



Communique: Workshop on rural allied health service and learning consortia

On 1 June 2021, the Commonwealth Chief Allied Health Officer (CAHO), Dr Anne-marie Boxall, the National Rural Health Commissioner, Adjunct Professor Ruth Stewart, and the Deputy National Rural Health Commissioner, Associate Professor Faye McMillan convened a workshop in Queenstown, Tasmania to explore the Service and Learning Consortia (SLC) recommendation from the former Commissioner's 2020 allied health report: *Improving the access, quality and distribution of allied health services in regional, rural and remote Australia*.

The SLC model consists of local private, public and not for profit service providers, training providers, and community representatives collaborating across multi-town and multi-sector networks, to create sustainable allied health positions and increase access to services in rural areas.

The workshop brought together more than 90 stakeholders from all over Australia, including but not limited to: representatives from Commonwealth, state and territory Departments of Health, Education and Disability; University Departments of Rural Health; allied health peak bodies; consumer representatives; and individual health professionals. Participants attended virtually or in person, with the event being hosted by the West Coast Council of Tasmania.

Four key components of the SLC model were highlighted. These aim to improve recruitment and retention of allied health professionals by making rural and remote allied health practice and training more attractive and better supported:

1. Local community driven governance;
2. Service integration with multiple consortium members;
3. Learning integration to allow meaningful and supported training environments; and
4. Business integration and back of house administrative support to access new funding and enhance clinical support.

Three case studies were presented at the workshop, which incorporate elements of the SLC model and have successfully increased access to allied health services in a region. These case studies were analysed by participants, in order to identify core elements that could be used in other regions as part of new initiatives.

Principles that were identified by participants to be consistent across regions in the development of an SLC model, included co-design, flexibility and locally driven approaches. It was noted that to design local level solutions, there needs to be co-contributions from all participating organisations.

Elements that need to be regionally tailored included having an awareness of the local profile of burden of disease to identify the priority services that are required, and linking in with the local government and other sectors such as education, aged care and social services to determine what support they can provide (for example, accommodation and infrastructure). The importance of putting the patient at the centre of the model was also discussed, to ensure the communities' needs are met and services are designed and delivered appropriately for those communities.

To pilot an SLC model, participants explored the funding sources available, and options for leveraging existing training and employment opportunities. Participants also discussed new graduate positions and whether more emphasis needs to be placed on funding these positions for longer than one year. The Allied Health Rural Generalist Pathway was raised as a positive way of overcoming

limited supported graduate and early career opportunities and providing structured career progression opportunities in rural and remote areas.

The role of allied health students in the SLC model was discussed, noting the benefits they can provide in addressing workforce gaps whilst being immersed in high quality rural training placements. Some challenges were highlighted including the transient nature of student placements, and the need to ensure supervisors were provided with funding and support to establish community networks and placements.

Workshop participants also identified potential barriers to adopting innovative funding approaches, such as:

- the short-term nature of some funding streams (for example, pilot programs and grants)
- the administrative burden associated with accessing multiple allied health funding streams (for example NDIS, aged care, education, and health), and
- the current fee for service MBS model, which is not accessible when supervising students.

The CAHO will raise outcomes of the workshop with her jurisdictional counterparts, and continue working with the Office of the National Rural Health Commissioner to progress funding options for progressing this recommendation. Deputy National Rural Health Commissioner, A/Professor Faye McMillan will continue to meet with rural health representative groups such as the National Rural Health Alliance, professional allied health associations and member organisations of the Australian Allied Health Leadership Forum, including Services for Australian Rural and Remote Allied Health, Indigenous Allied Health Australia, and the National Allied Health Advisors and Chief Officers to further explore opportunities to improve access to allied health services in rural Australia.