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Submission to Community Services and Health Industry Skills Council's Environmental Scan 2012

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This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Environmental Scan 2012

Introduction

The National Rural Health Alliance is comprised of 32 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health organisations (see Attachment 1).

The vision of the Alliance is good health and wellbeing for people living in rural and remote Australia. Its particular goal is equal health for all Australians by 2020. The Alliance believes that access to health care as close to home as possible is integral to achieving this goal.

The Alliance is keen to provide input to the Community Services and Health Industry Skills Council (CSHISC) 2012 Environmental Scan to emphasise particular issues that affect people in rural and remote areas. The *Guideline Questions for Environmental Scan 2012 submissions* (at Attachment 2) are more relevant to service providers or various sectors of the community services and health industry, so the Alliance's submission is more general in nature and does not respond specifically to those questions.

The role of community services and health workforce in health and wellbeing

Overall, people living in rural areas have shorter lives and higher levels of illness and disease risk factors than those in major cities. They do not have the same levels of access to good health as those living in major cities and are generally disadvantaged in their access to goods and services, educational and employment opportunities and income.[1] These factors are often referred to as the 'social determinants of health' which directly or indirectly impact on health and wellbeing.

The strength of the community services and health workforce in rural and remote communities is crucial in providing true primary health care, which encompasses a wide range of activity to improve the social determinants of health as well as the provision of direct health services.

Supply and demand

As is well known, there are serious shortages of health professionals in rural and remote areas in Australia. In general there is a gradient from major cities to very remote areas, with the shortages becoming worse with increasing remoteness. There is still a lack of adequate data about the existing health workforce (particularly for allied health), community needs and appropriate levels of workforce for the population.[2] There is also a lack of data on the

[1] AIHW 2011 http://www.aihw.gov.au/rural-health/

[2] *National Regional, Rural and Remote Health Workforce Strategy Draft Background Paper,* Health Workforce Australia, July 2011

numbers and types of services operating within the community services and health industries so that a meaningful and comprehensive disaggregation of workforce data is not available.[3]

Workforce data identified by rurality (using the Australian Standard Geographical Classification - Remoteness Area (ASGC-RA) system) should be developed for both the community services and health workforce. The data should cover the existing workforce, numbers of workers required to meet community needs and the emerging workforce (students), so that gaps and shortages can be identified and appropriate planning and programs can be put in place and then monitored.

The success and importance of the VET sector in the past can be seen by the more even distribution of enrolled nurses than other health professionals.

Indigenous health

The parlous state of Indigenous health remains the most important social challenge for Australia. To help remedy this situation, further actions must be taken to increase the numbers of Aboriginal and Torres Strait Islander people in the health professions and other vocations, including at VET level.

The education system from early childhood through to tertiary education needs to be strengthened to better meet the needs of Aboriginal and Torres Strait Islander people. A broad range of supports, mentoring, and supportive articulated professional education are required throughout the educational pathway.

Identifying potential health professionals at an early age and supporting them through their education and career development would assist. Leadership development programs and mentoring are very important because of the numerous demands placed on Aboriginal and Torres Strait Islander leaders who need to advocate for their people in multiple forums while also meeting both family and community obligations. The Australian Indigenous Doctors' Association (AIDA) has worked successfully to encourage and support Indigenous students to go into medicine and to run Indigenous Leadership programs.

Cultural awareness is particularly important for health professionals in rural and remote Australia because of the significant proportion of Indigenous people who live there. Cultural awareness education and training programs therefore need to be provided.

Services provided through the VET sector should be culturally safe for Aboriginal and Torres Strait Islander people, and health service providers need to recognise and manage power differentials to ensure that this is the case.

Building the capacity of the community controlled sector by supporting additional placements of community services, health students and young graduates will have a positive effect on the Aboriginal and Torres Strait Islander Health Worker (ATSIHW) workforce. These placements will promote peer supervision, formal and informal continuing professional developments (CPD) of the students and young graduates, and hopefully provide learning opportunities for the ATSIHWs. Informal learning activities such as self-study of reference material, clinical case discussion with other health professionals and internet research could

[3] Environmental scan2011, Community Services and Health Industry Skills Council, March 2011

indirectly assist ATSIHWs. This exposure could encourage Indigenous people who have chosen to undertake the Aboriginal and Torres Strait Islander Primary Health Care Certificate II and III to further their study and access pathways to a range of health careers.

From July 2012, people who register under the grandfather clause or who may be working towards achieving the Aboriginal and Torres Strait Islander Primary Health Care Certificate IV – Practice (in order to become registered under the National Registration and Accreditation Scheme as Aboriginal and/or Torres Strait Islander Health Practitioners) could also have the opportunity of having onsite access to supervision and CPD.

All applicants for Aboriginal and/or Torres Strait Islander health practitioner registration must be able to demonstrate they have an adequate command of the English language to the satisfaction of the Board. Given that in some of the remote services English is often a second or third language, the opportunity to practise English language skills is fragmented. Having an increased workforce and placements undertaking frequent visits to very remote communities would assist in English language proficiency.

Stream 2 of the Rural Health Continuing Education program, managed for the Federal Government by the NRHA, has supported Aboriginal Health Workers in the Northern Territory in receiving tuition to improve their literacy and mathematical skills.

Perhaps a better approach would be for health service providers to develop proficiency in Aboriginal languages so as to provide meaningful services to those for whom English is not a first language.

Increasing the rural and remote health and community services workforce

The serious maldistribution of the community services and health workforce must be addressed so that people in rural and remote areas have access to levels of health services comparable to those in other parts of the nation.

As one of the Alliance's correspondents has written:

> "It's important to have skills escalators where people can progress, for example, from AIN to Enrolled Nurse to Registered Nurse to Nurse Practitioner. Such a pathway spans the VET and university sectors. The National Broadband Network will facilitate studies at all these levels. Given the current emphasis on oral and dental health, we must not forget the dental therapy workforce."

There is evidence that rural background, rural education/training experiences and rural scholarships are predictors of ultimate rural work location[4] [5]. Establishment of a clear, well defined pathway to a health career in a rural or remote location, with appropriate support and mentoring through the years of education and during transition to work in a rural or remote area, would assist in attracting people to rural health careers. It would be essential to develop

[4] *Choosing general practice as a career – the influences of education and training,* Bunker and Shadbolt, Australian Family Physician 38:5, May 2009

[5] *Nature of association between rural background and practice location: A comparison of general practitioners and specialists,* Matthew R McGrail, John S Humphreys, and Catherine m Joyce, BMS Health Services Research 2011 http://www.biomedicacentral.com/a472-6963/11/63

and implement a strong marketing campaign targeted at high schools; tertiary institutions; students and their families – as well as at existing members of the rural health workforce.

Overall, students from rural areas are disadvantaged educationally when compared with those from major cities and tend to achieve lower marks on completion of high school.

> "Attendance figures, and particularly in high school, have actually got worse over the two years we've reported on and I think clearly children that are not attending school are going to have not only bad education outcomes, but it will flow into health and employment as well."[6]

Students from a rural background who have had at least five years in a rural area should have preferential admission to health and community services education programs and to scholarships that are available for these courses to enable them to re-locate as necessary for study.

Support should be provided for rural communities to 'grow their own' workforce.[7] A community could identify and mentor potential health and community service workers from the community and its schools or from within the current workforce. Provision of funding to enable a community to support a local person to complete education and training, perhaps with an obligation to return and work in local services during holidays and on graduation, would empower small communities to build their workforce from within the community.

The Alliance supports the increased focus on generalist practice across all professions, with broader scopes of practice and less rigid professional boundaries. It also supports the expansion of the 'assistant' workforce (allied health assistants, dental assistants, nursing and aged care support, and care workers) whose deployment has the potential to enhance and extend the capacity of health professionals and practices in areas of workforce shortage.

Many health professionals cannot operate at their highest level of efficiency because of excessive red tape, or lack of coordination, support or appropriate supervision. Such problems frequently lead to long hours of work and the potential for errors or burnout. In many rural and remote health services, the provision of adequate support, both within and outside the workplace (for the health professional as well as their family), would make a significant difference to retention of the workforce.[8]

Patient-centred care

A strong shift to patient-centred care will improve health outcomes. To enable this to happen, practitioners and health systems need to be more flexible, less 'siloed' and to recognise the roles and contributions of the patient themselves and the key people in the patient's life: family, carers and community supports. There need to be enhancements of health literacy and competencies within the community and for general workers within the health system, such as receptionists and ward clerks.

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[6] http://www.abc.net.au/lateline/content/2011/s3361963.htm

[7] A good example is at http://static.rbi.com.au/common/contentmanagement/AusDoc/pdf/RD_MAY11_P020_024.pd

8 See http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1584.2010.01139.x/full - "Systematic Review of Effective Retention Incentives for Health Workers in Rural and Remote Areas: Towards Evidence-Based Policy", AJRH.

While the notion of increasing mental health literacy is not universally applauded and is certainly not on its own a sufficient response to challenges in the mental health sector, the way in which the Mental Health First Aid training initiative has been rolled out provides a good example of how to increase health literacy within the community and for a wide range of health workers at all levels. This approach could be used across a range of health issues such as diabetes management and heart health.

The roles of case coordinator and care coordinator are essential parts of a multi-professional team. All health staff need to learn and take on the new role of 'health system navigator' to assist consumers and their families to work their way through the complexities of our health system. This will improve the provision of holistic care and the patient journey.

Support and networks for workers in rural and remote areas

Community services and health workers in rural and remote areas often lack support and networking opportunities that are more readily available in major cities. The use of technology for e-health and telehealth initiatives, for continuing education and training, mentoring and professional support, can be successful and should continue to be expanded. For many rural and remote service providers, financial support will need to be made available to set up the required infrastructure and to train local health personnel in its use. On-line mentoring and supervision should be funded and supported. In NSW, a 'virtual' mentorship program is provided via Skype with both participants receiving a fee.

The Mental Health Professionals Network provides a model for reducing professional isolation and providing mentoring and support, especially for young professionals new to rural and remote practice.

The difficulty in accessing continuing professional development locally is a major issue. Providing local CPD is a priority criterion for the RHCE 2 program - http://rhce.ruralhealth.org.au/about-rhce2). Rural and remote health and community service workers face significant travel and accommodation costs as well as the problem of leaving a gap in service provision for the time they are away. The Nursing and Allied Health Rural Locum Scheme (NAHRLS - http://www.nahrls.com.au/about-nahrls/)) has been funded to address some of these issues. However NAHRLS requires the workplace to pay for a locum and the staff on CPD. This is a deterrent and obstacle to having a locum - and rather than helping the organisation or area health service, it adds to their costs.

Also the Nursing and Allied Health Scholarship and Support Scheme does not fund backfilling of nursing, midwifery or allied health professional positions which makes it difficult for health professionals to take on CPD and postgraduate studies whilst they are working. Similar issues make leave for other purposes problematic as well, which can lead to burnout, disillusionment and departure from rural practice.

Regional Development Australia committees have great potential to have a positive impact on health systems and infrastructure. Each regional committee should be required to have a health sub-committee to work with agencies in the region to improve health infrastructure, workforce and service availability.

Existing regional entities such as local authorities, Regional Development Australia committees, Medicare Locals and Local Health/Hospital networks have a significant and developing role in providing support and resources for cross-sectoral leadership and support.

All such agencies should collaborate with the VET sector in their own areas and help attract, retain and successfully train health and health-related workers who can contribute so much to better health in rural areas.

Attachment 1

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRIG)	Australian Psychological Society (Rural and Remote Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

Attachment 2

Guideline questions for Environmental Scan 2012 submissions

How is the demand for services in your industry changing?

- What is driving change?
- How have you responded to these changes?
- What roles are emerging?

What workforce development trends exist?

- What are the current and emerging occupational shortages?
- What inhibits workforce development in community services and health?

How is workforce planning being undertaken in your sector, if at all?

What has been achieved to date in addressing workforce development challenges?

- What else is needed to address these challenges?
- What are the barriers and the opportunities in addressing these challenges?

How effectively are the training packages for community services and health supporting workforce development needs?

- What key changes are required to assist the industries in meeting their skills needs?

A new workforce development agenda proposes policy, strategies and funding that are broader than education and training only. How can workforce development and education/training policy best support community services and health industry growth and reform objectives?

Source: https://www.cshisc.com.au/docs/Escan/escan2012-key-trends.pdf