied Health (SARRAH).(4) The Forum describes allied health professionals as university qualified with "skills to retain, restore or gain optimal physical, sensory, psychological, cognitive, social and cultural function of clients, groups and populations", being "client focused, using inter-professional and collaborative approaches related to client needs, the community, and each other". The AAHLF does not delineate the specific disciplines included.

Allied Health Professions Australia (AHPA) is a peak body representing 20 national allied health association members and 6 organisational friends. AHPA also defines allied health professionals as university qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses, qualified at the Australian Qualifications Framework (AQF) (Level 7 or higher), who work in multidisciplinary teams to address patient priorities (included disciplines listed in Table 1).(2) Various states and territories (jurisdictions) also manage a range of allied health disciplines and other health workers under the banner of "allied health" (Table 1). The Department of Health and Human Services (DHHS) in Victoria noted that a multiplicity of professions, technical expertise, training pathways, sectors of practice and professional governance frameworks needs to be embraced within allied health policies. (3)

Table 1 – Different groupings of disciplines registered, included or managed by jurisdictions for “allied health”

National Registration and Accreditation Scheme (AHPRA)	Allied Health Professions Australia (AHPA)	Victoria #	New South Wales #	Queensland #
Chiropractic*	Audiology	Art therapy	Art therapy	Audiology
Medical radiation practitioners	Chiropractic*	Audiology	Audiology	Clinical Measurements*
Occupational therapy	Creative arts therapy*	Biomedical science*	Child Life Therapy*	Exercise Physiology
Optometry	Dietetics	Chiropractic*	Counselling	Leisure Therapy*
Osteopathy	Exercise & sports science	Diagnostic imaging medical physics	Diversional Therapy*	Music Therapy
Pharmacy	Genetic Counselling*	Dietetics	Exercise Physiology	Neurophysiology
Physiotherapy	Medical imaging and radiation therapy	Exercise physiology	Genetic Counselling*	Nuclear Medicine Technology
Podiatry	Music therapy	Medical laboratory science*	Music Therapy	Nutrition & Dietetics
Psychology	Occupational therapy	Music therapy	Nuclear Medicine Technology	Occupational Therapy
<i>Additional registered health workers that may be part of rural allied health teams</i>	Optometry	Nuclear medicine	Nutrition & Dietetics	Optometry
Dental hygienist*	Orthoptics	Occupational therapy	Occupational Therapy	Orthoptics
Dental prosthetist*	Orthotics & Prosthetics	Optometry	Orthoptics	Orthotics & Prosthetics
Dental therapy	Osteopathy*	Oral health (not dentistry)*	Orthotics & Prosthetics	Pharmacy
Oral health therapy*	Perfusionists*	Orthoptics	Pharmacy	Physiotherapy
Aboriginal and Torres Strait Islander Health Practitioners*	Physiotherapy	Orthotics & Prosthetics	Physiotherapy	Podiatry
	Podiatry	Osteopathy*	Podiatry	Psychology
	Psychology	Pharmacy	Psychology	Radiation Therapy
	Rehabilitation counselling*	Physiotherapy	Radiography	Radiography
	Social work	Podiatry	Radiation Therapy	Rehabilitation Engineering*
	Speech pathology	Psychology	Sexual Assault*	Social Work
		Radiation oncology medical physics	Social Work	Sonography*
		Radiation therapy	Speech Pathology	Speech Pathology
		Radiography	Welfare*	
		Social work		
		Sonography*		
		Speech therapy		

* May not be on lists of other jurisdictions, AHPRA or AHPA as of 2019 (1, 5, 6)

Not all disciplines managed by jurisdictions are considered allied health but are listed if they are managed by allied health advisors

12 Rural allied health and rural community need

Services for Rural and Remote Allied Health (SARRAH) emerged in 1995 as a grassroots organisation advocating for rural allied health workers (7). SARRAH includes a range of allied health professions including but not limited to: audiology, dietetics, exercise physiology, occupational therapy, optometry, oral health, pharmacy, physiotherapy, podiatry, psychology, social work and speech pathology.

Various jurisdictions have initiated rural training and support programs to achieve a skilled and distributed rural allied health workforce and services. The most advanced of these is the Queensland (led by James Cook University - JCU) rural generalist allied health training program. Within this program, "generalist allied health" is described as either a service, or a practitioner, responding to the broad range of healthcare needs of rural or remote communities by delivering services for people with a wide range of clinical presentations, across the age spectrum, and in a variety of clinical settings (inpatient, ambulatory care, community). The aim of allied health generalist services/workers is to deliver accessible, high quality, safe, effective and efficient care using strategies such as telehealth, delegation, extended scope of practice and partnerships (particularly for low volume but important areas of care).

The University Departments of Rural Health (UDRH) and their parent body, the Australian Rural Health Education Network (ARHEN) which was formed in 2001, represent rural nursing and allied health disciplines (8). The UDRH Program was established as a result of the 1996-1997 Federal budget after being identified as a key component of the Government's Rural Workforce Strategy (9). In 2016, UDRH funding was incorporated into the Rural Health Multi-disciplinary Training Program (along with funding for rural medical and dental training). Around 16 UDRHs in Australia provide clinical placements in rural and remote locations for health science students and have a role in developing evidence to inform rural health system quality improvement (8).

Rural and remote communities have access to fewer allied health services. Despite more allied health workers being produced nationally in recent years, workforce statistics suggest poor distribution (10). In 2016, 83% of psychologists, 81% of physiotherapists, 79% of optometrists, 77% of pharmacists, and 75% of podiatrists worked in metropolitan locations (MMM1) where only 70% of the population resides (10). The ratio of allied health workers per 100,000 population diminishes with increasing remoteness. This absolute deficit is in addition to the large distances, population dispersion, lower socio-economic and health status and higher health risk behavior of rural and remote that also impact on shortfall of workers relative to the number required (10).

In 2012, core primary care services needed for rural and remote communities were defined using a Dephi method with 39 experts - 'care of the sick and injured', 'mental health', 'maternal/child health', 'allied health', 'sexual/reproductive health', 'rehabilitation', 'oral/dental health' and 'public health/illness prevention'. The challenges of providing these services equitably in rural and remote areas required diverse strategies and strong service coordination (11). A follow up study identified that most of these core services were required even in communities as small as <1000 people (12).

Hospitalisation data reflects substantial unaddressed need within rural and remote primary care. One 2011-2013 study found that hospitalisations for oral and dental conditions were significantly higher for Indigenous infants and primary school-aged children from remote areas than age-matched metropolitan controls (13). Also over a one year period, a remote Northern Territory clinic transferred 789 children (aged <16 years - average age of 4.4 years) for care in a metropolitan centre (14).

Other literature directly reflects unmet need and barriers to accessing rural allied health services. O'Callaghan et al, identified that 85% of parents in rural NSW considered access to paediatric speech pathology services a prime concern, mainly related to lack of providers (15). Rural families faced long travel distances and costs for accessing services, lack of public transport, poor awareness of available services, and delays in treatment due to waiting lists. A further integrative review of the experience of rural mothers caring for children with chronic conditions identified that common challenges were accessing the right staff and resources, long travel times and social

isolation (16). Mitsch et al found there was limited access to rehabilitation for brain injury in rural and remote areas in New South Wales (NSW) related to funding, recruiting and retaining appropriately skilled health, rehabilitation and support staff (17). An international literature review reinforced the deficits in access to rehabilitation services in rural and underserved areas, mainly related to the supply and distribution of an appropriately skilled workforce (18).

Indigenous people are over-represented in rural and remote areas. Leach et al described otitis media which commenced in Aboriginal infants within 3 months of birth, progressed to chronic suppurative otitis media in 60% of the children and did not resolve throughout early childhood (19). Rural pharmacists identified that access and maintenance of medications with appropriate support was essential to manage the high burden of early onset chronic diseases experienced by rural Indigenous clients (20). Based on increased hospitalisations and deaths from suicide in remote Indigenous communities, Hunter identified more comprehensive upstream approaches were required rather than narrowly focused clinical services models (21). Another study identified that strong and collaborative workforce models were also important for improving the management and prevention of chronic diseases in rural and remote Indigenous populations (22).

Communities with younger populations relative to Australian averages may need early intervention services including for oral health. Gussy et al (2008) reported among rural Victorian parents (in towns 10-15,000 population) that tooth cleaning was done for 12-24 month year old infants "at least sometimes", however a large proportion lacked confidence and this was significantly related to the frequency of the cleaning (23). In another study, with multivariate models controlling for Indigenous status, living in a fluoridated area, low socio-economic status (SES), and age and sex, the mean decayed/missing/filled teeth of 5-10 year old and 8-12-year-old children in 2009 were significantly higher for rural children compared with metropolitan (24). Children in remote areas fared worst, mainly related to having more filled teeth. In another study of adolescents aged 11-17 years in rural Victoria, early lesions were found in 60% of students and advanced decay in 28%, associated with diet, mothers' education level being primary school and irregular check-ups (25).

Rural and remote service access is also affected by the health-seeking behaviour of rural and remote people. For small and dispersed populations who have lower access to healthcare, many working in self-employed industries, important health needs are not necessarily well-identified, nor acted upon. Rural and remote people tend to under-access health services due to poor health literacy, stigma, stoicism, long waiting lists, lack of medical providers as gate keepers, cost (time), distance (time), cultural safety and convenience (26-30). Unmet healthcare needs can in turn affect the ability to fully participate in education, work and community life (31).

13 The Commissioner's focus

Under Part VA of the Health Insurance Act 1973 (the Act), the National Rural Health Commissioner is required to consider the needs of the entire rural health workforce. For this reason, the review was deliberately broad and inclusive of allied health disciplines as defined by AAHLF, thus excluding medicine, nursing, midwifery, dentistry, paramedicine and non-clinical roles. Given the rural context requires cost-effective and sustainable models that can operate well across geographically distributed populations, allied health assistants, oral therapists/hygienists and Aboriginal and Torres Strait Islander health Practitioners were included in the search terms. Given the Commissioner reports to the Minister responsible for Rural Health, the review predominantly focused on the health sector, rather than disability, aged care, justice and education areas. The Commissioner's focus is on discerning policy options within the remit of the Commonwealth Department of Health, but the literature review was broader in order to understand the evidence from a whole of community perspective.

Section 2: Collecting the published evidence

21 Review question and search strategy

Scoping reviews are an effective way to summarise existing evidence and inform real-life policy and program questions (32). The following questions were posed:

What are the characteristics of the rural allied health workforce and their scope of practice?

What is the range of evidence about the rural allied health workforce and rural allied health services for informing policy development, specifically about issues of access, distribution and quality?

In line with scoping review methods, questions guided all aspects of data collection and extraction. A range of search terms was mapped based on the review questions. These were then iteratively developed to ensure sensitivity to the range of disciplines and rural contexts of interest. The final search included three key concepts, allied health (not specific to discipline names) using terms like “allied health”, “health work*” “therap*”, rural or remote practice, and training, recruitment,

retention and service models. To ensure relevance of material to informing Australian policy, a fourth concept limited the material to high income countries where previous global scale literature reviews had identified the most evidence about primary care/allied health: Australia, New Zealand, Japan, Canada and the United States (33, 34).

Six databases were selected based on scope and relevance of literature content: *Medline, Social Science Citation Index, CINAHL, ERIC, Rural and Remote Health, Informit Health Collection, and the Cochrane Database of Systematic reviews*. The search included literature published between February 1999 and February 2019. A Boolean search was applied based on the terms in each concept. The final search was restricted to English, producing around 8,000 articles considered both feasible within a time-limited review, and found to be sensitive when checked against ten allied health articles of different disciplines, countries and topics, already known to the authors. Other key published texts were found by hand searching and identified by key informants. The literature was entered into Endnote and duplicates were removed.

Concept 1	Concept 2	Concept 3	Concept 4
Rural OR remote	“health work*” OR “rural generalist” OR “allied health” OR “community health worker” OR “health assistant” OR “therap*”	train* OR curricul* OR develop* OR course OR placement OR immersion OR skill OR education OR qualification OR competen* OR recruit* OR retention OR *care OR *access OR model OR telehealth OR outreach	Australia OR New Zealand OR Japan OR Canada OR United States OR North America

22 Study selection

Study selection occurred iteratively, led by two team members and guided by whole-of-team weekly discussions. Titles and abstracts were screened and included if:

- Based in a rural or remote location
- Empirical study or literature review about allied health disciplines or services “in scope”
- Reporting outcomes
- Over 40% of results about allied health workforce
- From Australia, Canada, United States of America, New Zealand, Japan

Studies were excluded if:

- Low or middle income country
- Discussion or perspective only
- Clearly aged care, disability or education sectors
- Virtual service models not specific to supporting rural workforce or rural access
- <15 people in sample
- Full text not available (via find full text using Endnote, Google or direct library searching)

After abstract and title screening, relevant material was read in full text. All forms of investigation were considered potentially useful for informing policy directions. Data extraction criteria were determined based on the review questions, trialled and refined during first reading to ensure that they were fit-for-purpose. The following information was extracted:

- Country, location and year
- Health worker type/s
- Area of care
- Research question
- Study sample
- Study design / methods
- Outcomes
- Enablers or barriers

The extracted material was thematically analysed, firstly by reading the articles and recording preliminary ideas and thoughts, discussed at weekly team meetings. Secondly by re-reading and organising the material into themes (35).

Section 3: Results

31 The range of evidence

Of 7,429 articles, 205 were relevant from initial abstract and title screening. Of these, 85 were excluded using the above criteria, leaving 118 meeting the inclusion criteria. Two additional studies, not already in the database, were included from stakeholders, resulting in a total of 120 articles. Of these, 101 were empirical studies, 19 were literature reviews; 83 (70%) were published recently (2009-2019).

Of the 101 empirical studies, 11 were from another country - 8 from Canada, 2 the USA, 1 from New Zealand. The other 90 were based in Australia – 6 of which were national scale studies and 84 from one or more state or territory jurisdictions. Of jurisdictional studies, most (n=24) were from Queensland (including one which also covered Northern Territory (NT)), (n=22) New South Wales (NSW) and (n=21) Victoria (Vic) (including one which also included Queensland). Only 16 of the 84 jurisdictional studies were state or territory-wide. The others were based in a region (such as a cluster of towns or health service/s). Most (n=85) explored both hospital and community (non-hospital) practice settings, a further 23 focused on community (non-hospital) and only 12 on hospital only care.

The main themes were: workforce and scope of practice (n=9); rural pathways to train and support (n=44); recruitment and retention (n=31) and; models of service (n=36).

Of empirical studies, 83 were cross-sectional designs. Many (n=64) involved questionnaires 33 interviews and 11 focus groups. Only 8 studies used multivariate analyses and 15 used comparison groups (metropolitan workers, regular care, public workers or pre and post intervention testing). Putting these quality measures together, only three used longitudinal designs, controlled for confounders and used comparison groups.

32 Findings

The findings are summarised according to theme.

32.1 Characteristics of the workforce and their scope of work

The first theme described the characteristics of the rural allied health workforce and their scope of work.

SNAPSHOT OF EVIDENCE

Cross-sectional surveys estimated that around 11-35% of various allied health professions worked in rural areas. More than half of rural allied health professionals worked in the public sector; those more privately based were optometrists, podiatrists, pharmacists, physiotherapists and psychologists. Commonly, rural allied health workers serviced large catchments, visiting multiple communities and around a third had more than one job. Rural allied health professionals covered an extended scope of work using generalist and specialist skills to meet diverse community needs with limited infrastructure. Particular skills areas included in paediatrics, Indigenous health, chronic diseases, health promotion and prevention, primary health care and health service management. Service prioritisation and cross-regional networking were used to cope with high service demand.

An allied health workforce survey from South Australia in 2009 included 17 disciplines and achieved 1,539 respondents (response rate could not be calculated). It identified that the proportion of allied health workers working in rural locations varied by discipline (between 35-11%) (36).

In a cross-sectional survey in 2005 of 451 rural allied health workers in NSW, including 12 disciplines to which 49% responded, more than half of the respondents worked exclusively in the public sector and 11% said that they worked in both public and private sectors. The highest proportions of privately based workers were based in optometry, podiatry, pharmacy, physiotherapy and psychology (37). Another survey of allied health workers in rural western Victoria in 2003 to which 28% (n=138) responded, identified that 69% worked in public sector positions (38). In a survey of 84 rural physiotherapists working in Shepparton, Benalla and Wangaratta (response rate 79%), two-thirds worked part-time with most in the public sector (70%), with one third holding more than one position (39). One-third considered themselves generalists and one-third specialists. In a 2008-09 NSW rural allied health survey from 21 different allied health occupations, 1,879 (around 44%) responded showing 84% worked in towns >10,000 population, and were employed publicly (46%), privately (40%) or in both public and private sectors (11%) (40).

A 2005 survey of rural and remote occupational therapy managers (44% response, n=18 people) in South Australia identified that the most prevalent services provided were in areas of rehabilitative, health promotion, prevention and remediation (41). The vast majority were servicing large geographical catchments (89% over 100km), with travel time and distance between clients a key consideration in the service model. Respondents described the challenges for service delivery included the wide range of services needed for diverse client groups, the high client to therapist ratio, and limited human resources.

Merritt et al undertook a national survey of 64 outer regional and remote occupational therapists identified through business listings, receiving 37 complete responses. No practices were based in very remote towns (42). One quarter of respondents visited at least five towns each week and one third had other paid employment.

Adams et al described, based on interviews and surveys with public and private physiotherapists in a large region of one Australian state, that the scope of services was rationalised based on the overall size and skills of the available workforce in both public and private sectors of the region (43).

Bent conducted 17 interviews with allied health professionals in speech therapy, occupational therapy and physiotherapy working in Alice Springs hospital, the work involved supporting many Aboriginal clients, managing a large caseload and geographic catchment, and addressing a wide range client ages and conditions (44). The job involved providing advice and support for health clinical staff, bush nurses, and Aboriginal health assistants in schools. This required clear communication, support and careful prioritisation of workload. Enablers of their work and retention were inter-disciplinary networking and cooperation across the catchment, along with inter-agency mentoring systems and becoming an "expert generalist". Of respondents, 59% liked the diversity of the workload.

In another 2012-13 semi-structured survey of 33 from 40 eligible nutritionists who worked in remote Northern Territory Aboriginal communities in last decade, identified through the Department of Health and by snowballing, it was found that the scope of their work was not supported by their training. They were working across public health approaches, with limited training in cultural awareness and relying on materials that were from the nutritional field pedagogy but did not incorporate Aboriginal concepts of health and healthy eating (45).

In a national cross-sectional survey of 4,684 registered chiropractors to which 41.7% responded and indicated their practice location, 22.8% (n = 435) were based in rural or remote areas, and 4.0% (n = 77) in both urban and rural or remote areas. Statistically significant predictors of rural or remote practice compared with metropolitan work included more patients treated per week, practising in more than one location, working with no imaging facilities on site, often treating degenerative spinal conditions or migraine, often treating people over 65 years, and treating Aboriginal and Torres Strait Islander people. This study provided insights into unique practice challenges for rural or remote chiropractors include a higher workload and fewer diagnostic tools (46).

Hoffman et al reported the results of a self-administered questionnaire sent to 608 occupational therapists (seeking to select those working in adult neurological rehabilitation) in all rural areas of Queensland. Overall, 39 responses were received from relevant practitioners (not possible to calculate the exact response rate). The scope of work involved mainly home visits and modifications, equipment prescription, client/family education, and activities of daily living assessment and retraining. They travelled long distances to see clients, managed large workloads and worked with limited resources (47).

In a study to identify relevant chronic diseases curriculum for remote settings, the Northern Territory and Queensland governments brought stakeholders together (35 key informants) using surveys with remote staff to identify their current scope of work. It was found that there was little difference in the training and skills for chronic diseases work by discipline, although few were trained in population health. There was an identified need to improve the scope of work being undertaken in prevention and early intervention (these components were seen as challenging compared with downstream chronic diseases management) (48).

In interviews and focus groups with 18 participants from 8 disciplines in allied health in remote northern Australia, unique factors related to remote work were being organized but flexible, exhibiting cooperation and mediation, being culturally aware, knowing the community, and showing resourcefulness, resilience and reflectivity. This included being able to be an agent in a system where there were low resources and use knowledge and awareness across communities for shared problem solving (49).

In interviews with 37 GPs, 19 Queensland Health mental health staff and 18 community organisation participants from 8 general practices, 3 mental health services and 2 non-government organisations in 8 rural Queensland towns, consensus was reached that there were significant problems with inter-service communication and liaison in mental health services across the region (50).

In a national survey of 184 public hand therapists (physiotherapists and occupational therapists) working in rural and remote public hospitals and identified through direct contact, 64 responded (17.2% were physios). Over half of respondents reported that their scope of work involved providing initial splinting and exercise prescriptions and over 85% reported that they administered exercise protocols (51). Barriers to providing services in rural/ remote locations included transport, travelling time, limited staff, and lack of expert knowledge in hand injuries or rural/remote health care.

In terms of the non-Australian literature, there were two studies about scope of work, both from Canada. In surveys about rural rehabilitation practice with 6 occupational therapists and 13 physiotherapists in rural British Columbia (BC), Canada, serving a total of 15 rural communities of population <15 000, participants considered their generalist practice was 'a specialty' requiring advanced skills in assessment. They described 'stretching their role' and 'participating in, and partnerships with, community' as ways to overcome resource shortages. Reflective practice, networking and collaboration were deemed essential to maintaining competence. Stretching roles was a way of remaining 'client focused' by not turning people away just because that task is normally done by someone in a sub-specialist unit in the city (52).

Finally, in a self-completed survey of rural occupational therapists in working in rural Alberta and Saskatchewan, more than half worked in sole therapy positions, with challenges related to managing the generalist nature of rural occupational therapy practice. In terms of handling the scope of work, participants recommended "hands-on" experience during rural fieldwork placements, working in an urban setting prior to embarking on a rural career, coming from a rural background, and finding a mentor prior to working rurally. Some recommended increasing management and organisational skills content in the curriculum because they considered them essential skills for effective rural practice (53).

322 Assistants and training local staff to provide allied health services

There was a range of evidence covering the concept of allied health assistants (AHA) and training health workers in rural and remote locations for allied health tasks and working with visiting allied health teams.

SNAPSHOT OF EVIDENCE

Allied health assistants could be delegated around 17% of allied health work (same for rural and metropolitan areas). Highest delegation was possible in podiatry, speech and exercise physiology and included aspects like exercise, slings, functional therapies and excursions). However professional trust and governance (referral, tailored role, and supervision) are factors underpinning effective implementation. In rural and remote communities, training local health workers, including Indigenous health workers, for allied health tasks and working with allied health teams, facilitates improved early intervention, prevention, service coordination and enables culturally-safe care in areas like eye and oral health and access to medicines.

In Victoria, a state-wide study in 2009-2011 involving focus groups and a quantitative survey of allied health professionals in public health and community service positions, (783 rural respondents and 1,666 metropolitan), suitable allied health assistant (AHA) tasks were delineated along with how allied health professionals use their time. (54) This discerned that allied health professionals spend up to 17% of time undertaking tasks able to be delegated to an AHA (half were clinical tasks). This did not vary by rural or metropolitan context of work. Podiatry, followed by speech pathology and exercise physiology, recorded the highest percentage of AHA-attributable time that could be delegated. Tasks included exercise sessions, hydrotherapy, slings, community outings and functional therapy.

In 2009 in Queensland, 51 new allied health assistant roles were implemented in numerous hospital settings for 6-9 months at one of three levels: trainee, full scope, or advanced scope. There were generic position descriptions and task lists for each level. These were then audited over a two month period by trained allied health professionals working in pairs using systematic data collection methods (55). The main finding

323 Rural pathways to train and support

was that tailored (not generic) allied health assistant position descriptions were needed to account for different disciplines and their work context and the level of training of the assistant. They also identified the need for supervision frameworks. There was not enough delegation from allied health professionals to the roles, partly due to professional trust and clarity about roles and responsibilities.

In terms of competence, a rural Queensland hospital found that a global nutrition assessment (SGA), applied to 45 patients by 5 AHAs with a Certificate IV in Allied Health Assistance, produced equivalent results as those of qualified dietitians (n=3) (56). Although AHAs reported significantly lower confidence than dietitians ($t = 4.49$, $P < 0.001$), the mean confidence for both groups was quite high (AHA=7.5, dietitians = 9.0). There was some variation in the results of different components of the assessment tool between the two groups, but the results suggest that assistants could reliably undertake these assessments.

In an exploratory interview based study of 49 rural healthcare workers (including pharmacists) concerning access to community medicines in rural areas (<1500 population), it was found that maintaining continuity of access was challenging as patients moved between hospital and community (57). Generalist nurses and doctors were over-loaded and managing medications was an additional demand on their time. Solutions suggested were developing “extended community medication roles” with oversight of rural pharmacist, along with more long-term scripts.

Based on interviews with 32 health staff attending or working in remote clinics to provide oral care in 2005-2008, there was strong support for oral health roles for Aboriginal and Torres Strait Islander health practitioners (58). These roles could help to stem late intervention and reduce the demand on the visiting dental team along with aeromedical retrievals. Equally, to sustain access, partnerships and coordination of outreach and telehealth services, along with providing culturally safe care in Indigenous eye health, a literature review by Durkin et al considered there is potential to develop an Indigenous eye health role (59). This was particularly to address issues of prevention, early intervention and follow up.

A range of literature was focused on factors related to rural pathways, including student selection, training, additional skills attainment and professional support.

Tertiary training

SNAPSHOT OF EVIDENCE

Around half to two-thirds of rural allied health workers had a rural origin and half had some rural training experience. Rural and remote youth had a limited frame of reference for allied health professions, lacked access to required subject choices for course eligibility, needed to relocate to study allied health and faced more costs to participate. University Departments of Rural Health (UDRH) have increased rural training volume but only some provide up to 12 months’ training for selected disciplines). One univariate study showed that up to 12 months’ training related to 50% working rurally compared with 24% average rural work outcome across the disciplines and another multivariate study identified that 2-18 week rural placement and their self-reported high quality were associated with graduates working in rural areas in their first postgraduate year, once rural background was controlled for. Rural settings provided a range of unique learning environments. Apart from rural clinical placements, UDRHs also provide support for research/teaching and career pathways for mid-career rural allied health professionals.

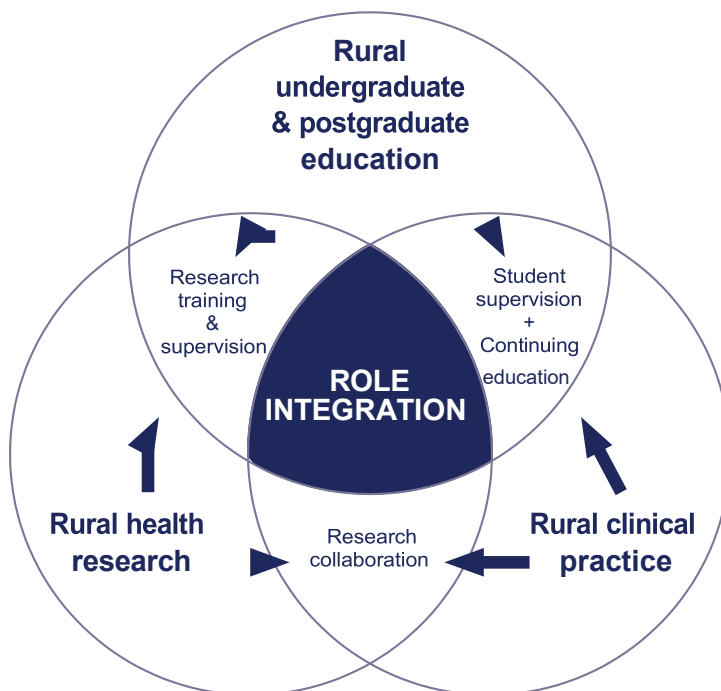
In a review of the evidence by Durey et al published in 2015, many factors considered effective for training rural doctors could also support the growth of the rural allied health workforce (60). Of 1,539 respondents to an allied health workforce survey in South Australia in 2009 (17 disciplines, response rate could not be calculated), 41% with a rural background and 17% with a metropolitan background worked rurally. (36) In a repeated cross-sectional survey of rural allied health workforce in one NSW region (>200 respondents spanning 12 disciplines with around 50% responding to first survey), the proportion of respondents of rural origin was about two-thirds in both surveys and about half had some rural experience during training (61). In a 2008-09 NSW wide survey of regional, rural and remote allied health professionals from more than 21 different allied health occupations contacted

via diverse communication channels, to which 1,879 responded (approximately 44% response rate), 60% had a rural background (40). Another cross-sectional survey of 605 rehabilitation professionals living and working in Northern Ontario, (occupational therapy, physiotherapy, speech–language pathology and audiology) in 2009 with 345 respondents, nearly two thirds were originally from Northern Ontario (62).

Attracting rural background students to allied health courses may be challenging. In interviews with 126 students in years 10–12, 52 parents, 10 grandparents, 76 teachers and 4 Aboriginal and Islander Education Officers (AIEO) from 15 secondary schools in rural and remote Western Australia in 2000, Durey et al identified structural and cultural barriers for rural and remote secondary students being attracted to and accessing health courses (63). Structural barriers included cost and information about courses and cultural barriers such as feeling capable and seeing allied health role models in the community. In terms of the rural training path, a national integrative review (up to 2012) of rural allied health training (14 disciplines) identified that pathways into tertiary studies in rural and remote communities were vague and often interrupted along with the return of graduates being haphazard (64). Rural secondary students had poorer access to subject choices for course eligibility and there were financial barriers to participating. Issues of daunting social isolation and separation from families and support systems are problematic to attend city-based courses. Students may also lack a frame of reference for accessing rural placement options. More tailored entry criteria, along with coordination and capacity building for rural training within rural courses were considered important.

Rural allied health training opportunities appear to be growing in Australia but many remain of short-duration. A survey of University of South Australia Division of Health Sciences Schools (training a range of allied health disciplines) in 2000, showed that between 5–20% of all allied health tertiary students did rural training, usually as a fieldwork placement in the final two years, but this was only short-term (65). The Schools identified strong potential to grow these opportunities. At the University of Newcastle, over a 12-year study period, the UDRH delivered 3,964 physiotherapy placements. Between 2003 and 2005 the average proportion of clinical placements occurring in metropolitan areas (MMM1) was 78% and in rural areas (MMM categories 3–6) was 22% (presumably no placements in MMM2 or 7 based on the location of the UDRH). In 2014, the proportion in MMM3–6 increased to 40%. There were also lower assessment marks for students trained in MMM1 than other categories (66). The UDRH model was conceptualised by Smith et al as facilitating all of clinical work, teaching and research, along with providing rural clinicians with career paths (schematically represented in Figure 2) (67). The article described an increase of rural placements (in placement weeks) at the University of Newcastle in dietetics, occupational therapy, radiography, pharmacy and physiotherapy from 300 in 2003 to nearly 800 in 2008. Another national cross-sectional survey of UDRHs in 2014–15, including 3,204 students who participated in rural training (46% were allied health respondents, the rest were from nursing/medicine), described strong ruralisation effects of rural training, with enablers being the quality of the experience, the supervisors and interaction with the community (68). Financial support, accommodation and internet were deterrents of ongoing rural practice intention.

Figure 2: Adapted from Smith et al depicting the integrated rural health education, research and clinical practice of UDRHs (67)



Two studies explored the quality of training for allied health workers in unique rural settings. One was of physiotherapists learning musculoskeletal therapy in rural emergency department. The training did not impact on the time it took to care for patients, and emergency department data showed that it provided an appropriate case-mix where the students gained experience for managing a range of conditions common in physiotherapy practice.(69) The other study was of training occupation therapists and speech pathologists in a brain injury rehabilitation unit in a regional hospital with supervisors who had dual roles of clinical work and case management. Focus groups and interviews identified that students placed with dual role supervisors gained a broad perspective holistic care (70).

Only two studies were identified which evaluated the outcomes of rural training on rural practice. Of 98 allied health students who completed 257 end-of-placement surveys (most completed one year of rural training) in Tamworth and Taree as of June 2014, 73% intended to work rurally at the end of the placement and by one year after graduation, 50% were working rurally compared with an average figure of 24% of graduates from the same disciplines (71). The other study, after controlling for rural background, identified that among 429 students from 12 health disciplines who did 2-18 week rural placements in Western Australia, rural placements and their perceived quality, related to working rurally in the first postgraduate year (72).

Additional skills and professional development

SNAPSHOT OF EVIDENCE

Approaches to developing more skills for rural practice and ongoing professional development included examples of rural curriculum for clinical skills, safety and quality, equity and cultural safety, and primary care and other practice models. Educational modules were delivered online and face-to-face, and participants appreciated flexible delivery on the basis that it improved their capacity to access training around their workload. Programs structured around service objectives and professional's learning needs were successful. Victoria implemented 12 months' advanced regional paediatrics training helping the physiotherapists to meet client needs in a catchment and helping to keep skilled professionals in the region. For professional development, NSW and Qld both described rural staff rotating into other units, including metropolitan tertiary paediatric units, to address specific learning objectives and develop professional networks relevant to their rural practice.

There were several examples of training for qualified rural allied health workers to develop specific scope for rural practice, community work and rural-specific service models. These included a rural and remote distance education program

in mental health, delivered by technology in 1999 across 10 rural sites to 31 health professionals (including nursing, allied health and Aboriginal health workers). The program consisted of three formal modules of learning, 3 written assignments, five days of residential school (either at the psychiatric unit in a region or in the city) and five days of clinical practice in a mental health setting. Six tutors with extensive mental health experience provided support to students by responding to general enquiries, marking assignments, arranging and participating in group discussions and co-ordinating a week of local clinical community placements. Immediate post-course learning outcomes were high and at four months, participants reported more clinical practice in liaison with the mental health team (73).

A new Graduate Certificate in Health (Remote Health Practice – Allied Health) was introduced for rural allied health workers employed with Queensland Health in early 2000s. It was based on an environmental scan of existing courses (74). The qualification incorporated learning about personal organisation (time, case-load and information management), models of service delivery (primary care) for Indigenous and other rural and remote communities and opportunities for advanced clinical skills development through a clinical placement. Students enrolled in the training pilot included four social workers, four occupational therapists, two speech pathologists, one pharmacist and one physiotherapist. Based on a review of the course via teleconference, email feedback and a written survey, there was strong support and participants considered that it helped them to improve their primary care skills and culturally safe practice, areas where they had limited previous exposure. The assignments were relevant, feedback was timely, and the clinical placement opportunities of 2 weeks were valuable.

In Western Australia, a new competency framework was developed and released in 2009. It addressed learning needs of senior rural allied health practitioners, to guide training and performance monitoring (75). The competencies covered learning for audiology, dietetics, occupational therapy, podiatry, physiotherapy, social work and speech pathology (excluding mental health and aged care), covering 88 areas of practice (service delivery, equity, professional practice, ethical practice, development and support, quality and safety and clinical skills), delineated based on literature review and consensus.

In Victoria, new postgraduate paediatric physiotherapy training was implemented over 12 months in 2008 with pilot funding for two new senior positions (76). The program was developed in consultation with various committees and an expert reference group. Weekly tutorials, case studies and presentations formed an important part of clinical rotations between hospital outpatients, specialist schools and the disability sector. The program resulted in increased access to skilled paediatric physiotherapy services for the regional catchment. Training increased knowledge and confidence, and provided a career pathway for local physiotherapists. The senior clinicians valued the introduction of appropriately skilled younger peers to their clinical practice.

An Allied Health Rural and Remote Training Scheme (AHRRTS) was implemented in Queensland in 2010 to support education and professional support for rural and remote allied health professionals working within Queensland Health (77). It incorporated distance-based and face-to-face delivery covering eight domains of service delivery, equity and diversity, professional skills, ethical practice, development and support, quality and safety, and clinical management, in line with an Allied Health Capability Framework. Participation was flexible and tailored to requirements of each worker. The AHRRTS included options for participating in the Allied Health Education Program (AHEP) as well, which was a clinical learning placement with an experienced professional. The AHEP was rolled out over two years across Queensland since July 2009 (78). In the rollout phase, 170 of 380 eligible allied health professionals participated. A review of barriers and enablers for accessing the program via 55 stakeholders semi-structured interviews suggested that flexible (online as well as FTF) delivery was important (some people like to get away from work, others couldn't access it unless online options were available), support from employers, particularly line managers, and time to participate.

Another educational secondment model was described in 2001 in Queensland. This involved 29 rural and remote Queensland speech pathologists, occupational therapists and dieticians spending time in a tertiary paediatrics specialist practice environment for two weeks over a 2-6 month period (79). The program enhanced clinical skills in clinical areas of interest (through observation, sharing ideas, practice and learning) along with networking and liaison between rural and metropolitan participants. Participants valued the support and the locum coverage provided by the Program.

NSW also developed a new educational secondment model to enable allied health staff in rural and remote areas to access tertiary-level hospitals or specialist health facilities to learn and network in areas of care important for their scope of practice for paediatric care (80). The 'Allied to Kids' program, a collaboration between the Children's Healthcare Network and NSW Health, involved rural clinicians nominating a learning objective and undertaking a secondment for up to 5 days, with travel and accommodation paid by the program. Of 106 expressions of interest over 2011-2014, 89 were eligible and could be supported and were completed – most were physiotherapists and speech pathologists. Pre and post program evaluations showed that secondments improved skills and confidence, extended networks and increased development of resources for rural units.

There was limited information about allied health mentorship and supervision, however, a review of the literature by the UDRH in Shepparton included 39 articles to discern models of mentorship that would be applicable to rural and remote settings. Four models identified were cloning, nurturing, friendship and apprenticeship. The latter three were considered applicable for rural and remote early professional learning. These need to be trialled and evaluated (81).

324 Recruitment and retention

SNAPSHOT OF EVIDENCE

Tertiary scholarships with rural return of service requirements could increase the uptake of rural work if coupled with the right support. Only one study measured retention longitudinally in rural health services, showing that between 2004 and 2009, median turnover of dieticians was 18 months, physios 3 years and social workers 4 years. Reduced turnover was predicted by employment at higher grade (2/3 versus 1) or aged >35 years. Part-time work did not predict turnover but turnover tended to increase with remoteness. Factors related to retention had substantial overlap across the literature (mainly cross-sectional surveys and interviews). These were broadly related to career path, access to relevant professional development (topic, time and cost), working in a supportive practice environment (clearly documented role, orientation to workplace, culturally safe work environment, having professional colleagues and allied health involved in decision-making) and the nature

of work (independence in role, variety of work, community focused and a feasible workload). Social and personal determinants were also factors. Intention to stay and turnover have the potential to vary between public and private sectors warranting tailored approaches.

One survey, conducted with international physiotherapy graduates (Victoria) seeking to be assessed on the Standard Pathway to become registered for practice in Australia found that, of fifty-seven (from 73) participants who responded to the question about work location, 56% said that they would consider working in a rural location (>100km from central business district). (82) Of those not open to working in a rural location, 12 cited family reasons.

Another study outlined a 2010 review of the Queensland Health Rural Scholarship Scheme (Allied Health) (QHRSS-AH). The Scheme involved two years' of university scholarship funding valued at \$21,000 per year for applicants agreeing to a 2-year rural return of service period upon graduation (83). The scholarships started in 1998 for students in physiotherapy, occupational therapy, speech pathology, social work, podiatry, psychology, pharmacy, radiography, sonography, and nutrition and dietetics. Participant data (n=146) and semi-structured interviews suggested 69% had completed or were completing the service period and of these, 86% were working rurally (57% rural or remote and 29% regional). Only 14% did not complete the return of service obligations and 3% deferred. Rural training during the undergraduate degree, health service orientation, mentoring and professional support were considered important for enhancing the program's outcomes.

A range of other studies explored recruitment and retention issues. One study outlined six focus groups with a total of 30 individuals from nine allied health professions and some managers in rural NSW (who had self-nominated from a 2008 NSW rural allied health workforce survey) to reach consensus about recruitment and retention factors (84). The key factors related to recruitment and retention were categorised as: personal (from rural area or attracted to rural life); workload related (breadth of clinical work and high demand/workload); professional development, career progression and recognition; and management-related including effort to recruit vacant positions. Key recommendations to address these factors were summarised:

- Involve local communities in attracting rural allied health workers
- Regionally-based universities
- Access to CPD through back-fill, travel subsidy and management
- Develop regional professional networks
- Invest in IT infrastructure
- Support extended practice roles and career development options
- Address workplace culture and stress management
- Train allied health managers and involve them in decision-making
- Preserve clinical work roles for allied health managers (84)

In a survey of rural physiotherapists based in regions of Shepparton, Benalla and Wangaratta, recruitment and retention issues noted included lack of career path, professional support, access to professional development and postgraduate education (39). Additional issues were the costs and time to attend courses, travel/distance and inadequate resources. Positive elements of rural practice were part-time employment opportunities, independence as primary health providers, practice variety and community recognition.

A review of international literature (up to 2009) about recruitment and retention of the occupational therapy and physiotherapy rural workforce identified 12 included articles (qualitatively focused) which suggested that the biggest factors related to recruitment and retention were practice support and career growth (85).

Keane et al identified different retention efforts needed for public and private sector rural allied health workers using data from the NSW rural allied health workforce survey inclusive of n=833 public and n=756 private allied health workers (86). Multivariate analysis showed that high clinical demand predicted intention to leave rural work both public and private allied health models (odds 1.4 and 1.6 respectively) and professional isolation and participation in community (OR 1.4 and 1.6) also contributed to private practitioner's intention to leave. In another cross-sectional survey of 451 rural allied health workers (12 disciplines) in NSW in 2005 (50% response rate), the mean time in current position was 10 years and half intended to leave in five years (37).

In a state-wide questionnaire distributed to 2,736 allied health professionals across Tasmania, identified from registration boards, professional associations, yellow pages directories and the Principal Allied Health Advisor in 2008 (response rate of 45%), univariate analysis showed retention (intention to stay for next two years) is multifactorial. Using multivariate analysis, job satisfaction was the strongest independent predictor (odds of staying 6 times higher if satisfied) (87).

A literature review (up to 2017) including 15 articles, identified that the factors important for the retention of Aboriginal and Torres Strait Islander health practitioners have some similarities and differences with those of non-Indigenous health workers. Notable factors were the need for a supportive and culturally safe workplace; clear documentation and communication of roles, scope of practice and responsibilities; and being appropriately supported and remunerated (88).

The only study to predict turnover using longitudinal data was based in Victoria. Eighteen health services were invited and 11 participated by providing de-identified individual level employment entry and exit data for dietitians, occupational therapists, physiotherapists, podiatrists, psychologists, social workers and speech pathologists employed between 1 January 2004 and 31 December 2009 (total of 901 allied health workers) (89). The median survival in the job by podiatrists and dieticians was lowest (18 months), then physiotherapists (3 years) and social workers (4 years). Proportional hazards modelling indicated profession and employee age (over 35) and grade (2 or 3) upon commencement were significant determinants of lower turnover risk (better retention). Turnover was not associated with part-time employment. Median costs of replacing allied health workers were between \$23-47,000 per worker depending on remoteness of health service (direct and indirect costs of turnover).

Based on interviews with 17 of 20 invited participants in a remote health service in 1997 (physiotherapy, speech pathology and occupational therapy), Bent indicated that lack of supportive management was a barrier to staying in remote allied health work, along with absence of orientation, delays in recruiting positions, and high turnover from lack of adequate professional development or support. Overall, 40% staff intended to leave in next 3 months.(44)

In a study with 26 nursing and allied health professionals (inclusive of 19 social workers, psychologists, Aboriginal Mental Health Workers and diversional therapists) in their first 5 years of work in community mental health services in rural New South Wales, issues for retention were: workplace conditions, career advancement opportunities and social and personal determinants (90). A “turnover theory” was developed positing that the gap between individuals’ professional and personal expectations and the reality of their current employment and rural-living experience stimulates turnover. In adjustment phase, this gap was mainly impacted by professional factors but in the adapted phase, personal factors become more important.

In terms of non-Australian studies, qualitative interviews with 26 long term employed allied health workers in rural Canada (6 speech language pathologists, 4 psychologists, 4 occupational therapists, 8 social workers, and 4 physiotherapists) revealed that they worked rurally because they could access rural education where they currently work, had a rural background, had positive rural experiences and recognised a community need for healthcare professionals (91). Variety and challenge of work, as well as enjoyment of adventure were other reasons.

Finally, a survey study of allied health workers in south-western Victoria in 2003 to which 28% (n=138) responded, identified that 69% worked in public sector positions. Only 53% (n = 50) of the professionals in the public sector intended to stay more than 2 years in their present position, compared with 84% (n = 27) of the professionals who worked privately (38). Reasons for intending to leave were mainly lack of professional support, poor management, lack of career structure and personal factors. Receiving orientation was related to increased intention to stay in the job.

325 Models of service

SNAPSHOT OF EVIDENCE

The number and range of allied health services available in regional catchments depends on the number and mix of professionals, their skills and local community need. Partnerships and networks between public and private providers and hospitals regionally, including shared care, maximises utility of available workforce for more comprehensive services. A rehabilitation network of 5 rural hospitals involving a

team leader/coordinator, clear referral pathway and staff training, also provided first ever access to rehabilitation in a rural catchment. Critical success factors included information and referral for eligible rural participants, staff education and leadership. Access to services in smaller communities is effective through outreach, telehealth and consideration of viable business models. For example, Medicare funded Chronic Disease Management was the main income source for 50% of occupational therapists working in outer regional/remote. Individual and home based cardiac rehabilitation (internet and phone-based) can be as useful as hospital-based models. Online consultations could provide equivalent quality service to that provided face-to-face for diabetic foot healing, rehabilitation and speech pathology. Some services need face-to-face delivery and providers and clients may prefer this. Where outreach and telehealth were used, training local staff to maintain service engagement and foster ongoing participation was important for success. An oral therapy program for Indigenous children was successfully implemented in Canada by using trained community workers who identified and engaged people for treatment by visiting dental therapists and hygienists.

The theme about models of service identified the importance of models of care for increasing access and maximising the comprehensiveness of services within limited resources. In a 2012 survey (n=34) and in-depth interviews (n=19) with physiotherapists and health service managers in regional, rural and remote services in Queensland, it was found that the physiotherapy services provided were decided based on available staff and their skills, along with the community need. (92) Overall public service decisions were driven by organisational priorities whereas private ones were driven by financial viability and skills. In a further article using this data, a matrix for decision-making showed the complexity of rural health service decisions.(93) Further work identified that public sector physiotherapists were more focused on acuity, relying on private physiotherapists to support the outpatient load. (94)

In terms of promoting patient care pathways, one NSW study identified, based on interviews and focus groups with 78 carers and 10 rural clients needing rehabilitation services, that many people were regularly: (i) travelling to access therapy; (ii)

waiting a long time to get therapy; and (iii) getting limited access to therapy after early childhood (95). A person-centred model was proposed for planning increased access to address client needs (Figure 3). It identified building the right services involved using multiple resources - local resources, travel, online service options and responsive outreach.

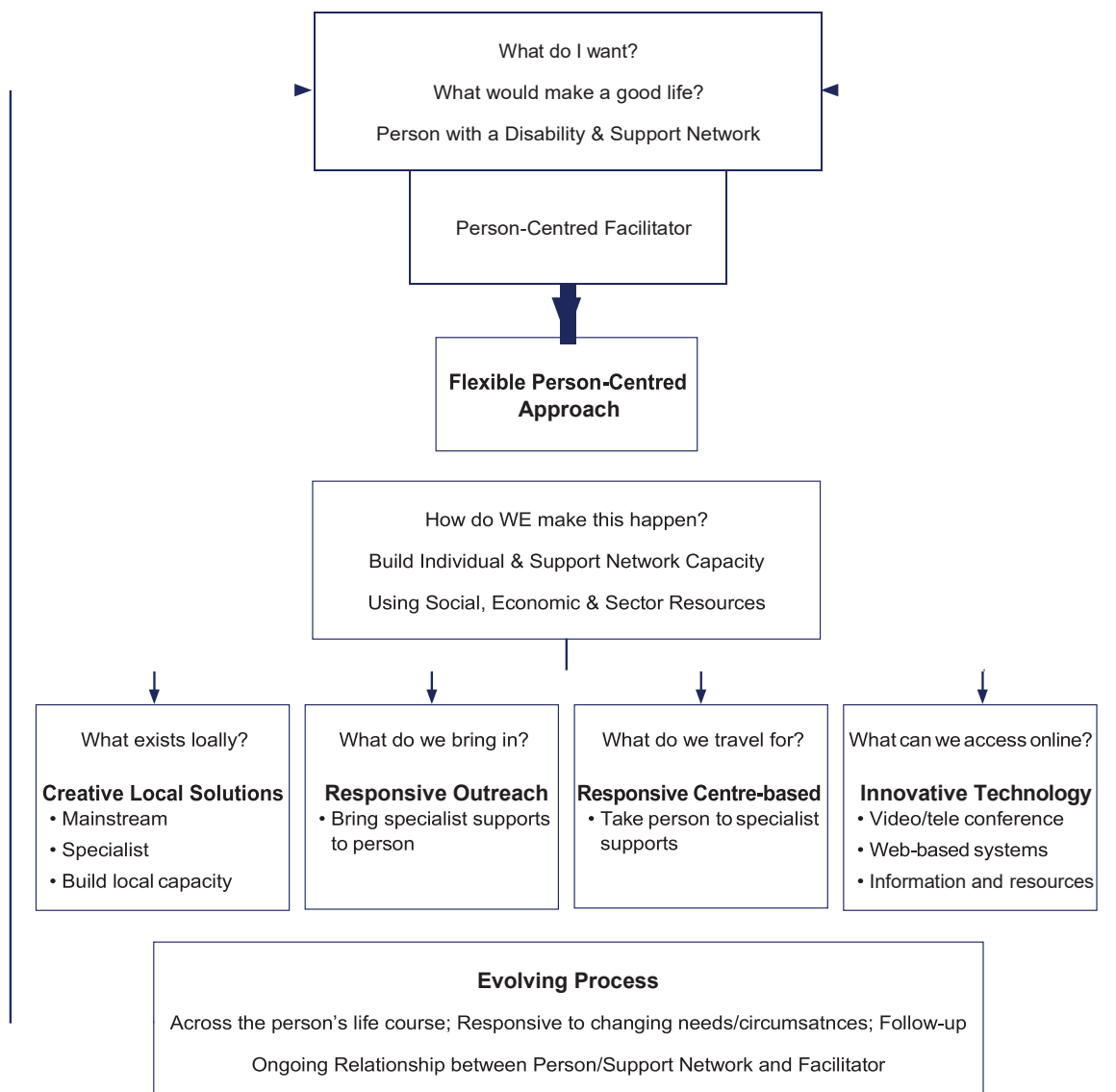
To cope with large geographic catchments and high client to occupational therapist ratios, a South Australian study identified using less labour-intensive service delivery models, multi-skilling of staff (recruiting right range of people skilled in different areas), networking (to manage waiting lists and access enough support for diverse client needs), and problem-solving (41). Further, to cope with barriers to accessing hand therapy rehabilitation (occupational therapy and physiotherapy) in rural/ remote locations, the service model incorporated flexible and realistic

goals and interventions, along with a shared care approach between metropolitan/regional and rural/ remote therapists (51). Shared care approaches were also suggested to address earlier intervention in mental health, based on a study of rural services in Queensland, involving interviews with 37 GPs, 19 Queensland Health mental health staff and 18 participants from community organisations (50).

In Victoria, a survey of private rural rehabilitation therapists (physiotherapists, occupational therapists and speech pathologists) (40% response rate), about policies to support access to rural services, identified that more partnerships between private and public practitioners in rural and regional areas is likely to increase the comprehensiveness of programs (more available skills, supervision options and better service coordination). (96)

Figure 2: Rural and Remote Person-centred Approach

Adapted from Dew et al depicting a person-centred approach to planning (95)



Collaboration between rural hospitals was equally important. In south-western Victoria five rural hospitals worked together to deliver the first ever rehabilitation service in the area (97). The model was based on a local assessment of community needs and health service capacity. The aim was to address functional recovery goals by delivering services across the rehabilitation team (different hospital sites and across a multi-disciplinary workforce), with dedicated project leadership. It involved staff education, team meetings, early intervention, and discharge planning. It achieved 112 admissions (2005-2006), (median clients aged 74 years), mainly for orthopaedic rehabilitation. Participants improved functionally at least as well as the Victorian State average for similar client groups (BI change 26.5 compared with 22.3 points, $p < 0.001$), with a shorter length of stay (13.8 compared with 22.3 days). Enablers were an approachable team leader and cross community referral pathway systems. Barriers were that rehabilitation beds were set up in the acute ward and not all staff were on board with a rehabilitation mindset.

In an integrative review (16 included studies) to identify barriers, enablers and pathways to cardiac rehabilitation for adults living independently in rural and remote areas of high-income countries, including Australia, it was found that access was driven by being referred to the rehabilitation program and knowing that it existed in the first place (98). The following recommendations were made for rural rehabilitation models:

- Eligibility criteria
- Flexible programs, face-to-face, internet and phone
- Education about cardiac rehabilitation for clinicians, patients and families
- Systems for easy referral and improving access by Indigenous populations
- Comprehensive programs - primary and secondary prevention, riskfactor management
- Improved funding

Outreach services were one model for increasing access to allied health services in smaller communities. A study was undertaken on outreach service planning for allied health chronic disease management across a large geographic catchment in Queensland (99). Consensus based planning identified that outreach services were best if regular, reliable, included case conferences and in-service education for local workers involved in ongoing local care.

A successful oral therapy outreach model for Indigenous children was implemented in Canada using trained community workers who identified and engaged people for screening by visiting dental therapists and hygienists (100). Piloted in 41 communities in 2004, the program was rolled out to 320 communities by 2012 and achieved screening and treatment of 23,000 Indigenous children.

Online services were also described as alternatives to face-to-face models. A systematic review analysed the international evidence for the effectiveness of alternative models of cardiac rehabilitation, including 83 articles published since 1999. Eight models emerged, but only individualized telehealth (telehealth addressing multiple risk factors and providing individualized assessment and risk factor modification) and community- or home-based cardiac rehabilitation were considered effective alternative models of cardiac rehabilitation, producing similar reductions in cardiovascular disease risk factors compared with hospital-based programmes (101).

Other studies considered the validity and applicability of online consultations in allied health. In Ottawa, Canada, online consultations with 12 allied health disciplines were made available to primary care providers (doctors and nurse practitioners) in a metropolitan and rural region in 2011-2016 (102). Primary care providers submitted requests online and allied health workers had 7 days to respond. Good uptake was demonstrated with minimal demand for additional face-to-face consultation and good resolution of the referral problem. The main services accessed were clinical pharmacy, addiction support and musculoskeletal services.

Another scoping review of Australian literature (44 studies published up to 2015) suggested that services provided by online consultations were equivalent in quality with face-to-face services for diabetic foot healing, rural rehabilitation and speech pathology (103). Some aspects of allied health work were suggested to not be amenable to online delivery. This was reinforced in another study of 5 allied health disciplines who undertook a health assessment on each of 12 patients in a high dependency unit 250km away through online (video) consultation and the following week, the same assessment face-to-face (104). In 35 cases out of 60, two independent raters agreed that the therapists' care plans were the same using the different methods. However, the providers preferred face-to-face work (based on Likert scale agreement). In each case, only the dietician's assessments did not differ significantly between the two modalities (as opposed to other disciplines - occupational therapy, physiotherapy, podiatry and speech pathology).

The costs of video-consultation based service delivery were deducted from real costs of face-to-face delivery of speech, podiatry, physiotherapy, occupational therapy and dietetics services (from a metropolitan hospital to a rural high dependency facility) over a three month period in Queensland (105). Costs were estimated based on fixed and variable components. Given an annual workload of 1,000 occasions of service (estimated based on three months' services), each video-based assessment was identified as costing \$84.93, compared with \$90.25 for face-to-face assessments.

A cross-sectional survey was done of 600 clinicians in around 2000 in NSW, inclusive of 125 allied health staff (e.g. psychologists, social workers, play therapists), along with doctors and nurses working in paediatrics aimed to understand attitudes to telemedicine by discipline, distance, and sector of practice (106). Based on a 31% response rate, the highest application of telehealth was for education, rather than patient management. Medical staff, and those in private practice considered telehealth had lowest utility for their practice. Rural clinicians had similar attitudes. Telehealth was considered to have limited capacity to replace traditional methods of face-to-face contact, phone and letter.

"Come N See" was a video-conferenced allied health speech therapy services from Sydney to rural and remote school children in NSW, with email follow-up (107). Over a 12-week period, children were offered therapy blocks of six fortnightly sessions, 30 minutes long. Sessions were delivered via low-bandwidth videoconferencing, with email follow-up. Instructions were provided to a therapist assistant and family member supporting the child. Interviews with school executives and therapy assistants noted that the program addressed a number of unmet needs for speech services, however, communication could be strengthened between providers.

In Victoria and Queensland, community participation in the implementation of oral health initiatives was enabled where the program was perceived as viable, sustainable and relevant to their needs, and when trusting relationships occurred with "the right people" and advisory groups (108).

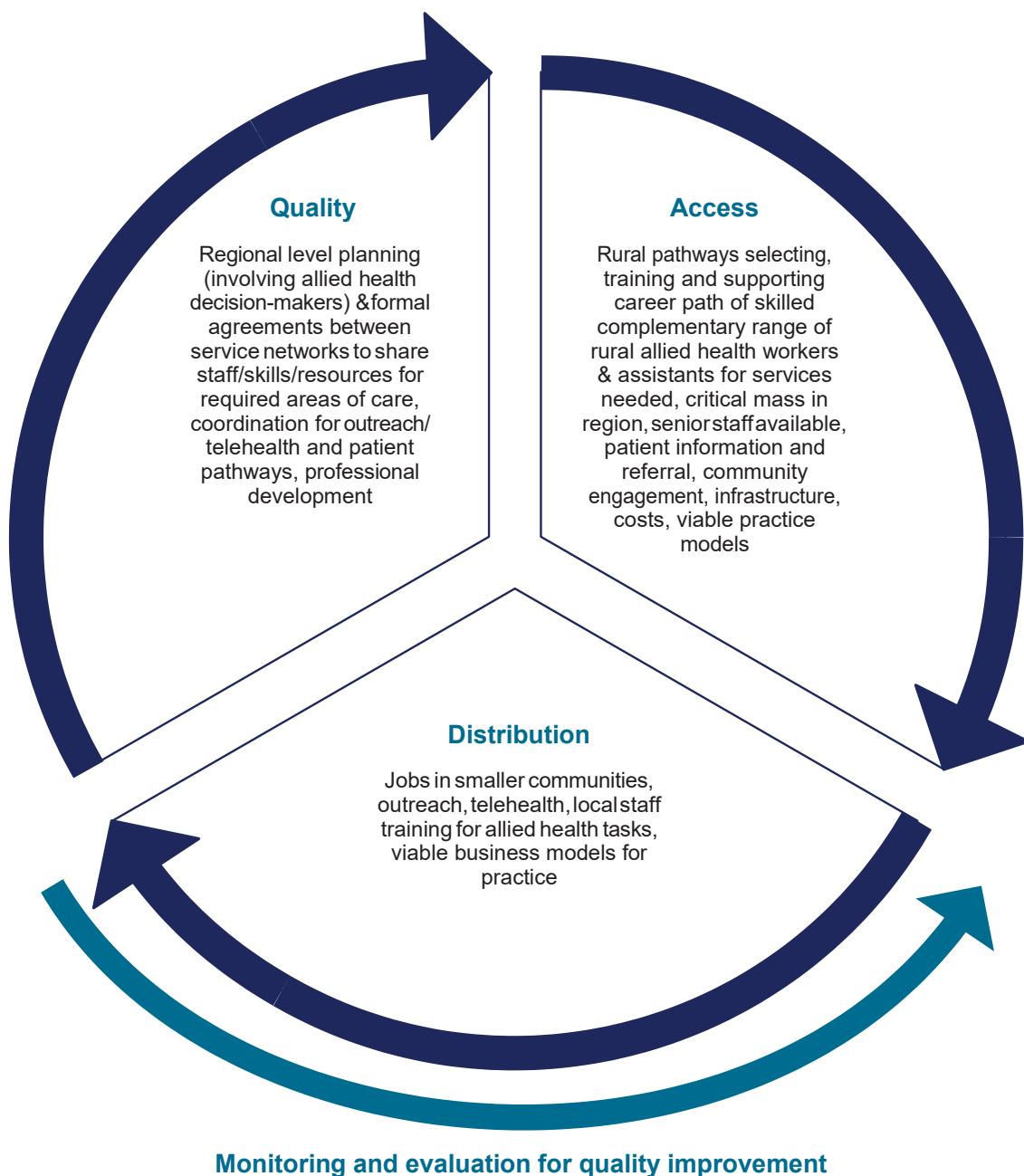
Viable models of funding was an important source of income for occupation therapists working in smaller communities. Medicare Chronic Disease Management was the main income source of around half of occupational therapists working in this context (42).

Section 4: Discussion

This scoping review has uniquely drawn on the most up-to-date published evidence about rural and remote allied health workforce and services to inform Australian policy. With 89% of the evidence from Australia, our country is relatively advanced in rural allied health research. Nineteen other literature reviews were identified, but this review included the largest volume and range of material. With a diverse range of allied health disciplines and rural contexts included, the findings provide an important backdrop for policy-making, and key inter-related factors for addressing access, distribution and quality can be deduced (Figure 4).

Based on the evidence, increasing access is likely to rely heavily on increasing skilled rural workforce development and retention by rural training and career pathways including more senior staff availability. Distribution of services requires jobs in smaller communities along with viable business models, training and service models like telehealth. Finally, quality demands a degree of integration of skilled providers and their coordination to address the patient pathways for rural and remote people. This is challenging given the multiplicity of professions working in different sectors, practice models and remuneration structures, but not impossible and strong examples were evident in the literature.

Figure 4: Matrix of factors to consider for quality, access and distribution based on the literature



As depicted in Figure 4, monitoring and evaluation underpins the achievement of access, distribution and quality. There are a number of elements required to strengthen the current evidence base in this field: both quantitative and qualitative studies, multi-disciplinary and outcomes-focused methods, and national scale. This will be enhanced by broader access to routinely collected data, linked data and an impetus to target evidence towards understanding impact of training, career support and employment and service models on access, distribution and quality. Understanding the effect of policies and programs helps to target interventions and optimise cost-benefits. UDRHs could lead this evidence generation, given the right resources and systems, noting that in 2008-2010 only 56% of UDRH research output was about rural health issues.(109)

Critically, the evidence suggests that accessible and high quality rural allied health services is depicted by: *An appropriately skilled and distributed workforce, working in viable, regionally-coordinated ways, to promote prevention, early intervention, and appropriate follow up and referral for additional care as required, through a closely networked array of services, suitable for the population's needs.*

4.1 What are the policy implications of these data?

Although there were few metropolitan to rural workforce comparisons, the rural allied health providers described had distinctive scope of practice fit to providing a breadth of services for wide population needs and using additional skills. Defining and recognising these rural skills could be a key driver of training for and uptake and retention in rural and remote allied health work. A key enabler would be to agree on rural practice credentials in key disciplines and relevant training and professional development avenues. Developing and recruiting more allied health generalist workers needs to also accommodate a sufficient staff base to release people for additional roles in training, teaching/supervision, telehealth and multi-site practice.

The largest critical mass of rural allied health services is publicly based and this needs to be continually fostered through jurisdictional approaches. Importantly, growing the primary health service base should complement salaried roles and provide a crucial buffer for more upstream prevention/management services. Private growth opportunities is particularly relevant for enabling

access to optometry, pharmacy, psychology, physiotherapy and podiatry. Opportunities for integration with the NDIS, My Aged Care and other sector revenue streams could also enable greater growth in the private sector.

Training and using allied health assistants and potentially micro credentialing of other health workers to undertake allied health tasks is likely to improve access to allied health services across wider catchments. It may useful to adopt national frameworks for this to occur over time, ensuring roles are adaptable to context and discipline (public and private sector), in consultation with rural health services and allied health professionals.

The evidence clearly points to the need for rural pathways to train and support rural allied health workers. Pathways start with attracting rural youth to allied health careers and connecting them with virtual or local mentors and rural pathways. Evidence in medicine demonstrates that return to region is enhanced by selecting and training people from the region (110). Rural scholarships and course bridging opportunities allow interested rural students to access integrated pathways between rural secondary and technical schools, rural TAFEs (allied health assistant courses) and universities.

Agreeing national targets and incremental growth for the selection of rural background students and longer, high quality distributed rural training is important. These could particularly target rural primary care workforce development for vision, hearing, mental health, maternal and child health, rehabilitation, chronic disease and Indigenous health outcomes as well as access to medicines and relevant (non-dentistry) oral health options. The current requirement under RHMTF is to provide “placement weeks” but “academic years” may be more valuable for rural return based on the emerging allied health literature and lessons learnt from rural medicine (111-113). Commonwealth RHMT Program funding to the may require specific delineation and possibly augmentation for this to be achieved (111). A range of issues including course accreditation, partnerships, placements, accommodation and supervisors may require targeted policy work and investment.

Implementing rural-facing curriculum to address the workforce and service needs of rural communities is also important (9). Evidence has shown that high quality rural allied health training can occur in non-traditional clinical settings (including primary and community care), beyond

hospital training commonly occurring in cities (69). Enabling medical students to experience a mix of distributed primary care and regional hospital placements improves their distribution compared with regional hospital placements alone (113). To achieve this in allied health, the RHMT Program staff may need more formal roles within curriculum and rural curriculum development for the various allied health professions.

Rural pathways include allied health workers being able to access jobs where there is senior clinician along with professional development. Good examples were of professional exchange programs where learning needs specific to the local service were addressed with flexible, tailored education modules for rural practice. Selected UDRHs and the Queensland rural allied health generalist pathway also have good professional development models for early career allied health workers (67). The RHMT Program could extend the expectation for activity in this area. The Government's Health Workforce Scholarships Program, which is well subscribed, supports professional development for allied health workers engaged in any private allied health work, but its outcomes haven't been published (114).

Scant evidence suggests that any compulsory rural return of service scholarships may be effective if coupled with the right support. Evidence from medicine suggests that bonded places have a mild positive impact on rural supply (113). However, medical students participating in rural training through real-time choice can achieve better distribution outcomes than contracting people to it (115).

The evidence suggests that building the size of allied health teams, including recruiting senior allied health worker roles (in public and private practice), can improve retention. Senior professional positions increase the potential for regional supervision and career advancement opportunities. All services, whether public or private, could improve orientation processes, provide clear positions for interesting jobs, give autonomy in role and involve allied health in decision-making. Bundled retention incentives have been suggested to work best for rural primary care, allowing tailored response to individual needs (116).

To attract and retain private providers, viable practice models are critical, including access to Medicare benefits that fit with population need and complexity. Allied health assistants may be useful to supplement private allied health teams in some instances, especially if they have cross-disciplinary roles of carrying out care plans in multiple sectors.

Integrating local providers for particular models of service can optimise patient care pathways in a region. Regional level planning of teams around catchment priorities, with clear eligibility and referral improves coordinated services. The different drivers at play in the public and private systems (financial viability) and the unique disciplinary practice models require consideration for brokering networked services. Dew provided a useful framework for patient-centred planning around what can be provided locally, supplemented by outreach or telehealth and what needs to be sought elsewhere through travel (95). This is acknowledged to be more complicated when public and private entities and multiple sectors are working to different agendas.

Outreach and telehealth are important options for extending the distribution of selected services. They work best if supported by a sufficient volume of staff, visiting regularly and providing training and real-time support for local health workers who implementing allied health care plans between visits. The Commonwealth currently funds a range of rural outreach programs, however, these have the potential to be expanded to more specifically address service coordination roles and effective sustained allied health multi-disciplinary teams (117). Telehealth items and its associated infrastructure are a clear way of promoting its use, however uptake depends on relevance, clinical equivalence, cost, provider interest and patient satisfaction.

Viable business models for practising sustainably in smaller communities is an important consideration for the Commonwealth. Policies such as strengthening access to Chronic Disease Management and Medicare telehealth items may help, along with subsidies or grants to cover travel time and infrastructure.

Conclusion

Australia is leading the evidence base with respect to rural allied health workforce and services. Findings suggest that allied health providers are working as generalists and need particular skills to maximise their effectiveness. Access and quality depends on a critical mass of skilled providers, working in complementary teams to address needs of regional catchments. This could be aided by selecting rural background students, providing more rural-based training, rural curriculum, supported rural jobs and rural career pathways including addressing job satisfaction. At the regional level, patient-centred service planning and coordination of public and private providers underpins access to more comprehensive and high quality services. For smaller communities, outreach and virtual consultations are critical for early intervention and continuity of care, but viable business models and an adequate staff base are essential to improve service distribution. A number of these areas have direct application to Commonwealth Department of Health policy and equally require strong engagement with jurisdictions and rural representation across the sector.

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