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TWENTY STEPS TO EQUAL HEALTH BY 2020

The NRHA's 20-Point Plan for improving health services and health workforce in rural and remote areas

Inspired by the terms of reference and work of the Senate Committee's Inquiry (see Attachment), the Alliance has produced this 20-Point Plan. The Plan is consistent with the views of the Alliance's 33 member bodies and each element of the Plan is specific enough to be adopted by governments as a new policy proposal. The total cost of the Plan would be modest, with some of the elements having no budgetary cost at all.

The elements of the Plan are listed in the chronological order in which they relate to the lifetime path of an individual who might work in the rural and remote health sector.

1. Getting more rural students into health professions

This first goal should be the subject of a coordinated series of campaigns to encourage high school students from rural and remote areas to enter health professional training. This work would be underpinned by the government mandating increased targets of rural student intake for all health professional faculties to 30 per cent, and requiring health science faculties to report publicly on the target. Other specific activities would include those to encourage rural students to apply for places in health science faculties. These programs would include modest additional funding for the health student clubs in the National Rural Health Students' Network to undertake their high school visits program, and micro-grants to organisations capable of producing good news stories about rural students in health professional training. These stories would be produced in various media forms: social media, television, radio and print. Among the results of this work would be more students in regional campuses with strong ties to rural and remote areas.

2. Getting more health students to undertake rural placements while in training

There is a desperate need to rationalise the system for rural placements in all health disciplines. The current situation is one in which individual universities compete for scarce places, and there is insufficient support for students when they take up rural placements (with the possible exception of medical students). The need for student accommodation is critical. These deficiencies of the current arrangements mitigate against undergraduates having the sort of supported, safe and successful placement which will lead them to further interest in rural and remote practice. Consideration should be given to increasing the mandatory requirement for undergraduate students to have at least some time in a regional placement. Curriculum development to support rural and remote practice is also an issue.

3. Getting more Aboriginal and Torres Strait Islander people into the health workforce

Some great strides are being made on this front already but efforts need to be redoubled, with the Federal Government showing leadership and providing necessary financial and institutional support. The benefits of having Aboriginal and Torres Strait Islander health staff to work with Indigenous patients are well-known. Successful developments on this front should be augmented by activity to ensure that people in the so-called 'mainstream' health system are equipped with the training and tools to work in ways that are culturally safe with Aboriginal and Torres Strait Islander people. (Canada has some good approaches to this.)

4. Ensuring positive modelling and leadership on rural practice for tertiary students

It is very dispiriting to hear anecdotes of the way health students are exposed by their teachers and mentors to unhelpful and one-sided views and myths about rural practice. Universities and professional associations should take the lead to ensure that both through the protocols and practices of their profession, and through the words and modelling of individual teachers and leaders, health professional practice in remote areas is promoted for what it is: challenging but rewarding, broad in scope, more frequently multidisciplinary and interdisciplinary, and undertaken in parts of Australia with strong social and community benefits.

5. Promoting knowledge of the various rural incentives available, and of the positive elements of rural practice, to late-year undergraduates and new graduates

It is clear that, even in their later years, many students and even their teachers are unaware of the range of incentives available for rural practice and the special programs designed to encourage and support clinicians in rural and remote areas. The Alliance has heard anecdotes of health faculty Heads who are not aware of the HECS reimbursement scheme for medical students. The Federal Government should increase and improve its communications with health professional bodies, universities, Health Departments and non-government organisations to make sure there is widespread knowledge about the incentives and support systems available.

6. Creating a greater proportion of supported placements for new health graduates that can be undertaken in rural and remote areas

Health Workforce Australia will be the key agency to increase the proportion of 'practice ready training' that is undertaken in rural and remote areas. This is the training that junior doctors and new graduates from nursing, dentistry and allied health courses need to undertake to further develop their skills and competencies in professional rural practice.

7. Increasing the proportion of vocational training for health professionals that is undertaken in rural and remote areas

Among other things, this will require the collaboration of professional Colleges and registration bodies to ensure that the accreditation of training posts is flexible enough to permit a greater proportion of training to occur in rural areas without any loss of quality and safety. The Alliance has completed work on this issue where junior doctors are concerned and it is clear that, with the goodwill and support of the range of regulatory bodies and organisations engaged, the settings in which vocational training is undertaken could be varied with great advantage for potential rural practitioners. Rural and regional communities would be better able to grow their own health professional and the vocational training system could in some circumstances be turned on its head. Rather than having training rotations based only in capital cities and major regional centres, with occasional placements in rural areas, the home base for vocational training could be in regional centres, with rotations in the cities as necessary for more specialised content.

8. Enhancing the capacity of existing practitioners in rural areas to accommodate, mentor and supervise new graduates and vocational trainees

This will require continued budgetary allocations to the upgrade of rural practices to enable them to provide space and infrastructure for vocational trainees. There also needs to be proper remuneration and support for the mentors and preceptors involved, including academic support for them and capacity building.

9. Extending the coverage of University Departments of Rural Health

The number and capacity of UDRHs should be expanded to ensure that all rural and remote regions are served by a UDRH and that they have enhanced capacity to support the training and placement in rural and regional areas of health professionals across the board.

10. High-level work to balance the incentives for health professionals to train for generalist rather than specialist practice

It is widely acknowledged that specialisation and sub-specialisation - and not just in medicine - can undermine efforts to recruit and retain health professionals in rural and remote areas. There needs to be a rebalancing within the professions so that broad, general qualifications and competencies are encouraged, enabled and competitive in terms of remuneration with specialties. The Federal Government should lead work on this with the professional Colleges and set targets and benchmarks to ensure that progress is made.

11. Targeted infrastructure and human resources programs to maximise the opportunities for use of information technology in health, including as back-up to training and mentoring of health professionals in rural areas

Flexibility of training posts and supervision can obviously be enhanced through greater use of information technology. This requires both the IT infrastructure and the human skills. The rollout of the NBN should further emphasise its benefits for rural and remote health. Improved IT infrastructure will also speed the adoption of telehealth and its further adaptation across other settings and applications, as well as supporting the uptake of eHealth records. IT innovations have great and ever increasing capacity to improve the safety of patient pathways for people in rural and remote areas who of necessity will receive more specialised care from cities and regional centres.

12. Enhanced support for the role and capacity of Rural Workforce Agencies

The Rural Health Workforce Agencies play a leading role in the recruitment and retention of health staff, and in provision of support for professionals relocating or taking up careers in rural and remote settings. There needs to be growing support for these agencies and enhanced recognition of the roles they play.

13. National leadership on work to ensure health practitioners are able to work collaboratively and maximize their individual contributions within their full scope of practice

With ever-increasing demand for health care, due to demographic ageing and greater volumes of chronic disease, and the shift to collaborative multidisciplinary health care as best practice, it is essential to make the best use of every health practitioner available. In the context of the team care approach which is already characteristic of rural and remote areas, this means that all health professionals should be working within their competencies to their full scope of practice. Patient care should not be delayed when the necessary attention can be provided safely and competently by another member of the team. The Australian health sector needs to work confidently through its fears about 'workforce substitution' to the situation in which there is optimal use of each member of the health professional workforce team.

14. Refurbishment of the recruitment and retention programs for health professionals to ensure their effectiveness for places in particular need and for the new generation of practitioners

The review of workforce programs being undertaken in the Department of Health and Ageing should start from the premise that, despite the wide range of programs in place, there is still severe mal-distribution of the health workforce, with rural an d remote areas consistently missing out. It should also be recognised that the increased numbers of health trainees and junior practitioners come largely from a new generation for whom there is no doubt a different balance of factors determining decisions about where and how to practice. Refurbishment of health workforce programs must include the development and application of an improved and consistent measure of health workforce shortage that extends beyond the geographic remoteness measures such as ASGC-RA and RRMA alone. Consideration should be given to extending the use of HECS reimbursement schemes to dentists, nurses and allied health professionals willing and able to practise in rural and remote areas.

15. Ensuring that the funding and governance of Medicare Locals equips them for their role in the identification of service gaps and provides them the wherewithal to fill those gaps

A great deal is expected of Medicare Locals, including with respect to service gap analysis and workforce development. Given the logistical challenges of greater distance and sparse populations, Medicare Locals that cover rural and remote areas will need particular support and funding to meet these expectations.

16. Greater involvement of Commonwealth, State and Territory governments in special cost sharing arrangements for salaried staff in areas of very particular need

It has proved to be consistently hard to recruit health or other professionals to some areas and communities in certain parts of Australia. Equal health for people in these 'hard to recruit' places will continue to depend on special arrangements between jurisdictions for such things as salaried health (including medical) positions. The 'worst first' principle should make it incumbent upon Federal and State/Territory Governments to put aside their differences and do whatever needs to be done to provide service to areas in great need.

17. Working with professional Colleges to ensure that mature-age clinicians willing to work part-time as mentors and preceptors are able to do so

Mature age health practitioners who want to relinquish full-time practice constitute a significant resource which should be better utilised. There will need to be agreement about registration and competence matters, so that creative and collaborative approaches can be developed in which their skills as mentors, supervisors and supporters can be used to best effect.

18. Improvement of national data collection and analyses to provide the means by which health outcomes can be measured for individual Medicare Locals and by rurality

Data on health professionals in practice and access to appropriate healthcare professionals and services is still deficient. The work of the Australian Health Practitioner Regulation Agency promises much, as does the forthcoming activity of the National Health Performance Authority. But there will need to be a measured and conscious effort to maximise the use of data available, including for the healthy communities reports to be produced by Medicare Locals. In terms of making progress towards equal health by 2020, much could be gained from having analyses of existing datasets by rurality.

19. An increased emphasis in Australia's health research effort on health service system research for rural and remote areas

Australia's health and medical research effort is currently focused to too great an extent on biomedical research. There needs to be greater emphasis on the social determinants of health, and on health service system research. The considerable capacity of Australia's rural and remote health research sector needs to be recognised and better supported.

20. Continued national commitment to building universal schemes for dental care and disability

The starts made in this year's Budget on improved dental health services and the national disability insurance scheme must be continued in the next few years. With uniform national schemes in place for these two key need areas, some of the inequity and disadvantage faced by rural people in these population groups will be ameliorated.

May 2012

Attachment

Senate Standing Committee on Community Affairs

Inquiry into the factors affecting the supply of health services and medical professionals in rural areas

TERMS OF REFERENCE

The factors affecting the supply and distribution of health services and medical professionals in rural areas, with particular reference to:

(a) the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;
(b) the effect of the introduction of Medicare Locals on the provision of medical services in rural areas;
(c) current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:
    (i) their role, structure and effectiveness,
    (ii) the appropriateness of the delivery model, and
    (iii) whether the application of the current Australian Standard Geographical Classification - Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes; and
(d) any other related matters.