SARRAH

Services for Australian Rural and Remote Allied Health

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The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) Evaluation

January 2025

Flinders University

The research team would like to acknowledge the Traditional Owners of the land on which we conduct our research, the Kaurna people of the Adelaide Plains. We would also like to acknowledge the Traditional Owners of the land on which SARRAH operates and the allied health professionals participating in this research live and work. We pay our respects to their Elders past, present, and emerging. We recognise and respect their cultural heritage, beliefs, and relationship with the land, which continues to be of great importance to Aboriginal and Torres Strait Islander people living today. We also pay our respects to Aboriginal and Torres Strait Islander Peoples from across Australia who have participated in this research.

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Contents

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AHA	Allied Health Assistant
AHP	Allied Health Professional
AHRGWES	Allied Health Rural Generalist Workforce and Employment Scheme
DCE	Discrete Choice Experiment
JCU	James Cook University
SARRAH	Services for Australian Rural and Remote Allied Health
TAHRGETS	The Allied Health Rural Generalist Education and Training Scheme
The Pathway	The Allied Health Rural Generalist Pathway

The term **Allied Health Profession** includes but is not limited to:
Audiology, dietetics, medical radiation, occupational therapy, pharmacy, physiotherapy, podiatry, psychology, social work, speech pathology.

The term **Trainee** refers to an allied health professional who participated in the Allied Health Rural Generalist Education and Training Scheme in a private practice or non-government organisation.

The following abbreviations are used in quotes
T – Trainee who has completed TAHRGETS
WT – Trainee who has withdrawn from TAHRGETS but participated in some of the scheme
M – Manager of a trainee who completed TAHRGETS
S – Supervisor of a trainee who completed TAHRGETS
WMS – Manager or supervisor of a trainee who withdrew from TAHRGETS
PT – SARRAH project team members employed to coordinate TAHRGETS

Modified Monash Model categories
The Modified Monash Model is used throughout this report to classify the location of private practices:
MM1 – Metropolitan areas
MM2 Regional Centres – locations within 20km of a town with a population of more than 50,000
MM3 Large rural towns – locations within 15km of a town with a population between 15,000 and 50,000
MM4 Medium rural towns – locations within 10km of a town with a population between 5,000 and 15,000
MM5 Small rural towns – all remaining inner and outer regional areas
MM6 Remote communities
MM7 Very remote communities
https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Throughout this report multiple sets of data were used including Qualitative data retrieved from trainees, withdrawn trainees, managers, supervisors and the TAHRGETS project team who agreed to be interviewed; Quantitative data from interviews and data received from the TAHRGETS project team in relation to activity, inputs, outputs and outcomes for all TAHRGETS participants. An online survey with allied health professionals from across Australia generated quantitative data for a discreet choice experiment analysis. Where possible, it has been made transparent which data is from which source.

Executive Summary

Introduction

This evaluation reviewed The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS), a workforce, service and education strategy aiming to increase access to a skilled allied health workforce for regional, rural and remote communities. The scheme was funded by the Australian Department of Health and Aged Care and incorporates formal education in rural generalist practice alongside structured supervision, workplace support and service development requirements for the non-government and private sector. TAHRGETS is coordinated by Services for Australian Rural and Remote Allied Health (SARRAH), the national lead organisation supporting multijurisdictional cooperation and collaboration for the Allied Health Rural Generalist Pathway (the Pathway).

TAHRGETS was implemented in private and non-government organisations in MMM3-7 locations across Australia. Of the 90 training positions, 60 were allocated to mainstream organisations, and 30 were assigned to allied health professionals working with Aboriginal Community Controlled Health Organisations.

Aims

The aim of this evaluation is to understand how well TAHRGETS achieved the objectives and outcomes outlined in the grant agreement, including:

- Improving the capacity, quality, distribution and mix of the allied health workforce
- Supporting private and non-government service providers to build capacity and expand service delivery
- Developing career pathways and improving retention of AHPS working in rural and remote areas.

Furthermore, the evaluation seeks to provide recommendations on TAHRGETS as a workforce strategy and program design.

Methods

A mixed method approach was undertaken to evaluate the scheme over a 3 year follow up period (2021-2024). Quantitative data on program participation, completions, and workforce data were analysed. Qualitative data was gained through semi-structured interviews with completing and withdrawn trainees, managers, supervisors and program staff to explore experiences, perceptions and impact of TAHRGETS. Additionally, AHPs across Australia who had not participated in the program, supervisors and managers were invited to participate in an online Discrete Choice Experiment survey to understand preferences for different program characteristics that might inform future implementation of the Pathway. Data was analysed using SPSS, Stata and NVivo to inform the evaluation.

Results

- Sixty-two individuals commenced in training positions, 60 in mainstream organisations (filling 100% of allocated quota) and 2 in ACCHOS (filling 6.7% of allocated quota).
- Thirty-seven (60%), trainees have completed or are expected to complete the program by the end of 2025, 36 of these are in mainstream organisations, and 1 in an ACCHO.
- The program demonstrated good mix, with individuals from nine different allied health professions undertaking the Pathway (out of the total ten professions that were eligible). These were dietetics, exercise physiology, occupational therapy, physiotherapy, podiatry, pharmacy, psychology, speech pathology and social work.

- The program demonstrated good distribution with individuals from MMM3-7 areas across 6 states and territories (all but Victoria and ACT) participating.
- Participating AHPs demonstrated improvements in competence and confidence in their rural and remote clinical practice and clinical skills.
- Enhanced capacity of the rural and remote allied health workforce was reported in teams where AHRG training positions were established
- Forty-seven service development projects were undertaken, benefitting trainees, teams and communities through the expansion of services and new models of care. This included 16 projects focusing on developing a new or expanding an existing service, and a number of projects developing training for other health professionals to increase their capacity and skills, or developing resources to be used in care delivery
- Seventeen AHPs were recruited into newly established positions, providing over 42,000 additional service hours in rural and remote locations.
- A positive economic impact was observed in the communities and towns where new staff were recruited.
- A withdrawal rate of 40% was observed. This rate is consistent with other AHRG Pathway programs, and is attributed to factors such as employment changes, personal circumstances, and difficulties balancing study and work demands.
- Of 30 training positions committed to Aboriginal Community-Controlled Health Organisations (ACCHOs), only two positions were established (6.7%). Limited funding options for allied health services in ACCHOs were a major barrier. Consequently, only a few allied health professionals are employed in ACCHOs, leading to low demand for rural generalist training positions in this sector.
- The discrete choice experiment (DCE) identified desirable characteristics to be included when designing similar programs in future. More than 100 AHPs and managers responded. Results indicated that program flexibility, where education and training can be completed in a more modular fashion (with consideration of micro credentialing) was highly valued. Coverage of costs for organisations and trainees was considered critical, with the potential of increasing program uptake by 33% compared to no coverage. Professional recognition and incentives for completion (e.g. increased salary) were also considered valuable.

Findings

- TAHRGETS is effective in enhancing the skills and knowledge of AHPs, thus improving the capacity and quality of the allied health workforce
- TAHRGETS has shown to be effective nationally, in mainstream private and non-government service settings, and for a wide range of professions.
- With regard to rural generalist training positions in ACCHOs, SARRAH undertook an extensive consultation process with community-controlled organisations to understand the barriers to implementation. Allied health services provided by ACCHOs tended to be funded over short-term programs, limiting the capacity of the ACCHO to undertake workforce development activities. Given that allied health rural generalist training positions are implemented over a two- to three-year period, this was a major impediment to establishing training positions in ACCHOs.
- TAHRGETS showed early signs of benefitting retention; however, long-term follow-up would be required to better understand this.
- TAHRGETS program implementation was challenged by long-standing rural workforce shortages, with subsequent impact on recruitment, retention and completion rates.

- Allied Health Rural Generalist training positions demonstrate a promising contribution to rural career pathways. However, formal recognition mechanisms for allied health rural generalists do not yet exist. Opportunities for career advancement, recognition of advanced or expert skills sets, and financial incentives such as higher remuneration or access to specific items in the Medicare Benefits Scheme, identified in the discrete choice experiment, may improve retention and training completion rates.
- Elements of the formal education program were not aligned to the needs of private and non-government service settings. A review of the Allied Health Rural Generalist Education Framework is required to ensure it meets the needs of rural generalists working in a range of clinical service settings.
- Private and non-government organisations need support to develop the rural and remote allied health workforce. This includes financial support to enable workplace-based training and clinical supervision, as well as support to build workforce capacity.
- While participants were generally happy with TAHRGETS implementation, there were elements of program design that could be improved. Given the average time for completion was over 24 months, a longer implementation program would allow for higher completion rates and more complete data collection. Additionally, feedback from program staff and participants also identified characteristics for participant selection (e.g. at least 12 months of experience) that they believed would enable program success.

  Furthermore, desirable program design characteristics identified in the discrete choice experiment may increase estimated program uptake and decrease withdrawals. These included flexibility in program design, coverage of costs for organisations and trainees, and recognition and incentives for completion and support for private and non-government organisations.

Limitations

- **Sample Size:** The number of AHPs and managers/supervisors interviewed for the evaluation was limited, particularly for those who had withdrawn from the program. This could mean some perspectives are underrepresented, although the evaluation notes that saturation was reached across the interviews, meaning there was high consistency in the feedback provided by interviewees.
- **Ongoing Program Implementation:** The evaluation was conducted while the program was still being implemented, so there may be minor changes in quantitative data upon program completion.
- **Lack of System-Wide Data:** The lack of system-wide allied health workforce data on recruitment, retention, and costs makes it difficult to compare the program's impact to industry norms.
- **Scope:** The evaluation scope did not include the long-term follow-up of trainees to understand TAHRGETS' impact on retention and career pathways, or the impact of rural generalist trainees and service delivery projects from a consumer perspective.

Recommendations

1. Investment in allied health rural generalist training should be sustained and strengthened as a mechanism to improve the capacity, quality, distribution and mix of the allied health workforce in rural and remote areas.
2. Enhance the capability of private and non-government organisations to meet community needs by training allied health professionals as rural generalists, using targeted workplace training grants, incentive payments, and other measures that support building service capacity

3. Governments should consider how to best harness allied health rural generalist skills and competencies, so that government, industry and rural and remote communities can benefit from the enhanced skills and competencies of this workforce, to improve health outcomes for rural and remote Australia.
4. Explore opportunities to recognise and advance the career of the expert rural generalists through mechanisms such as incentive payments for service delivery to priority populations and establishing teaching and training opportunities in private and non-government settings to strengthen the rural workforce pipeline.
5. A long-term evaluation is recommended to follow up past participants to better understand the impact of TAHRGETS on retention, career development and advancement.
6. Funding mechanisms that support services delivered by allied health professionals in ACCHOs should be reviewed to enable the sustainable delivery of allied health services for First Nations people in rural and remote areas.
7. Program characteristic likely to promote success include flexibility in education program design (that includes modules to be undertaken over a longer time period, 'construct your own' and/or allowing for micro-credentialling); professional recognition and incentives to improve completion rates for trainees; and detailed selection and intake processes for organisations and trainees. These design elements should be incorporated into future implementations.
8. Future activities supporting the training of allied health rural generalists should be implemented over a minimum period of five years to accommodate the time taken to complete rural generalist training and ensure whole data sets are available to evaluate outcomes.
9. Action is required in the short term to ensure consistency in the implementation of allied health rural generalist training positions across multiple professions, and preserve and progress the growth and sustainability of a single AHRG Pathway. Specifically, these activities include (but are not limited to) a review of the Allied Health Rural Generalist Education Framework, overseeing university accreditation processes, and advancing formal professional recognition for allied health rural generalists. This work is within scope for the AHRG Accreditation Council and National Strategy Group, both of which will require support to continue performing these functions.
10. Identification of optimal funding sources is needed to ensure ongoing sustainable development of the AHRG workforce. This process should consider how supports for training positions are funded in private and non-government organisations, across jurisdictions, service settings, client populations, and community needs.

1 Introduction

There are major health disparities between people living in rural and remote areas and those living in metropolitan areas with people living in rural and remote areas experiencing higher rates of death, injuries, disease and hospitalisation (Australian Institute of Health and Welfare (AIHW, 2024). Multiple challenges exist in the recruitment, retention and turnover of health professionals which has negatively impacted upon the provision of rural and remote services (AIHW, 2021). Workforce challenges result in reduced access to allied health services for rural and remote populations, despite a growing demand for these services (AIHW, 2024; Chisholm et al., 2011).

1.1 Allied health service settings in rural and remote Australia

Allied health professionals (AHPs) provide services to a large range of consumers, for a wide breadth of clinical presentations, working across the age spectrum and in a variety of healthcare delivery settings (inpatient, ambulatory care, community), and may work across sectors (health, disability, aged care, early childhood education).

Hospital-based allied health services are funded through the states and territories under the National Health Reform Agreement. Allied health services in private settings are accessed and funded through many sources on a fee-for-service basis, such as the Medical Benefits Scheme, National Disability Insurance Scheme, the Department of Veterans' Affairs, those subsidised by private health insurance, a range of third party and workers compensation schemes, and privately paying clientele. Allied health services accessed through non-government organisations may be funded through government and industry contracts, commissioned by Primary Health Networks, and may also include fee-for-service arrangements.

In rural areas, private practices are frequently required to work across several funding streams to achieve business viability. This mixed-business model requires the AHP in rural private practice to retain a broad skills set to offer services to a wide range of client population groups.

Health workforce maldistribution continues to impact on service access in rural and remote areas. Data supplied by the AIHW shows a decline in the number of registered full-time AHPs per 100,000 people with increasing remoteness, and low fill rates across all geographic areas for vacancies in the health professions (44% nationally in 2022) (AIHW 2024b). In this context, programs that support the recruitment and retention of allied health professionals are important to ensure rural and remote Australians have access to essential allied health services.

In Australia, there has been a heavy focus on initiatives to support the training of general practitioners such as the National Rural Generalist Pathway (NRGP), a dedicated medical training pathway for rural generalist doctors, the Rural Generalist training Scheme (RGTS) that provides funded training places and access to relocation payments, and the workforce incentive program that provides additional payments to doctors working in regional, remote or rural communities (Australian Department of Health and Aged Care, 2024a; Australian Department of Health and Aged Care, 2024b, ACCRM, 2024). To date, training programs and incentives for AHPs to work rurally and remotely have not been equal to those offered for general practitioners.

1.2 The Allied Health Rural Generalist Pathway

The Allied Health Rural Generalist Pathway (the Pathway) is a workforce, service and education strategy to increase access to a skilled allied health workforce for rural and remote communities. The Pathway was established to build the sustainability of allied health services, strengthen the rural workforce pipeline and address the maldistribution of the allied health workforce affecting rural and remote Australia.

Originally developed by the Allied Health Professions Office of Queensland, a pilot in 2014 involved the implementation of rural generalist training positions across Queensland Health rural and remote services. These positions were designed to improve recruitment and retention of AHPs, to increase access to health services for rural and remote communities and to improve the quality and sustainability of health service delivery. Over the following four years the Pathway was established in conjunction with SARRAH and James Cook University to incorporate a formal education program in rural generalist practice alongside dedicated supervision and support, quarantined study time at work and service development opportunities.

SARRAH advocated for further states and territory public health services to adopt the Pathway as an allied health workforce strategy, and the Pathway has since been implemented in New South Wales, Northern Territory, Tasmania and South Australia (SARRAH, 2023a).

1.2.1 Allied Health Rural Generalist Training Positions

Allied Health Rural Generalist (AHRG) training positions support the graduate/early career practitioner to develop relevant skills to meet the health needs of rural and remote communities. Where workforce shortages are acute, AHRG training positions are designed to improve attraction, recruitment and retention, and build the capabilities of allied health professionals and the multidisciplinary team.

An AHRG Training Position is appropriate for an early career practitioner in one of the following health professions:

Dietetics & Nutrition	Physiotherapy
Exercise Physiology	Podiatry
Medical Radiation Science (Radiography)	Psychology
Occupational Therapy	Social Work
Pharmacy	Speech Pathology

The AHRG Training Position should require the professional to practice with a generalist scope of practice within their relevant allied health profession.

An AHRG Training Position comprises three key elements:

1. **Workforce policy and employment structures** that align to development requirements and facilitate progression from entry-level competency to proficient rural generalist.
2. Implementation of **rural generalist service development projects** that support and engage rural generalists to utilise their developing skills to implement innovative and effective solutions to challenges they experience in delivering care across geographically dispersed and culturally diverse populations.
3. **Formal and work-based education and training** that supports the development of the clinical and non-clinical rural generalist practice requirements of the relevant allied health profession.

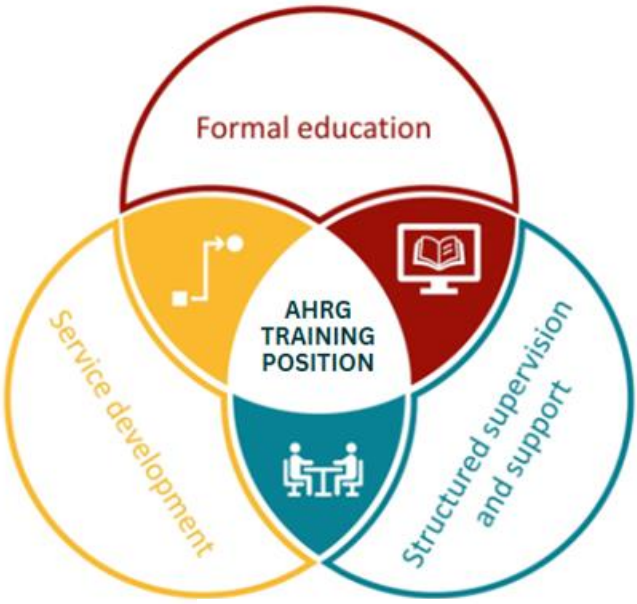


Image courtesy of SARRAH

The education component of the Pathway, hereafter referred to as the Rural Generalist Program, comprises two levels of postgraduate training. Level 1 is a non-award postgraduate program designed for early career rural or remote AHPs with less than three years of experience. It comprises 12 modules that are each six weeks in duration, requiring approximately 22 hours each to complete. The Level 2 program is a graduate diploma qualification with eight modules requiring approximately 130 hours per module and is designed for rural and remote AHPs who have more than two years of work experience. Both levels offer specialist training and education and include online coursework and service development projects (SARRAH, 2023a). The Pathway is available across ten allied health professions: nutrition and dietetics, radiography, occupational therapy, pharmacy, physiotherapy, exercise physiology, psychology, podiatry, social work and speech pathology. Recently, a Master of Rural Generalist Practice has also been introduced by JCU. This program is not in scope for TAHRGETS participants.

1.3 AHRGWES

SARRAH negotiated with the Australian Department of Health to commence a pilot to test the project in non-government and private sectors. As a result, the Allied Health Rural Generalist Workforce and Employment Scheme (AHRGWES) was launched in 2019 to implement the Pathway into private and non-government sectors operating in primary health care, aged care and disability. The AHRGWES pilot was funded by repurposing unspent Nursing and Allied Health Scholarship funding scheme grant money. The objectives of AHRGWES were to establish 40 new early career positions (20 at Level 1, 20 at Level 2) across a range of sectors to continue to improve access to allied health services in rural and remote communities. The scheme was designed to assist employers to recruit new employees or retain current employees by providing rural career advancement opportunities and incentives (SARRAH, 2023a). During the pilot program, 43 AHPs commenced the Pathway across five states and territories and 19 organisations. The majority of the trainees were occupational therapists with smaller numbers from physiotherapy, speech pathology, podiatry and dietetics. Of the 43 trainees, 20 completed the level 1 or 2 program.

2 TAHRGETS

Following on from AHRGWES, in 2021, the Allied Health Rural Generalist Training and Education Scheme (TAHRGETS) was funded by the Australian Department of Health and Aged Care as an expansion of the initial pilot. TAHRGETS provided 90 training positions for private and non-government rural generalist trainees. TAHRGETS provided workplace training grants to organisations to contribute to tuition costs and backfill for study leave and other costs incurred to support the rural generalist trainee to complete the pathway at the discretion of the employer. Trainees had the option of participating in the Rural Generalist Program (Level 1) for new graduates and the Diploma of Rural generalist Practice (Level 2) for early career AHPs. They were afforded dedicated supervision and study time at work and participated in service development projects that met the needs of the community in which they were practicing in (SARRAH, 2023b). Full details can be found in Appendix 1: TAHRGETS program guidelines.

TAHRGETS project team coordinated and administered the scheme and supported organisations and trainees in their participation, enrolment and completion of the Pathway. The TAHRGETS project team also developed and implemented a range of capacity building programs and networking and support opportunities for organisations participating in TAHRGETS.

2.1 Aboriginal Community Controlled Health Organisations

Of the 90 places, TAHRGETS included 30 training positions assigned for Aboriginal Community Controlled Health Services (ACCHOs) with an aim of increasing access to allied health services for First Nations people. SARRAH worked closely with the National Strategy Group, TAHRGETS advisory committee, Indigenous Allied Health Australia (IAHA), and consulted with National Aboriginal Community Controlled Health Organisation (NACCHO) and regional, rural and remote ACCHOs to identify approaches to implementing TAHRGETS training positions in ACCHOs (SARRAH 2023).

2.2 Pathway governance and infrastructure

2.2.1 National Strategy Group

The Allied Health Rural Generalist Pathway National Strategy Group (NSG) was established and supported by SARRAH during the implementation of TAHRGETS and provided governance and oversight to support the national expansion of the Pathway, critical to its long-term sustainability. The NSG is a multisectoral collaborative comprising stakeholders from government and industry with an interest in building a fit-for-purpose rural and remote allied health workforce. It provides oversight and collective advice to SARRAH to support the sustainability and growth of the AHRG Pathway nationally (SARRAH, 2023c). In 2023, the NSG formally endorsed SARRAH as the national lead organisation to support multijurisdictional cooperation and collaboration for the Allied Health Rural Generalist Pathway.

2.2.2 Allied Health Rural Generalist Accreditation Council

During the implementation of TARHGETS, SARRAH established the AHRG Accreditation Council as an independent council under SARRAH's corporate governance structure. The AHRG Accreditation Council has the primary function of accrediting university courses delivering AHRG programs. The council is made up of 9 members including allied health, Indigenous and consumer representation across Australian states and territories. An executive officer was also appointed to support the council in the establishment phase.

Funding for this research has been provided by Government of Australia Department of Health and Aged Care.

3 Purpose of the evaluation

3.1 TAHRGETS objectives and outcomes

As outlined in the Commonwealth grant agreement TAHRGETS has the following objectives and outcomes:

Objectives

1. Improve the **capacity, quality, distribution and mix** of the allied health workforce to better **meet the needs** of Australian communities and deliver a sustainable and well-distributed health workforce through the AHRGP.
2. **Support** allied health practitioners and **assist practices** to deliver local allied health **service capacity** in rural and remote Australia.

Outcomes

i Provide **support** to private and not for profit service providers, to **build capacity** and **expand allied health service delivery** in rural and remote locations.

ii **Increase the number of allied health rural generalists** in rural and remote locations as well as practices offering **greater access** through an extended range of services.

iii Develop **career pathways**, and improve the **retention** of allied health professionals working in rural and remote areas.

3.2 Research Aims

The overarching aim of the research is to evaluate the TAHRGETS scheme in relation to the objectives and outcomes outlined in the grant agreement, and to look at elements of program design that are working well and those that could be improved.

The specific aims include:

1. To measure the impact of TAHRGETS in improving capacity, quality, distribution and mix of the allied health workforce that better meets the needs of Australian communities.
2. To understand the impact of TAHRGETS in supporting allied health service delivery in rural and remote Australia.
3. To explore impact of TAHRGETS in the development of career pathways for allied health professionals in rural and remote Australia.
4. To determine the characteristics of the Pathway which are working well for the private and non-government sector, and which could be improved in the future.
5. To measure the number of AH professionals in rural and remote areas that have or are progressing towards qualifications in private practice and non-government organisations.
6. To measure TAHRGETS workforce outcomes in rural and remote Australia.
7. To examine the costs and benefits of TAHRGETS for participating organisations.

4 Methods

A mixed method approach was used to evaluate the TAHRGETS. The follow up period for data collection was January 2022 to October 2024. Ethics was approved by Flinders University Human Research Ethics Committee (HREC 6529) on 19/1/2024.

4.1 Data collection and analysis

Table 1: Data collection methods

Trainee interviews	Completing trainees participated in an interview exploring their experiences of TAHRGETS. These took place between January 2023 and October 2024 to align with each trainee's Pathway completion.
Line manager, supervisor interviews	Completing trainees' line managers and clinical supervisors were interviewed to explore their experiences supporting a TAHRGETS trainee and the impact of the Pathway on their service and consumers. Managers and clinical supervisors of trainees that had withdrawn from the Pathway were also interviewed. These took place between November 2023 and October 2024.
Withdrawn trainee interviews	Trainees who had withdrawn from the Pathway were interviewed to explore their experience of TAHRGETS and the reasons for their withdrawal. These took place between June 2023 and July 2024.
Project team interviews	TAHRGETS project team members were interviews to explore TAHRGETS contexts, inputs, outputs and outcomes between March and August 2024.
Discrete Choice Experiment	An online Discrete Choice Experiment survey was undertaken with AHPs, supervisors and managers who had not participated in the program to understand from a larger scale sample the components of the Pathway which could attract (or otherwise) potential participants to the program in future iterations.
Organisational data	Details of trainees and their organisations, and resource allocations via SARRAH

4.1.1 Interviews

Interviews were conducted by SARRAH with trainees who had completed the Pathway, trainees who had withdrawn from the Pathway, and managers and supervisors of both trainees and withdrawn trainees. Interviews were conducted between November 2023 and October 2024. All interviews were semi-structured and consisted of both closed-ended questions and open-ended questions. Interview participants included:

- 25 trainee interviews were completed
- 17 manager/supervisor interviews were completed
- 7 withdrawn trainee interviews were completed
- 4 manager/supervisor of withdrawn trainees were completed
- 115 online survey responses
- Organisational data based on 64 participants was collated.

Details of the TAHRGETS evaluation interview participants and demographics are available in Appendix 2.

Data from the interviews were collated in Excel by the SARRAH team and then imported into SPSS for analysis. The qualitative data from the interviews was open coded into Nvivo and then analysed and themed using the iPARIHS implementation science framework (Harvey & Kitson 2016). This implementation science framework enables qualitative findings to be analysed against factors relating to the innovation or program being implemented, recipients participating in the program and context in which the innovation takes place. For the purpose of this research, the open codes were synthesised for meaning against the iPARIHS framework to explore explain the multi-dimensional and complex components influencing the implementation of TAHRGETS. Case studies were developed using the qualitative data from the interviews (See Appendix 3).

4.1.2 Discrete choice experiment

This study used a DCE to evaluate participant preferences across various program attributes related to allied health professional training. A sample of 115 participants were recruited to participate online using a Qualtrics survey.

AHPs, supervisors and managers were invited to participate in an online Discrete Choice Experiment survey (DCE) to understand which aspects of the delivery and potential outcomes of the Pathway would drive uptake among AHPs, and/or supervisors and managers. The invitation to participate in the DCE was distributed via social media, through SARRAH and AHP bodies newsletters and a media announcement, with the primary aim to attract those who had not participated in the program, to gain feedback of the program design from a larger scale sample.

The participants completed a set of demographic questions followed by the Discrete Choice Experiment (DCE) component. Demographics and attitudes of responders to allied health and rural and remote practice are detailed in Appendix 4.

In the DCE, the participants were presented with a series of hypothetical choices between two program options, designated as Program A and Program B, across six key attributes. An additional 'no program' option was provided to capture scenarios where neither program was preferred. If participants initially selected the 'no program' option, they were prompted to make a subsequent forced choice between Programs A and B, ensuring a complete dataset for analysis of preferences.

The data from the DCE was analysed within the framework of random utility theory within STATA Statistical Analysis Software.

4.1.3 Organisational Data

Data on the resources used in the implementation of TAHRGETS were collected from SARRAH administrative databases and from interviews with trainees and supervisors. All resources were valued using appropriate published unit costs where available. Calculations for costs for trainee time was estimated based on their Allied Health profession using three unit costs, (1) average wage based on Australian Bureau of Statistics Employee Earning and Hours Microdata, (2) potential billable hours lost using applicable items from the Medicare Benefits Schedule and (3) billable hours lost using items for the National Disability Insurance Scheme prices for remote areas (Australian Bureau of Statistics 2023; Australian Government Department of Health 2024; National Disability Insurance Agency 2024). All costs were updated to a standard reference year (2024) taking account of inflation.

4.2 Program logic

The results of this evaluation have been analysed and presented using Program Logic Theory which is used to visually outline the causal relationship between contexts, inputs, outputs and outcomes (Funnell & Rogers 2011). Using program logic for this research enabled the measurement of effectiveness of the TAHRGETS through logically demonstrating how the context and TAHRGETS inputs contributed to the outputs and outcomes. The results are presented using the following logic framework (WK Kellogg Foundation 2004).

Table 2 Program logic framework

Context	Implementation			Results	
Influences	Resources and inputs	Activities	Outputs	Individual outcomes	Broader impacts

4.3 Applying the results

In *Section 7 Discussion and findings,* the results are mapped back to the objectives and outcomes of the grant agreement.

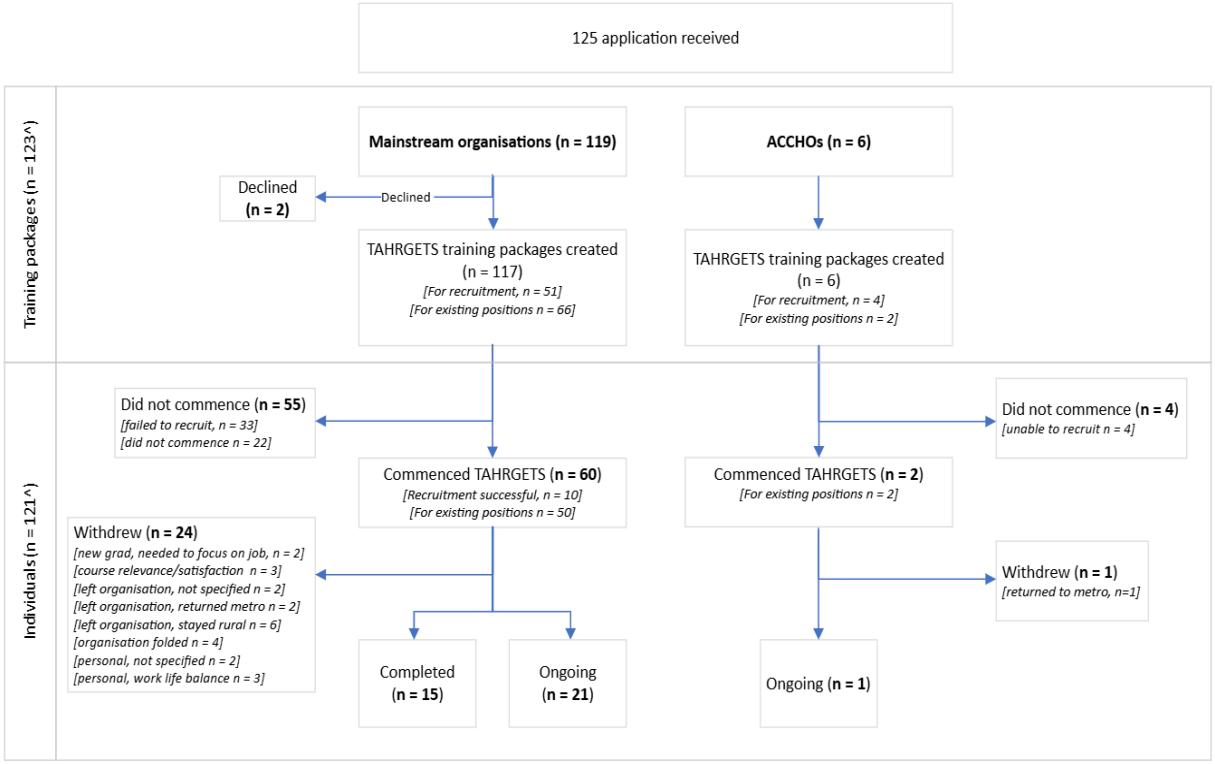
5 Results

5.1 Statistics overview: TAHRGETS participants and organisations

123 training packages were created for 121 individuals between January 2022 to October 2024 with 48 regional rural and remote organisations across Australia. Two people transferred organisations accounting for the additional two training packages. Sixty-two allied health trainees participated in TAHRGETS. Of these 62 trainees, 37 have completed or are planning to complete in 2025 and 25 trainees have withdrawn from the Pathway.

Organisations could apply for a TAHRGETS training package for an existing staff member or for a position that was vacant but that they intended for a new staff member. Sixty-seven training packages were created for existing staff within organisations and 54 recruitment positions (121 in total). Of the 54 recruitment positions created, thirty-seven training positions were not filled as recruitment was unsuccessful. Of the 67 existing staff packages, 22 were created with the organisation, but never commenced. Most packages that were active (trainees who have completed, enrolled trainees and withdrawn trainees), were supported by existing positions (n=52) rather than positions to be recruited.

Figure 1 Flowchart of TARHGETS training packages and individuals



^ Two people left their workplaces and continued with their Pathway with their new workplace. New training packages were started with the new workplaces, but the number of individuals remained the same

5.1.1 Allocation to mainstream or ACCHO

Sixty training packages were available for mainstream workplaces. Over the course of implementation and in response to attrition, a total of 117 (195%) training positions were created for mainstream workplaces. A total of 60 (100%) trainees commenced the pathway employed in a mainstream workplace.

Thirty training packages were available for ACCHO workplaces. Over the course of implementation six (20%) of training packages were created. A total of (3.3%) trainees commenced the pathway employed in an ACCHO

5.1.2 Allied Health workforce distribution and mix

Just under two fifths of trainees (39.1%, n=25) were occupational therapists and just under one fifth (17.2%, n=11) were dietitians. Most trainees were undertaking the Pathway in Queensland (54.8%, n=34), or New South Wales (25%, n=16). All states and territories were represented within the cohort excepting for the ACT and Victoria. Half of the trainees (50%, n=31) were completing Level 1 and half (50%, n=31) were completing Level 2. Just over four fifths (83.9%, n=52) were employed at their organisation prior to commencing the Pathway.

Of the two trainees within ACCHOs, one (50%) was a podiatrist, and one (50%) was a dietitian. Both trainees worked for the same organisation in the Northern Territory.

Most trainees (83.9%, n=52) were working in a private practice with half (48.4%, n=30) working in organisations that employ between 10-49 employees. Most trainees (82.3%, n=51) were working in sectors that provided a mix of services, with 14.5% (n=9) working specifically in the disability sector and 3.2% (n=2) in ACCHOs.

Organisations were mostly located in MM3 (32.3%, n=20) and MM5 (25.8%, n=16) areas. A smaller number of organisations were located in MM6 (9.7%, n=6) and one organisation was classified as MM1 (1.9%, n=1) but the trainee was located rurally.

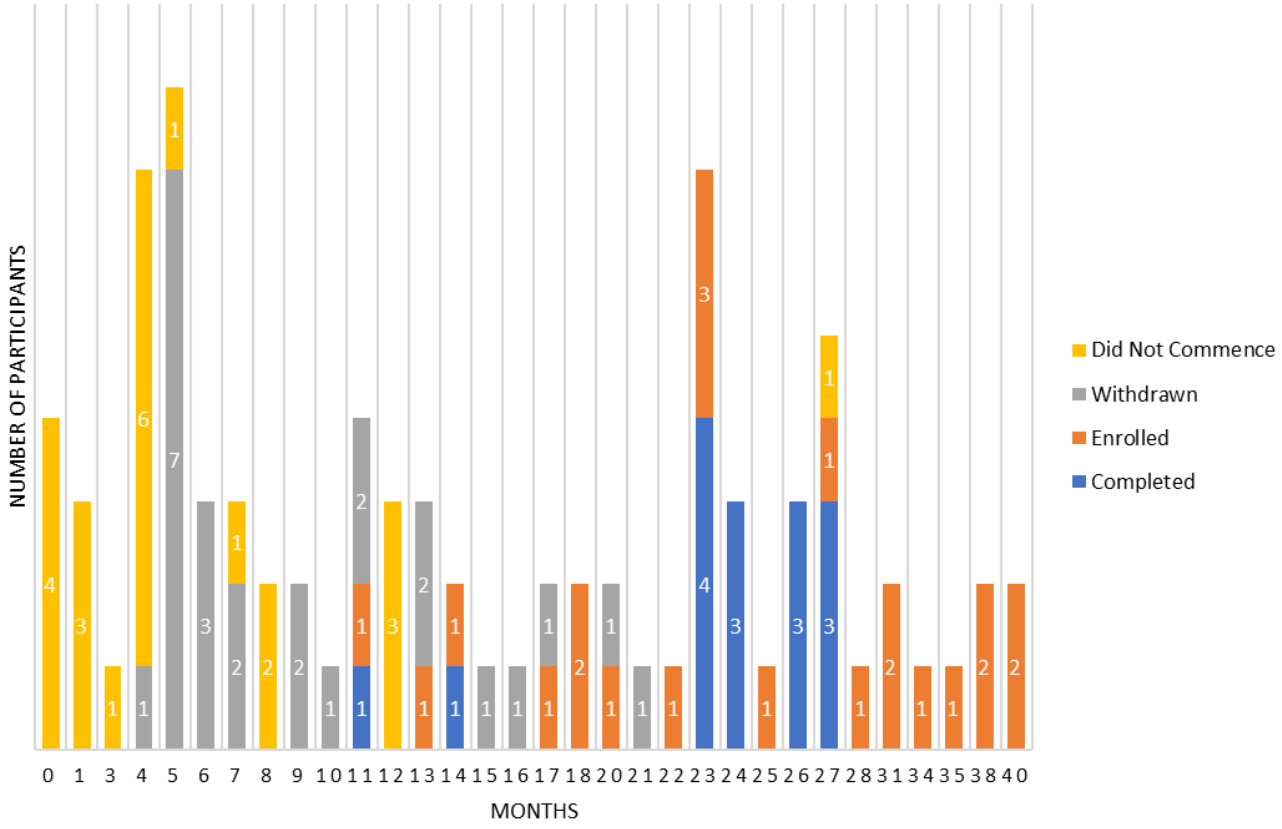
5.1.3 Recruitment of allied health professionals

Seventeen new AHPs (Table 8) were recruited to new positions in organisations (including withdrawn trainees). This included an additional five physiotherapists, five occupational therapists, and four pharmacists and three social workers or psychologists

5.1.4 Time in the program

Trainees in the level 1 program took between 11 and 24 months to complete the Pathway with an average of 20 months. Graphical representation of the time period that trainees spent in the program and their status is provided below (Figure 1: Trainee time in the program). Trainees undertaking level 2 took between 23 and 27 months to complete with an average of 25 months. Trainees who discontinued completed on average three modules (range 1-8 modules) before withdrawing from the Pathway and most withdrew within the first few months, particularly at month five. Withdrawals gradually decreased after the initial months but persist sporadically until month 21. Those who persisted past the initial months were more likely to remain enrolled or complete their participation.

Figure 1 trainee time in the program



NOTE: The number of months for the enrolled participants indicate their estimated time to completion. Please note the categories represent, trainees who entered the program but did not enrol in any formal university education before withdrawing (Did Not Commence), trainees who entered the program and commenced formal university education but withdrew without completing, those who are currently enrolled in the program with their time in the program estimated based on the expected date of completion (Enrolled), and those who have completed the formal education program as of October 2024 (Completed). One participant who did not commence had a much longer time period that usual before deciding not to continue with the program (27 months). This long lead time was due to an extended time to onboard the recruited trainee, and time allowed to settle into their new location, before they made a decision not to engage with the program.

5.1.5 Increased number of allied health rural generalists in rural and remote areas

At the end of the follow up period, 15 trainees had completed TAHRGETS, six completed the level 1 education program and nine completed level 2. 22 trainees (Level 1=10, Level 2=12) are expected to complete in 2025.

Of 62 trainees that commenced the pathway, 37 are expected to complete, demonstrating a completion rate of 60% and an increase of 37 allied health rural generalists in rural and remote areas.

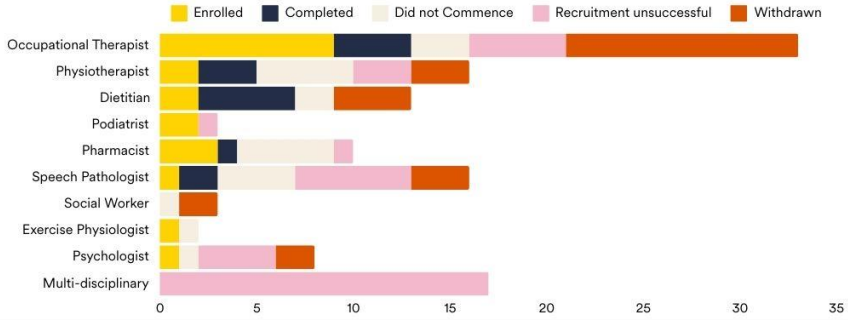
Of the 60 packages for mainstream allied health services, a total of 36 trainees are expected to complete, representing a 60% achievement rate against the goal of 60 mainstream positions. Of the 30 packages allocated for ACCHOs, 1 trainee is expected to complete.

Inability to reallocate or create new training positions in the event that trainees withdrew has limited overall numbers. This is due to overall program timelines and is explored further in 5.2.3

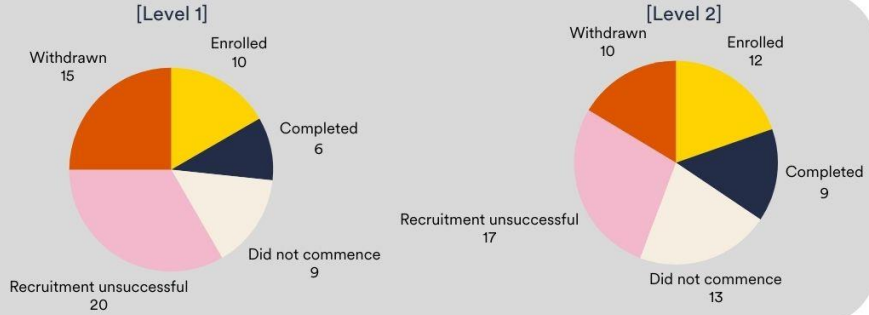
TAHRGETS AT A GLANCE

Participation by recruitment type

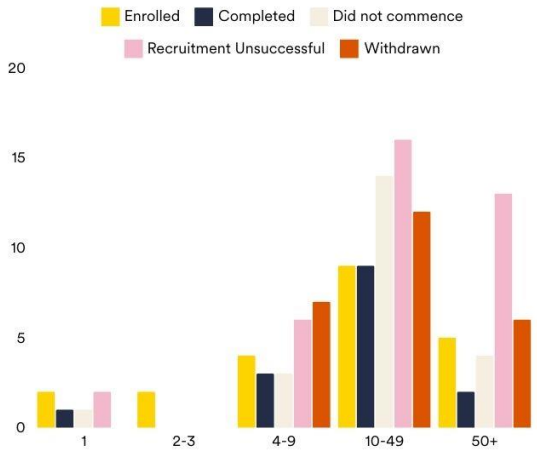
Participation by profession



Rural generalist program levels 1 and 2 participation



Organisation size - number of employees



TAHRGETS engagement by state

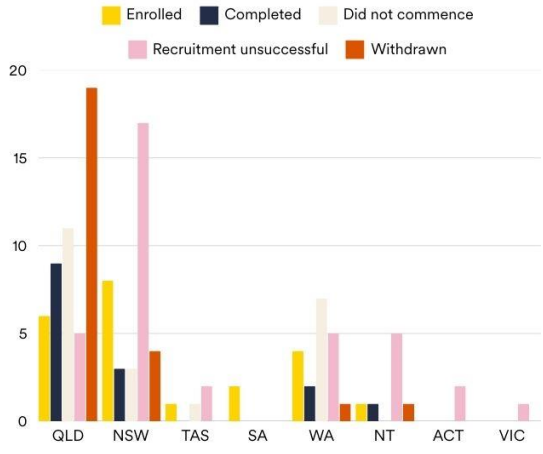


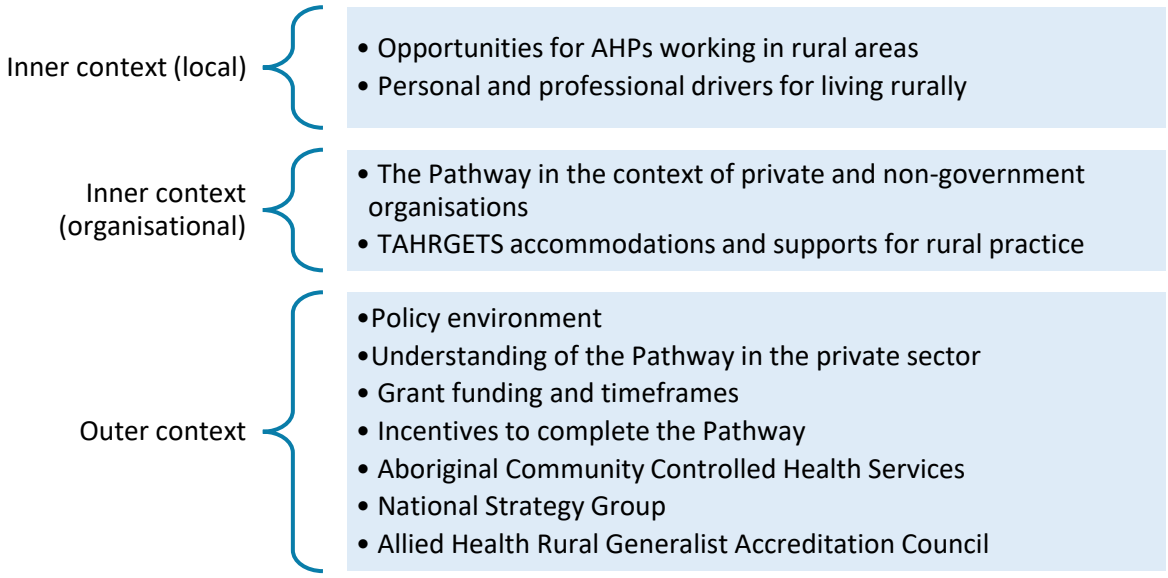
Table 3 Training packages by trainee as of 15th October 2024

	Enrolled *n* (%)	Completed *n* (%)	Did not commence *n* (%)	Recruitment unsuccessful *n* (%)	Withdrawn *n* (%)
Trainees	22 (18.2)	15 (12.4)	22 (18.2)	37 (30.6)	25 (20.7)
Recruitment type					
Existing position	16 (72.7)	14 (93.3)	15 (68.2)	-	22 (88)
Recruitment	6 (27.3)	1 (6.7)	7 (31.8)	37 (100)	3 (12)
State					
QLD	6 (27.3)	9 (60)	11 (50)	5 (13.5)	19 (76)
NSW	8 (36.4)	3 (20)	3 (13.6)	17 (45.9)	4 (16)
TAS	1 (4.5)	-	1 (4.5)	2 (5.4)	-
SA	2 (9.1)	-	-	-	-
WA	4 (18.2)	2 (13.3)	7 (31.8)	5 (13.5)	1 (4)
NT	1 (4.5)	1 (6.7)	-	5 (13.5)	1 (4)
ACT	-	-	-	2 (5.4)	-
VIC	-	-	-	1 (2.7)	-
MMM location					
1	1 (4.5)	-	-	-	-
2	3 (13.6)	3 (20)	4 (18.2)	6 (16.2)	4 (16)
3	7 (31.8)	2 (13.3)	7 (31.8)	17 (45.9)	11 (44)
4	4 (18.2)	2 (13.3)	3 (13.6)	5 (13.5)	3 (12)
5	4 (18.2)	7 (46.7)	3 (13.6)	2 (5.4)	5 (20)
6	3 (13.6)	1 (6.7)	5 (22.7)	7 (18.9)	2 (8)
Organisation size					
1	2 (9.1)	1 (6.7)	1 (4.5)	2 (5.4)	-
2-3	2 (9.1)	-	-	-	-
4-9	4 (18.2)	3 (20)	3 (13.6)	6 (16.2)	7 (28)
10-49	9 (40.9)	9 (60)	14 (63.6)	16 (43.2)	12 (48)
50+	5 (22.7)	2 (13.3)	4 (18.2)	13 (35.1)	6 (24)
Organisation type					
Disability not-for-profit	3 (13.6)	1 (6.7)	3 (13.6)	5 (13.5)	3 (12)
Healthcare not-for-profit	-	-	-	2 (5.4)	-
Private Practice/for profit	17 (77.3)	14 (93.3)	19 (86.4)	26 (70.3)	21 (84)
ACCHO	1 (4.5)	-	-	4 (10.8)	1 (4)
Other	1 (4.5)	-	-	-	-
Sector					
Disability	4 (18.2)	2 (13.3)	4 (18.2)	5 (14.7)	3 (12)
Aboriginal health	1 (4.5)	-	-	4 (11.8)	1 (4)
Mixed	17 (77.3)	13 (86.7)	18 (81.8)	25 (73.5)	21 (84)
Profession					
Occupational Therapist	9 (40.9)	4 (26.7)	3 (13.6)	5 (13.5)	12 (48)
Physiotherapist	2 (9.1)	3 (20)	5 (22.7)	3 (8.1)	3 (12)
Dietitian	2 (9.1)	5 (33.3)	2 (9.1)	-	4 (16)
Podiatrist	2 (9.1)	-	-	1 (2.7)	-
Pharmacist	3 (13.6)	1 (6.7)	5 (22.7)	1 (2.7)	-
Speech Pathologist	1 (4.5)	2 (13.3)	4 (18.2)	6 (16.2)	3 (12)
Social Worker	1 (4.5)	-	1 (4.5)	-	1 (4)
Exercise Physiologist	1 (4.5)	-	1 (4.5)	-	-
Psychologist	1 (4.5)	-	1 (4.5)	4 (10.8)	2 (8)
Multi-disciplinary	-	-	-	17 (45.9)	-
Level					
1	10 (45.5)	6 (40)	9 (40.9)	20 (54.1)	15 (60)
2	12 (54.5)	9 (60)	13 (59.1)	17 (45.9)	10 (40)

5.2 Context

Context	Implementation			Results	
Influences	Resources and inputs	Activities	Outputs	Individual outcomes	Broader impacts

The context in which TAHRGETS was implemented was explored through interviews with trainees, managers, supervisors and the TAHRGETS project team. Considering context enabled the exploration of factors contributing to uptake, participation, satisfaction and implementation of the Pathway in the private sector. In this report, context is considered in terms of inner (local), inner (organisational) and outer (external) in line with the iPARIHS implementation science framework (Harvey and Kitson 2016).



5.2.1 Inner context (local)

Inner context relates to the immediate context for trainees' participating in TAHRGETS. The majority of the inner context is described in the implementation section of this report in regard to supports, enablers and barriers for trainees participating in TAHRGETS (from page 28). In this section specifically, the context of living and working in rural areas is described.

RURAL OPPORTUNITIES

Working in rural areas gives early career AHPs opportunities they would not be afforded in metropolitan areas. AHPs in rural areas get to know their clients more and see the improvements made through the provision of consistent, client centred services. They also have career advancement opportunities early in their careers and undertake rewarding work. Trainees also reported rural work is appealing because the people are friendlier and value the work they do:

> *People just tend to be friendlier and also just getting more involved in the community because you do have more time so you feel like you're actually adding value to the community not just within work but also outside, and you do get to see people more regularly than you would in the city so you can follow up and actually see those improvements which you've implemented which I think is really beneficial (*WT2).

> *You don't realise the opportunities in rural and remote, because I just feel like the roles weren't advertised. One example is my best friend who is a physio in Sydney cannot for the life of her move from a level 2 to a level 3, whereas there's lots of opportunities around here to move up as an allied health clinician, which is really exciting and rewarding. So I love living here, I'm going to keep working here and there's actually great opportunities to move up in your career. That's the main thing (*T14).

REASONS FOR LIVING RURALLY – PROFESSIONAL AND PERSONAL DRIVERS

Interviewed trainees reported living and working in a rural area because of a passion for equitable health care and a desire to improve health outcomes for rural communities. They described being passionate about working in rural areas and a desire to work across a broad scope of practice. There are good opportunities for AHPs in rural areas and they liked being able to see the benefits of their work in the community:

> *I have lived in regional and rural areas my entire life and have seen how difficult it is to access and maintain healthcare services. I am passionate about servicing my community and ensuring that someone's health is not determined by their postcode (*WT6).

Trainees also described personal reasons for working in a rural area including a range of lifestyle factors. For those who had grown up in a rural area they reported the region as home, being close to family, good community connections. Others described a love of living regionally and a small community with everything close by:

> *This is our home now. We've moved and established ourselves as a family. The lifestyle and the type of work I've got as well is good (*T16).

5.2.2 Inner context (organisational)

THE ALLIED HEALTH RURAL GENERALIST PATHWAY IN THE CONTEXT OF PRIVATE AND NON-GOVERNMENT ORGANISATIONS

The Allied Health Rural Generalist Pathway is a relatively new concept and with the introduction of a pilot in private practices from 2019 and the first graduates in 2020. As a result, employing organisations were largely unfamiliar with the potential benefits and challenges of the Pathway and it took time for managers and supervisors to understand the expectations of the Pathway and their role in supporting trainees. In a range of circumstances, organisations chose to participate in TAHRGETS not knowing if it would benefit them, or potentially were hesitant to participate because they assumed it wouldn't benefit them:

> *So yeah, that could be that could be tricky for them to see that wait that there might be benefits if you if they stick with it and do it well. Understanding how this is going to benefit the team. You're regardless of whether that person stays or goes, and so that's probably a factor in for their challenges (PT).*

Interview participants did however report that rural generalist training is a priority for rural organisations who require AHPs to work across a broad scope of practice:

> *As a company providing rural outreach services across Queensland and New South Wales you need to upskill to be generalist allied health professionals (WMS2).*

As early participants of the Pathway in private practices, trainees also took time to understand the Pathway expectations, processes and outcomes. They reported needing more guidance, information and support than they anticipated as they participated. This was especially important for the service development component of the Pathway with trainees reporting a need for more guidance about what was expected of the project work. Trainees also mentioned that at times they needed more support and guidance from SARRAH to navigate expectations of the Pathway with their employer:

> *Having some outcome measures or milestones or a list of objectives that we want to meet/reflect on for the project* (T10).

> *I think initially when I started it was a bit difficult for my employer to first of all understand what the program was about from a business perspective and then I believe there was difficulty in accessing funding and just a bit of general confusion…. It would really help me out or any other future participant if it was just a little bit easier especially for people that don't know anything about the program at all… Even before signing up for the program I feel like its information that should be accessible for people to know what is expected and how it goes along* (T25).

Allied health practices in private practice need to manage staff workloads to ensure their businesses are financially viable. They are under pressure to attract and retain allied health staff in already thin market, many organisations are paying high wages to attract and retain their staff. While TAHRGETS gave organisations an incentive to offer AHPs, the pressure to accommodate trainee study time and

support for the Pathway is different to public health settings where funding is not as heavily reliant on billable hours and activity for viability/sustainability:

> *For me personally it was a struggle when I had some timeframes and demands from the work that needed to get done for clients. It was hard to quarantine a full day* (WT4).

> *And I think that that like to be fair, many of these organizations need that allied health and professional to hit their targets or they're going to be not viable. So it's that's an enormous pressure for them too, especially if they've had to pay more money to get that person in to start with. So there's a real umm, there's a real tension like the they're in a between a rock and a hard place, I think, yeah* (PT).

High and competing demands in private practice also described by trainees who felt they needed more flexibility in order for the Pathway to meet their needs. This included consideration for time away from the office on remote trips, and support for sole practitioners who found it difficult to prioritise study time without the support of a team. A range of supports were provided by the education provider and TAHRGETS project team but in some circumstances, it was too challenging to manage:

> *It was hard to fit in when you were at times away for an entire week. Needed a bit more flexibility, found it really challenging when asking for an extension and JCU weren't supportive* (T11).

> *The way that it's set up it really comes down to the individual that doing the program and their capacity. I think SARRAH were very understanding and supportive in their role, in sort of helping me and supporting me to try and get through the program but it was just out of everyone's control a little bit* (WT5).

TAHRGETS ACCOMMODATIONS AND SUPPORTS FOR RURAL PRACTICE

TAHRGETS project team provided organisations and potential trainees with education and guidance about the Pathway, they also advocated for the Pathway more broadly to raise awareness and understanding across the sector:

> *SARRAH provided me with the opportunity that I had no idea about to start with. I had no idea about these programs or opportunity and SARRAH was a bit of an advocate in that way, basically that I could do it and I had the opportunity to do it like everyone else across the area. And also, giving me that financial and professional support to actually enrol in TAHRGETS and have a go at something like this* (WT5).

> *That's what SARRAH does in already being rural and remote through its structure as an organisation and they are also our advocates for the sector. If the funding went somewhere else, I'm not sure how it would be placed. It did make sense for SARRAH to be the distributor of funds because they get this space* (T11).

TAHRGETS was flexible in allowing trainees to move organisations and continue the Pathway and this enabled several trainees to complete the Pathway despite changing employers. In some circumstances however this was not possible due to the new organisational context, changes to caseload or employment conditions:

> *My employer tried to see if there was a way to continue, but we just couldn't figure out a way to make it feasible with the type of assignments that I was doing in the course, they required a lot of client involvement, so wasn't really able to keep going. So we did try* (WT3).

Some AHPs who work in rural areas, live in metropolitan areas and commute to rural areas for work through outreach-based services. In the current iteration of the scheme, these AHPs were not eligible to participate in TAHRGETS. A recommendation from managers/supervisors was to include these staff in the Pathway, such as through organisations nominating staff who predominantly work in rural areas to be able to participate in the scheme:

> *So, my feedback would be if there was a different scale of documenting that even if that was a letter or some kind of statement from the organisation, we would be very happy to provide it. Because if that was the case, we would have potentially more people interested in engaging this program. But again, I completely understand that you can't train up people who may not be as invested and your funding is limited by the nature of how it works. So that personal feedback in terms of how our organisation works, but I respect why it's like that* (M2).

The TAHRGETS project team supported allied health trainees across a broad range of experience levels and circumstances. A large proportion of those who withdrew from the Pathway withdrew before commencement but after receiving information about the format and expectations of the Pathway. The TAHRGETS project team described the learning they gained while coordinating the scheme and the feedback received from organisations as helpful for identifying suitable candidates for the future. As TAHRGETS gave private practices the opportunity to participate in the Pathway for the first time, there was limited understanding in the sector about the intended benefits, expectations and program of study. TAHRGETS had clear key performance indicators including the number of trainees enrolled and completing the scheme. In order to meet these indicators, the TAHRGETS project team worked hard to enrol as many trainees and organisations as possible. At the time of enrolment, there was no evidence available about who was likely to succeed within different contexts and circumstances. If training positions were available to allied health practices in the future, the TAHRGETS project team and AHPs more generally would be more informed about the Pathway and be able to make a more informed decision about their participation.

5.2.3 Outer context

POLICY ENVIRONMENT

As workforce development programs tailored for the allied health professions, TAHRGETS and its associated program, *Building the Rural Allied Health Assistant Workforce*, were focused specifically on the development of the rural and remote allied health workforce. This sets them apart from other Commonwealth-funded initiatives aimed at developing Australia's health workforce.

The **Strengthening Medicare** initiative responds to the Strengthening Medicare Taskforce report(Australian Government 2023). While this initiative aims to improve primary care access and multidisciplinary team care, and includes recommendations to address the overall health workforce, current policies primarily focus on growing the nursing, midwifery, and First Nations health workforce. It does not specifically address existing shortages of allied health professionals in rural and remote locations.

Subsidised funding of undergraduate programs in Psychology and Social Work was introduced in 2021, and in 2024 additional postgraduate psychology places were announced. While welcome, these subsidies were not targeted to address existing maldistribution or increase the supply of workforce to rural and remote Australia.

The **Stronger Rural Health Strategy** (SRHS), includes the Rural Health Multidisciplinary Training program, the Workforce Incentives Program and a range of other programs that focus on workforce in rural and remote communities. These programs are administered by a broad range of agencies, with little coordination between the programs and notable differences in implementation from agency to agency or state to state.

- The **Rural Health Multidisciplinary Training** (RHMT) program aims to improve the recruitment and retention of medical, nursing, dental and allied health professionals in rural and remote Australia, by offering health students the opportunity to train in rural and remote communities. By far, most of this funding goes to medical workforce training.
  A 2020 evaluation of the RHMT program found a lack of mechanisms supporting the transition of allied health and nursing students who have participated in rural training onto a rural career pathway (KBC Australia 2020). The report included recommendations for supportive roles such as career guidance and vocational planning, supervision capacity development, early career support and development of training and career pathways. These types of supports for workplaces and early-career practitioners are incorporated into the TAHRGETS program.
- The **Workforce Incentive Program Practice Stream** offers support to General Practices to employ or engage allied health professionals. Allied health service providers are not eligible to receive these incentive payments. The effectiveness of this program in improving opportunities for allied health professionals to work in primary care settings is unknown.
- The **Rural Health Workforce Support Activity (RHWSA)** aims to improve the capacity, quality, distribution and mix of the health workforce to better meet current and future needs of rural and remote communities. In each State and Territory, Rural Workforce Agencies identify priorities through an annual Health Workforce Needs Assessment, supplemented by ongoing workforce planning and engagement at a local level. Allied health-targeted activities delivered through the RHWSA vary substantially from jurisdiction to jurisdiction.
- The **Health Workforce Scholarship Program** is a scholarship and bursary program for rural and remote health professionals including allied health professionals. Scholarships are administered by the relevant jurisdiction health workforce agency, with some regional differences in administration noted. Capped at $10,000 per annum, these scholarships are paid to individual health professionals working in primary care settings, for professional development in areas of clinical interest.
- The **Rural Locum Assistance Program**, administered by Aspen Health, provides locum coverage for existing workforce to enable health professionals to take leave, including for the purpose of professional development. It does not directly address rural workforce supply or distribution.

To summarise, while the Australian Government funds a range of rural health workforce development programs, these programs are administered independently of each other through different agencies and lack specific focus or targets to increase the rural and remote allied health workforce.

Throughout 2024 consultations were undertaken on the inaugural **National Allied Health Workforce Strategy (**Australian Government 2025), in draft at the time of writing. The strategy will consider how to better align the supply of allied health professionals with current and future needs.

COMPARISON TO MEDICAL RURAL GENERALIST TRAINING

Medical Rural Generalist training positions are a training option for doctors wanting to become specialist generalists. The program has an excellent retention rate with approximately 80% of fellows still working rurally 5 years after completion. The program is highly structured and includes training, professional experience, supervision and examinations over approximately five years. On completion of the training, doctors are qualified as Rural Generalist Fellows and can work autonomously, unsupervised, register as a consultant and importantly, are incentivised as are able to bill Medicare and insurers for their work. Before qualifying as Rural Generalist Fellows their work needs to be supervised and they cannot directly bill for their work.

Government funding is received by hospitals and practices to host doctors in training. This supports the practice to employ the doctor, supervise them and cover business costs. Practices may also be eligible for additional payments throughout the training process for supervisors.

Medical colleges deliver the rural generalist programs. Doctors in training co-contribute to the cost of their training programs in addition to government funding received by the colleges.

In addition, Rural Generalist Support and Coordination Units are funded in each state with federal funding to provide support to doctors in training as well as marketing, promotion, mentoring, coordination of the program overall.

Drawing direct comparisons between rural generalist pathways for Medicine and Allied Health is challenging. The medical profession is regulated through a single national registration board administered through the Australian Health Practitioner Regulation Agency (Ahpra), with medical education programs accredited through the Australian Medical Council. In contrast, there are currently 10 allied health professions eligible for rural generalist training positions, some of which are regulated through Ahpra, and others being self-regulated. Each profession has its own Council responsible for accrediting undergraduate education programs. Maintaining a single allied health rural generalist pathway is critical to ensure there is shared understanding and alignment between the professions regarding rural generalist skills and competencies.

Similar to the medical rural generalist training programs, TAHRGETS is tailored for the allied health disciplines, providing a supportive experience for new graduate and early career allied health professionals to develop their skills and competencies in rural and remote settings, and enabling employers to develop clinical supervision and workforce development capacity. However unlike the medical rural generalist training program, there are not yet the inbuilt incentives and system enablers for AHPs to complete the pathway.

UNDERSTANDING OF THE ALLIED HEALTH RURAL GENERALIST PATHWAY IN PRIVATE AND NON-GOVERNMENT SETTINGS

Allied Health rural generalist training positions are relatively new and there is generally a limited understanding of their purpose amongst funding bodies, governments and professional bodies. There is also a limited understanding of the skills and knowledge required for rural allied health practice in terms of valuing the broad nature of practice and the complexity of the work managed by often early career staff.

An indirect outcome for SARRAH is the reputation and expertise in relation to the Pathway. SARRAH has supported trainees and organisations in every state and territory in Australia and developed a very comprehensive understanding of Allied Health practice pressures, opportunities and the impacts of the generalist Pathway. SARRAH has also had the opportunity to engage with allied health services across contexts and service settings, from small single operator businesses to large organisations with many staff. This in depth knowledge has enabled SARRAH to represent and lead the implementation of the Pathway across Australia:

> *Well, it's been an opportunity for us to, you know, continue this Pathway that's been in the making for you know, what, 10 years, a long time to build on the work that's the already been established and to build on that pilot program that I was programmed. So I think it's positive that we're still moving in the right direction, and I think it's contributing to government health outcomes* (PT).

GRANT FUNDING AND TIMEFRAMES

SARRAH was funded by the Commonwealth Government to implement 60 rural generalist training positions in private and non-government organisations. Due to the challenges of recruiting and retaining AHPs in rural and remote areas and the limited awareness and understanding of the generalist Pathway, 60 positions translated into over 120 participants in the Pathway and many more false starts. Organisations had the opportunity to apply for a training position before recruiting an AHP, in some cases, these positions were not recruited into and so the training position was forfeited. In other instances, organisations appointed an existing staff member to a training position who declined the opportunity after receiving an orientation to the expectations and nature of the scheme. Others started the Pathway and did not finish. Each time these positions were not successfully completed, the TAHRGETS project team worked to re-allocate the training position,

either within the same organisation or with another organisation. TAHRGETS project team describe the challenges of meeting the scheme outcomes and the pressure they felt to retain trainees. As a result, TAHRGETS project team went 'above and beyond' to ensure trainees were satisfied and supported throughout their participation in the Pathway:

> *We want to see the benefits to the workplaces and the individuals as well. Yeah, we don't want the withdrawals* (PT).

The short grant timeframe for implementation meant that at a point in time, vacancies from withdrawals could no longer be re-filled because there was not enough time left in the funding arrangement for the new trainees to undertake the Pathway.

INCENTIVES TO COMPLETE THE PATHWAY

Participants discussed the limited incentives for completion of TAHRGETS, as the Pathway is not recognised by the government, peak bodies or funders of allied health services in terms of extended scope of practice, qualifications and learning:

> *I think for the government it's understanding that this is we're in a very different context to the medical rural generalist Pathway. We're much, much younger than the medical generalist Pathway and we're working across 10 professions, not one and so you we can't apply the same (metrics)* (PT).

Incentives are required for AHPs to participate in and complete the Pathway. Incentives could include endorsement of advanced skill, increased responsibility or practice scope, career advancement, contract changes or salary increases. The medical rural generalist pathway is well established with a range of professional and organisational incentives for doctors. Allied health incentives and specialisation endorsement could be modelled off learnings from the establishment of medical colleges. There are also no consequences for staff who choose to not complete the Pathway as the scheme did not involve a co-contribution of fees:

> *Retention is a serious issue, and I believe that a commitment to undertake the Pathway should be linked to the ongoing contract of the employee with the same organisation* (WMS4).

ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES

SARRAH worked closely with the National Strategy Group, TAHRGETS advisory committee, Indigenous Allied Health Australia (IAHA), and consulted with National Aboriginal Community Controlled Health Organisation (NACCHO) and regional, rural and remote ACCHOs to identify approaches to implementing TAHRGETS training positions in ACCHOs (SARRAH 2023). This extensive engagement identified that just one of the 18 ACCHOs consulted was employing a full team of allied health staff and the other organisations were predominantly contracting externally AHPs to provide services. ACCHOs utilise program or block funding, Medicare and National Disability Insurance Scheme (NDIS) funding streams to provide allied health service provision. These streams present a range of barriers to employing AHPs including short term, limited and restrictive funding arrangements. TAHRGETS consultation with ACCHOs indicated that their main focus for allied health was building a workforce. The organisations were largely unfamiliar with the Pathway and were unsure if the Pathway would be applicable to their context. In addition, the ACCHOs did not know if they would have allied health staff that could commit to a training Pathway that required up to 2 years of service.

NATIONAL STRATEGY GROUP

The Pathway is now a recognised and accepted rural workforce development strategy, that has evolved over time across state, government, private and non-government settings. The NSG will be essential to ensure that the future growth and development of the Pathway meets the needs of allied health rural generalists nationally, and across jurisdictions.

Under the guidance of the NSG, SARRAH has recently developed a roadmap to inform the next steps to a sustainable generalist pathway. The Road Map builds on the evidence for growing a rural allied health workforce pipeline and incorporates existing elements such as the formal education program, governance structures including the National Strategy Group and the Accreditation Council. The road map highlights where resources are required to support individual AHPs, employers, education providers and governments to collaborate toward a common goal in achieving and maintaining the highest standards of clinical practice, research and professional excellence in a rural allied health workforce. Central to the future sustainability of the Pathway, is the establishment of a college that will provide employers with a quality framework for effective teaching and training in rural and remote locations, and provide AHPs with professional recognition. It will also connect trainees with experienced and skilled supervisors and mentors and develop recognised pathways for AHPs in rural and remote communities. SARRAH is consulting with the sector regarding the feasibility of a college to support the ongoing development of the allied health rural generalist pathway, expanding beyond its current focus on early career allied health professionals to incorporate undergraduate rural clinical placements and ongoing professional development for proficient and advanced clinicians. A college could provide employers with a quality framework for effective teaching and training in rural and remote locations, connect trainees with experienced and skilled supervisors and mentors, and develop formal career pathways for AHPs in rural and remote communities.

ALLIED HEALTH RURAL GENERALIST ACCREDITATION COUNCIL

The AHRG Accreditation Council has developed accreditation processes and has assembled and trained an accreditation panel utilising pre-existing documents prepared for the Allied Health Professions' Office of Queensland, Queensland Health [deleted] by Australian Healthcare and Hospitals Association (Australian Healthcare and Hospitals Association 2018). James Cook University has agreed to apply to the AHRG Council for accreditation of their Rural Generalist Program, and the accreditation panel is assessing the application at the time of this report. The council have also explored different allied health contexts and scopes of practice and have collaborated with Indigenous Allied health Australia (IAHA) to explore the culturally responsive aspects of the accreditation standards to identify potential modifications of the standards following the pilot.

The continuity of the AHRG Council will be essential to ensuring the education component of the Pathway meets the ongoing needs of the AHPs undertaking the Pathway.

5.3 Implementation

Context	Implementation			Results	
Influences	Resources and inputs	Activities	Outputs	Individual outcomes	Broader impacts

5.3.1 Reasons for participating in TAHRGETS

Interviewed trainees were asked to rate how important a range of organisational, professional and personal reasons for participating in TAHRGETS were for them and then elaborate on any other reasons for participating (see figure 2 and 3). A large majority (84%, n=21) rated access to rural generalist program (education component) as important when making the decision to complete the Pathway. Post graduate education and training is expensive and TAHRGETS covered the costs of tuition which was a significant factor for trainees. Trainees also rated a desire to better meet the needs of their local community through accessing further education and finding ways to improve service provision with 80% (n=20) rating this as a reason for participating:

> *Yeah, more just to upskill my services, so to be able to have more impact on patients, more impact on communities* (T13).

Networks and lifestyle were significant reasons for participating in TAHRGETS. Two thirds of interviewed trainees (60%, n=15) cited their strong local professional networks as an important factor when deciding to participate in the Pathway. A large majority (84%, n=21) stated the lifestyle as an important factor with two thirds of trainees (68%, n=17) saying that already working in the town was a contributing factor.

Trainees elaborated on other reasons for participating, some chose to participate in TAHRGETS to develop skills and knowledge for generalist practice, they wanted to be able to work across a broad scope of practice and felt the Pathway would enable them to develop relevant skills for practice:

> *Develop my skills in a rural healthcare context. Being a new grad, looking for extra support in that rural environments* (WT2).

Protected time to study at work was also described by several trainees as a reason to. Having time away from clinical work to study in a busy private practice environment was enticing. Trainees reported the workload and performance indicators in private practice are high and having set time each week to do non-clinical work helped with their overall wellbeing. They were also able to access more professional development than they would otherwise have received in their organisation:

> *The change of pace. It's really hard and you burn out quite easily in private practice so having some paid time to do something that wasn't so mentally and emotionally draining was a reason as well* (T16).

> *And I guess there's also that financial incentive where that education is funded, we get paid for it. Whereas general professional development is capped at a couple of days a year. Yeah, so that was basically the reason for it* (WT4).

The factors that were rated as least important when deciding to complete the Pathway were access to a new graduate position, having a return of service obligation, having a positive training experience in a similar community whilst at university, not being able to find employment in a metropolitan area and employment for a spouse/partner.

Figure 2 Organisational factors influencing trainees' decision to complete the Pathway

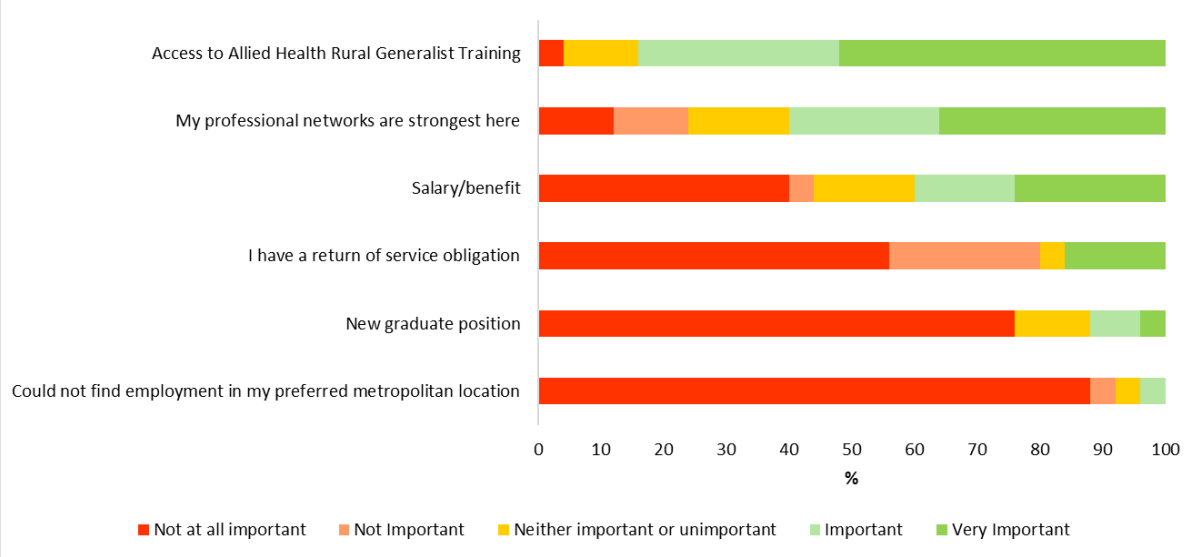
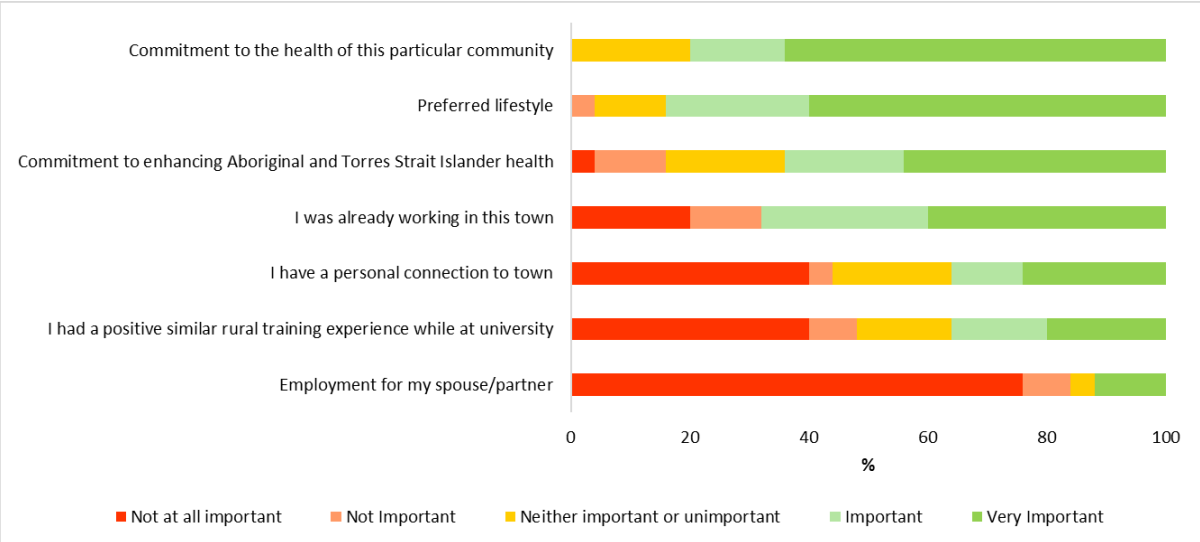


Figure 3 Personal factors influencing trainees' decision to complete the Pathway



5.3.2 Expectations of TAHRGETS

Trainees were asked about their expectations of the Pathway. Most were expecting the Pathway would enable them to improve their skills and knowledge, particularly in areas that were relevant to rural practice, for example telehealth, understanding their local community context and challenges accessing allied health services. Some trainees hoped the Pathway would build on skills and knowledge from their undergraduate education and give them a positive start to a rural career, with a range of trainees reporting feeling unprepared for rural practice after university:

> *A nice way to start expanding on professional development and learning different skills. University was very targeted through metro and hospital, coming into private practice in rural was difficult. Uni training was tailored to a completed different setting (T2).*

Building confidence and competence for practice was an expectation of several trainees as well as opportunities for career advancement. Trainees reported having a qualification or extra training

might enable them to apply for higher level positions in the future. Some hoped they would advance and broaden their scope of practice through their participation. Others were hoping the Pathway would help them develop leadership, project management and evidence-based practice skills that would support their career overall:

> *I anticipated that it would widen my scope of practice in rural and remote settings and also teach ways to work with existing services and families to more effectively deliver healthcare in these settings (WT6).*

5.3.3 Withdrawal rates and reasons for withdrawal

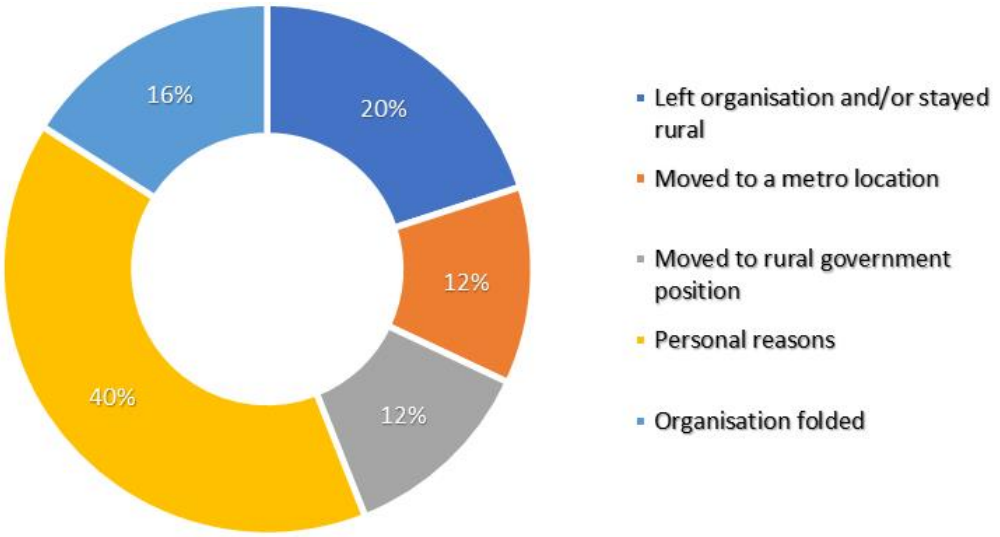
At the end of the follow up period 25 trainees withdrew from the program. Of these 15 were participating in the level 1 program and 10 in level 2; 24 were from mainstream allied health services and 1 was from an ACCHO.

Considered in context of the 37 expected completions, this represents a withdrawal rate of 40% [a comment here about being consistent with other evaluations.

REASONS FOR WITHDRAWING FROM THE PATHWAY

Among the 25 withdrawing trainees, 15 left due to changes in employment and 10 left for personal reasons. Specifically, three moved to a government position in a rural area, three moved to a metropolitan employer, five did not disclose their next employer and one organisation folded resulting in their four trainees losing their positions. Trainees who discontinued their employment were supported by the project team to continue the Pathway with their new employer and two trainees successfully did this. This highlights that personal circumstances and organisational changes were notable factors influencing withdrawals.

Figure 4 Reasons for withdrawal



The seven withdrawn trainees who participated in interviews were asked to explore their experience of the pathway, which allowed more detailed investigation of the factors influencing their withdrawal from the Pathway. Six of the seven reported they would recommend the Pathway to others despite not continuing themselves. The themes exploring reasons for withdrawing will be explored in detail below. In addition, during their qualitative interviews, the TAHRGETS team described ongoing challenges with access to supervision and management support some trainees experienced as contributing to withdrawals, these findings will be explored within the themes of supervision and management support provided by organisations from page 32.

TIME CONSTRAINTS

The majority of withdrawn trainees interviewed, described the challenges of time constraints which impacted their experience of the pathway. They described busy caseloads, conflicting priorities, work pressures and the challenge of quarantining study time as impacting their decision to discontinue the pathway. Many acknowledged that the Pathway and the support they received from TAHRGETS, and the university were great but that logistically they couldn't make it work due to their limited time availability. Trainees consistently reported being overwhelmed working full time and studying and negative impacts on their overall wellbeing:

> *Given that I felt overwhelmed by the workload and the impact it was having on me whilst working full time, I would say that the time allocated for me was not adequate* (WT6).

> *Mainly just time with a busy full time workload. I don't think I have any complaints; it was more just being busy on my end* (WT3).

Trainees who did not complete the Pathway described fitting study time into their work as a major challenge. Many of them reported the allocated study time was inadequate:

> *For me personally it was a struggle when I had some timeframes and demands from the work that needed to get done for clients. It was hard to quarantine a full day. And that's more on me than it was the program… I felt overwhelmed, time was an issue for me, and I just had to make a decision to say that this is not the right path for me at this stage* (WT4).

The variable study load was also described as impacting these withdrawn trainees time, especially when assignments were due:

> *Some weeks at the start of the modules it was fine, but once assignments started coming in it wasn't enough* (WT2).

RELEVANCE

The relevance of the education program was raised as a reason for discontinuing by some trainees. Reports of content not being relevant to caseloads was raised as well as reports of the content being previously learnt at an undergraduate level. One trainee also reported the training program content could have been more engaging:

> *I'm going to say no – The reason for that is it's very personal in terms of, it just felt really forced, so it didn't match with my caseload, if that makes sense. And so by doing that I couldn't really get the benefits of the case studies and the activities that we were assigned to do, because of that* (WT4).

FLEXIBILITY

A lack of flexibility in the education program structure was described by withdrawing trainees as a barrier. They reported it was not flexible enough for them working full time in terms of timeframes for completion of modules, case studies and service development activities. The program could also be more flexible in terms of deferral processes and taking breaks from study:

> *Great course, great content, but just the flexibility and the study opportunities, it's just not flexible enough when you're working full time – In my setting. It obviously works in other settings but in my setting, it was just too difficult, but everything else – it was a really fantastic program. I'm just really disappointed I couldn't see it though* (WT5).

CHANGES TO EMPLOYMENT

Some trainees changed employers while participating in the pathway and were unable to negotiate options for continuing with their new employer despite TAHRGETS processes and staff being supportive of this. Barriers included different employment conditions, changes to scope of practice and limited relevance to new roles. As the scheme was available for private and non-government practices, trainees who moved to a government position were ineligible to continue. Several of the withdrawing trainees were hoping to re-engage in the Pathway in the future if the opportunity arose, while others reported their new employment did not align with a rural generalist pathway:

> *..it's definitely something I will look into again because I really was thoroughly enjoying the course* (WT5).

> *My employer tried to see if there was a way to continue, but we just couldn't figure out a way to make it feasible with the type of assignments that I was doing in the course, they required a lot of client involvement, so wasn't really able to keep going. So we did try* (WT3).

5.3.4 Supervision and management support provided by organisations

Supervisors and managers within private practices and non-government organisations provided a range of vital supports to their trainees. They assisted them to protect and allocate the study time in their workload and manage their other commitments around study. They provided regular opportunities to debrief, discuss project work, balance study time and maintain motivation and momentum throughout the Pathway. Managers and supervisors provided a range of flexible supports to meet trainee needs:

> *We clearly set about in her roster of activities and her default diary, just like you would schedule in clients we scheduled in the appropriate study time and those sorts of things. So we were really intentional about having supervision at a specific time, time dedicated to her assignment and project work. So that was very well structured* (M2).

Working across organisations and trainee groups, it was clear to the TAHRGETS project team could see how crucial good supervision and support was for trainee success. When trainees received appropriate levels of support, the benefits for themselves and the organisation were significant:

> *And we have also seen the impact when the trainee feels really supported. A couple of trainees were trying to set up a new service in an organisation that was historically not an allied health service provider. The support and supervision they received from their manager was so great, that they stayed much much longer than we would have expected* (PT).

While interviewed trainees who withdrew from the Pathway did not explore this challenge in the research interviews, trainees who withdrew but chose not to be interviewed, reported support challenges to the TAHRGETS team as significant. The project team provided extensive support to trainees and organisations in an attempt facilitate regular supervision and manager support, but in some instances this lack of support led to trainees discontinuing with the Pathway:

> *There was one organisation that started with three trainees… In our regular meetings and catch ups, a lot of the discussion centred around their frustrations with their perceived lack of supervision, and how unsupported they felt. It was beyond our scope to get involved in workplaces HR processes, but we did have to provide coaching and strategies that they might be able to use with the supervisors and managers. We also had many meetings with the manager, just to clarify the requirements of the program. I think everyone was willing, but they had different expectations or understandings of what good supervision and support*

looked like in terms of access, frequency etc. In the end 2 of the trainees left, because they felt they needed more supervision than they were getting (PT).

SUPERVISION AND MANAGEMENT CHALLENGES

In a number of circumstances, managers and supervisors experienced challenges supporting a trainee. Some trainees required significant encouragement and guidance, this was particularly challenging when the trainee and organisation were not on the same page in terms of expectations and valuing the Pathway:

I don't think (the trainees) saw the possibilities that extended to them after having rural allied health generalist training so the broadening of their knowledge, the opportunities for greater employment in the future should they decide to work for other rural organisations (M8).

Participating in the Pathway was stressful for some trainees and organisations, especially when they felt pressure to juggle workload expectations and a work life balance. Maintaining billable hours while also setting time aside for study was a challenging balance to overcome. Several trainees were also balancing caring responsibilities outside of work which impacted their experience and support requirements. Some supervisors reported trainees didn't seek as much support as they would have anticipated despite being given permission to do so. In contrast, some trainees felt more support was needed from their organisation or they had difficulty finding a supervisor to support them. Organisations reported they would have benefited from more support and clarity of their role in the Pathway to enable them to better support their trainees:

I think the only thing would probably be that supervision side of things. I guess we got a little bit of information about it, but maybe if there was someone to touch base with from a supervisory point of view, maybe like expectations of supervisors… I feel like a lot of my information came second hand from her and her understanding of the program and the reporting requirements and stuff like that. (WMS3).

SUPERVISION AND MANAGEMENT BENEFITS

Several trainees reported the support they received from their managers and supervisors was an enabler for their success in the Pathway:

Having (supervisor) help guide us through that was very helpful because if I was to undertake a project like that I wouldn't have even known where to start, whereas now I can understand a lot more, like ok these are a couple of important things that need to get done. I wouldn't have thought about certain things before, like costs and how that affects the business and the company and how that affects care that we can provide and things like that (T12).

Supervisors and managers reported they needed to set more time aside for supervision than they had previously but generally this was not reported to be a challenge. Organisations were able to accommodate this additional support through structuring time into supervisors' workload allocation or doing supervision during travel time:

We definitely had to have time allocated to the supervision of the trainees which then took away somewhat from the clinical time that the supervisor had on hand, but in general it was nothing excessive, we didn't feel like it was too much to handle (M1).

Organisations reported the extra time required for supporting trainees was actually beneficial to enable them to achieve benefits for the service:

> *I didn't resent that though because I also love project work, rather than just seeing people over and over and thinking 'there's got to be more than this". So yeah, I would say that it's probably, over the past 18 months It would have cost me maybe at least 60 hours, but in terms of looking at innovation and design of a robust therapy approach that is relevant to our area, I think it's time well spent* (M6).

They also saw the opportunity to provide extra support to trainees as beneficial in terms of being more connected to staff and being able to offer more holistic support:

> *So extra support was required, that wasn't necessarily a bad thing though, because sometimes you don't connect with staff and so provided greater opportunity to connect with staff and it was really positive because then you not only heard about what was going wrong with study, you also heard what was going on in life or with clients or with whatever they might be doing at that time, so you provide a greater level of support because you're more available* (M8).

There were also benefits in terms of supervisors and managers extending their own critical thinking, problem solving and professional development. They learned through supervision discussions with the trainees and helping them with service development project planning:

> *It's quite a core value to me to promote skills in dietitians so I got a big buzz out of being able to help (trainee) on her project… I'm really excited about helping her get that opportunity in spreading it to (the region), so that were huge positives. And I enjoy being a supervisor it gives me more expertise and practice in the area* (S4).

TAHRGETS project team members also reported benefits for organisations who provided support and guidance to their trainees, they noticed these organisations were able to appreciate the benefits of staff engaging in TAHRGETS:

> *They can see much more success in the Pathway when they are investing through supervision and service development. The reason that I say this, is that it is often the workplaces that have solid supervision practices that come back and ask for more training packages, as they can see where the trainees are doing well, the supervisors are engaged and know what is happening in the service development space* (PT).

5.3.5 Strategies used by TAHRGETS to support organisations

TAHRGETS project team worked together to support organisations and anticipate their needs. They developed processes to assist organisations to navigate the Pathway, systems for tracking organisational engagement and support needs and offered a wide range of opportunities for organisations to get support from the team.

Organisations participating in TAHRGETS were located across vast rural and remote areas in Australia with high levels of demand and clinical complexity. TAHRGETS project team provided remote support to the organisations in the Pathway, but it was often difficult to engage with them:

> *The way we are not very evolved, we've always made assumptions that they're too busy for us and most of the time that is proven true because you set meetings, and they don't come you know you make phone calls, and they don't answer most of the time that is true* (PT).

TAHRGETS SUPPORT FOR TRAINEES AND ORGANISATIONS – PROJECT TEAM PERSPECTIVES

To increase engagement opportunities, TAHRGETS utilised a range of strategies including intensive support at the beginning of the Pathway to build rapport and assist with onboarding and set up of the trainee in the Pathway. They also utilised a range of mediums for communication and were responsive to organisational varying needs and communication preferences:

> *I think sometimes it's also just a way of building rapport early on, cause that's often when they need the support* (PT).

> *Once I found I had a connection, had it a communication happening one on one with people. Then they would stop to take note of what was on offer to them. That it wasn't until I actually kind of had a person to person moment that they really understood that there were all these other supports there for them* (PT).

They also undertook mental health first aid training to be able to better support organisations and individuals who were experiencing distress:

> *And I guess an unintended outcome of all of that has been that at the beginning of last year, I think it was we all or the end of the year before we all did mental health first aid training because we do end up fielding these kinds of questions and concerns* (PT).

As a result of the high level of communication and support from TAHRGETS, organisations and trainees utilised the TAHRGETS project teams for all queries and concerns about the Pathway rather than contacting the education provider (JCU) for education program specific questions. TAHRGETS project team reflected on this and reported they provided this additional support to ensure organisations and trainees were satisfied and supported as they did not want them to be unsuccessful in the Pathway or feel unsupported. TAHRGETS project team also felt it was confusing for organisations to know who to contact for different information, with TAHRGETS project team responsible for the coordination of the training scheme and the education provider responsible for the education program specifically. Examples of queries that should have been directed to JCU were questions about specific topics, assessments and learning activities:

> *JCU was doing the training, and SARRAH was doing the mentoring and support of the organisation to support the trainees. So that was a very difficult concept to get everybody to understand* (PT).

Balancing high work demands and study requirements was stressful for some trainees. TAHRGETS project team provided timely support to trainees and organisations as required. Although this was outside of the scope of TAHRGETS and sometimes the support required was not directly related to the Pathway, TAHRGETS project team had the skills and rapport to support them, and they felt they were filling a support gap:

> *I've had a meeting or an emergency call with the trainee who was just panicked and in tears because they were negotiating the requirements of the Pathway as well as their patient load as well as these other courses that their boss had enrolled them in last minute and they could not handle it all. And they just needed someone to talk to and there was no one else in their sphere removed from their contacts that they could talk to. So they came to us* (PT).

> *So we were very careful to try and do things that would be easy for them to access and to engage with them would be a value add rather than an extra thing* (PT).

Ideally, TAHRGETS project team could field challenges, questions and queries about the Rural Generalist Program to the education provider (JCU) to improve trainee and organisation experiences of the training program. In reality, trainee and organisational queries were often multifaceted, complex or not related directly to university topics. The team was also mindful that the education provider was working with large numbers of enrolled students across multiple jurisdictions and trainees often required immediate support and guidance which TAHRGETS project team were available to provide:

> *We're that troubleshooting contact point and so that's where we mediated between JCU and directing them to the right teams and stuff. So it's those kinds of things that, yeah, as well as the enrolment, like the practical logistical enrolment stuff and support around this service development projects and yeah, lots of things and that's not related to JCU exactly* (PT).

> *I think if it was, if they were studying, if they had independently chosen to study the Rural Generalist Program, then they would go to JC because there wasn't anybody else. But I think in some sometimes we are more accessible than JCU and so they come to us* (PT).

While implementing TAHRGETS, the project team developed broad and in depth knowledge about private practice and the kinds of challenges and needs that individuals and organisations were facing while participating in the Pathway. They developed a range of resources and systems to improve the scheme as it was being implemented. In the future, with more time and resources, better systems could be developed to help trainees and organisations navigate the pathway and to answer frequently asked questions:

> *It wasn't until I started sending out emails, like targeted emails to participants saying remember, remember this bit you got told when you were doing your induction? This is all available to you at no cost* (PT).

Traveling to allied health organisations in the future could be a useful strategy in increasing engagement and buy in with employing organisations. It could also be helpful in providing more intensive support for organisations that were facing difficulties participating in the Pathway. Face to face interactions could also enable SARRAH to have closer working relationships with employing organisations and be able to provide more targeted, meaningful support:

> *Learning relationships are at the basis of your identity as a learner, and though if you're don't have a sufficient relationship within there within the learning environment, it'll be difficult, and especially if rural, I think rural and remote umm, people who are used to doing that. The people business is quite important. Yeah, I think that's a gap…. And so I think it's that whole personal connection, I think more of that on the ground stuff would have. I mean digital, you know, video calls are good but if you've met someone in real life, it's a whole lot different, your interaction and those learning relationships are at the base* (PT).

SUPPORTS PROVIDED BY TAHRGETS PROJECT TEAM – TRAINEES PERSPECTIVES

Trainees reported receiving extensive support from the TAHRGETS project team. Supports included funding, individualised support and guidance and facilitation of the Pathway overall. Trainees felt they would not have been able to participate in rural generalist training without TAHRGETS funding. They described the TAHRGETS project team as key to keeping them on track and being available as needed for support throughout the Pathway:

> *To make it available to us – so give us access to it and to give us some financial support to be able to spend the time doing the study so we're not disadvantaged doing the study* (T13).

Being very supportive and open communication and have also been in regular contact to keep us on track and just offering support and guidance with the studies, with the project, with supervision and I suppose the whole concept is just encouraging us to stay living and working in rural areas (T14).

The financial benefit of that paid time to do these extra things and an opportunity to do something that's something a bit different to general clinical practice (T16).

Trainees also described TAHRGETS as being a bridge between the education provider, employer and trainee, providing support between organisations to facilitate participation in the Pathway and navigate systems and processes for all parties. Trainees felt TAHRGETS were their main contact for any challenges that arose, coordinating the Pathway and helping them implement their learning into service based projects and practices:

I think just being that point of contact that's not the university, but also helps the university and the work-based project come together and really supporting that work-based project more, I think SARRAH does that well. I think just being a good point of contact that ties it all together and makes sure that we're tracking well with the project and supporting wherever they can for implementing that project (T19).

TAHRGETS SUPPORTS FOR ORGANISATIONS AND TRAINEES – MANAGERS AND SUPERVISORS PERSPECTIVES

TAHRGETS provided organisations with support to navigate their involvement in the Pathway. This supported included advice and guidance for managers and supervisors in establishing support structures for trainees, allocating study time and navigating university systems and processes required for the training program. TAHRGETS project team provided timely support to organisations to promote successful engagement and completion of the Pathway:

(SARRAH provided) information on what's the best way to approach the course, what units should they trainees do (WMS2).

I think the input from SARRAH, was really helpful before and through the program (M7).

The financial support provided by the scheme also enabled organisations to fund time for study, supervision and service development activities:

I guess, supporting clinicians from a financial perspective and then also an advocacy perspective as well for the organisation to be able to allow the clinicians to take a day or half a day, otherwise with the organisational requirements around KPIs and things like that it would have been quite unachievable for them to partake in the course. That was probably the key thing (WMS3).

TAHRGETS facilitated meetings for managers and supervisors across organisations to receive support and information throughout the Pathway. Managers reported the meetings were helpful and highlighted the complexity of allied health services across rural and remote areas. They were able to learn from other organisations and developed strategies for supporting a trainee in their organisation:

I like the structured program, and I did appreciate the touch bases that I was involved in like in terms of extra work for me, the meetings that were helped by the broader SARRAH team, with update around where the program was at and other people who were also managing trainees at that particular point in time (M2).

The complexity organisations faced in terms of supporting trainees to participate in the Pathway was identified by managers and supervisors who reported that at times they needed more support to navigate the Pathway. This included simple tasks including enrolment processes through to more complex challenges around supporting a trainee and implementing a service development project in their business:

> *Maybe just talk through what's there, what's in the programs, how to access the website maybe, but that's probably just me as an older person, I'm sure younger people just jump on websites and get around it really quickly* (S4).
>
> *I didn't know what expectations was for supervisor – more information for small group or one on one* (S1).
>
> *But I guess if there could be some improvements to the course and the communication between the course provider and the businesses, that would increase our likelihood of wanting to engage in the training again, because it did help us recruit* (M1).

CAPACITY BUILDING

The TAHRGETS project team developed a suite of professional development opportunities for trainees, supervisors and managers to access in addition to the Rural Generalist Program which aimed to build organisational capacity. There were 97 enrolments across 11 capacity building programs over the follow up period. Programs were tailored to rural and remote allied health practice and were offered online with a range of synchronous and asynchronous learning activities provided. Participants participated in a total of 1056 hours of capacity building activities across the 11 programs. Trainees accounted for the majority of enrolments (58), followed by Managers (21) and Supervisors (18). The most popular courses were Project Management (27 enrolments: 21 Trainees, 3 Managers, 3 Supervisors), Leadership (24 enrolments: 10 Supervisors, 7 Managers, 7 Trainees) and AHA Models (18 enrolments: 9 Trainees, 5 Supervisors, 4 Managers). None of the other courses had Supervisor enrolments with a total of six or fewer enrolments over three years within each course. Courses like Mentoring and Productive Habits had minimal participation, with only 1-2 enrolments each. Further analysis of participation and trends over time can be found in Appendix 5.

Table 6 Capacity building program enrolments

Course Name	Manager	Supervisor	Trainee	Total[#]
AHA Models	4	5	9	18
Effective Presentations	1		3	4
Good mentor	1		2	3
Grant writing	3		3	6
Growth mindset	1		4	5
Leadership	7	10	7	24
Mentoring			1	1
Non-negotiables	1		4	5
Productive Habits			2	2
Project Management	3	3	21	27
Toolkit			2	2
Total[#]	**21**	**18**	**58**	**97**

Some participants enrolled in multiple courses, contributing to the overall higher enrolment numbers.

Organisations had the opportunity to participate in as many of the capacity building programs as they wished, and programs were offered for no charge. Of the respective groups, managers had the highest proportion of multiple enrolments (50%), followed by supervisors (20%), and trainees (2%).

The overall enrolment was 13% higher than the number of unique participants, showing some individuals across roles enrolled in more than one course. TAHRGETS project team explored organisational contexts and complexities with managers and supervisors and matched these with available supports and training for their individual circumstances:

> *There's a couple of times where one of the projects staff would say to me this this manager needs some support or this training needs could do the project management course like there was a bit of that going on, just a little bit of needs identification as we went along. So that was that was very good. So, the communication amongst the yeah, that was good, yeah* (PT).

Although initially intended for managers and supervisors, the TAHRGETS team opened courses up for trainees as well after demand became evident:

> *But when we had a targeted it at the team around the trainee, but when the trainees came and said, oh, can we do this? It was like, well, yeah, I guess if you want to, there's no reason why you can't, but that wasn't our intended target audience* (PT).

Capacity building participant feedback

Half of the managers and supervisors interviewed (50%, n=8) participated in the SARRAH online education offerings and all these individuals rated the education offerings as eight out of ten or higher. Many of the managers and supervisors reported that they were too busy and time poor to engage in training for themselves. They reported that supporting the trainees to manage their allocated study time and participate in service development projects was their main focus and there was limited time for their own professional development:

> *This is not really a criticism because I think it's really my own fault, it took me a while to sign up and get on to your website and look at these programs and that purely, I just didn't have time, I really wanted to do it and get into it and do other programs as well and it just felt too much for me and that's why it's taken me so long to get onto the leadership one, I needed a bit of space in my life* (S4).

Of the managers and supervisors who described their participation in the capacity building opportunities, most had participated in leadership and project management courses offered by SARRAH. The courses available were reported to be useful, high quality and relevant to private practice. Anecdotally, organisations also reported to TAHRGETS that they valued the allied health and rural and remote specific nature of the courses, in comparison to other courses they had completed which were more generic and less targeted to their needs:

> *I was really interested in the leadership, because I've done a fair bit of project work but I'd really just sort of floated along and I'd never envisioned myself as a private practice owner, and here I am. So I think having a framework around leadership and what it is, because I'm a speech pathologist, I'm not a manager by trade, so having that leadership component, that was cool* (M6).

As TAHRGETS was implemented and the project team felt the outcomes were different to what was originally anticipated. Initially the team had envisaged the outcomes of TAHRGETS would be include improved recruitment and retention but on reflection, the primary outcomes appear to be increased

capacity. Capacity for individuals to deliver services to their consumers and capacity for organisations to meet the demands of their local communities:

> *I think we're meeting the needs in this came back to my comment around the service development project where I think we are meeting needs, but we never said that there were needs to start with is around the capacity of the organization around the capacity of the workplace and the capacity of the individuals, both the trainee and the individuals in the workplace. I think that is where the Pathway has potential to meet the needs. We can use this Pathway to increase your workplaces capacity, but we have never talked about it in that way* (PT).

NETWORKING OPPORTUNITIES

Of the trainees who completed that were interviewed, seven (28%) participated in networking opportunities provided by SARRAH. Only one of the trainees that withdrew from the Pathway took part in the networking opportunities. They described benefiting from online discussions and notifications from TAHRGETS and feeling less isolated knowing support was available:

> *It was beneficial knowing that I wasn't in on it on my own, there were other people in similar situations* (T14)

When asked about engaging in these networking activities, trainees overwhelmingly reported that it was challenging to fit in these additional opportunities on top of study commitments. Trainees did not prioritise networking as they were focusing on the study requirements in allocated time which they felt were more important to complete. Some trainees reported a barrier to engagement was the focus on online networking with a preference for face-to-face opportunities. Having the opportunity to build rapport with other trainees in person would have make it easier to maintain networks online. It was also suggested that in the future, networking opportunities could be offered between modules in study breaks or locally:

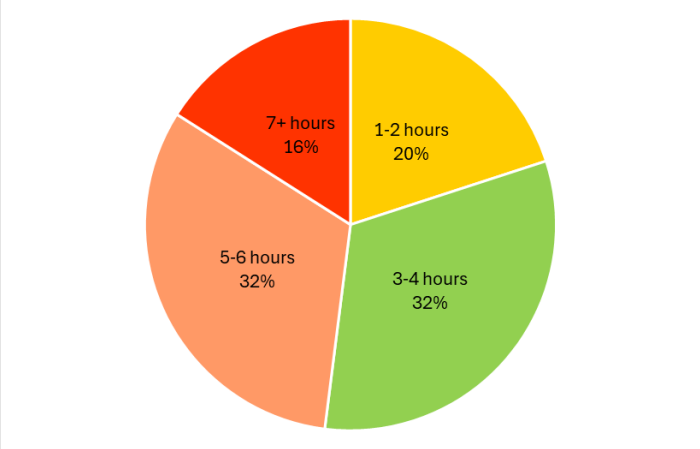
> *I didn't have time. All my time was chewed up with study. I think the way it was offered I would have accessed if I had time to do so. I just felt too stressed and too pushed on time* (T12).

> *I just don't love spending time on my computer when I don't need to. So doing that online social networking thing, I'm not going to engage in that. And I think even through JCU there was a lot of opportunity for people to post in discussion boards and basically no one did I don't know what you could do differently, I think that's just how it has to be with people. I think maybe just sending out a list, if people are happy, of people within a half hour radius or something if there are other people in the local area that are doing the program so that if you wanted to you could do in-person catch ups for a coffee* (T19).

5.3.6 *Trainee's study time at work*

Most trainees interviewed (64%, n=16) quarantined an average of 3-6 hours a week to participate in the activities as part of the Pathway. Five out of the seven trainees who withdrew quarantined an average of 3-4 hours per week during work time to participate in the activities as part of the Pathway with one trainee spending 1-2 hours and the other trainee spending 7+ hours per week.

Figure 8 Completing Trainees' time spent per week on activities of the Pathway during work hours

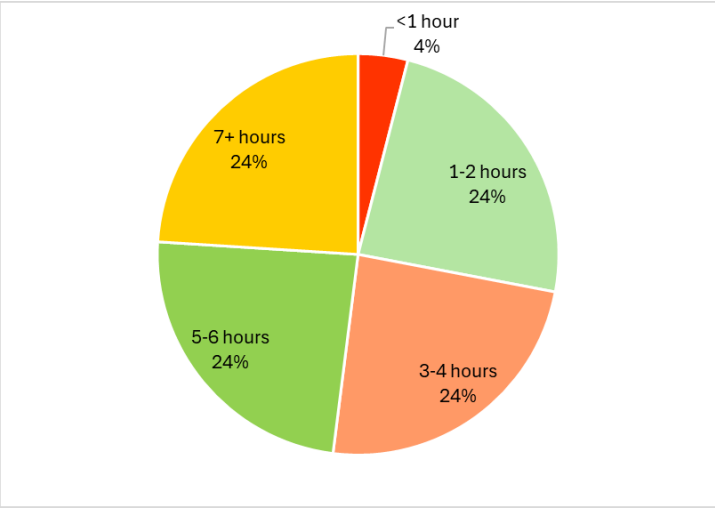


STUDY IN NON-WORK TIME

Trainees participating in TAHRGETS reported a wide range of hours spent studying in their own time with around half (54%, n=13) spending up to 4 hours a week with the other trainees (48%, n=12) spending more than 5 hours a week studying after hours. Three of the seven withdrawn trainees spent 1-2 hours per week on activities of the Pathway during non-work time with a further four spending 5 or more hours per week. This was challenging for trainees who were juggling family and other personal commitments:

> *I'm in the car 2 hours a day to get to and from work, trying to plan a wedding, my time management as a full-time worker, it's a lot more stressful to be doing study as well, however 4 days was a perfect balance with SARRAH and 34 hours of clinical work was perfect. I would commend people working full time and studying and doing the program* (T14).

Figure 9 Completing trainee's non-working time spent per week on activities of the Pathway



STUDY TIME ENABLERS

Protected study time was a significant enabler of TAHRGETS. Having the opportunity to undertake study related activities in work time was a key component described by trainees, managers, and supervisors. Trainees who were able to prioritise and structure study into work hours reported this was an enabler for their success in the Pathway. They reported employers who were flexible and supportive of the study time contributed positively to their experience in the Pathway:

> *I think we had really good structure, like we, at our workplace had to block out times when we were going to work on it through the work. We had our meetings scheduled weekly with everyone in the team. So, I think it was implemented quite well* (WT3).

Trainees also reported having time to implement service development projects was an advantage as they would not normally have had time to invest in high quality project work. They also had time to invest in the development of their skills and the development of their service:

> *Private practice is really busy, and it's probably underfunded so having dedicated time to put towards a big project such as ours and actually see it get off the ground was really beneficial, and it probably wouldn't have happened without it* (T16).

> *Time away from clinical caseload to develop the service, diversifying my skills to reflect a diverse rural population, having the time to assess community needs* (T10).

Managers and supervisors also reported trainees warmly received the quarantined study time, and it enabled them to enjoy and invest in the Pathway as they had dedicated time to focus on their learning:

> *I think it was, yes. Being involved in the TAHRGETS program meant that [name of trainee] had more time to invest in the course itself* (WSM3).

Interview data suggests that some trainees found they were able to manage their study related activities in their quarantined time at work while others found it more difficult:

> *It was mostly adequate but sometimes I had extra readings to do and would maybe need to spend a bit of time outside of work to do them or not do them at all in rare cases* (T12).

STUDY TIME CONSTRAINTS / BARRIERS

Time constraints at work negatively impacted trainees' ability to implement their learnings into practice and get the most out of the Pathway. Trainees reported negotiation with the employer was required to set aside time for study alongside the demands of private practice, but a range of factors impacted on their ability to do this. Trainees reported private practice work is demanding and complex and that they didn't have enough time at work to complete study related requirements. Some reported spending considerable time at home studying to pass the modules. In some instances, trainees felt they were unable to get the most out of their learning because they were focusing on passing the modules rather than having time to reflect on their practice and find ways of implementing their learning into their work.

> *More time allocated to study within working hours so that we could get maximum benefit from the subjects rather than just the minimum scraping through to pass* (T12).

> *It was not adequate at all. There was a lot of time spent outside of working hours even just to pass the courses. So I had to give up trying to do well in the course.... because I just did not have the physical hours..... time to do it well* (T13).

5.3.7 *Managers and supervisors' perceptions of study time*

Managers and supervisors also reported it was challenging for trainees to fit study requirements into allocated hours with suggestions that more time should be funded. They described the challenges associated with studying out of work hours and the negative impact this had on trainees' overall wellbeing. It was particularly challenging for trainees who were new to a workplace or had young families with reports of overwhelm and competing demands. In some instances, managers and supervisors had allocated study time but the trainees prioritised clinical work and so this was not always utilised. Managers and supervisors supported trainees where possible, but it was too overwhelming for some to continue:

> *Fitting in study with full time work and the start of the program was very difficult because it was a bit of a rush and that's where we lost a few of our starters because they hadn't got their head around it yet…. And the other challenges were fitting project work in with the study, with the full-time work in a way that they didn't have to do stuff after work, trying to streamline it all to make sure they had work life balance. So even though there were challenges they could be overcome and planned for and discussed and modified* (M8).

Time constraints also negatively impacted trainees' ability to implement their learnings into practice and get the most out of the Pathway:

> *More time allocated to study within working hours so that we could get maximum benefit from the subjects rather than just the minimum scraping through to pass. That's about it* (T12).

5.3.8 *Service development projects*

Forty-seven service development projects were undertaken. Most of the projects were undertaken by one trainee with five of the projects being undertaken by pairs or groups of trainees.

Projects had a variety of different outputs. Most projects delivered interventions or developed resources to be used by other AHPS in practice or to inform future services and/or training. For example, one speech pathologist trainee developed and delivered an oral language program to support oral language for students in a kindergarten in an MM7 rural location. After the intervention, the school purchased the program resources to be delivered by teaching staff. The speech pathologist trainee provided remote support after the project finished to help the teaching staff continue to deliver the program whilst funding was available:

> *They're really excited about it and want to learn more...I'm hoping like, yeah, I'm touching base with them remotely, but I just feel like that process would be better if we were still able to be involved as closely as we were last year* (T5).

Other projects also delivered a variety of interventions in the community, often to areas where services would not have been delivered if the service development projects were not undertaken. One trainee set up a clinic for diabetes management with a "one stop shop" style approach for referral pathways to other clinicians. This clinic is still ongoing and runs once a week. The clinic has led to increased access to a diabetes nurse educator, improved diabetes control and improved wound healing, and has also strengthened referral pathways to the local hospital and reduced wait time for patients to see a podiatrist.

Other projects whilst not ongoing provided vital services to patients who would not have received the service if the project had not taken place. For example, one project involved a pharmacist trainee delivering screening and smoking cessation assistance to patients without a fee which would usually incur a cost for the patient, whilst still being profitable for the pharmacy:

The bulk of pharmacy services work, cholesterol screening, blood sugar screening, all that, you charge the patient a fee. Yeah. I didn't charge the patients a fee here, and we still make money. So that's actually quite innovative and different (T8).

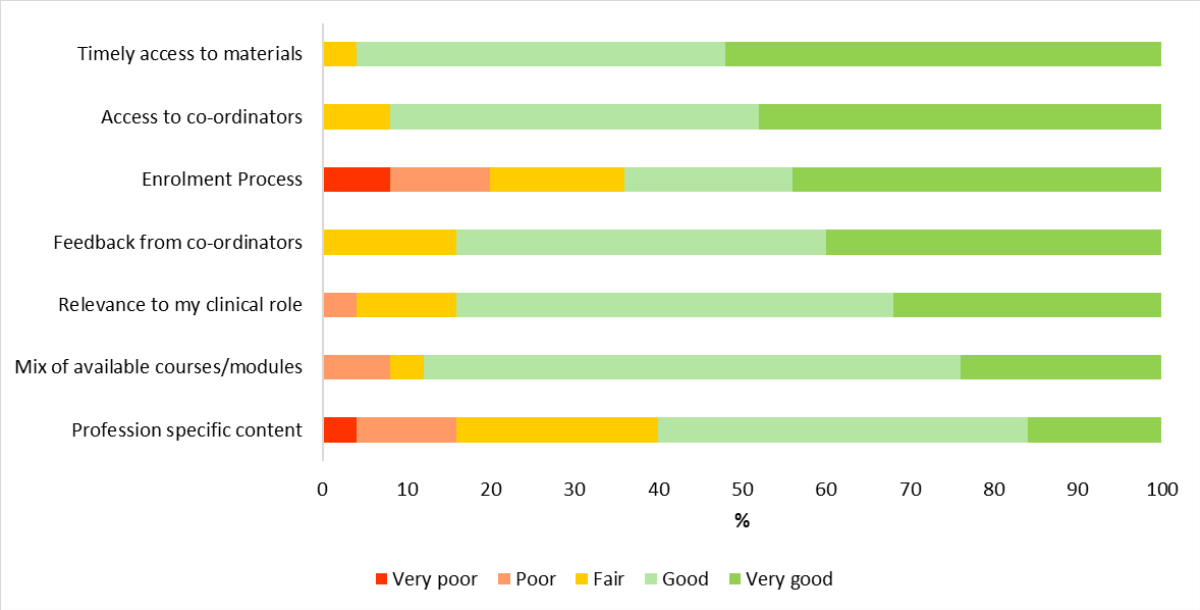
Other projects built upon existing services to increase service provision. For example, a dietitian trainee expanded a women's cooking program by proving an additional session per week. This additional session helped support management of diabetes to minimise the associated complications to both pregnant mothers and their babies.

Nearly all the trainees interviewed (96%, n=24) had completed the service development project. Most trainees (91.6%, n=22) stated the service development project was a beneficial experience (rated as six out of ten or higher) with an average rating of 8.6 out of 10. Nearly all the trainees interviewed who had withdrawn (6 out of the seven trainees) had commenced a service development project before they withdrew from the Pathway. For further detail about the projects undertaken please see Appendix 6.

5.3.9 *The Rural Generalist Program – education component of the Pathway trainee perceptions*

The trainees interviewed were asked to rate their experience of the Rural Generalist Program (education component) from very poor to very good against a list of factors including relevance, access to course coordinators, timely access to learning materials, feedback from course coordinators, profession specific content, mix of available modules and the enrolment process. The highest rated factors (rated as either 'good' or 'very good') were timely access to materials (96%, n=24), access to coordinators (92%, n=23) and mix of available courses/modules (88%, n=22). The profession specific content and the enrolment process were rated the lowest with 60% (n=15) rating profession specific content as 'very good' or 'good' and 64% (n=16) rating the enrolment process as 'very good' or 'good'.

Figure 10 Ratings of factors of the Rural Generalist Program



TRAINEE REPORTED CHALLENGES WITH THE RURAL GENERALIST PROGRAM (EDUCATION COMPONENT)

Trainees described challenges relating to the RGP that impacted their experience of the scheme overall. Consistently, participants reported they would have liked more engagement within the content of the program, including more interaction, guidance and feedback, more interesting and up to date content woven into the modules. Some trainees reported the Pathway could be improved with more structure. Completion of modules required significant self-directed learning and initiative to search for and synthesise evidence and at times the program didn't live up to trainees' expectations in terms of providing enough support for learning:

> *One of the subjects, neurological conditions, I thought "oh that will be good we'll go through and learn about different neurological conditions and the impact of that on different aspects of life", but it was actually no you just pick and go and research it yourself and do an assignment and I just found that kind of a waste of time to be honest. I just didn't feel that was particularly helpful or relevant* (T19).

Sometimes module content did not feel relevant to individuals' area of practice or didn't add value to their previous level of knowledge. Trainees reported the program may have been more suited to hospital based or public service AHPs or larger organisations with a larger client base:

> *It didn't match with my caseload, if that makes sense. And so by doing that I couldn't really get the benefits of the case studies and the activities that we were assigned to do, because of that* (WT4).

Some AHPs suggested more profession specific learning in the program would have enabled e them to specialise their skills within their field:

> *Maybe to advocate to JCU for some more profession specific subjects to be offered, rather than just general allied health subjects, some more like specific dietitian or specific OT or whatever the profession is* (T12).

While the project management content was highly valued and useable, some AHPs suggested it may be more helpful to implement a work-based project at the end of the Pathway after completing the coursework modules. It is also important to note that this was not consistently reported, and many trainees enjoyed the concurrent combination of coursework and project activities:

> *Now that I'd done the training, I wish that we had done the uni degree first and the training on how to deliver the project – then at the end deliver the project with the knowledge and training already done* (T3).

MANAGER AND SUPERVISOR CHALLENGES WITH THE RURAL GENERALIST PROGRAM (EDUCATION COMPONENT)

Several managers reported challenges with the fit of the rural generalist program for their service setting. At times it was challenging transferring the learning to private practice. Managers reported the program content appeared to be directed at public sector work and managers suggested the modules could be finessed to align more with private practice work. There appeared to be some modules that were more relevant than others and this was dependent on a range of factors. Having a choice of topics enabled trainees to focus on areas of interest and relevance which was helpful:

> *I know that she said some modules through JCU were really useful and others not so much, and it's probably because it's relevant to our project…. And I think it was actually really good to reflect on local cultural implications for the Aboriginal communities in our region and probably just drilling down a little bit… that probably wouldn't have happened without needing to submit a university assignment, so that and of course we actually did a whole team training based on that and that was really quite powerful* (M6).

Although it was acknowledged that the program couldn't possibly meet the needs of every rural AHP across a hugely diverse rural scope of practice, trainees found it difficult to maintain motivation when the activities or information was not relevant to their current practice. Managers suggested the program could be more flexible and include more content to improve the relevance for different practice areas and trainee needs/preference:

> *Different for different participants as their needs aren't the same. Concept of the program is great, the way it works is straightforward, content/structure that it is delivered through isn't right because it is quite rigid and doesn't suit adult learning environment always. Some of the modules were a bit lean on the content* (M4).

5.3.10 Costs of providing the TAHRGETS Program

Project management and support was provided by staff employed by SARRAH via a $976,157.73 budget (it should be noted that the support TAHRGETS provided was run concurrently with a similar project BRAHAW with project personnel shared across the two projects). This is equivalent to around $14,000 per Trainee enrolled in the program. The project staff provided 15,296 hours of work per year, averaging 2.6 FTE per year in support.

Table 7: Funding Provided by SARRAH and Costs to organisations provide TAHRGETS per participant

Component	Mean (SD)	Median (IQR)	Min	Max
Funding Provided by SARRAH				
Workplace Training Grant	$18,407 ($14,862)	$16,582 ($18,760)	$0	$51,600
Tuition fees	$8,957 ($9,809)	$6,400 ($13,500)	$800	$32,080
Costs to Organisation				
Trainee Salary	$10,596 ($9,243)	$9,351 ($13,127)	$3,400	$34,776
Lost revenue from NDIS	$54,950 ($54,386)	$42,422 ($91,037)	$19,120	$22,6418
Lost revenue from MBS	$26,783 ($24,321)	$23,045 ($33,886)	$9,990	$102,168
Level 1 Participants				
Funds Provided by SARRAH				
Workplace Training Grant	$11,634 ($9,300)	$8,600 ($15,943)	$0	$28,659
Tuition fees	$3,714 ($3,586)	$2,400 ($6,400)	$3,332	$11,200
Cost to Organisation				
Trainee Salary	$8,601 ($7,737)	$7,826 ($8,944)	$3,400	$31,878
Lost revenue from NDIS	$48,339 ($46,894)	$40,032 ($66,920)	$19,120	$179,249
Lost revenue from MBS	$22,500 ($21,131)	$19,361 ($21,472)	$9,990	$79,662
Level 2 participants				
Funds Provided by SARRAH				
Workplace Training Grant	$24,468 ($16,335)	$21,500 ($32,155)	$0	$51,600
Tuition fees	$14,345 ($11,201)	$14,548 ($22,510)	$3,332	$32,080
Costs to Organisation				
Trainee Salary	$12,843 ($10,158)	$12,342 ($16,157)	$4,409	$34,776
Lost revenue from NDIS	$62,871 ($60,648)	$50,190 ($95,057)	$30,088	$226,418
Lost revenue from MBS	31704 (26539)	29419 (42577)	$7,088	$102,168

Abbreviations: IQR, Interquartile range, SD, Standard deviation.
NB: Three methodologies of calculating total costs are included in the table. All incorporate the cost per participant of the organisational grants and tuition. Additionally, total cost (salary) has the cost of trainee time valued as the cost is salary for in work study time. Total cost (NDIS) has the cost of trainee time valued as lost potential revenue to the organisation using NDIS prices for the profession. Total cost (MBS) has the cost of trainee time valued as lost potential revenue to the organisation using prices from the Medical Benefits Schedule items for the profession.

Among the largest mean cost per participant for the Pathway was the cost of lost hours of billable time to the organisation. Depending on the perspective taken for valuing the trainees time this accounted on average for between $10,596 (for the salary costs only) and $54,950 (when considering lost revenue from NDIS billing) for the organisation. Mean costs of the trainee time was larger for the Level 2 trainees compared to the level 1 trainees on average.

Workplace Training Grants were provided to Organisations to support implementation of the program, including compensating for study time for the trainee, supervisor time, and supporting the service development projects trainees undertook as part of the program. On average, the Workplace Training Grants were sufficient to cover the salary of the trainee's 1 day per fortnight of study time with a minimal amount for the supervisor time or service development project.

Tuition fees were covered by SARRAH through the Commonwealth funding. Mean costs for tuition for the level 2 trainees ($14,345) were on average much higher than those for the level 1 trainees ($2,400).

The range of costs for all categories, including tuition, trainee salary, and lost revenue are all highly variable between participants, indicated by the large range of minimum and maximum values, and large estimates of dispersion around the measures of central tendency (i.e. the standard deviation and interquartile range).

5.4 TAHRGETS outcomes

Context	Implementation			Results	
Influences	Resources and inputs	Activities	Outputs	Individual outcomes	Broader impacts

5.5 Trainee (individual) outcomes

A large majority of trainees interviewed (92%, n=23) stated their expectations of the Pathway had been met and all agreed that they would recommend the Pathway to others. Just over half of the trainees interviewed who withdrew from the Pathway (n=4) felt their expectations of the Pathway had been met and six of them would recommend the Pathway.

Most of the managers/supervisors interviewed (88%, n=15) said they would be 'likely' or 'very likely' to recommend the Pathway to others. Two out of the four supervisors/managers of trainees who had withdrawn that were interviewed would recommend the Pathway but only one of these managers/supervisors was intending to apply for further Pathway opportunities for employees in the future.

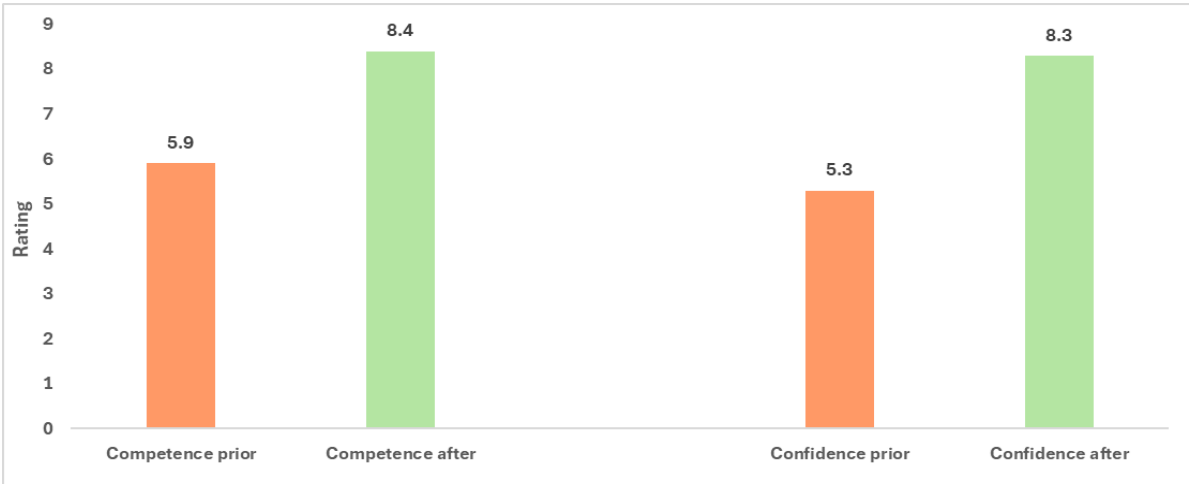
5.5.1 Competence and confidence

The interviewed trainees were asked to rate their competence and confidence working as a rural generalist AHP prior to the training and after the training. All the trainees rated their competence and confidence as improving after they completed the training. Prior to the training, the average rating for competence was 5.9 out of 10, this increased to 8.4 out of 10 after the training. The average confidence rating was 5.3 out of 10 before the training and this increased to 8.3 out of 10 after the training. Most trainees (92%, n=23) thought the Pathway had enhanced their clinical skills.

Trainees described the gaining of **confidence to tackle problems** and try new ways of working through a formal education program. AHPs advanced and diversified their generalist skills for practice:

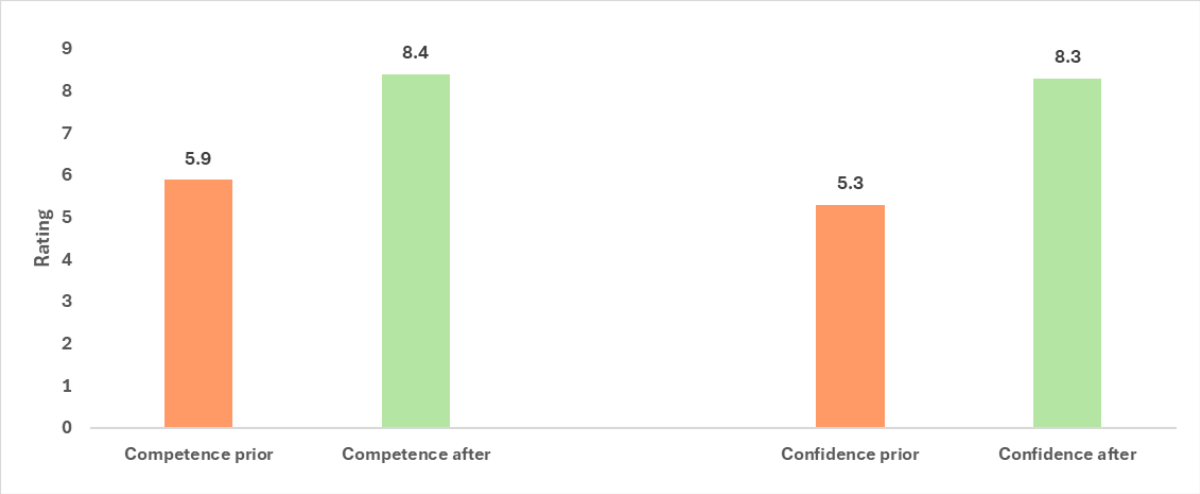
> *TAHRGETS gave me the confidence to take on and challenge myself a little bit more in terms of yes, I can do some further learning in that real high standard education, not just that generic soft tissue management or you know those sort of CPD – those quick little workshops. It was nice to have that confidence to actually take on something with a bit more meat to it* (WT5).

Figure 11 Trainee's average ratings of competence and confidence



All interviewed managers and supervisors believed the trainee's competence had improved while participating in TAHRGETS. The average rating given by managers and supervisors for trainee's competence prior to the training was 6 out of 10 and this increased to 8.4 out of 10 after the training. A large majority of managers and supervisors (94.1%, n=15) believed the trainee's confidence had improved since completing the Pathway. One manager rated their trainee's confidence as not improving but had already rated the trainee's confidence as high (9 out of 10) prior to the training. The average rating for confidence was 5.3 out of 10 prior to the training and this increased to 8.2 out of 10 after the training.

Figure 12 Manager and supervisor average ratings of trainee's competence and confidence



Through participating in TAHRGETS, managers and supervisors noticed AHPs developed confidence in their roles, confidence to make decisions, advocate for others and work with more autonomy. Confidence was also gained in sourcing up to date evidence and being able to justify their approaches to practice. Some managers reported trainees were able to work in more isolated locations with confidence and in areas with less structure and support. These gains in confidence were widely reported by managers and supervisors as significant for their organisation:

> *I think you can just tell they feel confident in their new knowledge, and that backs up their clinical skills and judgement for working within their area. Knowledge is more up to date, they're more confident in what they're providing is up to date and correct* (M9).

Competence development was also observable for managers and supervisors as trainees became more skilled. It was clear that trainees were working hard throughout the Pathway to develop and implement skills for practice. This was facilitated by a combination of education and practice experiences that complimented each other. Trainees became competent in identifying and overcoming barriers to service provision and had the opportunity to develop specialised skills in particular clinical areas of need for their service:

> *She worked really hard and certainly improved over time during the program* (M7)

> *but it's really coming from a really good understanding of the area, of our particular regional location and it's impacts and also probably an understanding of the barriers to effective service provision has been really positive, so I feel like, yes, it's been really useful for (trainee), but it's also been useful for the rest of us* (M6).

5.5.2 *Skills and knowledge for practice*

Interviewed trainees reported the TAHRGETS gave them the opportunity to **consolidate knowledge** from university into rural context as an early career practitioner. The program content enabled the development of skills that AHPs felt they were lacking in or required further development. The program also enabled trainees to solve problems and overcome clinical challenges as an early career professional:

> *So for me it felt like it was a really great way to cement some of that information we touch on at Uni and then expand on it a bit more through this program* (WT4).

> *Skills in areas that I previously was very much lacking skills in, so I was able to upskill in things I was needing to upskill in* (T12).

Participating in TAHRGETS enabled trainees to develop relevant skills and knowledge for practice. Trainees described developing skills in leadership, project management, telehealth evidence based practice, critical thinking and cultural responsiveness. The Pathway saw participants developing broad skills and knowledge for rural practice both within and outside of their own allied health discipline area. AHPs reported expanding their skill and knowledge in relevant and evidence based areas. They were then able to apply their learning to practice through relevant coursework and projects in the workplace:

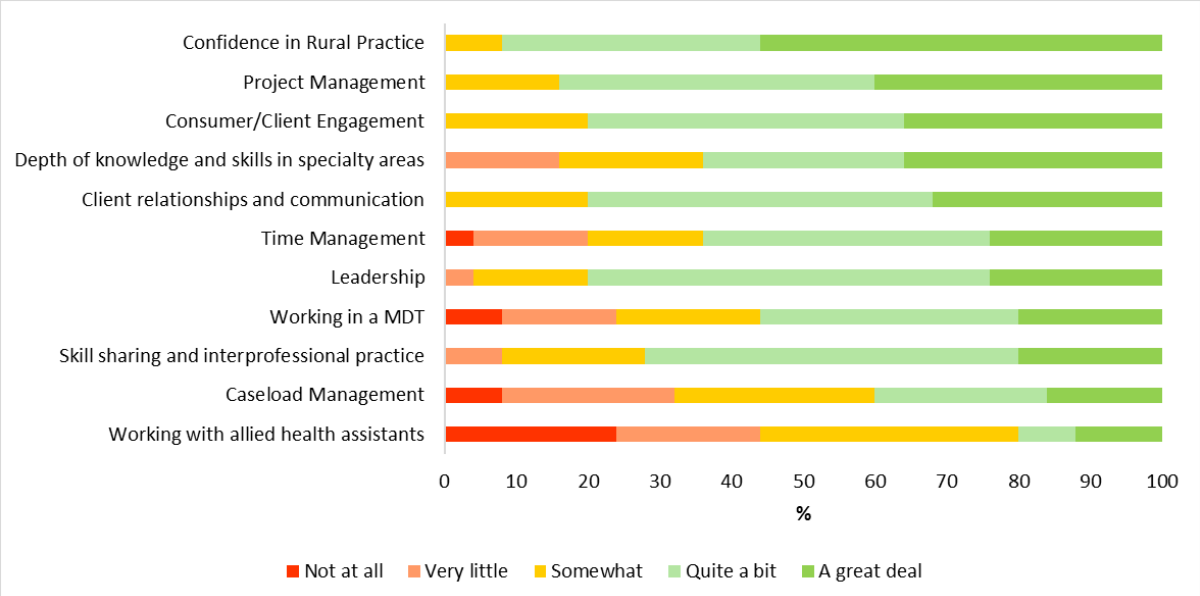
> *Greater experience, more learning opportunities. More experience in a range of different conditions and disabilities and how to manage different interventions* (T14).

> *Knowledge, building competence in delivering physio to rural and remote areas, Being aware of most recent developments in chronic disease management* (T3).

> *Lot of projects they gave made it relevant to the workplace and work* (T22).

The following chart outlines the trainees' ratings of the skills they believed were most developed through participating in TAHRGETS. The top-rated skills (trainees responding 'quite a bit' or 'a great deal') were confidence in rural practice (92%, n=23), project management (84%, n=21), consumer/client engagement (80%, n=20), client relationships and communication (80%, n=20) and leadership (80%, n=20).

Figure 13 Trainee skills developed as part of the Pathway



Managers and supervisors perceived TAHRGETS as an opportunity for AHPs to develop generalist skills that are relevant to rural practice, particularly where there is limited support and challenging situations to work through:

> *I think that the non-clinical stuff is the really important stuff when we're talking about rural generalism, and that's where we get people in that are that are early career professionals from being you know at a new grad level to being competent to you know, provide a service in a difficult and difficult setting with limited support. And that's the important stuff* (PT).

A range of organisations found TAHRGETS to be a good fit for their staff. The learning was applicable to their service and the consumers they worked with. Consistently, managers reported trainees gained broad critical thinking skills. Their ability to solve problems, analyse situations and manage complexity improved over the course of the Pathway. Their time management was also reported to have improved. These skills were reported to be imperative for delivering services across rural settings:

> *And I would say their level of analysis improved, like as opposed to A plus B equals C, just some broader understanding that life's a bit more complex than that, just being able to draw upon that kind of setting, was what came across from that perspective (*M2).

> *I think the training probably did give them some skills in critical think or thinking outside of the general line of their professional which obviously helped in a rural back setting* (M1).

Managers also found that with trainees increasing their broad knowledge and skills for practice, their scope of practice expanded, they had a better understanding of the roles of others and were able to work more effectively with colleagues and across the organisation:

> *I guess just expanding their scope of practice, just understanding their disciplines within more of a rural and remote context (WSM3).*

> *It just helped shift them up. I think the bit that I particularly appreciated was the units that helped the broader business models. And so that helped them look beyond just the dynamics of what are the skillsets of being an occupational therapist, to seeing it in the broader setting so that was a very steep learning curve for them and was well received by them (M2).*

5.5.3 Qualifications and learning opportunities

Managers and supervisors reported the opportunity to gain a qualification and participate in formal post graduate education a great advantage of undertaking TAHRGETS. They felt trainees were able to benefit not only from undertaking education and training but also being recognised for this through a qualification or university certificate. This was reported as being more valuable than traditional professional development courses offered to AHPs:

> *So the fact that it isn't just a course, but it fits as a post grad component is significant. Both in terms of the level of intentionality, assessment and development that the university has put in in making it that level of course. But in addition to that what that means for her in terms of her resume and things like that. So certainly from my perspective that's specifically what she talked to, in terms of yes, I've built my confidence and my competence but that actually means something in my education too* (M2).

5.5.4 Learning opportunities

Trainees found TAHRGETS to be a great Pathway, it was a **positive learning experience**. Several trainees reported that having the opportunity to undertake further study while working was as

significant advantage of the scheme including the access post graduate training costs and study time. Participants reported the pace and structure of the training program was an advantage of the Pathway. The scheme also gave trainees a change of pace at work with time to study breaking up the clinical work demands. Curriculum was broken up into manageable chunks and the set structure of topics and activities worked well:

> *I think the project, like you're doing little bits at a time based on your subject, which was really good, it wasn't too overwhelming. And the subjects of 6-week length were really good. I don't think I have any feedback on the actual content* (WT2).

Trainees reported that learning activities in the Pathway encouraged them to delve deeper into consumer needs, to identify ways of improving clinical outcomes and better meeting the needs of their community. As a result, they spent more time getting to know consumers and found proactive ways of working with consumers, they were exposed to new intervention approaches and were able to expand their role/scope of practice:

> *At the start I could meet the basic needs of the population group whereas now I have the knowledge to further that and have a more proactive approach and a health promotion approach rather than a reactive approach* (T10).

They also supervised more students and embraced leadership opportunities through participating in TAHRGETS. Trainees learnt about adult learning and education, leadership, operational aspects of organisations and management which was helpful in attaining of skills and confidence to do more within the organisation:

> *More experience in a range of different conditions and disabilities and how to manage. Different interventions. And I suppose I have had more and more students. And with that I did a subject which was teaching and learning in the health professions, through TAHRGETS, and that just provided me with more confidence to have student. Consolidated what I thought was the right thing to do and gave me some extra skills* (T14).

5.5.5 Developing networks

TAHRGETS enabled AHPs to develop new and expanded professional and community networks. They collaborated with new professionals and colleagues to support their own learning and provide a better service to consumers:

> *And I also felt like I had a greater network of people around me who supported me and to learn from. Through the program I've met quite a lot of other AHPs and lecturers that I've been able to learn from and that I feel like I would be able to keep communicating with in my work* (T18).

> *I feel like I know my area better which makes me feel like I know what I'm talking about a bit more, not in the clinical sense so much but in building that relationship with clients and also other health providers like GPs and other Allied Health* (T16).

5.6 Broad impacts

5.6.1 Allied health recruitment and retention in rural and remote areas

Three-fifths of trainees interviewed (60%) were employed full-time with 12% of trainees working part-time and 12% self-employed. Just under half of all trainees (44%) had only had one job since completing their allied health degree and most trainees (96%) had not changed their employer since completing the Pathway. The employing organisations provided services in a wide range of sectors. The most common sectors were private practice and the disability sector. All the trainees intended to continue employment in rural, region or remote communities for the next 2-5 years.

Six of the trainees interviewed who withdrew from the Pathway had 1-2 jobs since the completion of their allied heath degree and one trainee had had five jobs. Six of the withdrawn trainees were currently employed full-time with one self-employed. Only two of the trainees had changed their employer since withdrawing from the Pathway. The TAHRGETS employing organisations of the trainees who withdrew provided services in various sectors, the most common was disability. Six of the trainees who withdrew intended to work in rural, regional or remote areas for the next 2-5 years.

5.6.2 Job satisfaction

Managers and supervisors reported trainee job satisfaction improved during TAHRGETs; this was achieved through better balance of workload with the introduction of study time. While the capacity to undertake clinical work was reduced while studying, better job satisfaction was seen as advantageous for organisations in terms of overall quality and organisational outcomes. Giving staff the opportunity to study, improve their skills and knowledge at work was an opportunity that had not previously been available in private practice and to see the flow on effect in job satisfaction was rewarding for managers:

> *Job satisfaction improved – she enjoyed doing the service development project in the area of her choosing. Work capacity increased – trainee was returning from maternity leave, so it was a great way to return to work and increase capacity throughout the project. Quality of care definitely improved* (M9).

> *When you're just doing 15 clients back to back all day and then you just go "holy dooly, come on give me a break somewhere", but then when you put in a 2 hour study slot to learn something that's going to help you improve your care to those clients, you go "aww that's really great. Not everyone in allied health has an opportunity to be able to do that, but to have it in a way, that could be facilitated, that they could still be paid to be doing that time allowed them a whole new world of work satisfaction* (M8).

5.6.3 Organisational impacts

Flow on effects for teams was reported widely, trainees shared their knowledge and skills with colleagues enabling others to also benefit from the Pathway. As a result, participating in TAHRGETS had a whole of organisational impact and trainees had the opportunity develop leadership skills through teaching and sharing new skills and approaches to practice with colleagues:

> *Benefit for the team was the increased collaboration and having a set time to have those team discussions which everyone sees the value in, but it hadn't been established yet and for consumers it would be the benefit of having the team having more relevant and regular discussions about their care* (PT).

> *Has been an asset to the trainee and the business. Things she's picked up in different units, she's shared with other practitioners in a PD-like knowledge sharing* (M9).

They were able to train these guys who weren't doing a lot of their caseload as rural, but those guys could then still take that case work and that knowledge out into their rural communities to provide support and care, which I thought was absolutely brilliant (M8).

Trainees built capacity in organisations to develop and implement quality improvement projects. Through sharing their learning, implementing a project in collaboration with team members and model project management skills, whole teams benefited:

It's been useful for us in the knowledge trainee has been able to share, increasing the capacity of the organisation. Has given the organisation more of a sense of direction from the service development project and implementing some of those things further in the future (M9).

Trainees gained a better understanding of business processes enabling them to contribute to supporting the manager in their role and understanding the complexity of how businesses operate. In some instances, trainees also contributed to the support for other new staff with the development of projects relating to orientation and support programs:

As a private practice how invaluable it was to have that rural generalist approach not only because it's in our value set of who we are as an organisation, but secondly helping to build skills within our team for somebody who understands the dynamic of the other business components (M2).

5.6.4 Recruitment of allied health professionals

Workforce outcomes improved through organisations participating in TAHRGETS. Managers reported they had more applications for positions that were advertised with the opportunity to participate in TAHRGETS and saw the Pathway as an innovative, creative strategy of attracting and retaining staff to rural areas. They saw TAHRGETs as a recruitment incentive in a field that is often difficult to recruit to. Retention was also a positive outcome with organisations giving early career AHPs a reason to stay for longer as they completed the Pathway:

I guess it was a really nice segway for her to come from a city-based service into a rural area as an experienced clinician. And I feel like that's been really good for us because now she's continuing to work and obviously it's still remote but continuing to work with us and with more clients and so I think it's been positive, but just reflecting on attracting staff, I think that our project that was instigated by our involvement in TAHRGETS has increased our staffing (M6).

A great initiative. As an employer being able to attract people to a rural setting you need things that you can offer that are above and beyond. Being offered as an initiative. It's important that it exists as an offer to potential employees, even if they don't take it up (M4).

5.6.5 Consumer impacts

Managers reported services for consumers improved through their organisation participating in TAHRGETS. Organisations were able to deliver better engagement with the community through trainee involvement. This included better linkages and awareness of community supports and collaboration between providers. With the advanced skill development, organisations were able to better manage consumers complex clinical problems and provide a more collaborative, high-quality service:

In relation to the key stakeholders and community engagement, I think that's something that definitely improved. Thinking a little bit on a higher level about primary care delivery with the

community, so that sentiment that I communicated before…. Improved care, improved clinician knowledge, improved holistic care, more timely care, care diversification through the use of Allied Health Assistants and continued local care (M8).

Projects undertaken were generally consumer facing with new services and resources developed having tangible benefits for consumers. These included services closer to home, improved access to telehealth services and new, expanded and innovative service provision options:

Indirectly the increased collaboration between providers within our service has, I would say, had indirect benefits in the quality of care that they're being provided (M1).

5.6.6 Service development project outcomes

From an organisation perspective, the service development projects incorporated into TAHRGETS ensures the learnings from the Pathway are transferable to practice and had lasting impacts for organisations. The opportunity to integrate skills and knowledge in project management, needs assessment, critical thinking and evidence-based practice enabled trainees to make a significant contribution to their organisation. Supervisors and managers felt the projects gave trainees a real purpose in the organisation and an opportunity to make a difference. Trainees felt TAHRGETS enabled them to lead projects earlier in their career than they would have otherwise had the opportunity to do:

I think the service delivery project is what makes this valuable for private and NGO's. And so whatever changes we did in implementation around using a development plan and just picking some units or whether it's the whole thing, I think it's still needs to be, uh. Hinged on that service development project because I think that's where the value for the for the workplaces (PT).

Trainees collaborated with other team members to develop and implement projects which not only developed their own skills but those of others as well. They developed new services and models of practice and had the opportunity to implement programs they had designed from the stage of exploring community needs through to planning and running the program which was highly valued by organisations. Trainees implemented projects that organisations would have previously had difficulty resourcing which managers found to be advantageous:

The trainees did implement a process within our business that improved collaboration between the different Allied Health Providers and they really drove that as their project which was a really good outcome for them and the business as a whole. In doing that I think that it really improved their ability to be able to think about the impact or the influence of other professions on the more complex clients they were managing (M1).

We specifically had her working on a project that had to do with the dynamics of triage and waitlists within our caseloads which is exceptionally important considering the number of referrals we receive. And she actively went through a process of doing the research, getting consultations both from clients and our team members and things like that. And what she developed and created is something we still actively use (M2).

We wouldn't have that program if we hadn't had the TAHRGETS program. And particularly being able to do a bit of a deep dive into the needs of rural, remote and regional Australia as opposed to just therapy needs overall, has really informed how we modified a ready-made package to cater to the needs of people in our area (M6).

5.6.7 *Enhancing quality of care*

AHPs participating in TAHRGETS reported on completion of the scheme that they felt they had enhanced the care they were providing and were improving service outcomes. In particular they felt more confident in their skills and approach to care through engaging in study and work-based activities. Having the time to devote to professional development activities also enabled them to confident to try new intervention approaches as they were more knowledgeable and across the latest evidence:

> *The extra study gives me that confidence that what I'm saying is right and it's given me the time to go over those things that I might not have gone over if I didn't have the time to study them* (T12).

Service development projects built into the scheme assisted AHPs to implement their learning into practice. This enabled them to develop skills and contribute to the organisation in ways that may not have been possible so early in their career. They reported gaining the skills and confidence to identify community needs, plan and implement new services. AHPs also had dedicated time to develop and implement a project which enabled them to implement something that may otherwise have been challenging to find the time to do:

> *Having experience in changing service, and quality improvement. To know that its' possible to do it. That it's not as hard as it might seem* (T13).

> *Having dedicated time through the Pathway to do the project. Had I taken it on as an employee, it would have been on the side rather than having dedicated time to complete the project, meaning the project otherwise wouldn't have progressed as quickly and implement it* (T11).

5.6.8 *Timing to commence the Pathway*

Overwhelmingly, managers and supervisors felt TAHRGETS was not well suited to very new graduates, and it was more suited to AHPs with at least 12-month experience. In their first year of practice, new graduates encounter a steep learning curve as they orientate to a new workplace and are transitioning to an allied health role for the first time. Managers described this time of learning and acclimatising to practice as demanding and potentially limited new graduates' capacity to simultaneously study broad concepts. Others felt trainees could benefit from clinical experience in the workplace to relate their study to:

> *I actually think that a trainee shouldn't be a new grad, I think that it would be best if they were saying a minimum of two years out of uni. The reason being, I think as a new grad, people are trying to get their head around their job on a basic sense and perhaps don't have that capacity to see things from a larger perspective which is really what a rural generalist training program is trying to facilitate* (M1).

> *I would want them to have at least, probably 2 years under their belt, just because I think there's just so much to know, I'm assuming that they would be in a really supportive workplace with good quality supervision, but I think if you'd just come straight out of Uni and you had to face another day study a week and project work and just learning the ropes with clinic practice, that would be huge, even for people who are really motivated* (M6).

Trainees who were in their first year of practice while undertaking TAHRGETS also reported it was challenging to juggle acclimatizing into a new work role with study requirements at the same time:

> *With the time side of things, as new grads, especially with the level 1 when you're trying to learn how to be a dietitian or allied health professional and then undertaking that training it could be a lot and lead to burn out. On top of the fact we already know that burn out is higher in rural areas* (WT2).

One manager described their perception that early career AHPs are keen to progress their careers quickly and they do not want to wait for their experience to naturally develop. In these instances, undertaking the Pathway gives AHPs early access to post graduate training that they can leverage for career advancement opportunities and to develop the skills and knowledge needed for these roles. A supervisor also reported new graduates generally have more time and less responsibility outside of work which is also a good time to undertake additional study:

> *You sometimes you have to work 5-10 years in a place to actually be recognised for additional responsibility... I feel like there's a want to progress quicker within allied health within an organisation, that people aren't prepared to put in the time to be able to let that naturally occur, they want it when they want it – Which is ok, but if there's not that next thing for them to do or that next thing for them to go to, then they're going to look for other opportunities and I feel like if that rural allied health generalist opportunity is presented to them as another opportunity to develop themselves, and develop their resume to be able to say "well look at me I've got additional training to work in rural areas* (M8).

5.6.9 Benefits to employer, and community

Through the recruitment of seventeen new AHPs (Table 8) to positions with a program traineeship included, over 1,300 additional weeks of service were provided to the regions they were recruited to (including both the completed and withdrawn participants for the time they were participating in the program). This included an additional five physiotherapists, five occupational therapists, and four pharmacists and three social workers or psychologists.

As has been mentioned previously, the vast majority of the participants in the program were AHPs in Existing Positions with an organisation, wishing to improve their skills in rural health practice. Sixty-seven AHPs participated in the program while within their current employing organizations. They participated in the program for a total of 3,889 weeks while also providing services to their regions.

Table 8: Estimated benefits to community through AHP Trainees: Additional Hours of Service

Category	Discipline	n	Length of Stay in Program (Weeks)			Billable Hours Available		
			Total	*Mean (SD)*	*Median (IQR)*	*Total*	*Mean (SD)*	*Median (IQR)*
New Recruit Positions	**All**	**17**	1,390	82 (57)	83 (95)	42,250	2,485 (1,727)	2,515 (2,893)
	Occupational Therapist	5	548	110 (54)	109 (78)	16,651	3,330 (1,637)	3,305 (2,376)
	Pharmacist	4	432	108 (62)	130 (88)	13,145	3,286 (1,898)	3,961 (2,678)
	Physiotherapists	5	338	68 (46)	48 (78)	10,275	2,055 (1,411)	1,459 (2,363)
	Social Worker	2	-	-	-	-	-	-
	Psychologist	1	-	-	-	-	-	-
Existing Positions	**All**	**67**	3,889	69 (38)	52 (72)	118,203	1,762 (1,153)	1,578 (2,184)
	Dietitian	13	903	68 (40)	48 (65)	27,439	2,111 (1,169)	1,455 (1,989)
	Exercise Physiologist	2	-	-	-	-	-	-
	Occupational Therapist	22	1,303	54 (44)	57 (68)	39,616	1,722 (1,012)	1,724 (2,054)
	Pharmacists	5	269	54 (44)	52 (76)	8,174	1,635 (1,338)	1,578 (2,311)
	Physiotherapist	8	479	60 (39)	52 (66)	14,552	1,819 (1,177)	1,585 (2,004)
	Podiatrist	2	-	-	-	-	-	-
	Psychologist	3	174	58 (59)	24 (103)	5,277	1,759 (1,802)	721 (3,123)
	Social Worker	1	-	-	-	-	-	-
	Speech Pathologist	10	427	43 (39)	23 (78)	12,967	1,297 (1,162)	693 (2,367)

N.B Including both completed and withdrawn participants. Where sample less than 3 figures not reported due to concerns regarding small cell size.

Table 9: Estimated benefits to community through AHP Trainees: Additional Income to Region

Category	Discipline	n	Additional income via MBS ($)			Additional Income via NDIS ($)		
			Total	Mean (SD)	Median (IQR)	Total	Mean (SD)	Median (IQR)
New Recruit Positions	**All**	**17**	3,161,705	185,983 (128,852)	182,852 (249,576)	5,181,057	398,543 (289,569)	301,474 (503,936)
	Occupational Therapist	5	1,205,989	241,179 (118,574)	239,342 (172,037)	2,713,409	542,682 (266,807)	538,549 (387,104)
	Pharmacist	4	951,989	237,997 (137,454)	286,833 (193,911)	N/A	N/A	N/A
	Physiotherapists	5	874,794	174,959 (120,162)	124,236 (201,181)	2,105,746	421,149 (289,069)	299,349 (483,879)
	Social Worker	2	-	-	-	-	-	-
	Psychologist	1	-	-	-	-	-	-
Existing Positions	**All**	**67**	9,223,498	137,664 (93,678)	123,867 (158,513)	18,721,046	301,952 (202,057)	250,126 (355,966)
	Dietitian	13	2,336,123	179,702 (99,571)	123,867 (169,346)	4,471,231	343,941 (190,573)	237,075 (324,120)
	Exercise Physiologist	2	-	-	-	-	-	-
	Occupational Therapist	23	2,868,958	124,737 (73,301)	124,860 (148,763)	6,455,511	280,674 (164,936)	280,951 (334,735)
	Pharmacists	5	591,939	118,002 (96,912)	114,261 (167,382)	-	-	-
	Physiotherapist	8	1,238,998	154,875 (100,178)	134,959 (170,622)	2,985,383	373,173 (241,379)	325,186 (411,115)
	Podiatrist	2	-	-	-	-	-	-
	Psychologist	3	255,017	85,006 (87,068)	34,842 (150,911)	1,082,468	360,823 (369,577)	147,893 (640,571)
	Social Worker	1	-	-	-	-	-	-
	Speech Pathologist	10	1,102,168	110,217 (101,513)	58,975 (201,514)	2,109,499	210,950 (194,292)	112,876 (385,689)

N.B Including both completed and withdrawn participants. Where sample less than 3 figures not reported due to concerns regarding small cell size.

ADDITIONAL BILLABLE HOURS, ADDITIONAL INCOME, AND ADDITIONAL SPEND IN REGION

The AHPs recruited into new positions provided an additional 42,250 available hours to their employing organisations (excluding one-day per fortnight, to allow for the four hours per week of study time recommended by the program, and other non-clinical time) or an average of 2,485 hours per participant (See Table 8). The highest total hours per discipline provided were for occupational therapists (16,651), followed by pharmacists (13,145), and physiotherapists (10,275). Furthermore, these recruited trainees provided between over $3 and 4 million in estimated additional income via MBS or NDIS charges (estimated based on a 60% utilisation rate of the AHP available hours (National Disability Services, 2017; StewartBrown, 2023). Per trainee, additional income over their participation in the program is estimated at between $180,000 and 500,000. Estimates by allied health disciplines are provided in Table 9. It should be noted that where a utilisation rate (i.e. the proportion of a worker's time that is able to be recouped in MBS or NDIS charges, usually equivalent to face-to-face time spent with a client) is higher (i.e. 80%) the additional income would be greater (or vice versa for lower utilisation rates). AHPs have generally lower utilisation rates compared to some other workforces (e.g. person care workers) as their work can involve a greater proportion of non-face to face time (e.g. writing reports back to referring practitioners or writing referrals to facilitate treatment by other practitioners, preparation of materials for client treatment, travel outside of the expected). For AHPs in existing positions who took up traineeships, they were also able to contribute a significant amount of income to their organisations over the time period, despite taking on the traineeships and reducing their available time for their organisations by one day per fortnight.

Finally, the recruitment of new AHP into positions in rural and remote services contributes to the local economy because they are living and spending locally. For example, the recruitment of sixteen AHPs into trainee positions, resulted in an estimated additional spend on goods and services of over $2 million, based on an estimated weekly spend of $1,762 per week (Beforepay, 2024). For this calculation we assumed the spend from the AHP only, if a AHP moved with the partner, or family, the weekly spend would be greater and resulting economic activity in a region also larger.

SAVING IN RECRUITMENT COSTS

For those that completed the program and were interviewed, they all planned to stay for a significant period of time in their current region, i.e. between 2 and 5 years. Recruitment of AHPs into rural and remote areas has been found to be a significant cost to organisations, although the only data available on this currently was produced over 10 years ago. For reference, the median cost of turnover of one AHP position in rural and remote Victoria Health services at that time was between $10,000 and over $50,000 (Chisholm et al., 2011). At an estimated completion rate of around 50% for trainees who commenced the program (assuming those currently enrolled in the program and due to complete in 2025 do so), significant savings in recruitment costs for organisations could be achieved if these completing trainees do go on to remain in position for their planned additional 2 to 5 years. However, at this current stage we are unable to definitively comment on the overall completion rate of trainees in the program, or whether trainees who complete do in fact stay within their regions beyond the life of the program. Additional follow-up at a later time point would provide useful data on these points.

6 Discrete Choice Experiment

6.1 DCE Attributes and Element

The DCE included six attributes related to program characteristics, each with multiple elements which could be offered within the program. These attributes were as shown in Table 12.

Table 12 Description of DCE attributes and elements offered in programs

Attribute	Element	Abbreviation
Costs covered for organisation to participate (Cost coverage)	Nil (Base)	Nil
	University Course Fees	Fees only
	University Course Fees and time for trainee to participate	Moderate coverage
	University course fees, time for trainee to participate, time for their supervisor to participate including overhead costs	High coverage
Flexibility of Formal Study Program (Flexibility)	No flexibility. Must complete structured program within 1 to 2 years (Base)	Nil
	High flexibility. Able undertake individual modules from different universities to build your qualification.	High
Recognition of prior experience (Prior credit)	No recognition of previous experience or study in University Course (Base)	Nil
	Credit provided for previous experience or study for specific modules in university Course	Yes
Form of Recognition of training completion (Form of Recognition)	Continuing Professional Development Points for professional registration (Base)	CPD points
	University Qualification as a Rural Generalist	University
Increase in earnings after completing program (Earnings increase)	No change (Base)	None
	5% increase on current salary	5%
	10% increase	10%
	15% increase	15%
Professional development available to the broader team in the organisation (Professional development)	Not available (Base)	Nil
	Yes, self-paced online courses and resources plus additional facilitated courses delivered online	Yes

6.2 Statistical Analysis

6.2.1 Descriptive analysis and setting

All analysis was performed in Stata (version 17) and statistical significance was set at alpha= 0.05. Descriptive statistics were used to summarise participant characteristics across age, gender, professional role, allied health qualifications and the Modified Monash Model (MMM) categories.

6.2.2 Conditional logit model

Conditional logistic regression was used to analyse the DCE data, as this approach is well-suited for choice data in which participants select among alternatives within defined choice sets. Both dummy and effects coding were used to represent the attributes, with element 1 set as the reference category for each attribute. The dummy coding method compared each element of an attribute to a specific reference element (usually the lowest level of support for that element, e.g. no coverage of

costs to participate, or no flexibility in the formal study program etc), which served as the base for comparison. The base element for each attribute is indicated in Table 10. This allowed for direct comparison between each element and a defined reference category. Whereas the effects coding approach was used to estimate each attribute element's deviation from the average effect across all elements of the attribute. The omitted element for each attribute was set to reflect the negative sum of the included element, enabling comparison to the average effect rather than a single baseline element. The estimated coefficients therefore determined the relative impact of attribute element on choice likelihood. Positive coefficients indicated a preference for a given element compared to the average effect, while negative coefficients indicated an aversion.

6.2.3 Mixed logit model

A mixed logit model was employed to examine the preferences of participants across various program attributes. This model, in contrast to the conditional logit model, accounts for unobserved heterogeneity in preferences by allowing certain coefficients to vary randomly across individuals. Effects coding was applied to the categorical attributes to estimate deviations from the mean utility. As above, the omitted category was set to the negative sum of the included elements, enabling comparisons relative to the average effect across all elements of each attribute. The model was estimated for the overall sample as well as two sub-groups: AHPs and AH managers. The AHP sub-group included individuals who identified as either AHPs or AH students, while the manager sub-group consisted of participants who reported managing either small or large AHP teams. Sub-group analysis was conducted to explore potential variation in preference based on the professional roles. Each attribute was included as a random effect, allowing for individual-specific preferences while capturing the overall population trend.

6.2.4 Choice Probability Estimation

Following the mixed logit model estimation, predicted choice probabilities were calculated for each elements of the attributes. This involved generating probabilities for both the overall sample and the two sub-groups (AHPs and managers). Predicted probabilities were computed to estimate the likelihood of choice relative to the base element for each attribute. The choice probabilities were estimated to facilitate meaningful interpretation of the mixed logit model and highlight which attributes and elements were most influential in participants' decision-making.

6.3 DCE results from a mixed logit model

6.3.1 Overall sample

Table 13 presents the results from a mixed logit model with effects coding for categorical attributes for the overall sample (N=85). The results from the mixed logit model were similar to the conditional logit model. When no costs were covered the coefficient was negative and significant (p-value=0.005), indicating an aversion to this option relative to the average effect. The coefficients for attribute elements where varying degrees of university cost coverage were provided (Fees only and Moderate coverage), were positive, although not statistically significant, suggesting a potential preference over the reference element. In addition, the highest offered cost coverage did not appear to impact preference significantly. Participants showed a significant preference for the highest earnings increase (15%), with a positive and significant coefficient (p-value=0.003). Lower earnings increases (5% and 10%) were not significant, while no change in earnings reflected an aversion with a significant negative coefficient (p-value=0.001).

The flexibility attribute indicated a strong preference for higher flexibility with a significant positive coefficient (p-value<0.001), suggesting that participants valued flexibility in study programs. The coefficient for options that recognised prior experience or study and offered credit for assessment tasks and modules was positive and significant (p-value=0.002). The base option that did not offer credits for prior experience or study showed a corresponding significant negative preference indicating a preference for programs that provided some recognition of prior experience. There was a significant preference options that offered a formal recognition as a rural generalist with a university qualification, with a positive coefficient (p-value=0.001), indicating that participants valued higher recognition over continuing professional development points alone. Participants also showed a positive, statistically significant preference for options offering self-paced professional development available to the wider team, as compared to no broader professional development offered.

Table 13 Mixed logit results for effects coded attributes for the overall sample

Variable	Element	Coefficient	p-value	95% CI
Cost coverage	Nil	-1.17	0.005	-1.99, -0.35
	Fees only	0.55	0.297	-0.48, 1.58
	Moderate	0.53	0.102	-0.11, 1.17
	High	0.09	0.831	-0.71, 0.88
Earnings increase	No change	-1.07	0.001	-1.73, -0.41
	5%	-0.55	0.126	-1.26, 0.16
	10%	0.29	0.405	-0.39, 0.97
	15%	1.34	0.003	0.45, 2.22
Flexibility	Nil	-0.49	<0.001	-0.67, -0.30
	High	0.49	<0.001	0.30, 0.67
Prior Credit	Nil	-0.37	0.002	-0.60, -0.14
	Yes	0.37	0.002	0.14, 0.60
Form of Recognition	CPD points	-0.38	0.001	-0.61, -0.16
	University	0.38	0.001	0.16, 0.61
Professional Development	Nil	-0.24	0.047	-0.47, -0.00
	Yes	0.24	0.047	0.00, 0.47

6.3.2 AHPs

Table 14 presents the results from a mixed logit model with effects coding for categorical attributes for the AHP sub-group only (N=56). In contrast to the model including the overall sample, coverage of university fees was not, suggesting no strong differential preference for options dependant on the 'cost' covered. However, similar to the overall model, a significant negative coefficient for the base 'earnings' (p-value=0.007) indicated an aversion to options with no earnings increase. Additionally, the coefficient for a 15% earnings increase was positive and significant (p-value=0.044), suggesting a strong preference for substantial increases in earnings. Other increases in earning, i.e., 5% and 10%, did not show statistically significant preferences.

For the attributes 'flexibility', 'prior' and 'recognition', the coefficients demonstrated similar preferences to the overall model. Participants showed a strong preference for high flexibility (p-value<0.001), options that offered credits for prior study and experience (p-value=0.008) and with recognition of learning with a formal rural generalist university qualification (p-value=0.038). However, in contrast to the overall model, for the 'professional development' attribute none of the elements were statistically significant. This indicated no strong preference or aversion for options with or without the availability of professional development courses for the broader team in the sub-group comprising the AHPs.

Table 14 Mixed logit results for effects coded attributes for the AHPs' sample

Variable	Element	Coefficient	p-value	95% CI
Cost coverage	Nil	-0.91	0.123	-2.06, 0.25
	Fees only	0.23	0.768	-1.29, 1.75
	Moderate	0.52	0.271	-0.40, 1.44
	High	0.16	0.783	-1.00, 1.33
Earnings increase	No change	-1.37	0.007	-2.37, -0.37
	5%	-0.26	0.614	-1.25, 0.74
	10%	0.37	0.479	-0.65, 1.39
	15%	1.25	0.044	0.03, 2.48
Flexibility	Nil	-0.51	<0.001	-0.78, -0.24
	High	0.51	<0.001	0.24, 0.78
Prior Credit	Nil	-0.46	0.008	-0.80, -0.12
	Yes	0.46	0.008	0.12, 0.80
Form of Recognition	CPD points	-0.33	0.038	-0.64, -0.02
	University	0.33	0.038	0.02, 0.64
Professional Development	Nil	-0.26	0.133	-0.60, 0.08
	Yes	0.26	0.133	-0.08, 0.60

6.3.3 *Managers*

Table 15 presents the results from a mixed logit model with effects coding for categorical attributes for the manager sub-group (N=27). The coefficient for the option where no costs were covered was negative and statistically significant (p-value=0.036), similar to the overall model. Although this suggested a strong aversion in this sample to options where no costs are covered, other elements which involved varying degrees of cost coverage, were not statistically significant, indicating no clear preference among these elements. There was no significant preference or aversion for options with 0%, 5% and 10% earnings increase. Notably, the coefficient for options with a 5% increase in earnings was marginally statistically significant with a negative coefficient (p-value=0.075), suggesting a slight aversion. A significant positive coefficient for options with a 15% increase in earnings (p-value=0.043) suggested a preference for the highest earnings increase as in the overall model.

Among the attributes 'flexibility', 'prior', 'recognition' and 'professional development', significant preferences were only observed for the 'flexibility' attribute in this sub-group. Specifically, options with no flexibility exhibited a significant negative coefficient (p-value=0.005), indicating an aversion, while options offering high flexibility showed a significant positive coefficient (p-value=0.005), suggesting a strong preference for program structures that allowed greater study flexibility.

Table 15 Mixed logit results for effects coded attributes for the managers' sample

Variable	Elements	Coefficient	p-value	95% CI
Cost coverage	Nil	-1.66	0.036	-3.21, -0.11
	Fees only	0.99	0.288	-0.84, 2.82
	Moderate	0.66	0.263	-0.49, 1.80
	High	0.01	0.992	-1.41, 1.42
Earnings increase	No change	-0.61	0.246	-1.65, 0.42
	5%	-1.19	0.075	-2.50, 0.12
	10%	0.31	0.579	-0.79, 1.42
	15%	1.49	0.043	0.05, 2.93
Flexibility	Nil	-0.54	0.005	-0.92, -0.16
	High	0.54	0.005	0.16, 0.92
Prior Credit	Nil	-0.23	0.275	-0.65, 0.19
	Yes	0.23	0.275	-0.19, 0.65
Form of Recognition	CPD points	-0.44	0.056	-0.89, 0.01
	University	0.44	0.056	0.01, 0.89
Professional Development	Nil	-0.23	0.297	-0.67, 0.21
	Yes	0.23	0.297	-0.21, 0.67

6.3.4 Estimated choice probabilities

Below is a summary of the average difference in predicted probabilities for each element compared to the base element offered of the respective attributes.

The predicted probabilities indicate varying elements of preference across the different attributes as shown in Table 16 for the overall sample and by sub-group (AHP and managers). For the 'cost' attribute, options that offered coverage of university fees or university fees plus time for trainee to participate both have a predicted probability of 0.21, suggesting equal likelihood of selection for these options relative to no cost coverage option. In terms of 'earnings', there was a clear preference for a 15% increase, with a predicted probability of 0.34, followed by 10% at 0.19, and 5% at 0.06, indicating a progressive increase in preference for higher earnings relative to no change in earnings. Moderate-to-high 'flexibility' attribute had a predicted probability of 0.12, indicating a preference for flexibility in the program. The attributes of 'prior' and 'recognition' that offered credits for prior experience and offered a formal recognition as a rural generalist, respectively, demonstrated predicted probabilities of 0.07 and 0.05, showing relatively low desirability of these options compared to when they were not offered. Finally, the 'professional development' attribute that provided development opportunities for the broader team had the lowest predicted probability of 0.02, indicating minimal likelihood of selection for this option over having no professional development opportunities at all. Overall, higher earnings and moderate cost coverage appear to be the most preferred attributes in the model.

In the AHP sub-group, the 'cost' attribute, options that included only university fees and university fees as well as time for trainee to participate, time for their supervisor to participate including overhead costs both demonstrated a predicted probability of 0.12. However, the option that offered cost coverage for university fees and time for trainee to participate was slightly preferred with a probability of 0.16, indicating moderate preference for partial cost coverage over no cost coverage. For the 'earnings' attribute, there was a clear preference for higher earning potential, with probabilities increasing progressively from 5% (0.13) to 10% (0.22) and peaking at 15% (0.35), suggesting participants significantly valued higher earnings. The high flexibility option within the 'flexibility' attribute had a predicted probability of 0.12, indicating a preference for programs that offered more flexibility. The attributes 'prior', 'recognition' and 'professional development' demonstrated low predicted probabilities of 0.08, 0.04 and 0.02, respectively. This indicated a limited preference for options that provided credits for prior study/experience, formal recognition and professional development courses for the broader team relative to not offering this component. Overall, participants demonstrate the highest preference for increased earnings, while the availability of professional development courses appeared to be less influential in their decision-making.

For the mangers sub-group, the 'cost coverage' attribute offering coverage of only university fees showed the highest choice probability at 0.33. This was followed closely by the option covering university fees and trainee participation time at 0.30, and then the option covering university fees, trainee participation, and supervisor participation with overhead costs at 0.22. In terms of 'earnings', preferences typically increased with higher wages relative to baseline of no change. A 5% increase had a slightly negative preference (-0.07), a 10% increase had a choice probability of 0.13, and a 15% demonstrated the highest choice probability within this attribute at 0.29. The 'flexibility' attribute with high flexibility had a predicted probability of 0.13, indicating some preference for flexibility in program options over a strict structure. 'Prior' attribute with option offering credits for prior study/experience had a predicted probability of 0.05, showing limited interest in recognition of prior experience over the baseline of no credits offered. 'Recognition' attribute offering formal recognition as a rural generalist had a slightly higher choice probability of 0.07, indicating a relatively low preference for formal recognition over receiving continuing professional development points. Finally, the 'professional development' attribute, which offered professional development courses for the broader team, had the lowest predicted probability at 0.03, suggesting minimal preference for this attribute within the program relative to having no professional development opportunities

available. Overall, participants prioritised moderate cost coverage and higher earning potential, while other attributes, such as prior credit, formal recognition, and professional development support, had lower impact on their choices.

Table 16 Estimated choice probabilities by attribute level for overall sample, AHPs and the manager sub-groups

Attribute	Element	Predicted Probability		
		Overall	**AHP**	**Manager**
Cost coverage	Fees only	0.21	0.12	0.33
	Moderate	0.21	0.16	0.3
	High	0.16	0.12	0.22
Earnings increase	5%	0.06	0.13	-0.07
	10%	0.19	0.22	0.13
	15%	0.34	0.35	0.29
Flexibility	High	0.12	0.12	0.13
Prior Credit	Yes	0.07	0.08	0.05
Form of Recognition	University	0.05	0.04	0.07
Professional Development	Yes	0.02	0.02	0.03

7 Findings and Discussion

TAHRGETS and its associated program, Building the Rural Allied Health Assistant Workforce, provided a comprehensive, coordinated, and structured approach to rural and remote allied health workforce development, informed by the health needs of rural communities.

Unlike the rural generalist pathway for medicine, with a single clinical council and registration board, there are currently 10 allied health professions eligible to participate in the AHRG Pathway, which are a mix of regulated and self-regulated professions that each have responsibility for accrediting undergraduate education programs. Maintaining a single allied health rural generalist pathway is critical to ensure that a shared understanding, alignment and consistency of training standards is maintained across professions

The structure of allied health rural generalist training positions, and the capacity-building supports that sustain them, were developed collaboratively by a broad assembly of organisations across the Australian healthcare sector over more than a decade. In this regard, TAHRGETS has benefitted from iterative trials and evaluations in state and territory health services to ensure consistency in program design and execution. As a result, it is possible to compare TAHRGETS outcomes with those achieved in the state and territory jurisdictions.

TAHRGETS differs from other health workforce development programs outlined in section 5.2.3 because it brought together and coordinated the funding supports for the different elements of rural generalist training positions in one scheme. TAHRGETS provided a central point for trainees and their employers to access guidance and support to complete training position requirements, assisting them to align their training with the health needs of rural and remote communities.

By contrast, the range of health workforce development programs outlined in section 5.2.3 are implemented across a broad range of agencies, with no coordination between them and no publicly available data regarding the impact on allied health workforce numbers or distribution. Whether these programs have been effective in growing the rural and remote allied health workforce is unknown.

TAHRGETS was implemented independently of and prior to an overarching national allied health workforce strategy. This may have contributed to lack of clarity regarding where TAHRGETS fitted within the Australian Government's health workforce program. Nonetheless, the concentration of workforce development supports for the allied health professions in one scheme enabled greater visibility and accountability which should be considered in future health workforce planning.

The following section discusses the TAHRGETS evaluation results in the context of:

1. The objectives and outcomes as outlined in the Commonwealth grant agreement
2. Program design

7.1 Objectives and Outcomes

*7.1.1 Objective 1: improve the **capacity, quality, distribution and mix** of the allied health workforce to better meet the needs of Australian communities and deliver a sustainable and well-distributed health workforce through the AHRGP; and*

*Outcome 1: provide support to private and not for profit service providers, **to build capacity** and **expand allied health service delivery** in rural and remote locations*

This evaluation demonstrates TAHRGETS has led to improvements in individual and organisation capacity and quality and expanded allied health service delivery.

Quantitatively, this has been shown at an individual level through:

- Improved measures of trainee and manager reported competence and confidence. Trainee and manager ratings of competence increased from approximately 6/10 to 8.4/10; and confidence ratings increased from 5.3/10 to more than 8/10.
- More than 80% of trainees reporting *quite a bit* or *a great deal of skill* development in rural practice; project management; consumer/client engagement; client relationships and leadership.
- Increased numbers of rural generalists with 37 trainees expected to complete training requirements
- The recruitment of 17 new AHPs which resulted in an additional 42,250 hours of service for rural and remote communities.

Qualitatively, as a result of their participation, AHPs feedback supported these findings with trainees being more able to manage clinical complexity, solve problems and use evidence-based practice. TAHRGETS supported AHPs early in their career to provide a high quality service in their community.

Consumers and local communities benefited from TAHRGETs trainees' improved skills, knowledge, and engagement locally. Quality of care provided by trainees was enhanced through having dedicated time to implement new approaches and evidence-based approaches to care.

The ability of health professionals to work to their full scope of practice is becoming increasingly important to enable the delivery of services that meets the needs of their community (*Unleashing the Potential of our Health Workforce*, Australian Government 2024). TAHRGETS provided an environment for AHPs to retain a broad scope of practice in their profession and safely build new skills. This workforce will be capable of responding to changes in service and consumer needs across aged care, disability and healthcare in Australia.

Further feedback has described how the benefits to service capacity and quality extend beyond the individual. Organisations benefitted from participating in TAHRGETS directly as trainees gained skills and knowledge, and indirectly as the trainees shared their learnings across the team. This is complemented further by quantitative data showing 85 trainees, managers and supervisors participating in over 1000 hours of capacity building professional development activities provided by TAHRGETS developing a range of skills and knowledge including leadership, project management and allied health assistant models of care

In terms of distribution and mix, the evaluation showed TAHRGETS to be applicable across a range of professions and geographies. AHPs from nine allied health professions and working in MMM 3-7 across six states and territories participated in TAHRGETS. Most of the trainees who participated in TAHRGETS were embedded in their rural community and expressed a passion for and commitment to rural and remote health.

Service development projects were designed to improve access and quality of allied health services across a wide range of practice areas. Service development projects made significant impacts to access and innovation and consumers benefited from enhanced service delivery and evidence-based practice. Many of these have continued beyond trainees' involvement in TAHRGETS. It should be noted that evaluation of the impact of the service development projects is beyond the scope of this evaluation.

Recommendation:

1. Investment in allied health rural generalist training should be sustained and strengthened as a mechanism to improve the capacity, quality, distribution and mix of the allied health workforce in rural and remote areas.

7.1.2 *Objective 2: **support** allied health practitioners and **assist practices** to **deliver local allied health service** capacity in rural and remote Australia; and*

*Outcome 1: provide support to private and not for profit service providers, to build capacity and **expand allied health service delivery** in rural and remote locations*

Private and non-government allied health services are an essential component of primary healthcare in Australia, delivering a wide range of services to vulnerable populations. But allied health services are not accessible to many people living in rural and remote areas to help manage chronic health conditions, disability or mental health concerns. This creates significant areas of unmet need. AHPs, managers and supervisors are under pressure to manage competing demands, administrative requirements across multiple regulatory frameworks and revenue streams, and high workload expectations.

Through TAHRGETS, SARRAH provided organisations with support and guidance to build workforce and service capacity through a suite of targeted professional development programs, training grants and networking opportunities. Establishing training positions enabled organisations to support their employees to participate in formal training at work, receive dedicated supervision and implement service development projects, while enabling supervisors and managers to focus on service development.

This program delivered immediate benefits to organisations and communities through increasing availability of AHPs locally and increasing available service hours. There is no lag time between a trainee commencing in their position and increased service access. Communities benefit from this service for the entire period the AHP is in training to become a rural generalist. This benefit is retained by the community regardless of whether the AHP completes the training.

Where AHPs were recruited to newly-created positions, TAHRGETS contributed to expanded allied health service capacity and delivery in MMM3-7 locations. Seventeen AHPs recruited to new positions, providing over 42,000 service hours to their organisations even when considering their 4 hours per week study commitment. This increased service capacity improved access to allied health services for rural and remote communities and contributed to bolstering the sustainability of the organisation.

Furthermore, service innovations and quality improvement delivered by service development projects had significant positive impacts for local communities, organisations and consumers. These projects assist practices with local allied health service delivery, designed for local community needs. Local benefits derived from these service development initiatives, for example the establishment of a new falls prevention program, were retained by the service and the community regardless of whether the trainee stayed with the organisation.

All interviewed trainees planned to stay in their current region for an additional 2-5 years following completion of the program. This could significantly reduce recruitment costs for organisations, enable longer-term service and workforce development, and provide continuity of care for rural and remote populations.

Recommendation:

2. Enhance the capability of private and non-government organisations to meet community needs by training allied health professionals as rural generalists, using targeted workplace training grants, incentive payments, and other measures that support building service capacity

7.1.3 *Outcome 2: **increase the number of allied health rural generalists** in rural and remote locations as well as practices offering greater access through an extended range of services*

There was excellent uptake of TAHRGETS training packages, with a total of 123 packages created (117 mainstream and 6 ACCHO) between 2022 and 2024.

62 individuals commenced in training positions during program implementation, 60 in mainstream organisations, 2 in ACCHOs (see section 7.1.5 for further detail regarding ACCHOs). At the end of the follow-up period, 15 had completed training with an additional 22 continuing. It is expected that all 37 of these trainees will complete their training requirements by the end of 2025, a completion rate of 60%, which is consistent with evaluations in other jurisdictions. The overall numbers of allied health rural generalists and completion rates were impacted by contextual factors, discussed further in section 7.2.1.

TARHGETS supported the recruitment of 17 new positions that resulted in more than 42,000 additional hours of service delivery over the course of the program

While TARHGETS was effective in increasing the number of allied health rural generalists with enhanced skills and competencies, the ability of private and non-government organisations to utilise these new skills was limited by funding models that do not sustainably support service delivery. For example, allied health rural generalists are trained to identify and address service gaps for vulnerable priority population groups (e.g. management of COPD or diabetes), however the Medicare Benefits Schedule does not adequately cover the cost of service provision.

Recommendation:

3. Governments should consider how to best harness allied health rural generalist skills and competencies, so that government, industry and rural and remote communities can benefit from the enhanced skills and competencies of this workforce, to improve health outcomes for rural and remote Australia.

7.1.4 *Outcome 3: develop career pathways, and improve the retention of allied health professionals working in rural and remote areas*

AHPs participating in TAHRGETS gained rural generalist skills and knowledge, enabling them to participate in service development project work early in their career. Trainees developed new skills, their competence and confidence to work as a rural generalist increased, their ability to work across clinical areas improved, they were able to implement their learning in evidence-based practice and they were more able to manage clinical complexity.

AHPs felt that accessing these opportunities so early in their career would not have been possible without TAHRGETS. Furthermore, they developed skills in project management and were guided to design, implement and evaluate service development projects.

There are early indicators of positive impacts on long-term retention from the program. Completing the rural generalist course requirements gave trainees a reason to stay. Trainees who completed or are planning to complete their training indicated a desire to continue working rurally for at least 2 years following completion. The true impact of the AHRG Pathway on retention will only become clear through follow-up with TAHRGETS participants over time.

Organisations participating in TAHRGETS benefited through trainees' improved job satisfaction, which had a flow-on effect across the whole team. Trainees built capacity in organisations through

the sharing of skills and knowledge with others, and TAHRGETS training positions were seen to be an innovative, creative and attractive opportunity for early career AHPs.

Recruitment and retention of AHPs in rural and remote areas remains challenging due to ongoing workforce shortages and there is much competition between private, not-for-profit and public organisations to attract AHPs, and this has also been reflected in journey of trainees in the TAHRGETS programs.

Regarding formal career advancement, it should be noted that training allied health rural generalists in private and non-government settings is a new concept, and relatively new within state jurisdictions. When compared to the more established medical rural generalist program, which has benefited from more time, investment, and a cohesive policy environment, allied health rural generalist training is less mature.

Currently, rural generalist training does not align directly to any recognised or formal career advancement opportunities for AHPs. This evaluation did not include a follow-up of trainee outcomes, and there were no reports of career advancements noted during the reporting period. Rural generalist graduates in other jurisdictions have experienced career progression opportunities (Dymmott et al 2024). A medium-long term follow-up evaluation is recommended to track career development and longer-term implications.

Current funding mechanisms in private and non-government settings do not recognise or remunerate expert or advanced scope of practice in the allied health professions. This limits opportunities for career progression for allied health rural generalists. Often, career advancement for a rural generalist will involve taking up a senior role that puts them in leadership and management positions, removing them from clinical service delivery. Addressing these limitations will require exploration of ways to recognise the expert rural generalist. This could include opportunities to link formalised skills acquisition with incentive payments for services to priority populations, and remunerating teaching and training (of undergraduates and early-career AHPs) in clinical service settings. These options are supported by the findings of the Discrete Choice Experiment.

Allied Health service delivery transects multiple levels of systems of government funding. Strategies that improve the retention of AHPs have wide-ranging benefits for rural communities and funding bodies. Ongoing investment in initiatives that support the retention of AHPs is required to bolster the success of rural generalist training pathways and the resulting improved access and quality of services for local communities.

More work is needed to measure the impact of allied health rural generalist training and to develop opportunities for rural AHPs to be recognised for enhanced skills and qualifications in order to incentivise AHRG Pathway uptake and completion. The National Strategy Group and AHRG Accreditation Council will be essential to this work.

Recommendation:

4. Explore opportunities to recognise and advance the career of the expert rural generalists through mechanisms such as incentive payments for service delivery to priority populations and establishing teaching and training opportunities in private and non-government settings to strengthen the rural workforce pipeline.
5. A long-term evaluation is recommended to follow up past participants to better understand the impact of TAHRGETS on retention, career development and advancement.

7.1.5 Rural generalist training positions and ACCHOS

At an early stage in implementation, the SARRAH project team identified that the KPI to establish 30 AHRG training positions in ACCHOs was not going to be met, with only two of the 30 packages allocated to ACCHOs commencing the Pathway. In response SARRAH collaborated with ACCHOs, IAHA and the TAHRGETS advisory group to understand the challenges to uptake of TAHRGETS in the community-controlled sector and explore possible solutions. A range of barriers to engagement were identified, and the results are reported in *Engagement Summary: SARRAH and Aboriginal Community Controlled Health Organisations: allied health lessons learned during the implementation of TAHRGETS and BRAHAW* (Appendix 7).

The report summarises perspectives gained from consultations with 18 ACCHOs, four ACCOs, and two peak bodies, revealing an extremely limited number of ACCHOs with established allied health services who could utilise rural generalist training packages.

ACCHOs are funded through the Australian Government's Indigenous Australians Health Program, a range of state and Commonwealth program and grant funding, and the Medicare Benefits Schedule (MBS). Most ACCHOs offered social and emotional wellbeing programs funded through government grants, some accessed MBS items (e.g. for psychology services under a Mental Health Plan), a few are NDIS providers. Variations in allied health service delivery models within ACCHOs ranged from a reliance on externally contracted professionals to a mix of internally employed and externally contracted staff. Service types varied and were dependent on funding models available.

In this context, very few ACCHOs were in a position to engage with SARRAH regarding the establishment of rural generalist training positions. Funding models, infrastructure, and professional isolation were some of the identified barriers for rural and remote ACCHOs preventing the establishment of sustainable allied health teams. Funding mechanisms that support services delivered by allied health professionals in ACCHOs should be reviewed to enable the sustainable delivery of allied health services for First Nations people in rural and remote areas. This needs to occur so that targeted allied health workforce development initiatives can be implemented effectively in the community-controlled sector.

The evaluators were engaged on TAHRGETS well after the SARRAH team had completed consultations with stakeholders and the report collated. This, and in view of the time elapsed since the consultations took place, meant the evaluators limited their data collection to the ACCHOs and trainees who participated in TAHRGETS. However, the evaluators drew from the report findings highlighting important themes regarding allied health service delivery, workforce development, the relevance of TAHRGETS, and the challenges faced in successfully allocating training positions.

Further work is required to support allied health workforce development in ACCHOs and consider cultural contexts of the rural generalist program more broadly before further investment and participation in rural generalist training positions is possible in this sector.

Recommendation:

6. Funding mechanisms that support services delivered by allied health professionals in ACCHOs should be reviewed to enable the sustainable delivery of allied health services for First Nations people in rural and remote areas.

7.2 TAHRGETS program design

7.2.1 Program acceptability

TAHRGETS offered early career AHPs and employing organisations access to rural generalist education, professional development activities, funding, and support that were previously only available to state-based public health services. Overall feedback indicated that

- The development of generalist skills and knowledge was relevant to practice, and trainees had the opportunity to implement their learnings through work-based learning activities.
- TAHRGETS was responsive to participant needs in delivering evidence-based, timely, and flexible support in the private sector.

ELIGIBILITY AND INTAKE

Consideration should be given to understanding the trainee and organisation's readiness to participate and how this is incorporated into the program's detailed selection and intake processes. Readiness indicators may include rurality of background (trainee), whether the training position is for an existing or new (recruitment) AHP, and the trainee and organisations understanding of the training position requirements.

Rural background is known to be one of the most consistent predictors of the rural medical workforce (KBC Australia 2020). Of the trainees interviewed in this evaluation, 79.2% reported a rural background, suggesting that this program is attractive to APHs with a rural background. In TAHRGETS, of those trainees who withdrew and were interviewed, six of the seven reported a rural background. This suggests there may not be a strong relationship between rurality and program success. However, given the small number of withdrawn trainees interviewed, this observation should be considered cautiously.

Given the impact of chronic workforce shortages in rural and remote areas, and the high number of training positions where recruitment was unsuccessful, TAHRGETS may be more relevant for private and non-government organisations where positions are already filled. Notwithstanding, TARHGETS facilitated the recruitment of 17 new AHPs that resulted in more than 42000 additional hours of service delivery over the course of the program. If the objective of future program implementation includes recruitment to newly established training positions, sufficient time must be allowed for recruiting and onboarding a new employee.

In 22 instances, where SARRAH worked with employers to establish training positions, training did not proceed. This outcome arose due to either the employer or the AHP changing their mind, possibly once the full extent of training requirements and expected outcomes were better understood. Activities that continue to increase understanding of the AHRG Pathway, its applicability, and the training position requirements should continue.

WITHDRAWALS

Of the 62 AHPs who commenced rural generalist training, 25 (40%) withdrew before completing training requirements. This rate is consistent with findings from evaluations of training position implementation in other jurisdictions (Dymmott et al 2024, McMaster et al, 2021 Barker et al 2021) and studies exploring turnover of early career AHPs in rural and remote areas (Chisholm 2011).

The 25 trainees who withdrew completed on average 3 program modules before withdrawing. Given that the majority of trainees left due to employment and personal circumstances, and not dissatisfaction with the course, these 25 trainees and their communities will have benefitted from the skills and knowledge gained, and are well positioned to achieving post-graduate qualifications at a later date. Long term follow up is required to explore this further.

Completion and withdrawal rates must be considered within the context of implementation. TAHRGETS was implemented in the context of severe and chronic workforce shortages impacting rural and remote Australia, where allied health professionals seeking work in rural and remote areas continue to have a substantial choice of employment options, and turnover rates are high as those AHPs move to higher-paying jobs and/or more senior roles. Furthermore, TARHGETS was designed for early career Allied Health Professionals (AHPs) working in private and non-government organisations in the context of a fee for service environment. This introduces an additional load on the trainee while they are consolidating their clinical skills.

To meet the requirements of the training position, if the AHP moves to a new employer which is common in early career stages, then they need to reach an agreement with the new employer to establish the workplace training supports to enable them to continue their training. If trainee moves to a state health service then they are not eligible to continue under TAHRGETS.

Withdrawal rates should also be considered in the context of limited incentives for AHPs to complete the Pathway compared to generalist training for rural doctors (Sen Gupta et al 2013). Attainment of Rural Generalist qualifications does not automatically result in higher levels of responsibility, pay or recognition for AHPs' additional skills and competencies.

FAILURE TO RECRUIT

Of the total number of packages created (123), 55 were applied to vacant positions as part of a recruitment strategy, and of these only 16 positions were filled. This represents a fill rate of 29%, well below the national average for all health professionals of 44% in 2022 (AIHW 2023)). This result may be an indicator of the significant workforce shortages observed by employers in rural and remote areas. It implies there are few AHPs seeking work in rural and remote areas and they have many employment options to work in areas of personal clinical interest.

TIMING TO COMMENCE THE PATHWAY

Managers and supervisors recommended AHPs should have at least 12 months experience before participating in TAHRGETS to enable them to transition into the workforce before embarking on further study.

TIME IN THE PATHWAY AND FLEXIBILITY

Both the level 1 and level 2 programs took on average longer to complete that the initial program guidelines suggested, with level 1 taking on average 20 months, and level 2 taking on average 25 months, and noting that there are still trainees continuing on the pathway at the time of the report.

This had significant implications for overall program performance, given that less than half of trainees had completed their training requirements at the time of this report. Considering other evaluations have found it can take 2.5 – 3 years to complete rural generalist training (eg Dymmott 2024) , the three-year timeframe for TAHRGETS was insufficient to fully implement and evaluate outcomes. Future program design should ensure adequate program timeframes to allow for trainees to flexibly undertake the education component at a pace that optimises their success.

Trainees, managers, and supervisors felt that flexibility was important, including allowing completion of individual modules of formal education or ability to pause training. Findings from the DCE supported this. Flexibility in the formal study program was highly attractive. A modular or 'construct your own' approach to the program of study, by allowing completion of individual modules across different universities, and/or considering micro-credentialling was associated with an increased update of 12% compared to a traditional single-education provider and pre-structured model. Future program design should consider how study program flexibility could be incorporated. Future program iterations that support the establishment of AHRG training positions should accommodate adequate program lead-in time, as well as trainee preferences for pathways leading to formal qualifications, and support trainees who may be working around personal commitments such as parental leave and carer responsibilities.

These findings support the need to take a medium- to long-term view to demonstrate the effectiveness of rural generalist training as a strategy to improve access to allied health services in rural and remote Australia. In order to accommodate recruitment and onboarding processes (12 months), average training periods (up to three years) and to ensure sufficient time to collect data from completing trainees (12 months), a minimum period of five years is suggested.

INCENTIVES

The Discrete Choice Experiment and survey sought to understand the value of the Pathway to the sector, and the potential benefits of a program such as TAHRGETS which were most attractive.

Recognition of completion of rural generalist training was highly attractive to trainees, including through higher remuneration. For example, results from the DCE indicated a hypothetical increase in salary for those completing the program was highly favoured, with a 34% increase in uptake for a program associated with a 15% increase in salary upon completion. However, other forms of recognition, e.g. professional recognition should also be considered.

Recommendations for program acceptability:

7. Program characteristic likely to promote success include flexibility in education program design (that includes modules to be undertaken over a longer time period, 'construct your own' and/or allowing for micro-credentialling); professional recognition and incentives to improve completion rates for trainees; and detailed selection and intake processes for organisations and trainees. These design elements should be incorporated into future implementations.
8. Future activities supporting the training of allied health rural generalists should be implemented over a minimum period of five years to accommodate the time taken to complete rural generalist training and ensure whole data sets are available to evaluate outcomes.

7.2.2 Program implementation: AHRG Pathway requirements

THE RURAL GENERALIST PROGRAM (EDUCATION COMPONENT)

The evaluation identified specific learnings for consideration in future implementation of the Pathway. The Rural Generalist Program could be better suited to private practitioners if:

- learning materials were revised. In some circumstances the Rural Generalist Program curriculum did not align with private practice and trainees felt modifications could be made to adapt learning modules for private practice contexts.
- tuition patterns were flexible to consider different contexts of practice.

These activities are in scope for the AHRG Accreditation Council which, through a licensing agreement with the Queensland Government, is well-positioned to review the AHRG Education Framework. The capacity of the Accreditation Council to continue this work is subject to ongoing funding.

7.2.3 Program implementation: System requirements

Establishment of the AHRG Pathway NSG and AHRG Accreditation Council have been key achievements of TAHRGETS implementation. This infrastructure will be essential to the future growth and sustainability of the AHRG Pathway, to ensure national consistency of training standards for allied health rural generalists across multiple professions, and for enhancing the quality and capacity of rural and remote allied health services across jurisdictions and allied health service settings.

AHRG Pathway system requirements should be centrally coordinated to ensure national minimum standards for AHRG Pathway training are maintained. Essential activities include:

- Address gaps in understanding of the AHRG Pathway across jurisdictions, including its applicability in a range of service settings, implementation requirements, and potential impact on service access and capacity
- Completion of the accreditation process for universities to deliver rural generalist programs

- Review of the AHRG Pathway Education Framework to ensure it is fit for purpose across a range of allied health service settings
- In consultation with the sector, progress mechanisms for professional recognition and career advancement for allied health rural generalists at different stages of their career.

7.2.4 Program implementation: Support

FUNDING AND COSTS

As outlined in the program guidelines, TAHRGETS provided funding to cover tuition fees for the formal university education, and funding to organisations to support training within the workplace for the trainee. The training grants provided to organisations generally offset the salary of the trainee for taking study time within work hours, and did not fully cover other associated costs (e.g. supervisor time, support for the service development project).

Managers and supervisors acknowledged the importance of this financial support. This finding is supported by the DCE, that found that coverage of education-provider fees or contribution towards trainee salary during the program would increase estimated program uptake by 33% compared to no coverage of costs among managers of AHP.

However, other costs should also be considered. Costs to the organisation in lost revenue during that time was at least double that of the salary of the trainee. Notably, there was significant variation at an individual level in the costs for a trainee to participate in the program, but these overall appear reasonable compared to other similar programs. The cost of participating in the program did vary significantly based on the perspective of the analysis taken – where the trainee's time spent working on the program was valued using their salary only the cost was around half that of when the lost potential revenue from the Medicare Benefits Scheme or the National Disability Insurance Scheme was considered (see section 5.3.10). Generally, participating organisations absorbed the loss of potential revenue, considering that the benefits accrued by reduced turnover, an overall increase in available service hours, increased trainee capacity and confidence, and improvements gained through the service development project, made this a worthwhile investment. However, the long-term sustainability of this approach should be considered.

Broadly, the costs to provide the TAHRGETS program (within the non-government sector) are similar to those to provide training positions within state-government funded public health services (Dymmott et al., 2024). However, there are significantly different drivers in terms of costs and benefits for non-government organisations compared to public organisations, and further consideration of these in the implementation plan will likely improve program engagement. For example, coverage of salary of a trainee considers only part of the costs to an organisation – when considering the impact to organisations the loss of billed income is at least double that what is covered in the salary component provided in TAHRGETS. However, a mitigating factor for organisations is the potential for increased revenue generated by a trainee during their billable hours, especially where the position was used to recruit a new Allied Health professional to an organisation.

It should be noted that TAHRGETS differs from other AHRG programs in state-government funded public health services. Unlike state-government funded public health services, which are (predominantly) single-funded, TAHRGETS organisations operate in a fee-for-service business model. 85.5% of participating private and non-government organisations provided a mix of services with funding from a range of sectors (e.g. primary health care, disability, aged care, education, private, mental health, Aboriginal Health); and 14.5 % of participants worked specifically in the disability sector.

Fee-for-service arrangements are transactional, and generally do not account for service and workforce development. There is significant variation in how organisations approach quality improvement, service and workforce planning. In the context of thin markets where business

sustainability is marginal, the capacity to invest in service enhancement and workforce development is challenging. For allied health service providers, the availability of financial supports to invest in workforce and service development work is scant. Supports made available through the Stronger Rural Health Strategy and other scholarship programs are not designed for allied health professionals nor allied health service delivery settings.

Sustainable funding for AHRG training positions in private and non-government settings might consider blended models, sourced across programs and agencies that are related to the types of allied health services provided and linked to the community needs. This approach requires a level of coordination to bring available supports together.

CAPACITY BUILDING

Capacity building activities provided by SARRAH for the broader workforce of the participating organisations were well received but it was challenging for trainees, managers and supervisors to find the time to participate in additional professional development while undertaking TAHRGETS.

Recommendations for program acceptability:

9. Action is required in the short term to ensure consistency in the implementation of allied health rural generalist training positions across multiple professions, and preserve and progress the growth and sustainability of a single AHRG Pathway. Specifically, these activities include (but are not limited to) a review of the Allied Health Rural Generalist Education Framework, overseeing university accreditation processes, and advancing formal professional recognition for allied health rural generalists. This work is within scope for the AHRG Accreditation Council and National Strategy Group, both of which will require support to continue performing these functions.
10. Identification of optimal funding sources is needed to ensure ongoing sustainable development of the AHRG workforce. This should consider how the supports for training positions are funded in private and non-government organisations, across jurisdictions, service settings, client populations, and community needs.

8 Limitations

8.1 Program and system data limitations

There are limitations in the small number of AHP and managers/supervisors who were interviewed for the evaluation. This was largely due to loss to follow up, and was particularly evident for those who had withdrawn, where only seven withdrawn trainees and four managers/supervisors of withdrawn trainees were interviewed. It was difficult for the evaluators and the SARRAH team to get hold of participants who withdrew, especially if they also left the organisation and community. This is mitigated however, by the available data reaching saturation, i.e., the information gleaned from the interviews became consistent across participants as analysis progressed and new themes were not being identified in the data. Therefore, it is likely that more interviews would not necessarily introduce new information. Regardless, there is a small risk that new understanding would be gained through a larger interview cohort, particularly with regard to withdrawals.

Additionally, given that the program is still being implemented at the time of evaluation, there may be changes to the quantitative data over time until program completion.

There is a lack of system-wide allied health workforce data, including information on recruitment and retention timeframes and related costs and savings specific to rural and remote organisations. This makes understanding the impact of TAHRGETS on retention by comparison to industry norms challenging. Further long-term follow-up evaluation of TARHGETS participants would be required to more fully understand the effects of pathway completion on retention (both in the workplace and within rural and remote communities). This was out of scope for this evaluation.

8.2 Scope of the evaluation

The following were not included in the scope of this evaluation. Inclusion of these in future evaluations may provide valuable insights to program design and impact:

- Reasons for trainees and organisations choosing not to commence the pathway, as this cohort was not followed
- Long-term follow-up of trainees to better understand retention (both within the workplace and within rural and remote communities) as well as impacts on career pathways and advancement
- Evaluating the impact of rural generalist trainees and/or the service delivery projects from a consumer level. Assumptions have been made that the increased number of rural generalists and increased quality and capacity of the allied health workforce and service delivery will positively impact consumers. Further evaluation could include the community-level impact of service delivery projects.

9 Recommendations

Recommendations are listed here

1. Investment in allied health rural generalist training should be sustained and strengthened as a mechanism to improve the capacity, quality, distribution and mix of the allied health workforce in rural and remote areas.
2. Enhance the capability of private and non-government organisations to meet community needs by training allied health professionals as rural generalists, using targeted workplace training grants, incentive payments, and other measures that support building service capacity
3. Governments should consider how to best harness allied health rural generalist skills and competencies, so that government, industry and rural and remote communities can benefit from the enhanced skills and competencies of this workforce, to improve health outcomes for rural and remote Australia.
4. Explore opportunities to recognise and advance the career of the expert rural generalists through mechanisms such as incentive payments for service delivery to priority populations and establishing teaching and training opportunities in private and non-government settings to strengthen the rural workforce pipeline.
5. A long-term evaluation is recommended to follow up past participants to better understand the impact of TAHRGETS on retention, career development and advancement.
6. Funding mechanisms that support services delivered by allied health professionals in ACCHOs should be reviewed to enable the sustainable delivery of allied health services for First Nations people in rural and remote areas.
7. Program characteristic likely to promote success include flexibility in education program design (that includes modules to be undertaken over a longer time period, 'construct your own' and/or allowing for micro-credentialling); professional recognition and incentives to improve completion rates for trainees; and detailed selection and intake processes for organisations and trainees. These design elements should be incorporated into future implementations.
8. Future activities supporting the training of allied health rural generalists should be implemented over a minimum period of five years to accommodate the time taken to complete rural generalist training and ensure whole data sets are available to evaluate outcomes.
9. Action is required in the short term to ensure consistency in the implementation of allied health rural generalist training positions across multiple professions, and preserve and progress the growth and sustainability of a single AHRG Pathway. Specifically, these activities include (but are not limited to) a review of the Allied Health Rural Generalist Education Framework, overseeing university accreditation processes, and advancing formal professional recognition for allied health rural generalists. This work is within scope for the AHRG Accreditation Council and National Strategy Group, both of which will require support to continue performing these functions.
10. Identification of optimal funding sources is needed to ensure ongoing sustainable development of the AHRG workforce. This process should consider how supports for training positions are funded in private and non-government organisations, across jurisdictions, service settings, client populations, and community needs.

10 Conclusion

TAHRGETS is an innovative workforce development initiative. TAHRGETS integrates formal postgraduate education, with workplace supports and service development in a way that grows both the rural and remote allied health workforce and service delivery, tailored to local community needs.

The support provided through TARHGETS has benefited AHPs and their private practice and non-government workplaces in MMM3-7 regions across Australia. Training packages have enabled organisations to support AHPs to participate in rural generalist training at work, receive dedicated supervision, and participate in service development projects.

TAHRGETS has shown to be effective in improving capacity, quality, distribution and mix of the allied health workforce and expanding allied health service delivery. These improvements are mediated through a mix of impacts at both an individual (e.g. competence, confidence and skill development) and organisation (e.g. recruitment and retention, additional hours of service and service development project) levels.

At the completion of the program it is predicted that TAHRGETS will result in 37 Allied Health Rural Generalists (completion rate 60%). Further, this demonstrates an achievement of 60% against the goal of 60 positions for mainstream organisation and 3% of the goal of 30 positions for ACCHOs. The ability to achieve more rural generalist numbers within mainstream organisations was limited by time constraints, preventing reallocation of positions that were withdrawn. The limited participation from ACCHOs resulted in only two out of 30 Aboriginal training packages beginning the Pathway. SARRAH's 2023 engagement report highlighted that funding challenges, professional isolation, and variations in service delivery models were barriers to ACCHOs directly employing, on long-term contracts, their own teams of AHPs who would be available to participate. The report suggests a sustainable allied health workforce must be established in rural and remote ACCHOs before programs like the Pathway expand.

The withdrawal rate for TAHRGETS is approximately 40%, and is consistent with AHRG Pathway evaluations in other jurisdictions. TAHRGETS withdrawals must be considered with implementation contextual factors such as lack of formal recognition and incentives, as well as flexibility limitations of the program implementation. A large proportion of trainees who withdrew from the pathway left due to personal or employment related reasons rather than challenges with the Pathway and most reported they would recommend the Pathway to colleagues.

Whilst there is not yet a formal career advancement tied to the Pathway, early indicators for workforce and service outcomes are positive. Infrastructure such as the NSG and AHRG Accreditation council will be critical to advancing this outcome.

The support offered by TARHGETS assisted practices to increase service capacity and develop a rural generalist workforce. The financial support was valued, but it is important to note this did not cover the full costs for the organisation to implement training positions, with the shortfall being covered by the organisation. The long-term sustainability of this approach should be considered in future program design.

Other program design elements may impact the effectiveness of the program such as selection of trainees. Consideration should be given to trainees who are embedded in their rural community and demonstration passion for rural and remote health. Further, working in the private sector is demanding and the work is complex, consideration should be given to delaying commencement of the Pathway until after the first year of practice.

The DCE provided further insight into program characteristics that may be attractive to potential Pathway participants. Covering the costs of participation for trainees (i.e. covering the cost of the formal education fees), a hypothetical increase in salary on completion of the program, and

flexibility of the program (e.g. ‘construct your own’) were highly favoured attributes of program design.

Reflecting the workforce shortages in allied health across Australia more generally, a significant number of new positions for trainees were created by organisations but never filled as they could not recruit a suitable candidate for the position. Recruitment and retention of AHPs in rural and remote areas remains challenging due to ongoing shortages and there is much competition to attract AHPs between private, not-for-profit and public organisations. This has also been reflected in journey of trainees in the TAHRGETS programs. However, trainees who completed or are planning to complete rural generalist training, indicated a desire to continue working rurally for at least 2 years following completion. It is imperative that initiatives that support the retention of AHPs continue to be supported in order to improve access and quality of services for local communities.

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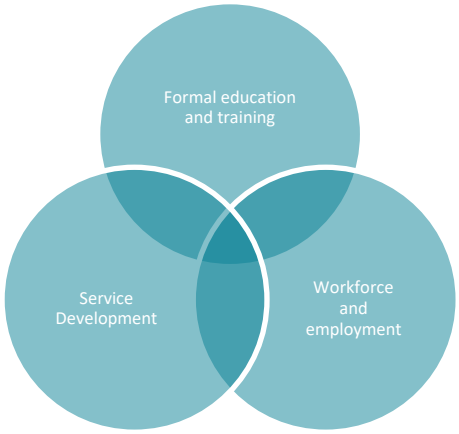
Appendix 1: TAHRGETS Program Guidelines

Overview

The Allied Health Rural Generalist (AHRG) Pathway aims to support the growth, sustainability and value of the rural and remote allied health workforce and the proliferation of rural generalist service models that deliver accessible, safe, effective and efficient services for rural and remote consumers.

The AHRG Pathway provides a framework for allied health service providers operating in rural settings to employ new graduates and early career allied health professionals, providing them with intensive support, formal training, and ensuring that safe and high-quality health care is provided to clients.

This workforce development initiative is structured around three key components:



- A formal education program that supports the development of the clinical and non-clinical rural generalist practice requirements of the relevant allied health profession.
- Workforce policy and employment structures that support the trainee to develop their skills and capabilities such as structured supervision.
- Rural generalist service models that support and engage allied health professionals to implement innovative and effective solutions to the challenges of delivering care across geographically dispersed and culturally diverse population

The AHRG pathway is available to the following professions:

Nutrition and Dietetics	Occupational Therapy,	Pharmacy,
Physiotherapy	Podiatry	Radiography,
Speech Pathology Exercise Physiology (Level 1)	Psychology	Social Work

The Allied Health Rural Generalist (AHRG) Pathway has shown success in the recruitment and retention of allied health practitioners within state health jurisdictions. The Allied Health Rural Generalist Workforce and Employment Scheme (AHRGWES) built on these learnings by expanding Pathway implementation into private and non-government sectors.

Funded by the Commonwealth Department of Health The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) will further expand AHRG Pathway implementation by supporting additional training positions for private and non-government organisations providing allied health services. This support will include education funds for trainees and workplace training grants for employers to support implementation.

TAHRGETS objective

TAHRGETS will providing funding and implementation support for primary care allied health providers to develop or redesign existing positions into designated early career rural generalist training positions. TAHRGETS will provide funding support packages for 90 new

AHRG Training Positions to be created in 2022 for an up to 3 year funding term, completing by June 2024.

Of these positions, 30 training positions will be dedicated to Aboriginal Community Controlled Health Organisations, or organisations providing allied health services to Aboriginal communities.

Applying for positions

Organisations wishing to apply for TAHRGETS must be able to demonstrate they meet the eligibility criteria.

Organisations will be able to apply for a maximum of four Level 1 and four Level 2 training position support packages.

Eligibility

To be eligible for TAHRGETS the organisation must:

1. Private or non-government organisation providing allied health services that are predominantly non-state-health based.
2. Be located within an Modified Monash Model area classified MMM 3-7, or
   - or be located within an MMM 2 and provide the majority of your services within MMM 3-7 regions
   - or be an organisation located elsewhere, where the employed trainee lives and works in a community in an MMM 3-7 area.
3. Be willing and able to meet the mandatory requirements (described below, and summarised in Appendix 1)
4. Agree to actively participate in reporting and evaluation processes.

To be eligible for TAHRGETS the trainee must

1. Have a qualification (and where appropriate be registered), in one of the nine eligible professions.
2. Be an Australian citizen or resident.
   - Certain temporary Visa holders will be considered on a case by case basis.

Mandatory requirements

Participation in the AHRG Pathway includes mandatory requirements to support the trainees work integrated development.

1. Education

The education component of AHRG Pathway is a two-level program, encompassing rural generalist practice development. James Cook University (JCU) are currently the only providers of this program.

Level 1 **James Cook University (JCU) Level 1 Rural Generalist Program**

The level 1 pathway is tailored to early career professionals and those new to rural and remote practice. Ideally the trainee will have completed their probationary period with the employer. Practitioners complete a program of 12 modules with each taking six weeks to complete.

Course: Rural Generalist Program (Allied Health)

Time allowed: 18 months.

Level 2 **James Cook University (JCU) Graduate Diploma of Rural Generalist Practice**

The level 2 pathway is targeted at professionals with 2 or more years of clinical experience. Over a period of 18 months to 2 years (part-time study load) practitioners complete a Graduate Diploma in Rural Generalist Practice comprising 8 units. The program supports progression from early career to proficient rural generalist practitioner.

Course: Graduate Diploma of Rural Generalist Practice

Time allowed: 24 months.

NB: The Level 2 education requirements for Medical Imaging are found in Appendix 2

2. Supervision

The trainee must be provided with structured supervision. For the Level 1 program this is expected to be a discipline specific supervision, for the Level 2 this supervisor can be from another discipline.

Additionally for ***medical imaging,*** the organisation must indicate they are able to meet the supervision and support requirements of the Medical Sonography qualification.

3. Service development project

The rural generalist trainee must **participate** in a service development project over the course of the program. The specific nature of the project will vary depending on the needs of the service and community. Common project themes are:

- Delegation and better use of support workers (assistants)
- Expanded scope, including skill sharing between the Allied Health professions.
- Service expansion using technology: including telehealth to deliver remote services
- Partnerships that bring care closer to home for rural and remote consumers

4. Allocated development time

A minimum of 0.1FTE (up to 0.2FTE) is allocated to enable the trainee to participate in the mandatory requirements. (*please note that this is what your employer implementation package in intended to support).

Time for study for the Level 1 would be mostly work integrated, however for the Level 2 there is an expectation of a personal time commitment to study.

5. Reporting

The organisation must provide quarterly reports to SARRAH as per template provided.

At project completion trainees and organisations must provide a short presentation on the process and outcomes of their service delivery project. This should be accompanied by a brief summary.

6. Evaluation

The participating organisations will contribute to, and support the trainee and other key stakeholders (e.g. co-workers, other managers, clients or local service providers) to participate in routine data collection activities that contribute towards the evaluation of TAHRGETS project, including but not limited to:

(a) Surveys and interviews to collect organisational, contextual and qualitative information and to plan appropriate data collection activities for the life of the project;

(b) data relating to service development projects

Data collection activities will be planned in collaboration with the participating organisation, an external evaluation and research team and supported by SARRAH project staff.

Funding and supports

Education Funds

SARRAH will contribute education funds to cover the cost of the formal education component of the pathway, paid directly to the education provider.

Level 1 pathway; up to $11,000 per participant

Level 2 pathway; up to $31,000 per participant

Workplace Training Grants

SARRAH will contribute workplace training grants paid to the organisation. The organisation can be flexible in using these funds which are intended as an in part compensation to cover backfill to support the rural generalist trainee to complete education, supervision and service development project components of the program. Payments are made prospectively on a quarterly basis.

Level 1 pathway; $21,500 per participant over 1 year

Level 2 pathway; $43,000 per participant over 2 years.

TAHRGETS participants will also have access to support through individual SARRAH memberships, access to education offerings and other resources

Summary of TAHRGETS program guidelines

	LEVEL 1	LEVEL 2
Eligibility – organisation		
Private or non government organisation (providing non-state-health funded services)	Essential	Essential
Location is in MMM 3-7[1]	Essential	Essential
Be willing and able to meet the mandatory requirements (see below)	Essential	Essential
Agree to participate in reporting and evaluation processes	Essential	Essential
Eligibility – trainee		
Professional qualification	Dietetics, Occupational Therapy, Medical Imaging, Pharmacy, Physiotherapy, Podiatry, Speech Pathology, Psychology, Social Work	Dietetics, Occupational Therapy, Medical Imaging[2], Pharmacy, Physiotherapy, Podiatry, Speech Pathology, Psychology, Social Work
Residency	Australian citizen or resident (temporary visa holders will be considered on case by case basis)	Australian citizen or resident (temporary visa holders will be considered on case by case basis)
Recommended years of experience	New graduate up to 2 years	2 years or more
Mandatory Requirements		
Support trainee to complete formal education	Course: Rural Generalist Program (Allied Health) Provider: JCU Time allowed: 18 months Mostly work integrated study	Course: Graduate Diploma of Rural Generalist Practice Provider: JCU Time allowed: 24 months Study commitment in personal time required (See Appendix 2 for Medical Imagers)
Provide structured supervision	Discipline specific	Discipline specific or multidisciplinary
Provide allocated development time[3]	Minimum 0.1 FTE (up to 0.2FTE)	Minimum 0.1 FTE (up to 0.2FTE)
Provide trainee with service development project and project support	Essential	Essential
Implementation package funding and support	Trainee education funds up to: $11, 000 Workplace training grants up to: $21,500 (over 1 year) Free SARRAH memberships Specific SARRAH education and resources Other support as identified	Trainee education funds up to: $31, 000 Workplace training grants: $43,000 (over 2 years) Free SARRAH memberships Specific SARRAH education and resources Other support as identified

Approved Level 2 Education program for Medical Imaging

- Any accredited, entry-level qualifying program in medical sonography (2 year part time) (https://www.asar.com.au/course-accreditation/asar-accredited-courses/)

  In addition, if not previously completed in the JCU Level 1 Rural Generalist Program:

- Any 3 of the following modules (*Source JCU Level 1 Rural Generalist Program - Rural Service Delivery Domain*):
  - MO1001 Project Management Skills
  - MO1002 Rural and Remote Community Context or MO1003 Aboriginal and Torres Strait Islander Community Context
  - MO1004 Rural and Remote Organisational Context
  - MO1005 Strategies for Rural and Remote Service Delivery
  - MO1006 Quality Improvement
  - MO1007 Project Evaluation and Translating Outcomes
- Module MO1016 Fast Focused Assessment with Sonography in Trauma (FAST) (*Source JCU Level 1 Rural Generalist Program – Clinical Skills Domain*)
- Module MO1027 Remote Medical Imaging. (*Source JCU Level 1 Rural Generalist Program – Clinical Skills Domain*)
- Module MO1025 Education and Training (*Source JCU Level 1 Rural Generalist Program – Service –specific clinical skills Domain*)
- For medical imaging education funds for the level 2 education contributed by SARRAH is also capped at $31,000. The proposed funding breakdown for medical imaging is:

Item	**Estimated c**	**SARRAH contribution**
6 Level 1 Modules (e 800 per module)	$ 5,500	Full
Medical Sonography	$ 9,000*	Full for Commonwealth Supported Places (CSPs) In the event that CSPs are not available will part contribute up to a total education fund of $28,000

*based on current costs of Commonwealth Supported Places at various universities

Appendix 2: TAHRGETS evaluation interview participants and demographics

Demographics of interview participants

Trainees

Most trainees were female (88%) and ranged in age from 23 years to 52 years (mean = 31 years). Just over one third of trainees (36%) were occupational therapists, 16% were physiotherapists and 16% were dietitians. Approximately four fifths of trainees (79.2%) described themselves as having a rural or regional background with just under three-quarters (71.4%) spending 11 or more years living regionally or rurally prior to commencing university. Just over two thirds of trainees (68%) had undertaken a clinical placement in a regional, rural or remote area. The length of clinical placements varied with placements ranging from 2 weeks to 20 weeks with an average duration of 10 weeks.

Withdrawn Trainees

All seven trainees interviewed who had withdrawn from the Pathway were women with an average age of 28. Five of the trainees were occupational therapists and two were dietitians. Six of the seven withdrawn trainees described themselves as having a rural or regional background prior to commencing allied health training and had spent more than 11 years living in a rural or regional area before commencing university. Six trainees had undertaken a rural clinical placement during their allied health studies. The duration of the placements ranged from 15 weeks to 26 weeks with an average duration of 20 weeks.

Table 1 Demographics of interview participants: Trainees and withdrawn trainees

	Trainees	Withdrawn trainees
Gender, *n (%)*		
Male	3 (12)	-
Female	22 (88)	7 (100)
Age (years)		
Range	24-52	22-42
Mean	32.2	28.6
Profession, *n (%)*		
Dietitian	4 (16)	-
Occupational Therapist	9 (36)	5 (71.4)
Pharmacist	3 (12)	2 (28.6)
Physiotherapist	4 (16)	-
Podiatrist	2(8)	-
Speech Pathologist	3 (12)	-
Rural Background, *n (%)*		
Yes	19 (79.2)	6 (85.7)
No	5 (20.8)	1 (14.3)
Years living rurally prior to Uni, *n (%)*		
<1 year	4 (19)	
1-2 years	1 (4.8)	
7-8 years	1 (4.8)	
11+ years	15 (71.4)	6 (100)
Clinical Placement, *n (%)*		
Yes	17 (68)	6 (85.7)
No	8 (32)	1 (14.3)
Average weeks (mean)	9.8	20.4

Managers/Supervisors

The managers and supervisors who were interviewed came from a variety of allied health professions with most (29.4%, n=5) physiotherapists. A large majority (88.2%, n=15) had worked more than 6 years in a rural or remote area. All managers and supervisors had managed or

supervised AHPs prior to managing/supervising a TAHRGETS/AHRGWES trainee. Nearly all the managers/supervisors (94.1%, n=16) had managed or supervised more than four AHPs prior to the Pathway. Approximately three fifths of supervisors/managers (62.5%) were supervising/managing one TAHRGETS trainee with just under a fifth (18.8%, n=3) managing three trainees.

Managers/Supervisors of withdrawn trainees

Two out of the four managers/supervisors were occupational therapists, one was a pharmacist, and one was a dietitian. Their employing organisation provided services across multiple sectors including the disability sector (n=3), community health sector (n=2), aged care sector (n=2), and private practice sector (n=2). Three of the managers/supervisors had been practicing for more than five years, and three had prior experience of supervising an AHRG trainee.

Table 5 Demographics of interview participants: Managers and Supervisors

	Managers/Supervisors *n, (%)*	Managers/supervisors of withdrawn trainees *n (%)*
Profession		
Dietitian	3 (17.6)	1
Occupational Therapist	3 (17.6)	2
Pharmacist	1 (5.9)	1
Physiotherapist	5 (29.4)	-
Podiatrist	1 (5.9)	-
Speech Pathologist	3 (17.6)	-
Psychologist	1 (5.9)	-
Years working in a rural area		
2 years	1 (5.9)	1 (25)
5 years	1 (5.9)	-
6+ years	15 (88.2)	3 (75)
Number of AHPs previously managed/supervised		
3	1 (5.9)	-
More than 4	16 (94.1)	-
Number of trainees managed/supervised		
1	10 (62.5)	2 (50)
2	1 (6.3)	-
3	3 (18.8)	1 (25)
4	1 (6.3)	1 (25)
More than 4	1 (6.3)	-

Appendix 3: Case studies

Case study 1: Trainee

Lucy comes from a rural/remote background and undertook a rural clinical placement for five weeks as part of her degree, which she completed in 2012. Lucy is a self-employed physiotherapist working in a private practice in a rural setting in Western Australia. She chose to undertake the Pathway to upskill in rural generalist and physiotherapy and believes the Pathway has improved her clinical skills.

Her service development project involved providing a hip and knee osteoarthritis exercise program in the community which has continued. Lucy's physiotherapist knowledge improved, and she developed professional networks through the University course, which she would not have achieved without the funding allowing her to study in work time:

> *'I have a better understanding of other roles in multi-disciplinary teams in rural health and improved my science base and critical thinking about evidence-based practice and best practice'.*

Lucy believes the training is important and provides useful content, but without employer and financial support, the training would be less attractive to trainees and employers and very difficult to complete. She suggests increased flexible training options could potentially entice more professionals to work rurally. Lucy is planning to continue to work rurally as she lives locally and runs her own business.

Case study 2: Trainee

Rebecca has a rural/remote background. She completed her degree in podiatry in 2013 which involved two rural clinical placements. Since completing her degree, Rebecca has worked as a podiatrist in rural and remote communities.

Rebecca undertook her training in the Northern territory in an ACCHO. She chose to complete the training as it offered her a Pathway to further her career. Rebecca enjoyed getting more involved with SARRAH and being provided with time to do the training which helped her implement a project within the community that otherwise wouldn't have been implemented. However, she would have liked more flexibility for the course as she found it challenging if she was away to complete the recommended work. Rebecca didn't access the SARRAH networking opportunities for trainees as she was part of other podiatry networks.

Rebecca's competency and confidence has grown because of the Pathway:

> *'It gave me more confidence and a few more years in a rural setting working in a multi-disciplinary team, learning more about those specialised areas. Practice makes perfect – it gives me more confidence being in this space'.*

Rebecca believes the training has helped her to develop an allied health career:

> *'To grow and develop at Congress, you needed to have further education/training. I couldn't be a Grade 4 position without the training, so this offered a career pathway.'*

Rebecca will continue to work at the same organisation part-time as she enjoys working in the small community and likes the lifestyle it provides.

Case study 3: Trainee

Katie finished her allied health degree in 2020 and is now working full-time as a pharmacist. Katie does not have a rural or remote background but undertook two placements in rural areas. She chose to undertake the Pathway to understand more about public health and prevention in rural and remote areas.

Katie's service development plan involved providing a COPD screening and smoking cessation service to local patients free of charge:

> *'The bulk of pharmacy services work, cholesterol screening, blood sugar screening, all that, you charge the patient a fee. Yeah. I didn't charge the patients a fee here, and we still make money. So that's actually quite innovative and different.'*

Katie believes her expectations of the Pathway were met and thinks her confidence, competence and clinical skills were improved by completing the Pathway. The main benefits she experienced were learning to be adaptable and thinking outside the box, developing project management skills to help her envision other projects, and understanding research to facilitate innovation. Katie would recommend the Pathway to other AHPs. Katie plans to move states but wants to continue to work rurally:

> *'You have more capability to change people's lives in a rural area than you do in the city where you're a dispensing robot and nothing else and I hate the idea of being a dispensing robot.'*

Case study 5: Withdrawn trainee

Sarah is a dietician and chose to undertake the Pathway in a private sector in Queensland straight after university to further her studies and to gain experience in a rural and remote area. Sarah was keen to develop a project and to put her new skills in to practice in the private sector. She found that the extra time connecting with clients within the community helped her to gain a better understanding of her client's issues that she would not have necessarily developed in a standard appointment time.

Unfortunately, Sarah didn't take advantage of the SARRAH networking opportunities offered for trainees as she was busy with her full workload. Sarah changed her employer during the Pathway and would have liked to continue the training but unfortunately, this was not an option due to the work not aligning with her new position in a public hospital:

> *'I withdrew because I left my old job. My employer tried to see if there was a way to continue, but we just couldn't figure out a way to make it feasible with the type of assignments that I was doing in the course, they required a lot of client involvement, so wasn't really able to keep going. So, we did try.'*

Sarah is no longer working in a rural or remote area but would consider this option in the future and she is also open to undertaking other university courses.

Case study 4: Trainee

Jasmine is a full-time speech pathologist who graduated in 2017. Jasmine does not have a rural or remote background and due to the research component of her degree she was unable to complete a rural/remote placement as part of her studies. Jasmine had no prior experience of working rurally but after she graduated, she chose to work rurally as there were more job opportunities than in the city.

Jasmine thinks the Pathway helped her to diversify her skills, participate in leadership opportunities and develop her project development skills. She also believes her competence and confidence improved because of the Pathway:

> *'I feel like I'm quite confident and can throw myself in but I'm aware that as a rural generalist you're working across the scope of practice, and you can always learn something else. I think my competence changed through exposure to different learning opportunities and having the time to apply those skills. Some of which was achieved through my projects and some through the coursework.'*

Jasmine completed a service development project that involved the implementation of a whole class oral language program to support the four pillars of oral language. The service would not have taken place without the service development project as no funding model exists to support NDIS providers to deliver this type of service:

> *'My favourite part was being able to provide a service in a MM6 area that otherwise would not have been provided.'*

The school involved in the project purchased the program and the teachers and education assistants are now delivering the program with remote support by Jasmine:

> *'I'm providing remote support for them to continue the program this year…but I wish could still sort of provide that support at the classroom level…I just feel that the process would be better if we were still able to be involved as closely as we were last year.'*

Jasmine was happy with the support from SARRAH:

> *'SARRAH was really helpful as a bridge between the TARGHETS person like me and the university, SARRAH was really helpful in that communication and organising the scholarship funding and everything so that I could continue with the units and also supporting me when I had to do like I had to withdraw from the unit and go back and do it…the pastoral care element.'*

She is intending to continue to work in rural and remote areas as she is passionate about equitable access to healthcare and feels it suits her values. Jasmine is also starting a PhD and thinks the program helped her secure the placement:

> *'Through the TAHRGETS program and completing the graduate diploma, that was also helpful in me securing my placement for our PhD, which I'm commencing so, yeah, I've got a scholarship to complete my PhD now. So I felt like that me showing initiative and completing a graduate diploma and study was, was, you know, really attractive…I wanted to continue my education in rural and remote health through a PhD.'*

Case study 6: Manager

Sasha is a HR manager who has previous experience of managing AHPs. Sasha managed an occupational therapist completing Level 2 of the Pathway in a private regional practice in Queensland. She noticed the training made the trainee more confident and articulate, and that it helped her to develop her skillset in a broader setting:

> *'I feel like because they started to believe in themselves, they became much more articulate in terms of the type of caseload they wanted to be involved in and the areas of passion they had in terms of what was of interest to them. And I would say their level of analysis improved, like as opposed to A plus B equals C, just some broader understanding that life's a little bit more complex than that'.*

Sasha believes the Pathway had a positive impact on the organisation:

> *'I found it a fantastic course to bridge that gap between the knowledge of the solo practitioner and their health degree and as a private practice how invaluable it was to have that rural generalist approach not only because it's in our value set of who we are as an organisation, but secondly helping to build skills within our team for somebody who understands the dynamic of the other business components.'*

For the service development project, the trainee developed a new system for triage and waitlists due to heavy referrals at the practice, and this system is still in place.

Sasha ensured the trainee had a structured week by allocating appropriate time for study and supervision. She thinks the trainee liked the Pathway as it led to a recognised qualification as well as building upon her confidence and competency. Sasha believes the rural generalist program is great but thinks improvements could be made in refining some of the units.

Sasha thinks the ideal stage for an AHP to undertake the Pathway is a minimum of 18 months after graduation:

> 'I would think they would at a minimum have to be 18 months post new grad. I think any earlier than that and they're already too flustered with the dynamics of being an employee. So I think an exceptionally competent new grad might be able to transition into that space at that 18-month mark, but I would say for most people it's probably the 2-year mark where they would be starting to think that. For some clinicians it might even be later because of the importance of the topic matter.'

Sasha liked the structured Pathway, and the broader meetings organised by SARRAH as it was beneficial to hear from other people's experience but sometimes found them challenging due to the differences between the structure of the training across states and therefore found some more relevant than others. She did not participate in the SARRAH online education offerings. She thinks a 1-1 follow-up from SARRAH for managers and supervisors during the Pathway would be of value.

Case study 7: Supervisor

Cheryl is a speech pathologist who has been working in a rural/remote area for over 6 years and has experience of supervising several speech pathologists prior to supervising a TAHRGETS trainee.

Cheryl supervised a Speech Pathologist completing the Level 2 qualification in a non-profit organisation in New South Wales.

Cheryl believes the trainee increased her knowledge and experience, gained a better understanding of rural practice and engaged with stakeholders that she wouldn't have necessarily had contact with.

Cheryl provided support by helping the trainee to manage her study days (one day per fortnight) and provided flexibility for the study time, for example if she had a project deadline. However, she felt the course demands were high for the allocated time, and on occasion thought the trainee was overwhelmed by the amount of work, often having to study during evenings and weekends:

> *'It is a really good program, it's good to have the opportunity to further people's studies …if there was a bit of an estimated hours per week…so that people know at the start what sort of commitment they are looking at, it would probably help workplaces and prospective students.'*

Cheryl did not find her workload was significantly impacted by supervising the trainee as she integrated the extra support into the monthly professional supervision sessions. She particularly enjoyed the clinical discussions:

> *'I enjoyed having those clinical discussions with her about the course content and, and the project and trying to support her and I guess trying to help, brainstorm ideas, work together to, to help Emily complete the project and things.'*

Cheryl suggested the Pathway would be ideal for trainees two to four years after graduation whilst university is still fresh in their minds, but not for new graduates as it could be overwhelming. She thinks the Pathway could be improved by providing more specific clinical topics rather than general topics to align more with the trainee's interests. Cheryl took advantage of the SARRAH online education offerings for supervisors but felt there should be more information and opportunities at the start of the project:

> *'The content was interesting, relevant to my practice and high quality…but maybe more information and opportunity to have sort of, you know, small group or one on one conversations at the beginning of the program to let me know the structure and how it all works and what's my job as a supervisor?'*

Cheryl thinks the Pathway is extremely valuable for trainees:

> *'I'm hopeful that she [trainee] feels the sense of achievement and can reflect on all of the great knowledge that she's got from the course…the subjects and the course content that I know she worked on will definitely set her up for career progression.'*

Appendix 4: Allied health survey

Participants

A total of 115 participants completed the online survey. Seventy-nine AHPs, and 36 managers and supervisors of AHPs.

Allied health Professionals

Background

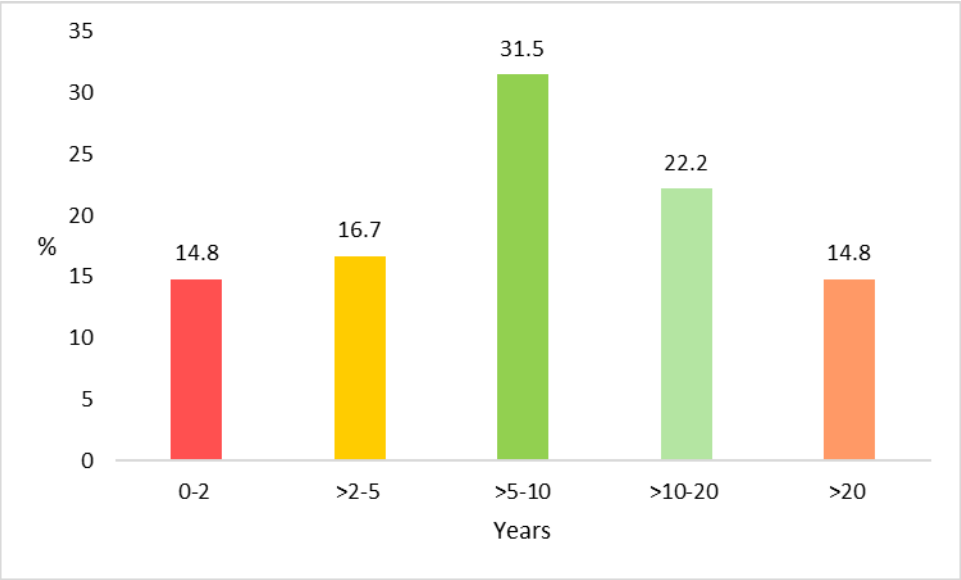
A large majority of AHPs (89.1%, n=49) were female. Most AHPs were aged between 21-30 (43.6%, n=24) or 31-40 (32.7%, n=18). A large majority of AHPs (81.5%, n=44) were born in Australia. Approximately half (51.9%, n=28) were married or in a domestic relationship and just under a quarter (24.1%, n=13) were single. Two-fifths (42.6%, n=23) of AHPs had caring responsibilities. The median household income was $125,000 to $149,999 per year.

Table 1 Online survey participant demographics: AHPs

Participant characteristics	*n (%)*
Gender	
Male	6 (10.9)
Female	49 (89.1)
Age	
21-30	24 (43.6)
31-40	18 (32.7)
41-50	4 (7.3)
51-60	6 (10.9)
61-65	3 (5.5)
Marital status	
Single	13 (24.1)
In a relationship	10 (18.5)
Married/domestic partnership	28 (51.9)
Divorced/separated	1 (1.9)
Prefer not to say	2 (3.7)
Born in Australia	
Yes	44 (81.5)
No	10 (18.5)

A third (31.5% n=17) of AHPs had graduated between 5-10 years ago and just over one fifth (22.2%, n=12) had graduated between 10-20 years ago. Nearly three-fifths of AHPs (57.4%, n=31) had lived in a rural or remote area before they were 18 years old. The average number of years living in a rural or remote area was 14 years. Three quarters of AHPs (75.9%, n=41) had undertaken a rural or remote placement as a student, with an average of 1.5 placements.

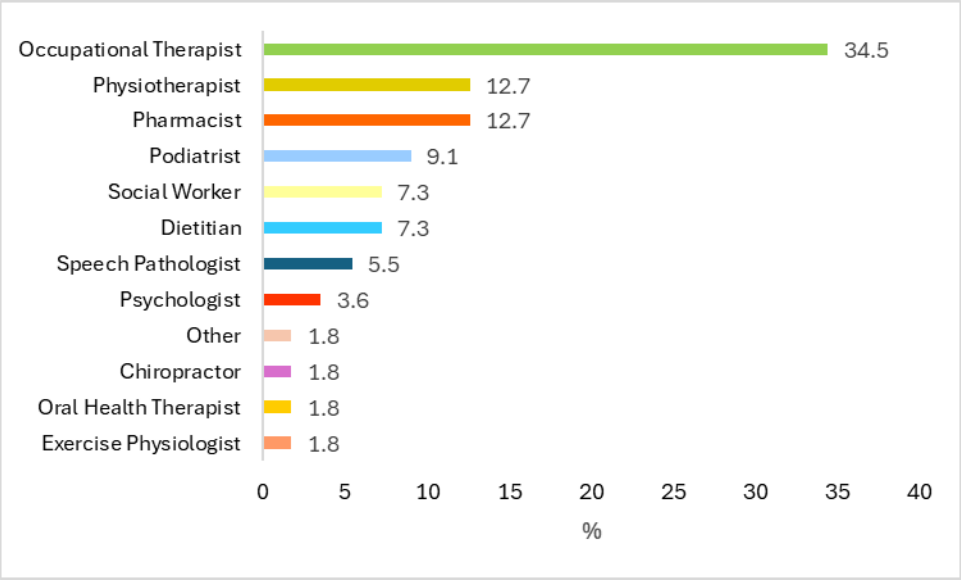
Figure 1 Years since graduation as an AHP



Employment

Over a third of AHPs were occupational therapists (34.5%, n=19), 12.7% (n=7) were pharmacists and 12.7% (n=7) were physiotherapists. Just over half of AHPs (53.3%, n=32) were working full-time, a third (33.3%, n=20) were working part-time and 10% (n=6) were students. More than half (63%, n=34) were currently working in a rural or remote setting and one fifth (20.4%, n=11) had previously worked in a rural or remote setting. AHPs worked in a variety of settings with the most popular settings being small multiple purpose community health facilities (21.5%, n=17), private practice clinics (17.7%, n=14) and large tertiary hospitals (16.5%, n=13). Most AHPs clients were funded by the public Health System, aged care and the NDIS.

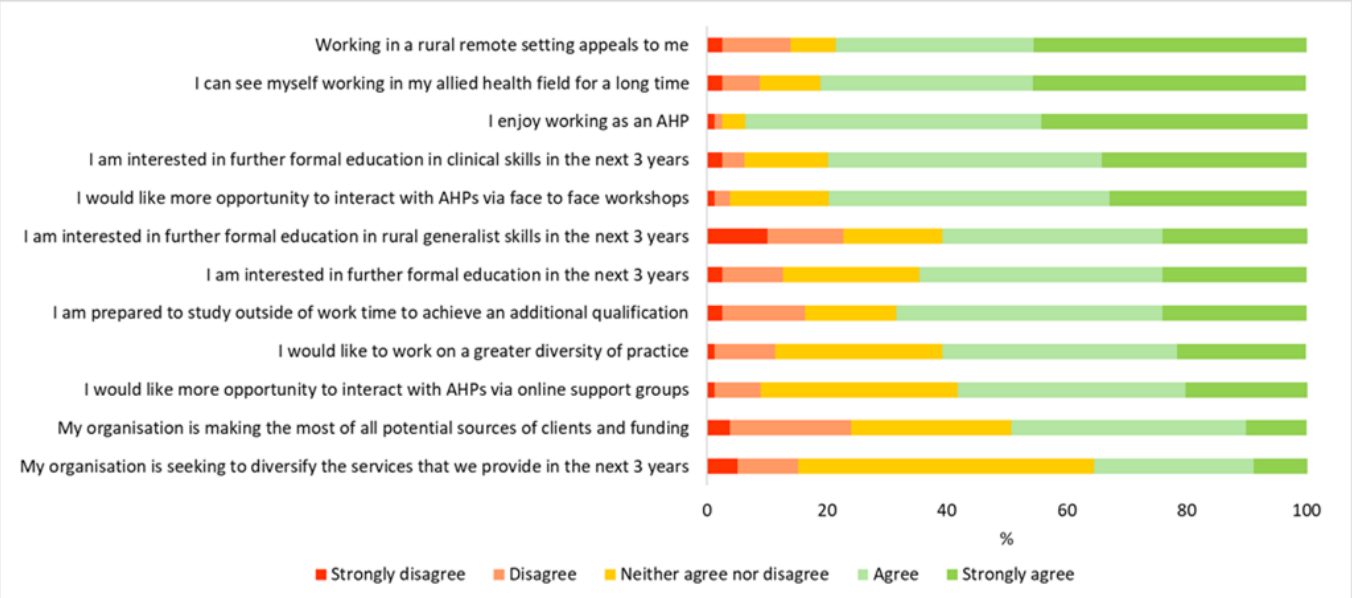
Figure 2 AHP qualification



Attitudes to working as an allied health professional

AHPs were asked about their attitudes to working as an AHP and their attitudes to undertaking further formal education and training. Just over three quarters of AHPs (78.5%, n=62) agreed that working in a rural or remote setting appeals to them and a large majority (93.7%, n=74) agreed that they enjoy working as an AHP. Three-fifths (60.8%, n=48) agreed that they would like to work on a greater diversity of practice and four-fifths (81%, n=64) could see themselves working in the allied health field for a long time. More than half (58.2%, n=46) of AHPs would like more opportunities to interact with other AHPs via online support groups and 79.7% (n=63) would like more opportunities to interact with AHPs via face-to-face workshops and meet ups. Half of AHPs (49.4% n=39,) agreed they were making the most of all potential sources of clients and funding at their current employment. 68.4% (n=54) of AHPs agreed that they would be prepared to study outside of work time to achieve an additional qualification and over three-fifths (64.6%, n=51) agreed that they would be interested in undertaking formal education or training in the next 3 years. A further 79.7% (n=63 agreed they would undertake further formal education or training in clinical skills in the next 3 years and three-fifths (60.8%, n=48) agreed they would be prepared to undertake further education or training in rural generalist skills in the next 3 years. Half of AHPs (49.4%, n=28) were unsure whether the service they work for was seeking to diversify the services they provide in the next 3 years.

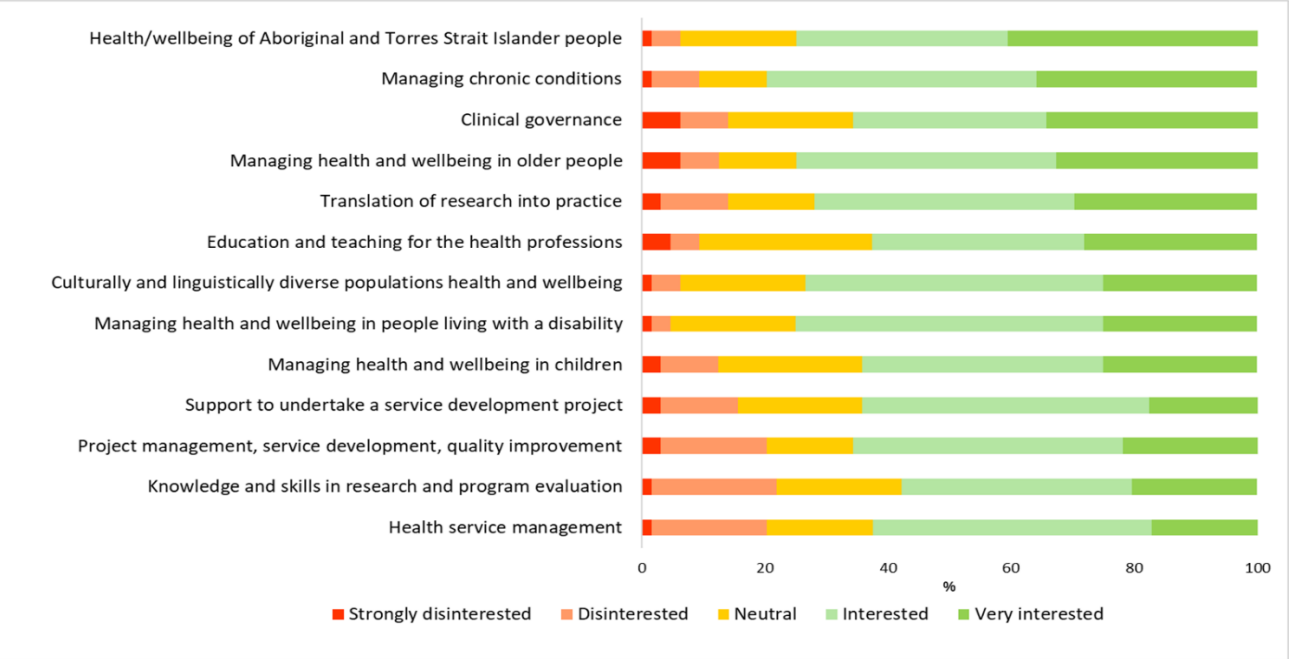
Figure 3 Attitudes to working as an AHP



Topics of formal study or professional development

The courses that AHPs said they would be most interested ('interested' or 'very interested') in were managing chronic conditions (79.7%, n=51), managing health and wellbeing in older people (75%, n=48), managing health and wellbeing of people living with a disability (75%, n=48) and supporting the health and wellbeing of Aboriginal and Torres Strait Islander people (75%, n=48). The courses that AHPs were least interested ('strongly disinterested' or 'disinterested') in were knowledge and skills in research and program evaluation (21.9%, n=14), health service management (20.4%, n=13) and project management skills, service development and quality improvement (20.3%, n=13).

Figure 4 Topics of formal study or professional development



Managers and supervisors

Background

A large majority of managers and supervisors (88.5%, n=23) were female, and most were aged between 31-40 (38.5%, n=10) or 41-50 (38.5%, n=10). Most of the managers and supervisors (96.2%, n=25) were born in Australia and approximately three-fifths (61.5%, n=16) were married or in a domestic relationship. Just over half of managers and supervisors (53.8%, n=14) had caring responsibilities. The median household income was $125,000 to $149,999 per year.

Table 2 Online survey participant demographics: Managers and supervisors

Participant characteristics	*n (%)*
Gender	
Male	3 (11.5)
Female	23 (88.5)
Age	
21-30	3 (11.5)
31-40	10 (38.5)
41-50	10 (38.5)
51-60	3 (11.5)
Marital status	
Single	5 (19.2)
In a relationship	1 (3.8)
Married/domestic partnership	16 (61.5)
Divorced/separated	3 (11.5)
Prefer not to say	1 (3.8)
Born in Australia	
Yes	25 (96.2)
No	1 (3.8)

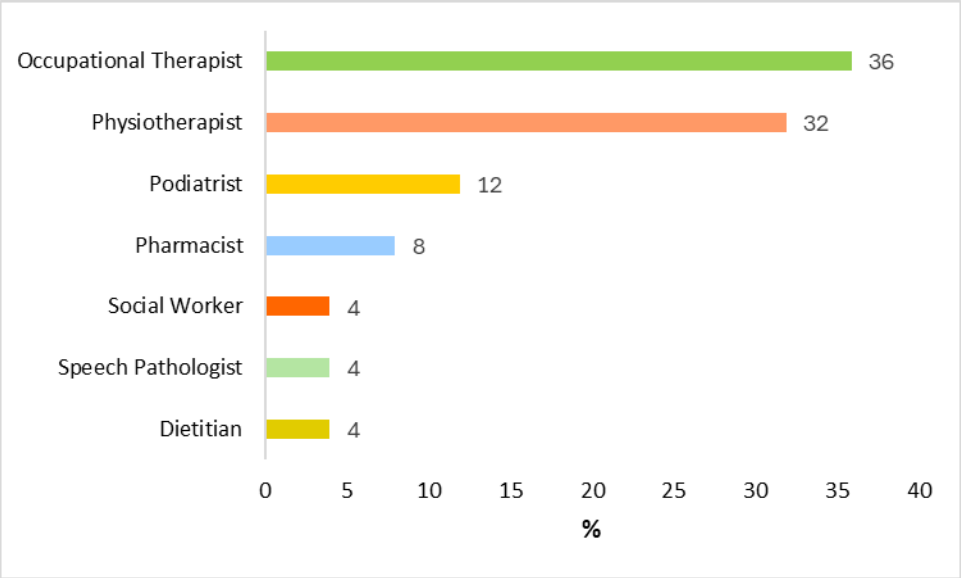
The majority (73.1%, n=19) of managers and supervisors had graduated at least ten years ago. Just under half of the managers and supervisors (46.2%, n=12) had lived in a rural or remote area before they were 18 years old. The average number of years living in a rural or remote area was 17.3 years.

Four-fifths of managers and supervisors (80.8%, n=21) had undertaken a rural or remote placement as a student, with an average of 1.7 placements.

Employment

Over a third of managers and supervisors (34.6%, n=9) were occupational therapists and just under a third (30.8% n=8,) were physiotherapists. Just under three quarters of managers and supervisors (72.4%, n=21) were working full-time. More than half (57.7%, n=15) were currently working in a rural or remote setting and one fifth (26.9%, n=7) had previously worked in a rural or remote setting. Managers and supervisors worked in a variety of settings with the most popular settings being private practice clinics (40%, n=12) and small multiple purpose community health facilities (23.3%, n=7). Most of their clients were funded by the public health system, NDIS and self-funded.

Figure 5 Managers and supervisors AHP qualification

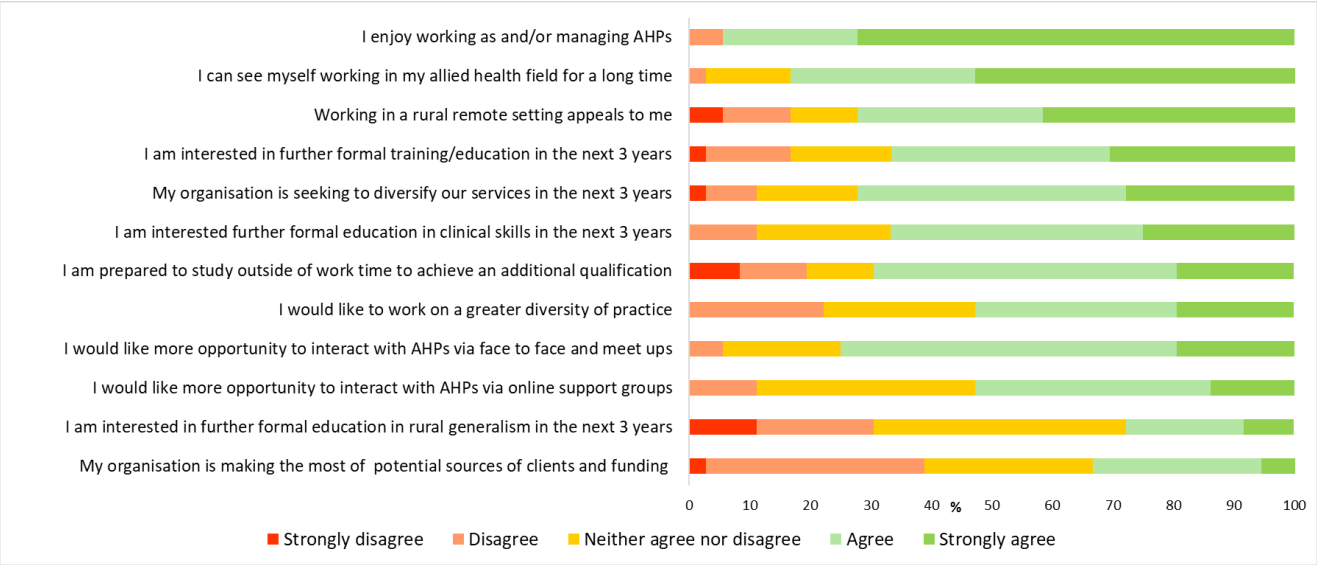


Attitudes to working as an allied health professional

Managers and supervisors were asked about their attitudes to working as and AHP and their attitudes to undertaking further formal education and training. Just under three quarters of managers and supervisors (72.2%, n=26) agreed that working in a rural or remote setting appeals to them and a large majority (94.4%, n=34) agreed that they enjoy working as an AHP. Just over half (52.8%, n=19) agreed that they would like to work on a greater diversity of practice and just over four-fifths (83.3%, n=30) could see themselves working in the allied health field for a long time. More than half (52.8%, n=19) of managers and supervisors would like more opportunities to interact with other AHPs via online support groups and three quarters (75%, n=27) would like more opportunities to interact with AHPs via face-to-face workshops and meet ups. One third (33.3%, n=12) agreed they were making the most of all potential sources of clients and funding at their current employment.

69.4% (n=25) of managers and supervisors agreed that they would be prepared to study outside of work time to achieve an additional qualification and two-thirds (66.7%, n=24) agreed that they would be interested in undertaking formal education or training in the next 3 years. A further 66.7% (n=24) agreed they would undertake further formal education or training in clinical skills in the next 3 years. Only 27.8% (n=10) agreed they would be prepared to undertake further education or training in rural generalist skills in the next 3 years. Nearly three-quarters of managers and supervisors (72.2%, n=26) were unsure whether the service they work for was seeking to diversify the services they provide in the next 3 years.

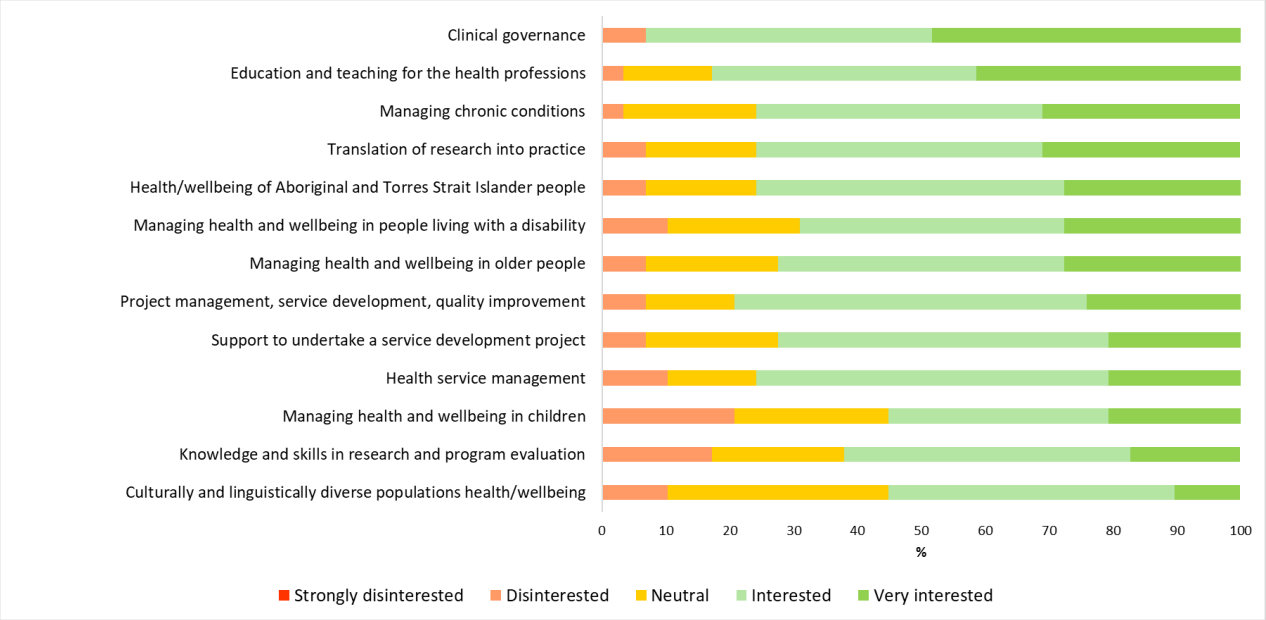
Figure 6 Attitudes to working as an AHP



Topics of formal study or professional development

The courses that managers and supervisors said they would be most interested in were clinical governance (93.1%, n=27), education and teaching for the health professions (82.8%, n=24), and project management skills, service development and quality improvement (79.3%, n=23). The courses they were most disinterested in were managing health and wellbeing in children (20.7%, n=6) and knowledge and skills in research and program evaluation (17.2%, n=5).

Figure 7 Topics of formal study or professional development

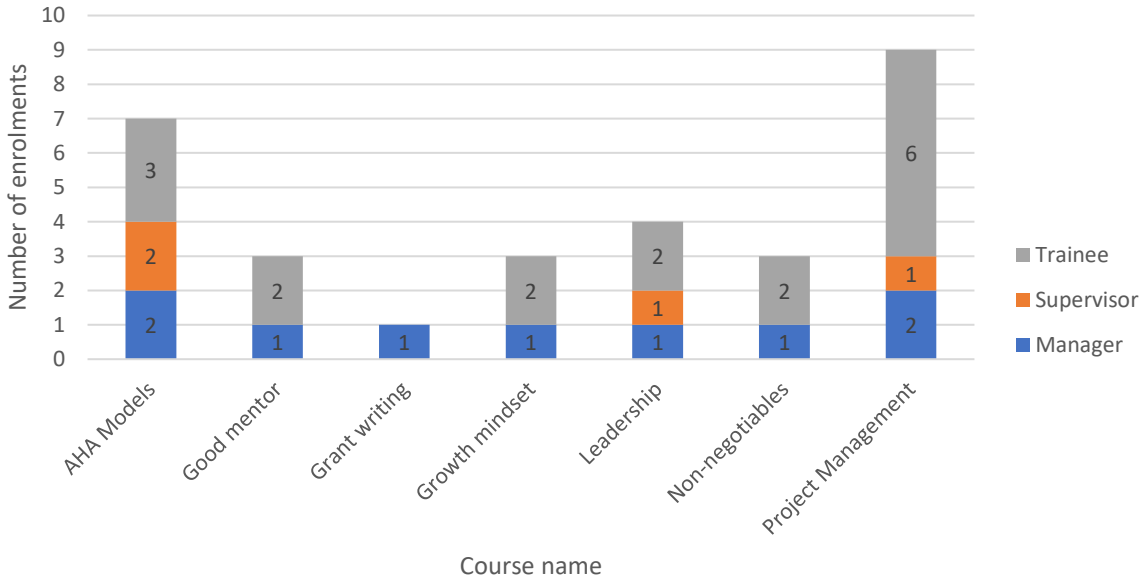


Appendix 5: Capacity building enrolment and trends over time.

2022

In the year 2022, there were 30 enrolments across seven courses, with 17 enrolments by Trainees, 9 by Managers, and 4 by Supervisors. Project Management had the highest participation with 9 enrolments (6 Trainees, 2 Managers, and 1 Supervisor). AHA Models followed with 7 enrolments (3 Trainees, 2 Managers, and 2 Supervisors). Courses like Good Mentor, Growth Mindset, and Non-negotiables each had 3 enrolments, primarily driven by Trainees and Managers. Leadership had 4 enrolments (2 Trainees, 1 Manager, and 1 Supervisor), while Grant Writing had minimal participation with only 1 enrolment (Manager). Overall, Trainees had the highest participation, while Managers and Supervisors participated selectively in key courses like Project Management and AHA Models.

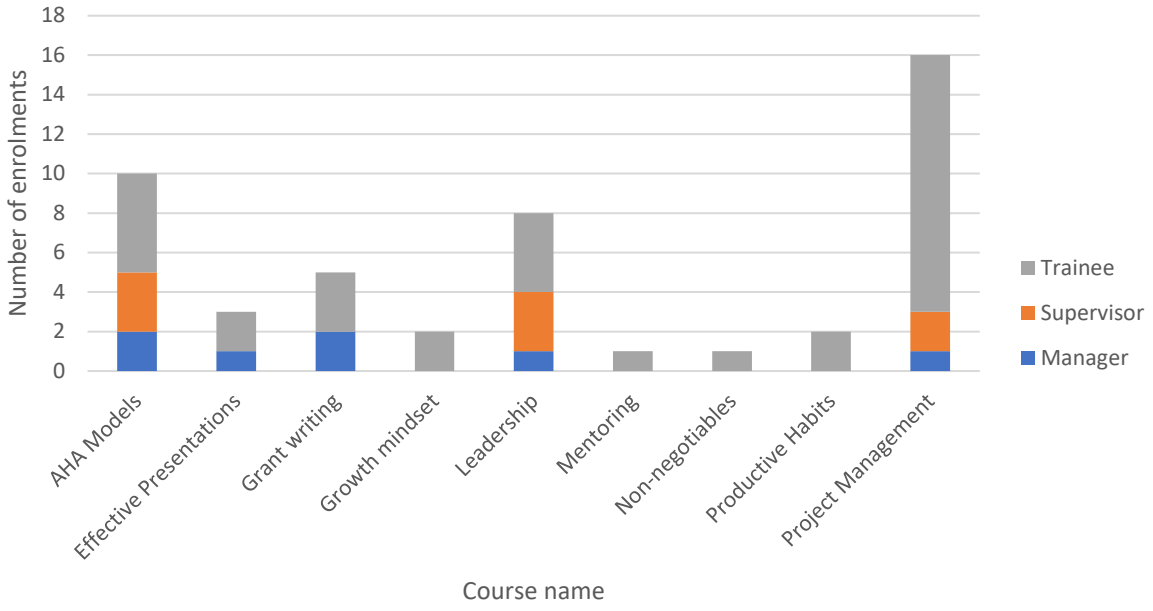
Figure 1 capacity building enrolments in 2022



2023

In the year 2023, a total of 48 enrolments across nine courses were noted, with 33 enrolments by Trainees, 8 by Supervisors, and 7 by Managers. Again, Project Management had the highest participation with 16 enrolments (13 Trainees, 2 Supervisors, and 1 Manager), followed by AHA Models with 10 enrolments (5 Trainees, 3 Supervisors, and 2 Managers). Leadership also had a notable participation with 8 enrolments (4 Trainees, 3 Supervisors, and 1 Manager). Courses like Grant Writing and Effective Presentations had moderate participation with 5 and 3 enrolments, respectively, primarily driven by Trainees. Courses such as Mentoring, Non-negotiables, Growth Mindset, and Productive Habits had minimal participation, with each seeing only 1-2 enrolments, primarily from Trainees.

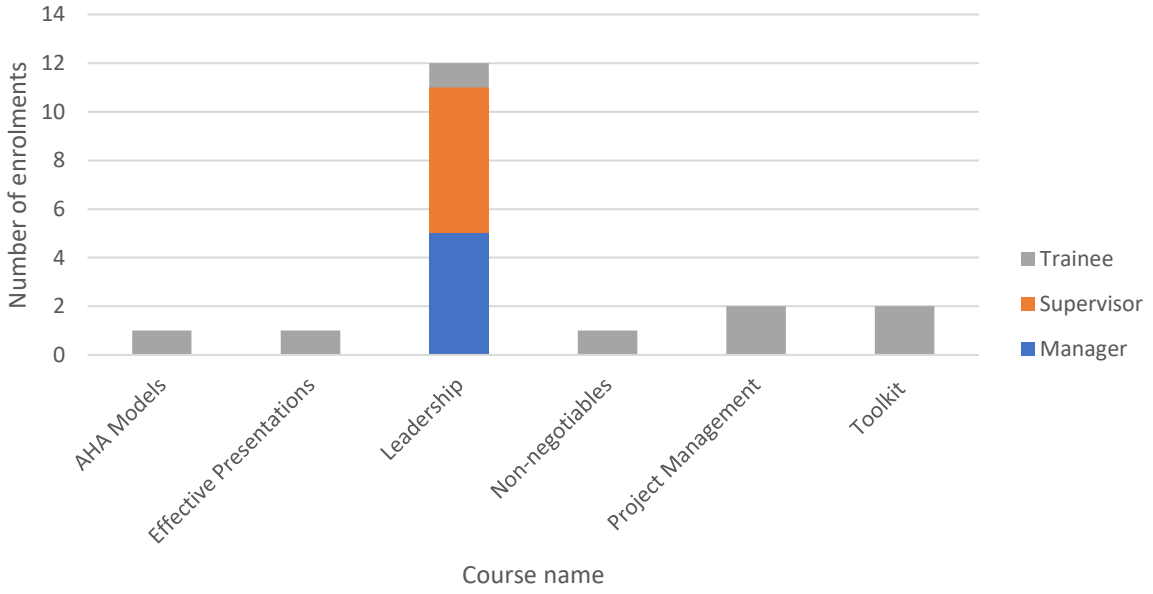
Figure 6 capacity building enrolments in 2023



2024

In contrast to the previous years, there were a total of only 19 enrolments across six courses in 2024, with 8 enrolments by Trainees, 6 by Supervisors, and 5 by Managers. Leadership had the highest participation with 12 enrolments (5 Managers, 6 Supervisors, and 1 Trainee). Project Management and Toolkit each had 2 enrolments, exclusively by Trainees. Courses such as AHA Models, Effective Presentations, and Non-negotiables had minimal participation with only 1 enrolment each, all by Trainees. Overall, Supervisors and Managers focused primarily on Leadership, while Trainees participated across all courses with lower overall enrolment numbers.

Figure 7 capacity building enrolments in 2024



Appendix 6: Service development projects

Name of project	Project details	No. of students
Development of a Resource Bank for Home Practice	***Description*** The development of a series of brief, informative videos aimed at parents and caregivers to support them to develop their understanding of allied health roles and basic therapy strategies. This will increase community education and assist parents to be more effective agents of therapy during home practice sessions. ***Aim*** By focusing on development of high-quality, accessible resources for consumers the aim is to increase their education and therefore improve their engagement with therapists, as well as therapy outcomes for the children engaged in therapy. ***Outcome*** Resources developed to be used in practice.	3
Early Intervention Consultation Model of Practice in a Rural Area – A Pilot Project	***Description*** To explore an alternative early intervention consultation model for private clients in a rural area. The model aims to provide children and their families with time limited but timely engagement with an occupational therapist, and who would otherwise be subject to long waiting lists due to services being filled with an overwhelming number of NDIS ongoing therapy clients. ***Aim*** To increase education, improvement engagement and interaction with therapists and increase follow through of strategies and recommendations at home. ***Outcome*** Informed new service delivery method.	1
Better Knees	***Description*** 8-week program (physiotherapy session via telehealth and education session via email) delivery for patients with diagnosis of knee osteoarthritis. ***Aim*** Improve patient pain coping skills, decrease levels of pain, elude unnecessary medical imaging, defer, or eliminate the need for surgical intervention, improved quality of life scores and improvement of other existing co-morbidities achieved through weight-loss and exercise. ***Outcome*** 8-week program.	1
AHP Delegation Project	***Description*** The project will explore and negotiate what is to go into the training package for AHPs. ***Aim*** To share information and empower staff while empowering the community and building sustainability through use of a delegation model and implemented training package. ***Outcome*** Developed a training package (policies and procedures) to improve accessibility to allied health.	1
Accredited high risk foot clinic	***Description*** Multidisciplinary clinic, for active wound clients, able to escalate for hospital admission, vascular or surgical intervention “one stop shop” style approach. Diabetes management with diabetes nurse educators, referral pathways to other clinicians (dieticians, endocrinologist, surgeons etc).	1

	Aim Increase access to diabetes nurse educators, improve diabetes control and improve wound healing. Strengthen referral pathways to local hospital. ***Outcome*** Multidisciplinary clinic continuing to run once a week. Increased access to a diabetes nurse educator, improved diabetes control and improved wound healing. This has also strengthened referral pathways to the local hospital. Reduced wait time to see a podiatrist and many people are seen within a few days of referral.	
Eating Disorders: Knowledge, Attitudes and Practices amongst health professionals at an ACCHO	***Description*** The project will explore knowledge attitudes and practices of staff at Congress through A) a KAP survey link B) focus groups Participants will be recruited across range of clinical services and disciplines. ***Aim*** To identify gaps in knowledge and practice, identify possible areas for education and if capacity allows, create an educational resource for health workers based on the outcomes of the survey and focus groups. ***Outcome*** Developed an educational resource for health workers.	1
Expanding a Women's Cooking Group for Diabetes	***Description*** The dietitian is currently facilitating a fortnightly cooking group targeting pregnant women with diabetes. The proposed expansion of the Women's Cooking Program will see it expand to weekly sessions on a Wednesday morning. ***Aim*** To help support management of diabetes through a good diet to minimise the associated complications to both pregnant mothers and their babies. To build positive social benefits in the creation of a safe space for women to come together, prepare and eat a meal together whilst engaging with the health service and health education. ***Outcome*** Provided an extra session per week for the duration of the project.	1
Culturally responsive assessments in remote communities.	***Description*** Guidelines and recommendations for allied health staff around culturally responsive NDIS assessments for First Nations clients. ***Aim*** To develop procedures and assessment tools. ***Outcome*** Developed guidelines and recommendations for allied health staff.	1

Facilitating best practice multidisciplinary practice	***Description*** Developing a robust multidisciplinary approach across rural sites. ***Aim*** To develop a robust multidisciplinary model to enhance service delivery outcomes and collaboration between therapists working within the multidisciplinary setting. ***Outcome*** Developed practice guides for therapists.	2
The improvement and expansion of medication review across QLD Central Highlights	***Description*** Home Medication Review is a clinical visit from a pharmacist to the patient's home under a physician's referral to focus on the safety and quality of medication use. It provides an opportunity for interprofessional collaboration and deep medication training for patients. ***Aim*** To focus on creating a network with general practitioners to increase the number of patients receiving this clinical service. ***Outcome*** Developed a new clinical service.	1
Tech Talkers Project	***Description*** Development of a training program for families of children using Augmentative and Alternative Communication, that can be delivered online, with a face-to-face component. ***Aim*** To develop a training package. ***Outcome*** Delivered an online and face-to-face pilot service to families. This service is continuing.	1
Implementing Allied Health Assistants	***Description*** Implementation of allied health assistants into a rural and remote area. ***Aim*** To build a sustainable service delivery model for a remote MM4-6 community. ***Outcome*** Developed a service delivery model.	1
Kindergarten Oral Language Program (KOLP) – A Whole Class Speech Pathology Intervention	***Description*** Implementation of a whole class oral language program to support the four pillars of oral language: Vocabulary, Comprehension, Phonological Awareness, Grammar Oral Narrative for Kindergarten students. ***Aim*** 1.Develop oral language skills of kindergarten students 2. Improve early identification of children with speech, language and communication needs and support referral pathways 3. Build relationships and share knowledge with educators in a primary school. 4. Build a sustainable delegation service delivery model for a remote MM7 community. ***Outcome*** Developed a service in an area that otherwise would not have been provided. The school purchased the program to be delivered by teaching staff and the AHP is now providing remote support to help them to continue to deliver the program. Unfortunately, due to a lack of funding the AHP can no longer provide support to deliver the program.	1

New Graduate Program - 'Focus on Foundations'	***Description*** To develop a structured and supportive occupational therapy new graduate two-year program. ***Aim*** 1. To attract and maintain new graduate OTs to live and provide OT services in the rural community. 2. To provide new graduate OTs with the support and structure required to sustain a financially viable service. 3. To have successful marketing advertising for new graduates to express interest in the position. 4. For the new graduate and existing team members to have clear guidelines about expectations. ***Outcome*** Developed a new graduate program and have recruited new graduates to commence in 2025.	1
COPD Screening & Smoking Cessation	***Description*** Screening for Illicit substances and tobacco use via E-Assist + COPD screening and/or consult on COPD stepwise management. ***Aim*** To provide COPD screening and smoking cessation assistance without a fee. ***Outcome*** Provided a non-fee service that hadn't been provided previously.	1
Upskilling support workers in rural and remote locations to implement recommendations by mental health clinicians	***Description*** Needs assessment and development of educational resources to train rural and remote support workers in basic skills to implement recommendations by mental health clinicians. ***Aim*** To educate allied health assistants and support workers in relation to occupational therapy and mental health. ***Outcome*** A support worker education resource was developed.	1
Integration of Allied Health Assistants with a Rural Allied Health Service	***Description*** Incorporating allied health assistants into an existing allied health model in a way that supports patient centred care specifically in feeding therapy, dietetics and exercise physiology services. ***Aim*** To improve the company's services. ***Outcome*** The project has established training modules, recruitment procedures, communication systems, and marketing materials to support AHA integration. It has reduced wait times and enhanced client satisfaction. The service is ongoing with plans to expand the reach into additional regions.	6
Occupational Therapy Service Development	***Description*** Integrate occupation therapy service in a further region. ***Aim*** To reduce travel time for rural participants and increase positive therapy outcomes for rural participants. ***Outcome*** Developed a service in an area that previously did not have the service that is ongoing.	1

Chronic Lung Protocol	***Description*** This project is focused on reviewing the current chronic lung protocol in place in the Kimberley region, Western Australia and updating any clinical details within the protocol. The focus is spirometry as there is currently little to no spirometry being performed in the region. ***Aim*** To add spirometry to standard practice across our Aboriginal Medical Service clinics including the smaller outreach clinics. ***Outcome*** Developed education resources including pamphlets for inhalers, educational video resource and decision-making tools for use of inhalers.	2
Skill sharing for clinicians and educators working with children in rural and remote communities	***Description*** Understanding and supporting skill sharing for clinicians and educators working with children aged 0-7 years in rural and remote communities. ***Aim*** To understand the challenges of the community and put support in place to overcome the challenges experienced. ***Outcome*** Resources are being used by the wider team at the organisation.	2
Health At Every Size Pilot Service	***Description*** To establish an accredited weight neutral dietetics pilot service and utilise the results of the pilot service to develop a key set of recommendations for future service delivery of weight neutral services within the organisation and Midwest. ***Aim*** The purpose of this project is to increase access to weight neutral health services for individuals living in the Midwest. ***Outcome*** Developed a pilot program to increase access to weight services. The results of the pilot program were used to produce recommendations for future service delivery.	1
Transdisciplinary practise in rural and remote communities	***Description*** To draft and pilot a transdisciplinary model of care within the allied health team for communities for clients currently receiving limited services; not meeting evidence-based practice guidelines for service delivery over the 12 months. ***Aim*** To extend the scope of clinicians and provide quality care to consumers, ensuring clinicians are operating at the top of/extended scope. ***Outcome*** 2-month project (withdrew prior to finishing) but resources were developed prior to student withdrawing.	1
Occupational Therapist role in supporting formal diagnosis of childhood disability in rural and remote Australia	***Description*** A mixed-methods approach, combining qualitative interviews with healthcare professionals involved in childhood disability diagnosis and quantitative analysis of diagnostic processes and outcomes data. Diagnostic records and patient outcomes will be analysed to assess the effectiveness and efficiency of current diagnostic processes. ***Aim*** The project aims to gain insights into the roles, challenges, and perspectives in the diagnosis of childhood disabilities. ***Outcome*** Developed resource package.	1

Development of a business framework for efficient and effective utilisation of allied health assistants in private practice	***Description*** The service development project will look at developing a business framework for efficient and effective utilisation of allied health assistants in private practice. The project will consider allied health assistant competencies and a supervision structure, together with work output required for the allied health assistant role to be financially viable. ***Aim*** Given the current recruitment and retention challenge in rural locations, the allied health assistant role offers potential to address the significant shortfall of allied health services in rural and remote Australia. ***Outcome*** Developed a business framework for effective and efficient utilisation for allied health assistants in private practice.	1
Implementation and provision of Vital Health allied health services to the local community	***Description*** Implementing regular allied health service provision from Vital Health to a regional town due to community need. This involves the planning and development of regular service provision that can be maintained for the community to access essential private and funded allied health services within their town. ***Aim*** To plan and develop the regular service provision so it can be maintained for the community to access essential private and funded allied health services within their town. ***Outcome*** Ongoing service due to the original support from the program and has since grown delivering physiotherapy (weekly), speech and occupational therapy (fortnightly) and dietetics and exercise physiology (monthly).	1
Developing a group paediatric therapy program	***Description*** Paediatric participants were not getting timely access to services due to long wait lists. This determined our population focus on the project, focusing on group therapy programs for participants ages 4 to 14 as this was the range with the most unmet referrals. ***Aim*** To develop a group therapy program targeted towards paediatric participants that can be delivered both in Cairns and rural communities. ***Outcome*** Developed a group paediatric program and this was delivered as an intensive 2-day program. There are plans for the program to continue.	1

Appendix 7

Engagement Summary: SARRAH and Aboriginal Community Controlled Health Organisations

ALLIED HEALTH LESSONS LEARNED DURING THE IMPLEMENTATION OF TAHRGETS AND BRAHAW

2023

The purpose of this document is to outline SARRAH's approach to understanding the positioning of allied health professionals and allied health assistants within Aboriginal Community Controlled Health Organisations (ACCHOs) as they relate to the allied health rural generalist pathway and building the rural and remote allied health assistant workforce; and to summarise the feedback from ACCHOs regarding allied health and allied health assistants and these programs.

It should be noted that not all views expressed in the report are attributed to all ACCHOs.

Acknowledgements

The SARRAH team has been privileged to participate in many conversations to inform this paper. These conversations have been held on many First Nations lands across Australia, either in person visiting, or meeting via video or telephone conference.

SARRAH would like to acknowledge and pay our respects to the Elders of these many lands and thank them for their ongoing custodianship of the land, waters and skies where we live work and play.

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SARRAH	Services for Australian Rural and Remote Allied Health
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
AHA	Allied health assistants
TAHRGETS	The allied health rural generalist education and training scheme
BRAHAW	Building the rural and remote allied health assistant workforce
AHRG	Allied health rural generalist
AH	Allied health
NACCHO	National Aboriginal Community controlled health organisation

EXECUTIVE SUMMARY

Services for Australian Rural and Remote Allied Health (SARRAH)is currently implementing two workforce development initiatives establishing supported training positions within allied health service providers across rural and remote Australia:

- Allied Health Rural Generalist (AHRG) training positions through The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) program; and
- Allied Health Assistant (AHA) training positions through Building the Allied Health Assistant Workforce (BRAHAW) program.

In alignment with performance indicators, each program has allocations for training positions within Aboriginal Community Controlled Health Organisations (ACCHOS).

As part of the activities against these performance indicators, SARRAH has undertaken an extensive engagement process with ACCHOs, ACCOs and relevant peaks across Australia. This engagement was undertaken with regards to organisations' interest and ability to participate in either workforce development pathway.

This engagement process has allowed SARRAH to build an understanding of allied health services in ACCHOs - their current service provision, and the supports necessary for this provision to thrive within ACCHOs; as well as the role that SARRAH's workforce programs play in the current context. Figure 1~~Figure 1~~, below, is based on feedback from this engagement process, and provides a summary of the identified barriers to a thriving allied health service within ACCHOs.

For one of the programs – Building the Rural and Remote Allied Health Assistant Workforce (BRAHAW) – this engagement process has resulted in the achievement of all allocated training positions.[1]

For the second program – The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS) – this engagement process has resulted in an understanding of the barriers to successful achievement of these allocated training positions.

For SARRAH, the engagement process has not concluded, rather it has established a foundation for ongoing and future program delivery and advocacy, in close partnership with Indigenous Allied Health Australia (IAHA). The work has also confirmed SARRAH's focus on First Nations communities' access to allied health services for all rural and remote communities as part of ongoing advocacy and project work.

More broadly, the work has highlighted the need for a cohesive review of policy drivers and funding mechanisms with a view of enabling allied health service delivery by ACCHOs, and the opportunity for collaborative research in this area.

[1] At the time of writing, noting that numbers may fluctuate during the term of the program.

What we have heard

implementing allied health workforce development initiatives in ACCHOS

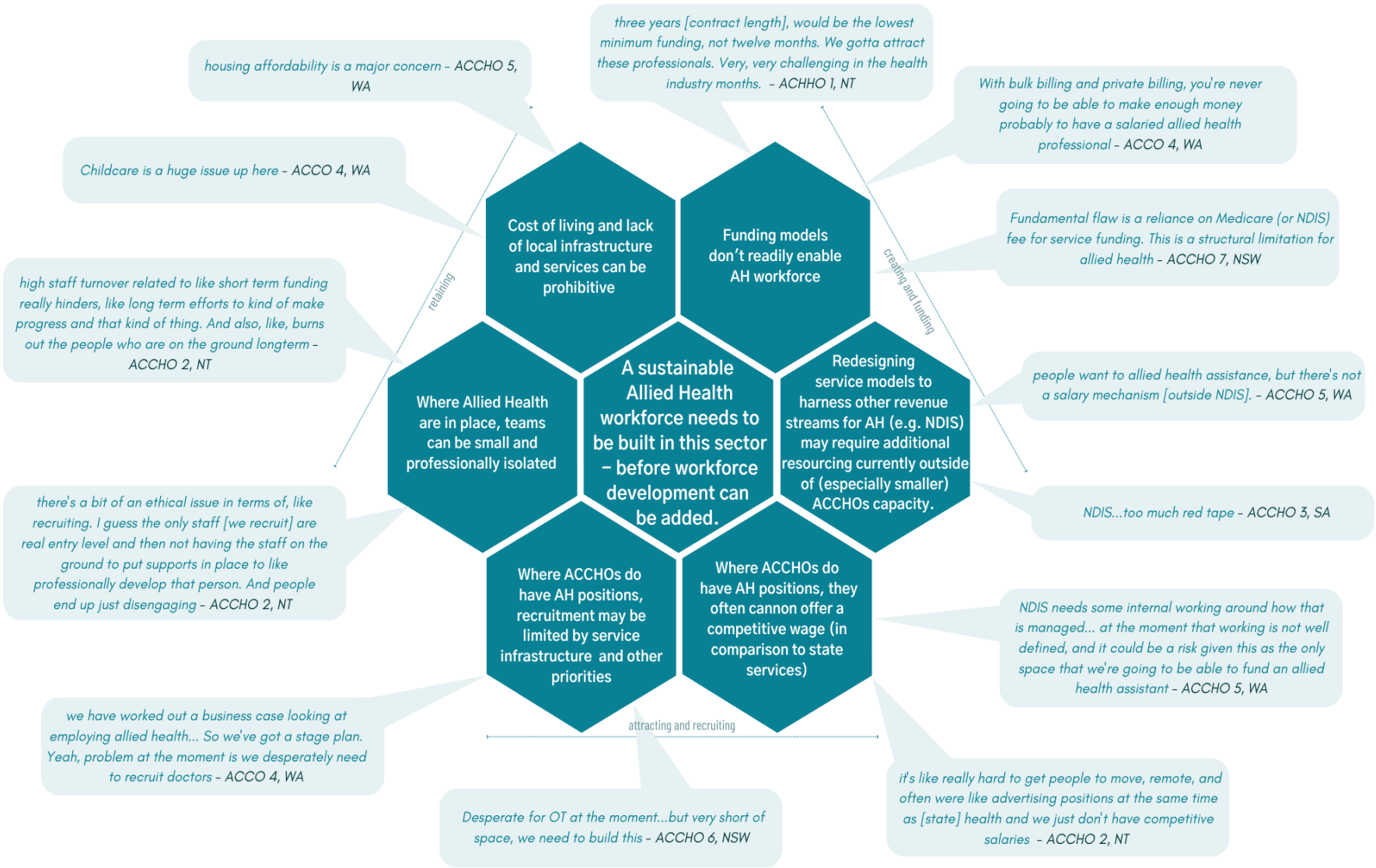

Figure 1: Overview of engagement

INTRODUCTION

Background of project

Services for Australian Rural and Remote Allied Health (SARRAH) has received funding from the Commonwealth Department of Health to deliver two (three-year) workforce development initiatives focussing on the rural and remote allied health workforce. Funding for these programs represents the first new Commonwealth investment specifically for the rural and remote allied health workforce in many years. The programs received three years' funding, with funding to be expended or fully committed by September 2024

1. *The Allied Health Rural Generalist Education and Training Scheme (TAHRGETS)* (Allied Health Rural Generalist Pathway - 4-GCRQIYP) focuses on the further development of the qualified Allied Health Professional.
2. *Building the Rural and Remote Allied Health Assistant Workforce (BRAHAW)* (Allied Health Assistant Workforce Package - 4-GCRQJ18) focuses on the development of a rural and remote Allied Health Assistant (AHA) workforce.

In both programs, a training position must be created by the employing organisation. This training position may be a newly established position that the organisation wishes to recruit to, or to place an existing member of the workforce. SARRAH provides education funding for the trainee, workplace training grants for the organisation, and support, capacity building, and resources to all participants.

In TARHGETS, the training position is allocated to an already qualified Allied Health Professional[2], and the trainee must undertake the Allied Health Rural Generalist (AHRG) pathway[3] with the support of their employing organisation.

In BRAHAW, the training position is for an Allied Health Assistant. Through the program, the organisation follows a roadmap to the development of an AHA service. The trainee undertakes training (with or without certification) to deliver, under supervision, the AHA service delivery model, and the organisation undertakes the establishment of the required governance; and the workplace training and supervision and support of the AHA[4].

Under the grant agreements, both programs have a fixed number of training positions allocated to Aboriginal Community Controlled Organisations (ACCHOs). For TAHRGETS, 30 of the 90 packages are allocated to training positions within ACCHOs. For BRAHAW, 15 of the 30 packages are allocated to training positions within ACCHOs. The aim of these targeted allocations is an increase in access to allied health services for First Nations people (note, these are not allocations specifically for increasing Indigenous allied health workforce).

Achieving these allocations are identified as key performance indicators for the grants.

SARRAH's approach to implementing the ACCHO training positions and engagement of the ACCHO sector has been developed following advice and guidance from the TAHRGETS and BRAHAW advisory committees, SARRAH's close partner, the Indigenous Allied Health Association (IAHA), and NACCHO. These activities have resulted in the development of strong relationships with many

[2] Current eligible allied health professions: Dietetics, Occupational Therapy, Pharmacy, Physiotherapy, Podiatry, Radiography, Speech Pathology, Psychology, Social Work

[3] The Allied Health Rural Generalist Pathway is an innovative workforce development strategy to increase access to a highly skilled allied health workforce for rural and remote Australian communities. This innovation is enacted through the use of three trusted mechanisms: formal education, structured supervision and support, service model development. For more information see https://sarrah.org.au/ahrgp

[4] For more information on BRAHAW, see https://sarrah.org.au/brahaw

ACCHOs across the country and contributed to a depth of understanding of the enablers and barriers to implementation.

TAHRGETS

As of June 2023, SARRAH had received a total of six applications for TARHGETS training positions (6/30) from ACCHOs. Two applications received were for existing Allied Health Professionals within an ACCHO. Four applications established new training positions with the organisation intending to recruit to these positions. Of the two existing allied health positions – one withdrew to return to her home in Sydney. Of the four recruitment positions, all have failed to recruit. One AHRG ACCHO trainee remains (1/30).

BRAHAW

As of June 2023, SARRAH is oversubscribed with 20 of 15 training positions for AHA allocated within ACCHOs.

The BRAHAW program has received significantly more applications from ACCHOs than has TAHRGETS. Additionally, BRAHAW has had interest from mainstream organisations wishing to employ locally based First Nations Allied Health Assistants.

Purpose of stakeholder engagement

To successfully implement training positions within the TAHRGETS program, SARRAH sought to identify ACCHOS satisfying the following requirements:

- are rural and remote
- have an organisational priority to deliver allied health services
- have Allied Health Professionals employed.

To successfully implement training positions within the BRAHAW programs SARRAH needed to identify ACCHOS satisfying the following requirements:

- are rural and remote
- have an organisational priority to deliver allied health services
- have Allied Health Professionals who are either employed or externally contracted, to delegate to and providing training and supervision to an AHA
- already fund, or are able to fund, AHA positions within their current business.

Furthermore, SARRAH needed to ascertain whether individuals within these organisations had the interest and capacity to participate in the workforce development pathways.

The identification process has been illustrated below, in *Figure 2*.

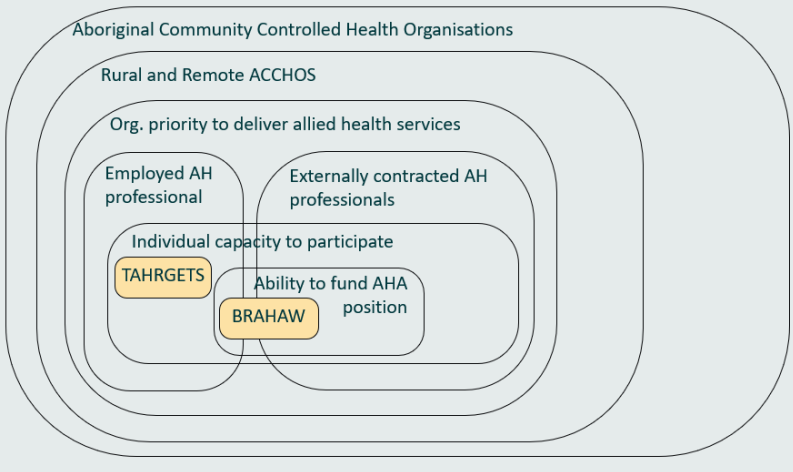

Figure 2: Identifying ACCHOs and individuals to target during the engagement process.

The identified **purpose** of the engagement process was to:

- identify appropriate ACCHOs;
- increase ACCHO understanding of workforce development pathways; and
- secure ACCHO participation in the workforce development pathways.

To ascertain eligibility, SARRAH has asked the following questions:

1. What does allied health service delivery look like in your organisation? (Status of allied health within ACCHOs)
2. Under what conditions would allied health service delivery thrive in your organisation? (Enablers and Barriers to allied health within ACCHOs)
3. Would SARRAH's workforce development initiatives help to optimise these conditions? (Reception of the TAHRGETS and BRAHAW programs)

Scope and limitations of report

This report is focused on the engagement with, and feedback from, the Aboriginal and Community Controlled Sectors with regards to their interest and ability to participate in either the TAHRGETS or BRAHAW workforce development pathways.

METHODOLOGY

Stakeholder engagement

Engagement with stakeholders has been led by SARRAH's engagement strategy. This strategy, illustrated in *Figure 3Figure 3* below, has been an evolving and iterative strategy over the course of the TAHRGETS and BRAHAW planning and implementation phases.

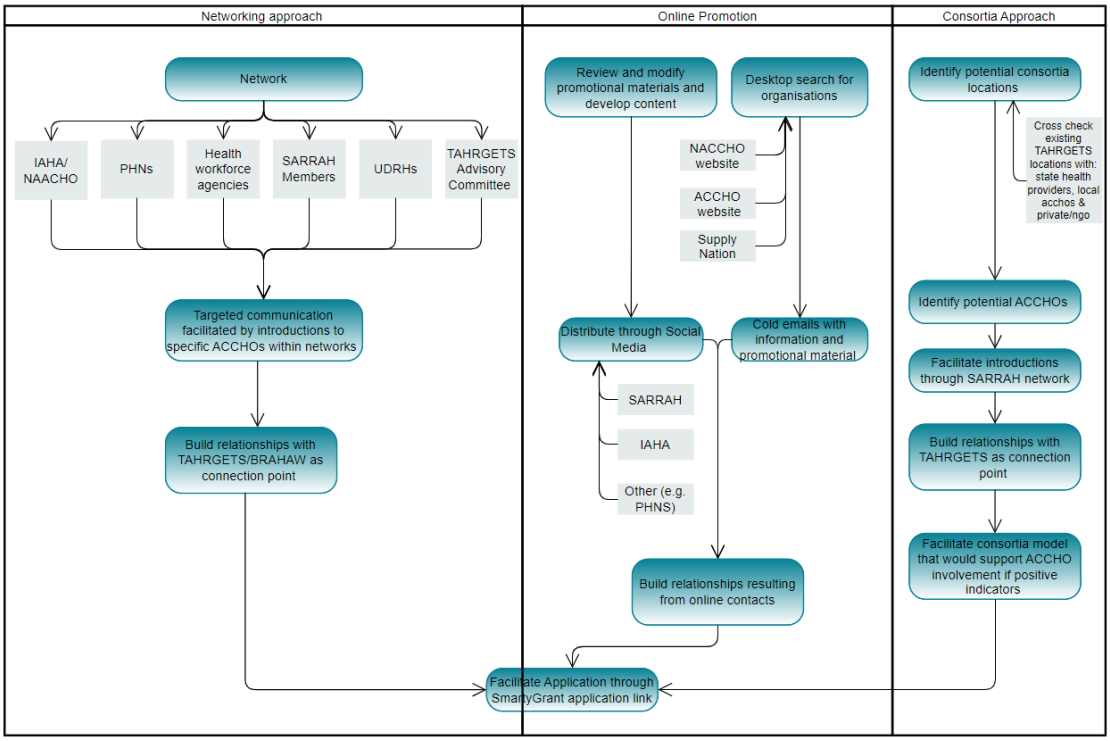

Figure 3: SARRAHs engagement strategy: identifying ACCHOs and individuals to target during implementation.

Figure 4, below, further explores the networking approach outlined in the engagement strategy.

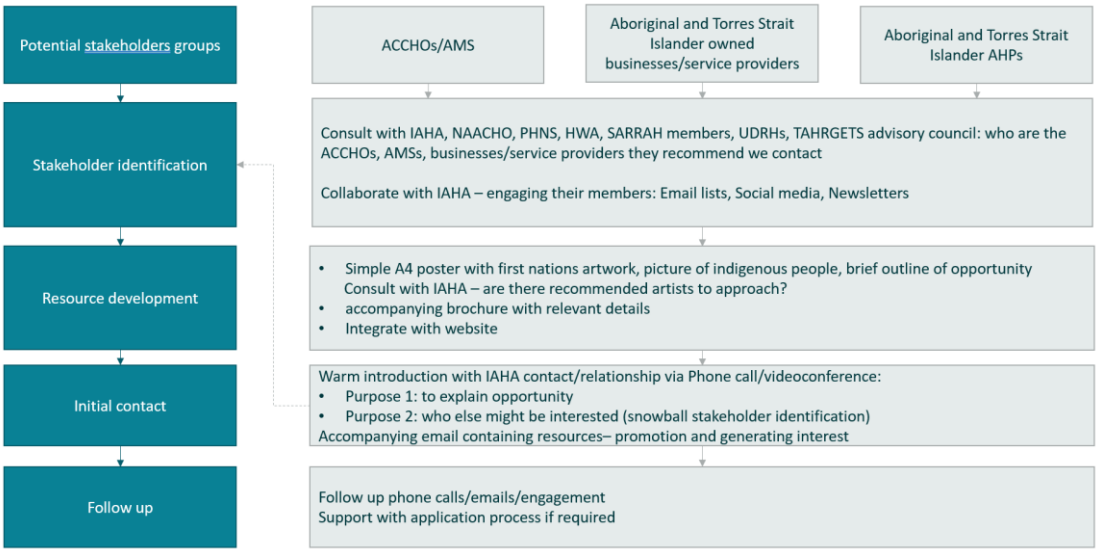

Figure 4: SARRAH Identifying ACCHOs and individuals to target during the engagement process.

Communication with stakeholders was distributed across the SARRAH team, with all members of the TAHRGETS and BRAHAW implementation team as well as the SARRAH CEO and Policy and Advocacy Director contributing to these activities. The decision of who engaged with stakeholders was made based on the level and type of engagement, and where existing relationships already lay. A summary of communications can be found below in *Table 1*.

Party engaged	New engagement[1]	What/how did engaged group contribute? [2]	Outcomes? [3]
Indigenous Allied Health Australia	N	Provided advice and guidance, distribution of promotional material through networks and membership, warm introductions to ACCHOs potentially interested in the project	Relationship ongoing Increased profile of TAHRGETS/BRAHAW increased SARRAHs network of ACCHOs
National Aboriginal Community Controlled Health Organisation	N	Provided advice and guidance. Facilitated relationships with ACCHOs with program interest	Relationship ongoing Increased profile of TAHRGETS/BRAHAW increased SARRAHs network of ACCHOs
Aboriginal Community Controlled Health Organisations	Y, N	Considering program applicability in their setting, Snowball identification of other potentially interested ACCHOs.	Some ACCHOs not interested – relationships not ongoing at this time. Some ACCHOs interested but not capacity/interested individuals – relationships ongoing. Some ACCHOs applications received for training positions – relationships ongoing
Primary Health Networks - **Rural PHN group** - **Individual rural PHNs**	N	Provided advice and guidance, distribution of promotional material through networks	Relationships ongoing Increased profile of TAHRGETS/BRAHAW
Health workforce agencies	N	Provided advice and guidance, distribution of promotional material through networks and membership, warm introductions to ACCHOs potentially interested in the project	Relationship ongoing Increased profile of TAHRGETS/BRAHAW increased SARRAHs network of ACCHOs
University departments of rural health	N		Relationships ongoing Increased profile of TAHRGETS/BRAHAW
TAHRGETS Advisory Committee	N	Provided advice and guidance, distribution of promotional material through networks and membership, warm introductions to ACCHOs potentially interested in the project	Ongoing, continue to provide guidance and advice in the implementation of TAHRGETS
SARRAH members	N	Asked to consider program and distribute to networks	Ongoing

1 New engagement as part of this project consultation

2 Contribution of engaged group: Classify the contribution according to which stage in your research project the engagement has occurred. For example: Design; Implementation/fieldwork; report writing; review. Consideration of findings/recommendations; Communication / dissemination

3 Change: Outcomes in terms of changes in engagement – relationships / structures, networks including creation of new networks; formalizing relationships e.g., through MoU's.

Table 1: Engagement of external individual/groups/networks

Table 2, below, lists the resources developed by the implementation team to support ACCHO stakeholder engagement and communication.

Resource	TAHRGETS	BRAHAW
Program guidelines	✓	✓
Posters	✓	✓
Social media tiles and contents	✓	✓
Short videos	✓	✓

Table 2: Resources developed.

A summary of communication methods used in the stakeholder engagement, can be found below in, *Table 3*.

Communication method	Audience Reached	Response
Cold call emails **SARRAH undertook a desktop screen of rural and remote ACCHOS regarding allied health service provision. Those with obvious allied health services listed on their website were sent emails that introduced SARRAH and provided preliminary information about the TAHRGETS and BRAHAW programs and invited further conversations.**	ACCHOS identified in desktop search	No meaningful ongoing engagement using this method
Third party introductions **SARRAH was introduced to ACCHOS via a third party from within SARRAHs extensive stakeholder network. Once an introduction was made, SARRAH followed up via email providing more information about the TAHRGETS and BRAHAW funding and inviting further conversations**	ACCHOs who SARRAH did not yet have relationships with.	Resulted in meaningful engagement with ACCHOs
The conversations **Through face-to-face visits, videoconferencing, telephone calls and emails SARRAH has had conversations with ACCHOs about allied health, professionals and AHAs. These conversations have included discussions with organisations CEOs, Clinical Directors, Executives, Clinical Managers, Allied Health Professionals and Aboriginal Health Workers.**	ACCHOs that SARRAH had pre-existing relationships with, or that SARRAH had been introduced to.	Deepened relationships, increased understandings of workforce development initiatives.

Table 3: Methods of Communication

Ongoing engagement activities

Engagement activities remain ongoing. SARRAH continues to work with partners to further build relationships with ACCHOs, as well as deepen understanding of workforce development initiatives.

ENGAGEMENT FINDINGS

To date, SARRAH has engaged with 18 ACCHOs (17 regional, rural and remote, 1 metropolitan based), four ACCOs, and two peaks (Indigenous Allied Health Australia and National Aboriginal Community Controlled Health Organisation). These rich, ongoing conversations have provided SARRAH with an understanding of what allied health service delivery looks like in ACCHOs; enablers and barriers for thriving allied health service delivery within ACCHOs, and the current role and relevance of SARRAH's workforce development initiatives.

Findings are reported against the three focus questions used in the engagement.

1. What does allied health service delivery look like in your organisation? (Status of allied health within ACCHOs)
2. Under what conditions would allied health service delivery thrive in your organisation? (Enablers and Barriers to allied health within ACCHOs)
3. Would SARRAH's workforce development initiatives help to optimise these conditions? (Reception of the TAHRGETS and BRAHAW programs)

Status of allied health within ACCHOs

Findings indicated that allied health service delivery differs across ACCHOs due to variations in employment structures and services provided.

VARIATIONS IN EMPLOYMENT STRUCTURES

Only one of the ACCHOs employs an entire allied health team, the remainder range from relying entirely on externally contracted Allied Health Professionals to provide services; to those ACCHOs who have a mix of some internally employed and some externally contracted Allied Health Professionals

VARIATIONS IN SERVICES PROVIDED

The reported allied health services provided also varied. Most ACCHOs provided social and emotional wellbeing services (program funding) and some accessed Medicare billing for psychology services under a mental health treatment plan. Most ACCHOs also had funding for the provision of primary allied health services related to chronic disease management through programmatic funding (short term grant agreements). Few ACCHOs reported Medicare being a primary source of allied health revenue. Some of the ACCHOs are registered NDIS providers with growing disability allied health service provision. Contributing factors for this large variation can be grouped into the themes listed here and discussed in the following Enablers and Barriers section.

- Creating and funding allied health positions
- Attracting and recruiting allied health professionals
- Retaining allied health professionals

Enablers and Barriers to allied health within ACCHOs.

CREATING AND FUNDING ALLIED HEALTH POSITIONS.

Within ACCHOs, funding of allied health services fall predominantly into one of the three categories, as summarised below:

1. Program/Block funding.

Program block funding is normally tied to specific health outcome areas. Allied health positions may be created as part-time or full-time positions for the duration of the program contract (often only one to two years long, sometimes three).

> *three years [contract length], would be the lowest minimum funding, not twelve months. We gotta attract these professionals. Very, very challenging in the health industry months.*
> *- ACHHO 1, NT*

Recruitment into these positions is generally limited to a cohort of allied health professionals who are already local, or who are prepared to move rural and/or remote for a short period of time with no guarantee of ongoing employment. The ability to employ Allied Health Assistants within these models may be limited by grant funding agreements.

> *With bulk billing and private billing, you're never going to be able to make enough money probably to have a salaried allied health professional - ACCO 4, WA*
> *Fundamental flaw is a reliance on Medicare (or NDIS) fee for service funding. This is a structural limitation for allied health - ACCHO 7, NSW*

2. Medicare funding

The limitations of funding allied health services through Medicare are well documented. At this time, Medicare is not a sustainable mechanism for fully funding Allied Health Professional positions, and there are no existing mechanisms for funding Allied Health Assistant positions through Medicare. Further subsidising through out-of-pocket expenses or top up block funding is required for a viable workforce model.

3. NDIS funding

> *NDIS...too much red tape - ACCHO 3, SA*

NDIS provides the most likely mechanism for creating and delivering sustainable allied health services, providing funding mechanisms for employing both Allied Health Professionals and Allied Health Assistants. However, through this engagement, ACCHOS have reported varying opinions of, and willingness to engage with NDIS. Some ACCHOs consulted are NDIS providers and are building in this space. Some have been NDIS providers but do not see the benefit and are letting their status lapse, others are not providers and are considering it, and others are not providers and have no short-term plans of becoming providers.

ATTRACTING AND RECRUITING ALLIED HEALTH PROFESSIONALS

Where ACCHOs have established Allied Health Professional positions, there are often barriers in attracting and recruiting to roles.

In the absence of viable funding mechanisms that enable creation of and recruitment to ongoing allied health positions, there is often a reliance on fixed term contracts. Recruitment to fixed term contracts in rural and remote Australia comes with additional difficulties of:

- attracting Allied Health Professionals to move to rural and remote areas.
- having available medium-term accommodation available at an affordable rate
- having an allied health network large and consistent enough to create a supportive professional environment.

Furthermore, ACCHOs may not be able to provide competitive salaries when compared to other service providers (e.g., state health jurisdictions)

> *it's like really hard to get people to move, remote, and often were like advertising positions at the same time as [state] health and we just don't have competitive salaries - ACCHO 2, NT*

Some ACCHOs have been able to create positions, but the physical infrastructure has not been sufficient for additional staff, or finite resources are redirected to other priorities.

> *Desperate for OT at the moment...but very short of space, we need to build this - ACCHO 6, NSW*
>
> *we have worked out a business case looking at employing allied health... So we've got a stage plan. Yeah, problem at the moment is we desperately need to recruit doctors - ACCO 4, WA*

Consequently, many ACCHOs, when not able to employ Allied Health Professionals locally, provide services through contracting external Allied Health Professionals. These may be local or fly-in-fly-out providers.

RETAINING ALLIED HEALTH PROFESSIONALS

Some of the factors mentioned above in the ability to attract Allied Health Professionals also affect retention. For ACCHOs these can include community factors such as liveability as well as professional factors. The cost of living and lack of local infrastructure and services can be prohibitive to both attraction and retention.

> *housing affordability is a major concern - ACCHO 5, WA*
>
> *Childcare is a huge issue up here - ACCO 4, WA*

When employed in ACCHOs Allied Health Professionals may be the only Allied Health Professional or may be employed in a small team. In the conversations SARRAH heard that there is a risk for Allied Health Professionals feeling professionally isolated, contributing to high turnover.

there's a bit of an ethical issue in terms of, like recruiting. I guess the only staff [we recruit] are real entry level and then not having the staff on the ground to put supports in place to like professionally develop that person. And people end up just disengaging - ACCHO 2, NT

high staff turnover related to like short term funding really hinders, like long term efforts to kind of make progress and that kind of thing. And also, like, burns out the people who are on the ground long term - ACCHO 2, NT

UNDER WHAT CONDITIONS WOULD ALLIED HEALTH SERVICE DELIVERY THRIVE IN YOUR ORGANISATIONS

Through the engagement process, the most consistent messaging heard from ACCHOs was the need for a sustainable funding mechanism for salaried Allied Health Professional positions; that this mechanism facilitates ongoing or long-term employment contracts that are competitive with state health jurisdictions.

Further to this, ACCHOs reported that there is a recognised need for an economy of scale of allied health services that would allow the formation of supportive teams, and the efficiencies to sustain the 'back-of-house' structures that enable allied health service delivery.

…certainty…you need some scale… you need some team capacity
- ACCHO 1, NT
structures and supports in place within the team to set that up to really thrive - ACCHO 2, NT

Reception of the TAHRGETS and BRAHAW programs

TAHRGETS

The reception of the TARHGETS workforce packages by ACCHOs has been mixed. Many ACCHOs had little understanding of the AHRG pathway. This is consistent with the evaluation of the Allied Health Rural Generalist Workforce and Education Scheme (AHRGWES), the pilot preceding the TAHRGETS program. This lack of understanding was more apparent in organisations such as ACCHOs/AMSs for whom allied health service provision has not to date been seen as core business. Through SARRAH's engagement, knowledge and understanding of the pathway is growing. While most ACCHOs engaged with have been supportive of and interested in developing their allied health workforce, their interest is focussed on how to secure a stable allied health workforce, an acknowledgeable first step before workforce development initiatives can be applied.

For those ACCHOs who employed Allied Health Professionals, there were still some concerns regarding the applicability of the pathway for their current context. The Level 2 AHRG Pathway has a two-year (minimum) timeframe. Allied Health Professionals, employing ACCHOs and SARRAH need some assurance that the Allied Health Professional is likely to be employed for at least the two years the pathway would take to complete. This was problematic for ACCHOs where contracts of one or two years were the norm.

For those ACCHOs who relied on externally contracted service providers, the pathway offered no perceived direct benefit, as the workplace training grants and supports would go to the employing organisation. Furthermore, some employing organisations would not be eligible if they are offering fly-in-fly-out services from metropolitan areas[5].

The feedback and contextual information gathered through this process is essential to understanding why the implementation of AHRG training positions within ACCHOs has not worked at this time.

BRAHAW

The reception of the BRAHAW packages by ACCHOs is very positive. Given this workforce development initiative focuses on local workforce and there is not a requirement for the supervising and delegating Allied Health Professionals to be employed internally, there is scope to accommodate flexible and innovative approaches to developing this workforce.

This positive response is evident in the oversubscription of available BRAHAW training positions.

SARRAH understands that organisations who have limited experience delivering allied health services may require additional assistance to understand and support the essential relationship between the supervising and delegating Allied Health Professionals, and how this will function if the Allied Health Professional is employed externally.

[5] SARRAH does not currently consider applications from metropolitan based allied health services providing fly in fly out services. This decision was based on a priority at the time to develop a rural and remote workforce.

IMPLICATIONS NEXT STEPS

This engagement process has been essential to shaping SARRAH's role in increasing access to allied health services for First Nations communities.

Implications for SARRAH

This report informs three key action area for SARRAH:

1. Ensure that SARRAH's program delivery continues to promote increased access to allied health services for First Nations communities. Programs should prioritise service providers with proven track records of working with First Nations communities (including ACCOs and mainstream organisations)

2. Ensure that SARRAH continues to work closely with IAHA so that programs wherever possible promote the growth of an Indigenous health workforce, and that this workforce is distributed within rural and remote Australia.

   This should include reimagining how the pathway could be used for Indigenous Allied Health Professionals, to increase their skills, knowledge and exposure to rural and remote practice and increase their likelihood of moving into rural and remote practice.

3. Ensure that SARRAH continues to work closely with IAHA and NACCHO to communicate the unique issues raised by ACCHO and ACCO stakeholders to policy and decision makers.

Broader recommendations

1. That policy drivers and funding mechanisms are reviewed with the view of making changes that promote and enable ACCHOs to deliver sustainable allied health services to better manage the health needs of First Nations communities.

2. Undertake collaborative research into allied health service delivery by ACCHOs.

   This report summarises a small consultation process directly related to workforce development initiatives currently implemented by SARRAH. This report offers some preliminary recommendations to support collaborative research into allied health service delivery by ACCHOs.