Symbiotic partnership to grow the health workforce in rural and remote Australia

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Introduction

- Presentation largely draws on the findings of a review of Aboriginal Community Controlled RTOs funded by the Department of Health and ageing, and comparator RTOs (publicly funded and blended funding)
- Focuses on key factors impacting on educational outcomes for ATSIHWs to inform a sustainable training model
- Recommendations from the review were supported in the Mason Review of Australian Government Health Workforce Programs (2013)
- Importance of clinical education capacity in the primary health care setting to grow the health workforce

Context: ATSIHW training

- National Aboriginal and Torres Strait Islander Health Worker training package – developed by Community Services and Health Industry Skills Council, 2007
- Qualifications – Certificate II to Advanced Diploma in practice care or community care stream
- 2010/11 – 33 RTOs offering course (TAFES and Community Controlled)
- Limited availability of Cert II (entry level) and limited advanced HW education opportunities.

Key Elements of Training Model

Element	Variations		
Training Approach	Block training	Outreach (reverse block)	
Numeracy and literacy development	Contract/employ teachers to deliver language, literacy, numeracy	Cert I general education (scope of RTO)	
Student support	Block – educator visits 1-2x/yr or Field officer employed by RTO - visits	Reverse block – provided by educators	Preceptor in health centre, trained by RTO
Placements	Employed – in workplace	Pre-employment – negotiated by RTO	
Workplace assessment	Sessional assessor visits workplace	By Educator	ATSIHW/ RN Cert IV Training and assessment

Educational Outcomes

CONTEXT

Measuring educational outcomes – course completion and length of completion is difficult in VET sector (all RTOs) :

- Absence of unique student identifier
- Ill defined concept of student commencement

Tend to use competency (unit) completion

Health field competency completion 83% v 79% across the sector (NCVER 2010)

REVIEW FOUND:

RTOs offering ATSIHW qualification – approximately 50% competency completion

Student withdrawal tended to be lower if student employed by a health service (similar to apprenticeship)rather than on placement as pre-employment student.

Challenges for ATSIHW training

RTOs (Community controlled and mainstream) service a highly disadvantaged student population

Students undertake placements/work distant to the RTO

Health services/centres:

- Limited capacity for supervision – workload, clinical acuity, staff turnover
- Limited clinical education capacity within primary health care settings
- Supervisors may not understand scope of practice for ATSIHWs (students and qualified)

RTOs – difficult recruiting and retaining qualified staff (Short-term funding community controlled) ->lack of internal capacity-> financial risk->educational achievements->financial risk

Factors impacting on educational outcomes

RTO

- Quality of governance and management
- Funding sources- short term v continuity/core
- Market – small and dispersed – no economy of scale, resource intensive
- Payment on completion –impacted by withdrawal, prolonged completion impacts on cashflow

Training Model

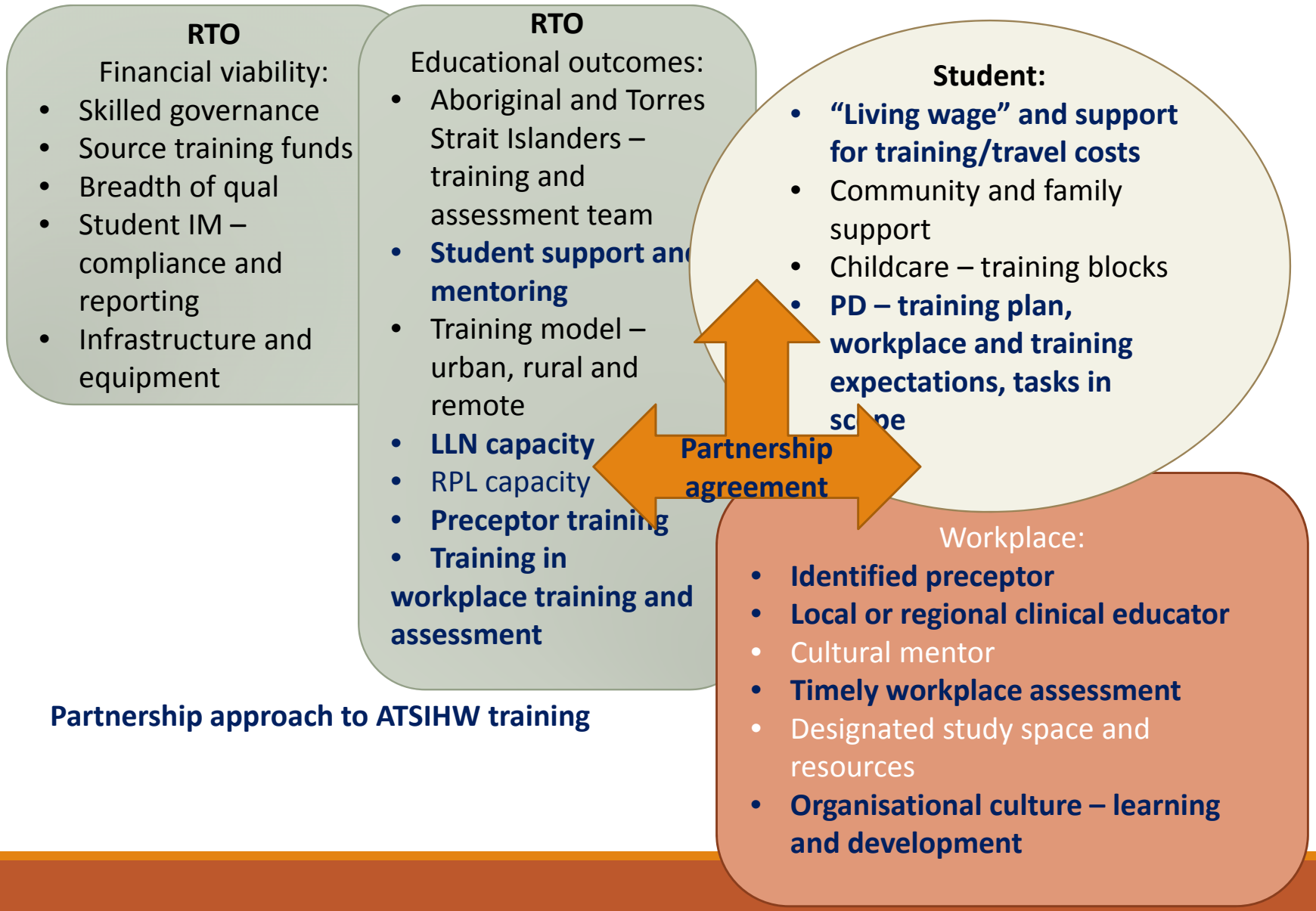
- Block training – economies in delivery BUT: Barrier to enrolment, risk of withdrawal (family/community), release for training – financial disincentive
- Capacity of employer/workplace to provide supervision
- Negotiated roles and responsibility of RTO, workplace and student
- Capacity for workplace competency assessment

Student

- Literacy and numeracy support
- Adequacy of financial support – pre-employment V employed

Sustainable training model demonstrate:

Value to:	**Students**	Competencies to achieve nationally recognised and accredited qualification
	Employer and Industry	Confidence in skills and knowledge of ATSIHW to deliver health interventions Client and program information management Work with others internal and external to workplace
	Funders	RTO has governance, management and training capacity for workforce development deliverables
Financial viability of the RTO		Meet operating and governance costs
		Meet training costs, accreditation and compliance
		Capacity to expand/develop new markets



Partnership approach to ATSIHW training

Clinical educator capacity: The missing element

Policy environment

- Increasing focus on clinical workforce training in rural and remote to:
- Increase exposure to R&R and Indigenous health to influence career paths
- Meet increasing demand for student clinical placements across professions
- Increase health workforce participation by Aboriginal and Torres Strait Islanders

BUT

Workforce issues challenge capacity of R&R health services to provide clinical supervision for students, junior health professionals and ATSIHWs

AND

Clinical Educators are in acute but largely absent in R&R settings

Recommendations

1. The primary health care workplace is recognised as a partner with Registered Training Organisations in the training of ATSIHWs. To support this, the Australian Government, Department of Health supports the establishment of clinical educator positions to work across clusters of Aboriginal Community Controlled Health Services to provide clinical training and skills development to ATSIHW students, health profession students and early health professionals. The clinical educators are employed by regional ACCHSs, or auspiced by an ACCHS to have a regional role.

2. State and Territory health departments establish primary health care clinical educator roles to support the training and development of ATSIHWs and junior health professionals employed by the state and territory health services, and health profession students undertaking clinical placements with these services.