

## Symbiotic partnerships to grow the health workforce in rural and remote Australia

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### Growing the Aboriginal and Torres Strait Islander health worker workforce

Building Indigenous health workforce capacity is a key underpinning requirement to Closing the Gap in Indigenous health disadvantage. The Aboriginal and Torres Strait Islander health worker (ATSIHW) workforce is recognised as a key component of the primary health care workforce. In addition to participating in the delivery of comprehensive primary health care, ATSIHWs provide a crucial link between Aboriginal Community Controlled and mainstream health services, and between health services and communities to break down some of the known barriers to Indigenous people accessing health care including cultural relevance and appropriateness of health services, gender imbalance, racial discrimination, transport needs and cost of the care.<sup>1</sup>

Increasing the Aboriginal and Torres Strait Islander health workforce across all professions is a key strategy to promote access to health care for Indigenous people<sup>2</sup>, and when coupled with increased availability of health services establishes the necessary platform for improvement in health outcomes. However, while 2.5% of the Australian population are Aboriginal and Torres Strait Islander people<sup>3</sup>, only 1.8% of the national health workforce is made up of Aboriginal and Torres Strait Islander people.<sup>4</sup> The projected growth in the health and community services sector in the five years to 2014-15 was 3.3% per year with 211,500 new jobs needed.<sup>5</sup> While Aboriginal and Torres Strait Islander participation in VET training is strong in the health and community services sector (5%)<sup>6</sup>, it is not translating into comparable rates of employment in the sector.

A review of the literature on pathways for Indigenous school leavers to undertake training or gain employment concluded that Aboriginal and Torres Strait Islander people “can become disengaged, disaffected and discouraged at any (or all) stages of the journey between school, training and ongoing work”.<sup>7</sup> Therefore, building the Aboriginal and Torres Strait Islander health workforce requires targeted efforts across the workforce development continuum:

- entry point – to support and enable entry into education and training
- training – to support Aboriginal and Torres Strait Islander people through the training journey
- retention – for ongoing support once Aboriginal and Torres Strait Islander people are in the workforce.

This paper focuses the development of the ATSIHW workforce, and identification of key elements needed to support a sustainable training model.

### Aboriginal and Torres Strait Islander health worker training

The national Aboriginal and Torres Strait Islander health worker training package was developed by the Community Services and Health Industry Skills Council in 2007, introducing clearly defined national training requirements for health workers. The training package covers qualifications ranging from Certificate II, Aboriginal and Torres Strait Islander Primary Health through to an Advanced Diploma qualification in a practice stream or community care stream. In 2010-11, there were 33 Registered Training Organisations (RTOs) offering courses within this package inclusive of public colleges of Technical and Further Education (TAFE) and Aboriginal and Torres Strait Islander Community Controlled organisations. However, the distribution of RTOs across Australia was not consistent, and there were limited opportunities for advanced health worker education i.e. Diploma and Advanced Diploma courses.<sup>1</sup> Detailed analysis of 9 of these RTOs indicated limited availability of Certificate II courses, and hence access to entry level courses.<sup>8</sup>

RTOs offer training under various models. Key elements of training models are outlined in Table 1.

**Table 1 Key elements of health worker training offered by RTOs**

|   |   |
|---|---|
| <b>Training approach</b>  |   |
| Block training  | Students attend a training centre, as a group, for intensive education and training. The duration and frequency of the blocks can differ between RTOs, but are typically of 2-3 week duration, offered a number of times for a unit of competency.<br>Block training offers efficiencies of Educator time.<br>This is the predominant approach to training. |
| Outreach (reverse block)  | Majority of training occurs in the health centre, with the educators working with the ATSIHW on a one to one or small group basis.<br>This training can be supplemented by short training blocks in a regional centre to minimise time away from the community.   |
| <b>Numeracy and literacy development</b>  |   |
| Offered in various ways including:  |   |
| <ul style="list-style-type: none"> <li>• Contract or employ teachers/tutors to deliver language, literacy and numeracy (LLN) programs</li> <li>• Certificate I in General Education added to scope of RTO</li> </ul>  |   |
| <b>Student support</b>  |   |
| This can include logistical support to attend blocks, mentoring, assignment support, tutorial support, job seeking/CV preparation, pastoral support.  |   |
| Approaches include:   |   |
| <ul style="list-style-type: none"> <li>• In reverse block training models, usually provided by educators</li> <li>• Preceptors identified in health centre and trained by RTO in preceptorship</li> <li>• Block training – educator visits the student once or twice a year while on placement or supported by Indigenous field officer employed by RTO to work with preceptor and clinic staff.</li> </ul> |   |
| <b>Placements</b>   |   |
| <ul style="list-style-type: none"> <li>• Where student employed, placements occur in workplace</li> </ul> OR <ul style="list-style-type: none"> <li>• Pre-employment students – negotiated by the RTO with the health centres in community in which student lives</li> </ul>  |   |
| <b>Workplace assessment:</b> Competency assessment has to be undertaken by qualified workplace assessor   |   |
| Various approaches:   |   |
| <ul style="list-style-type: none"> <li>• Use Educator as assessor</li> <li>• Sessional assessors visit workplace</li> <li>• Train qualified ATSIHW and/or Nurses – Cert IV Training and Assessment to undertake assessment in the workplace.</li> </ul>   |   |

## Educational outcomes

The absence of a unique student identifier, and ill-defined concept of student commencement has historically created technical difficulties in measuring course completion within the VET system. This has been relevant for all RTO types (i.e. TAFE, private and Aboriginal Community Controlled), and across industries. However, recent reforms to the VET sector, including the introduction of a unique student identifier will enable better measurement of educational outcome i.e. course completion, and length of time for completion.<sup>9</sup>

Recognising these limitations, a national study to measure educational outcomes indicated competency completions (i.e. unit completion rather than course completion) of 79% in the VET sector overall, with higher rates in the health field (83%).<sup>10</sup> Analysis of competency completion for a sample of RTOs offering the Aboriginal and Torres Strait Islander Health Worker qualification averaged just over 50%.<sup>8</sup> This study found student withdrawal from courses tended to be lower if the student was employed by a health service (similar to an apprenticeship arrangement), rather than on placement as a pre-employment student, with financial support through Abstudy.

## Factors to inform sustainable business models to deliver a qualified ATSIHW workforce

Within the context of training and development of the ATSIHW workforce, sustainable business models need to demonstrate:

|                                |                       |  |
|--------------------------------|-----------------------|--|
| Value to:                      | Students              | Competencies to achieve nationally recognised and accredited qualification   |
|                                | Employer and Industry | Confidence in skills and knowledge of the ATSIHW to provide health interventions; undertake client and program information management; work effectively with others internal and external to the workplace |
|                                | Funders               | RTO has governance, management and training capacity to meet workforce development deliverables  |
| Financial viability of the RTO |                       | Meet operating and governance costs  |
|                                |                       | Meet training costs, accreditation and compliance  |
|                                |                       | Capacity to expand/ develop new market   |

However many RTOs (community controlled and mainstream) service a highly disadvantaged student population. Students undertake placements, or work in health services distant to the RTO. The health services frequently have limited capacity to provide supervision and support due to high clinical workload and/or staff turnover, which can negatively impact on educational outcomes. The short-term funding cycle, and challenges in recruiting and retaining suitably qualified staff within the RTO contributes to lack of internal capacity, financial risk to the organisation, and compounds impact on educational achievements of the RTO.

The key factors contributing to the achievement of educational outcomes relate to the RTO, the training model and the student (Table 2).<sup>8</sup>

Therefore building the capacity of RTOs to support and develop the ATSIHW workforce requires:

- Longer term investment in organisations to attract and retain suitable and skilled staff, establish and maintain strong governance and management structures and processes, with adequate resourcing to provide the training model best suited to the needs of students, employers and communities
- Establishing an enabling environment within the workplace to support the education and training delivered by RTOs to improve educational outcomes for students
- Program administration and reporting mechanisms that support the RTOs to maximise existing capacity, rather than deplete it, such that over time they can access existing and alternative funding streams and meet new training markets.

**Table 2 Positive and negative factors impacting on educational outcomes for ATSIHWs**

| Factor  | Positive   | Negative  |
|---|--|---|
| <b>RTO related</b>  |  |   |
| Quality of governance and management  | <ul style="list-style-type: none"> <li>Builds capacity to identify and act on opportunities</li> </ul>   |   |
| Short term funding, multiple small funding sources  |  | <ul style="list-style-type: none"> <li>Heavy reporting burden</li> <li>Difficulties in recruitment and retention of quality staff</li> <li>Challenges the development of internal capacity within RTO</li> </ul>                    |
| Small and dispersed market  |  | <ul style="list-style-type: none"> <li>Difficult to develop economies of scale, financial viability, resource intensive</li> </ul>  |
| Competitive funding- payment on completion, place allocation  |  | <ul style="list-style-type: none"> <li>Decreases financial viability where retention in training is challenged</li> <li>Prolonged completion time impacts on cash flow</li> </ul>   |
| <b>Training Model</b>   |  |   |
| Block training  | <ul style="list-style-type: none"> <li>Economies in training delivery</li> </ul>   | <ul style="list-style-type: none"> <li>Barrier to enrolment</li> <li>Increased risk of withdrawal – family and community responsibilities</li> <li>Release for training, financial disincentives to student and employer</li> </ul> |
| Capacity of employer/ workplace <sup>1</sup> to provide supervision to support student and skills development | <ul style="list-style-type: none"> <li>Where available, improves retention, competency completion</li> </ul>   | <ul style="list-style-type: none"> <li>Not available, prolongs development of skills and competencies</li> <li>Increased risk of withdrawal</li> </ul>  |
| Negotiated and agreed role and responsibility of RTO, workplace and student                                   | <ul style="list-style-type: none"> <li>Promotes supportive learning in the workplace</li> <li>Improves student retention</li> <li>Promotes work readiness</li> </ul>         |   |
| Capacity for workplace competency assessment  | <ul style="list-style-type: none"> <li>Timely assessment to promote competency completion</li> <li>Capacity to undertake Recognition of Prior Learning assessment</li> </ul> |   |
| <b>Student</b>  |  |   |
| Inadequacy of financial support (Abstudy, Away from Base)   |  | <ul style="list-style-type: none"> <li>Withdrawal from training, source alternative employment options</li> </ul>   |

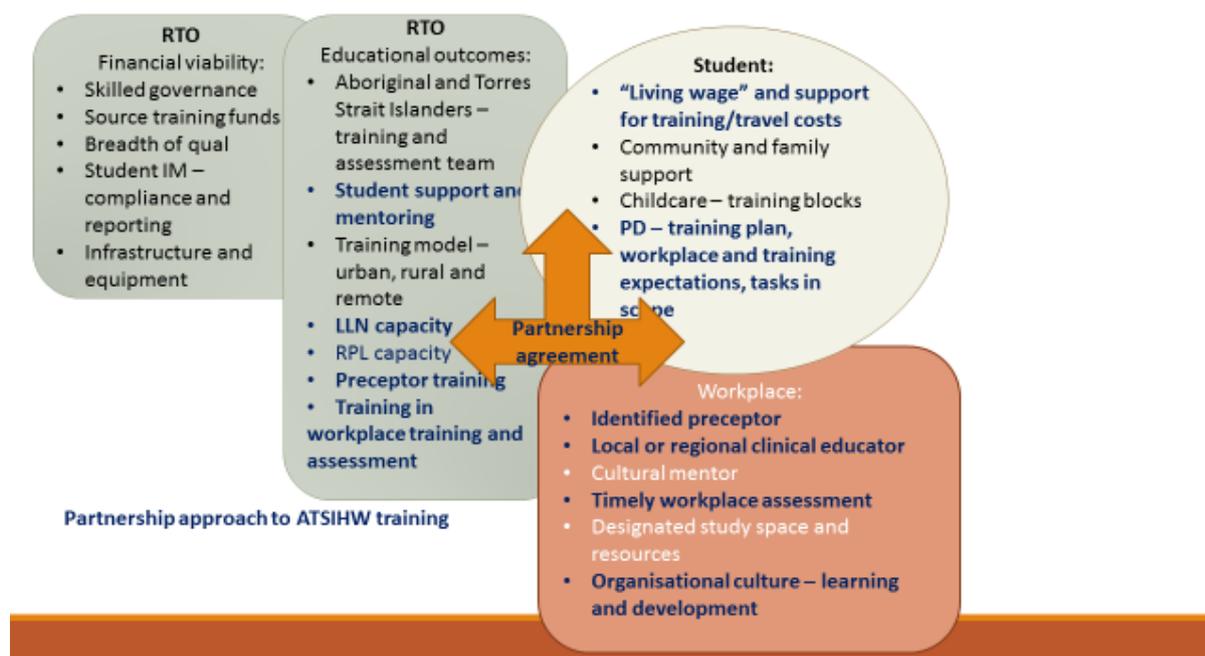
### Overview of Sustainable Business Model<sup>8</sup>

A sustainable model to support the training and development of the Aboriginal and Torres Strait Islander health workforce requires a symbiotic partnership between three components (Diagram 1):

- the organisation delivering training (the RTO)
- the student
- the employer and workplace.

<sup>1</sup> Employer/workplace – some students are employed by a health service, while others may be on Abstudy and undertake a placement within a workplace.

Diagram 1 Partnership approach to ATSIHW training



### Component 1: RTO

*Financial viability* - through established and skilled governance and management processes; core operational funding to enable capacity to source alternate training funds and meet emergent training needs; training delivery costed from first principles; breadth of qualifications to build critical mass; effective student data information management systems to support compliance and reporting; infrastructure and equipment.

*Educational outcomes achieved* - through Aboriginal and Torres Strait Islanders as key members of the training and assessment team; student support and mentoring; training model that supports engagement of men and women and relevant to urban, regional and remote; capacity to provide language, literacy and numeracy support; skills development in information management; capacity to RPL; training workplace preceptors; quality and accredited courses; partnership agreement with employer/workplace to articulate roles and responsibilities of the RTO, workplace and student.

### Component 2: The Student

Commencement and completion of training achieved through – “living wage” and financial support to meet training travel costs; community and family support; availability of childcare during training blocks; position description to articulate training plan, workplace/placement and training expectations, and tasks in scope.

### Component 3: The Employer/Workplace

Promote student educational outcomes through – identified preceptor in workplace; local/regional clinical educator to provide clinical training and support in the workplace; cultural mentor; designated study space and resources; timely workplace assessment; organisational culture to support learning and development of staff.

To implement this model requires changes to the current training model inclusive of:

- Structural shift in responsibility to employer/workplace as a training partner, supported through funded preceptor and regional clinical educator
- Increased utilisation of traineeships and apprenticeships by the employers to support a living wage for the student

- Partnership agreement between RTO, employer and student
- Core funding for RTOs that enables the development of organisational and training capacity to meet current and emergent educational requirements of a small, dispersed and disadvantaged workforce.
- Costing of the current and emergent training delivery models from first principles to inform government of the “real” cost of training this workforce to inform funding allocations and training bids.

### Clinical educator capacity in rural and remote health service settings: a missing element

Over recent years there has been increasing focus on the need to build clinical workforce training capacity in rural and remote health service settings as a strategy to increase exposure to rural, remote and Indigenous health practice, and to influence decision-making when health professionals are choosing a career path; to meet increasing demand for student clinical placements across professions. At the same time, government policy at a state, territory and commonwealth level is seeking to increase participation of Aboriginal and Torres Strait Islander peoples in the health workforce.

Remote health services are challenged to have the clinical supervision capacity needed to offer clinical placements for health profession students, supervision and on-site training for ATSIH workers and junior health professionals due to a range of workforce issues including:

- Staffing models where there is a high reliance on locums and agency doctors and nurses, and/or fly-in fly-out workforce, with limited continuity of clinical staff
- Staff turnover
- Patient load and acuity limiting capacity of experienced clinical staff to supervise students, junior nurses and ATSIHWs.<sup>11,12,13</sup>

Whilst clinical educator capacity is a feature of education and training in the acute sector, it is absent, or very limited in rural and remote primary health care. This is a key gap in the primary health care system, but is essential to the development of the ATSIHW workforce and the development of a remote ready health workforce.

### Conclusion

State, territory and commonwealth governments have stated policies to increase Aboriginal and Torres Strait Islander participation in the health workforce, and to build the rural and remote health workforce. However, until there is investment in clinical education capacity in rural and remote primary health care settings, over and above usual clinical supervision, these workplaces will continue to be challenged as effective training partners for ATSIHWs, students and early health professionals.

### 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 and 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.

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## Presenter

**Kristine Battye** is the managing director of KBC Australia, a public policy consulting company she established in 2001 specialising in policy analysis, program evaluation and strategic advice to governments and non-government organisations. The focus of much of Kristine's work is in health service planning, service modelling, workforce planning and policy development, and program evaluations and reviews. Kristine has predominantly worked in the rural, remote and regional health and community services sectors, and has undertaken a number of state and national projects to review the delivery of health services and programs to rural and remote Indigenous communities. Kristine has a particular interest in education, training and development to prepare a health workforce for rural and remote practice.