Submission to Community Services and Health Industry Skills Council 2014 Environmental Scan (EScan 2014)

Respondent details

A. Organisation name: National Rural Health Alliance (NRHA)

B. States/Territories the organisation operates in: member organisations are national organisations, represented across all Australian States and Territories.

C. Does the organisation have specific responsibilities in relation to rural and/or remote areas? Yes
The NRHA is currently comprised of 34 Member Bodies, representing health consumers, health and aged care professionals including doctors, nurses, allied health, researchers, health educators, students, the Indigenous health sector and consumers including Country Womens Association and Parents of Isolated Children.

D. Main role of the organisation: The Alliance's broad representative base places it in a unique position to collect and disseminate information, determine key issues that affect health and wellbeing in rural and remote areas, and provide a breadth of vision on rural health matters to governments, educational and research institutions, and other professional bodies.

E. Sector(s) the organisation is engaged in.

The Alliance works with its Member Bodies http://www.ruralhealth.org.au/about/memberbodies :

- to promote the benefits of life in rural and remote Australia;
- to identify priority needs in rural and remote health and promote appropriate action;
- to research key issues in rural and remote health and develop knowledge about them;
- to disseminate relevant information and knowledge to those with an interest in rural and remote health;
- to provide feedback to governments on the health impacts of their policies and services in rural, regional and remote communities;
- to encourage stronger organisations and population groups to recognise and support those which are vulnerable;
- to develop strategic alliances with other groups that have the potential to improve rural and remote health outcomes; and
- to undertake resourced project and contract work that supports its vision.

Changes to the community services and health workforce

Q1: In the previous 12 months, what have been the key changes in workforce demand and requirements in your sector? (Either nationally and/or in a particular region)

National reforms in the disability care, aged care sector (including dementia and Alzheimer's), and health workforce reforms will have significant impacts on rural and remote workforce and bring opportunities for more personal carers, allied health assistants, disability carers and Indigenous health practitioners / workers who will require TAFE training.

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,(AIHW 2011 http://www.aihw.gov.au/rural-health/). 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.

Q2: What is driving the changes in workforce demand and requirements in your sector? (Either nationally and/or or in a particular region)

http://ruralhealth.org.au/sites/default/files/publications//nrha-factsheet-way-forward.pdf

The shift to client/patient-centered care in aged care and disability care sectors will impact on the workforce requirements and training of health professionals especially those working in rural and remote locations. Practitioners and health systems will need to be more flexible, less 'siloed' and to recognise the roles and contributions of the client/patient themselves and the people in the patient's life: family, carers and community supports. There needs 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.

In Disability Care and Aged Care, the roles of Case Coordinator and Care Coordinator with local knowledge and connections are very important in a multi-professional team. In order to have adequate numbers of these coordinators, local people and health professionals will need to be up-skilled to work collaboratively and locally with regional teams (Hub & Spoke , FIFO). All health staff will 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. See the NRHA Opinion Pieces *Equitable disability care for people in rural areas http://www.ruralhealth.org.au/opinion-pieces, and Health and disability service models in rural and remote areas http://www.ruralhealth.org.au/news/health-and-disability-service-models-rural-and-remote-areas.*

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 professionals 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. Refer to http://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/submission/sub-twenty-steps-16-may-12.pdf

The RAMUS Scheme, managed by the Alliance for the Department of Health and Ageing, assists selected students with a rural background to study medicine at university. In addition to their rural background, RAMUS scholarship holders are selected on the basis of financial need and demonstrated commitment to working in rural Australia in the future. See http://www.ruralhealth.org.au/ramus.

Workforce development priorities

Q3: What new workforce development priorities are emerging in your sector? (Either nationally and/or or in a particular region)

The final report of **the Mason Review of Australian Government Health Workforce Programs** was publicly released on 24 May 2013 - http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~chapter-4-addressing-health-workforce-shortages-regional-rural-remote-australia.

In regards to RHCE2 - Recommendation 4.17 states: **"**The Rural Health Continuing Education (RHCE) program (Stream 2) provides a good basis for supporting postgraduate training in allied health and nursing, but is significantly oversubscribed. The Commonwealth should consider expanding this program and linking it to other training initiatives, subject to the availability of further funding. Timeframe: Longer term – expansion will be subject to funding availability."

20 steps to equal health for rural people by 2020

The Alliance's 20-point plan recommends greater acknowledgement and support for University Departments of Rural Health and Rural Health Workforce Agencies. It identifies work practices that are constrained to the urban practice models of the past as challenges to be overcome, and increasing access to broadband and the other infrastructure and knowledge needed to make the most of e-Health are among developments being closely monitored because of their contribution to successful recruitment and retention. http://nrha.ruralhealth.org.au/cms/uploads/publications/twenty_steps_to_equal_health_for_website_11may2012.pdf

Disability & Aged Care workforce in rural and remote areas

Determined efforts should be made to overcome:

- the shortages in rural and remote areas of medical, nursing and allied health professionals;

- the lack of access to community support services (eg reliable and appropriate transport and mobility equipment); and
- the lack of available/affordable home based services (eg Home Help) required for disability and aged care.

Action to remedy this situation should include:

- broadening the training opportunities available to health professionals (especially in allied health), disability support workers, aged care workers, and locals who can provide non-professional support;
- consolidation of part-time health positions to full-time, fairly renumerated**, sustainable jobs across the local community to address the changing needs of health, aged and disability sector clients; and
- increased availability of allied health therapy and counselling services.

Some of the additional health professionals, who will need to be recruited to rural and remote areas and existing local professionals whose scope of practice might increase, will need additional training and support.

To address disability workforce training issues, the NDIS Transition Agency should set up collaborative arrangements with University Departments of Rural Health and other education providers to help provide such training. (NRHA Final Report June 2013, *Delivering equitable services to people living with a disability in rural and remote areas*, FaHCSIA Practical Design Fund (NDIS) Project 2013).

**The Alliance favours flexible approaches to funding for health professionals so that they can work together and make the best use of local resources in delivering multidisciplinary services, working collaboratively with visiting specialist services to provide ongoing care. This approach is highly relevant to people with disabilities and dementia in country areas, so that they can benefit from specialist care within the context of their own community, and with the support of their usual carers and health and aged care providers.

Health promotion and early intervention

The Alliance supports a stronger emphasis on health promotion and early intervention in rural and remote Australia where health risk factors are higher. Preventive measures such as those to reduce smoking, risky alcohol consumption, obesity, diabetes and other health risks should be tailored specifically to reach those communities and groups which have the greatest need. These measures should include multidisciplinary teams working together to build local community capacity to sustain healthy environments in which these major risks to health are minimised at the community level.

National Rural Health Plan

The Alliance supports the development of a national Rural Health Plan to operationalise the National Strategic Framework for Rural and Remote Health and to build on the success of *Healthy Horizons*. It should include specific targets, performance indicators and national accountability. A coherent national plan and framework for rural and remote health services is required as a matter of urgency. The piecemeal approach to rural health challenges – with divided government responsibilities – is not delivering adequate or fair levels of care to the 32 per cent of Australians who live in rural and remote communities. The overall purpose of a National Plan would be to identify and work towards meeting key priorities in rural health care within given time periods, to report on progress towards these priorities and to provide accountability on the question of what outcomes national reform measures are delivering for people in rural and remote Australia.

Examples of actions/ interventions and their impact on the care industry
Q4: Please describe any specific activities that aim to address existing and emerging workforce development priorities - and the impact these activities have had.

Rural Health Continuing Education Stream 2 program
Health care professionals working in rural and remote Australia have an ongoing need for access to high quality continuing professional development and professional peer support. However, their access is often limited by issues relating to their location, workload and required commitments of time and other resources. The RHCE2 Program has been developed to help rural and remote health professionals to overcome these constraints, see http://rhce.ruralhealth.org.au/about-rhce2.

The primary objective of the RHCE2 program is to help Aboriginal Health Practitioners/Workers, allied health professionals, nurses, midwives and general practitioners in rural and remote areas of Australia to access cost-effective, timely and relevant continuing professional development (CPD). Details of the funded projects can be found RHCE2 website, http://rhce.ruralhealth.org.au/grant-allocation.

Occupations represented in four RHCE2 funding rounds included general practitioners (including some trained overseas), nurses (including enrolled nurses, practice nurses, cancer and respiratory nurses, remote area nurses), midwives, Aboriginal Health Workers, aged and palliative care workers, podiatrists, dieticians and nutritionists, audiologists, physiotherapists, psychologists, pharmacists, occupational therapists, dental therapists and oral health workers, mental health and social workers, Alcohol and Other Drugs workers and sexual and reproductive health workers.

In June 2013, an external evaluator was appointed to undertake a national evaluation of the RHCE2 program. The final report is due in December 2013, interim results may be available in October 2013. The evaluation includes key stakeholder and fund holder surveys, analysis of projects data and outcomes, 8-10 case studies and recommendations.

Many of the current RHCE2 projects have developed and piloted new models and a wide range of resources and technologies. Another 3-5 years is needed to demonstrate/consolidate the transferability, portability and viability of these models and to allow customisation of the products for other locations or to implement nationally.

Other scholarship programs (NAHSSS & SARRAH) and locum programs (NAHLS and Doctor Locum programs) are targeted at *undergraduate and postgraduate individual* health professionals. Whereas RHCE2 is targeted at *groups of individuals and organisations accessing, developing and delivering /implementing postgraduate professional development and up-skilling of practising health professionals in rural and remote Australia.*

RAMUS Scholarships for rural students studying medicine

The RAMUS Scheme http://ramus.ruralhealth.org.au/about assists selected students with a rural background to study medicine at an Australian university. In addition to their rural background, RAMUS scholarship holders are selected on the basis of financial need and demonstrated commitment to working in rural Australia in the future.

RAMUS scholarship holders receive $10,000 a year during the completion of a standard medical degree at their chosen university. This financial support assists scholarship holders to overcome the financial barriers to studying medicine at university, particularly the costs of moving and living away from their family support structures.

The RAMUS scholarships are not bonded. Scholarship holders are encouraged to take part in activities to maintain and strengthen their ties to rural Australia and to develop an appreciation of work as a medical practitioner in rural areas. All scholarship holders have a rural doctor as a mentor and are required to be a member of their university's student rural health club. About 500 rural doctors across Australia participate in the Scheme as mentors.

Dental Incentives

The shortage of public dental professionals is particularly pronounced in rural areas. About 28 per cent of public jobs were recently unfilled in rural New South Wales and the figure may well be higher in more remote areas. Private dental services, too, are more easily accessed in major urban centres than in small or moderately large rural towns. Dental specialist care is often much more difficult for rural and remote people to access.

Between 2005 and 2014 the number of Australian dentistry and oral health graduates is expected to double to around 600 a year.

- More than 100 overseas trained dentists now qualify and register to practise in Australia each year.
- During the past six years Griffith, Newcastle, La Trobe and Charles Sturt Universities have established both dentistry and oral health courses, while James Cook University now offers dentistry. Each new dental school promotes a strong rural student focus and a rural and Indigenous service focus.
- The coverage of fluoridation is spreading, particularly where it is most needed in Queensland and country Victoria.
- Disadvantaged people would have a great deal to gain from a program such as Denticare, providing it clearly addresses rural and remote inequities through strong policy and funding decisions.

Undergraduate and continuing education programs for Australia's health professionals should be re-shaped to instil and maintain a service culture that focuses on health and wellbeing, health equity and person- and population-centred care. There needs to be a national strategic effort to address maldistribution of dentists and address recruitment and retention of greater numbers of dentists, dental hygienists and dental/oral health therapists to rural and remote areas and to public dental services generally. Refer: www.ada.org.au .

Medicare Locals

Out of the 61 Medicare Locals across the country 26 have more than 50 per cent of their population in rural and remote areas. Issues facing these organisations are different from those in metropolitan areas – how they provide after-hours services is a prime example. Rural Medicare Locals are working together to develop ways and means of addressing health services to improve the health of people living in rural and remote Australia.

The Australian Government provides funding to Medicare Locals to administer the Access to Allied Psychological Services (ATAPS) program. The ATAPS program provides people with access to effective low-cost treatment for those with **mild to moderate** mental disorders that can respond well to focussed psychological strategies – see http://amlalliance.com.au/medicare-local-support/primary-mental-health/overview. Other Australian government funded programs implemented through the Medicare Locals and general practice include the Mental Health Nurse Incentive Program (MHNiP) and the Rural and Remote Mental Health Services program.

Need for more Allied Health services under the ATAPS Program working in rural and remote areas?

The following health care professionals are eligible to provide services through ATAPS which is coordinated locally through each Medicare Local:

- Psychologists;
- Appropriately trained nurses;,
- Occupational therapists;
- Social workers; and
- Aboriginal and Torres Strait Islander health workers

Credentials in the mental health field and maintaining the appropriate continuing professional development requirements of the relevant professional bodies are also required to ensure a continuing high level of service delivery and improved outcomes for consumers.

Data Sources

HWA Workforce Innovation and Reform http://www.hwa.gov.au/work-programs/workforce-innovation-and-reform, http://www.hwa.gov.au/sites/uploads/WIR-Strategic-Framework-for-Action-progress-report-V3.pdf

AHPRA http://www.ahpra.gov.au/About-AHPRA/AHPRA-in-Numbers.aspx and http://www.ahpra.gov.au/Health-Professions.aspx

Health Workforce Australia http://www.hwa.gov.au/health-workforce-2025

COAG Reform Council. Disability 2011-12: Comparing performance across Australia. 30 April 2013. http://www.coagreformcouncil.gov.au/reports/disability/disability-2011-12-comparing-performance-acrossaustralia

Vision for the future community services and health workforce

Q5: How does the community services and health workforce need to change to meet future demands?

The NRHA seeks a commitment from the government to a refurbished approach to the rural and remote health workforce, with an emphasis on optimal distribution and skill mix rather than just the absolute numbers. An improved and re-oriented approach to health workforce recruitment and retention should include an integrated rural training pathway for nurses, allied health professionals, dental, professionals, pharmacists and doctors. Seamless transition for rural health students from education to training and employment will deliver a better supply of health workers for services in rural and remote areas. We also encourage Government to work with Medical Colleges to encourage registrar training in general surgery and medicine to be based, as is general practice, in regional settings with strong hospitals and high quality services. Urban based postings should be an 'outreach' to add specific experience.

Q6: What new job roles do you think there is a need for, and in each case is the need national, state-wide or regional?

Older Australians are a rapidly growing group with both special vulnerabilities and

underutilised skills and capacities. With appropriate supports and interventions they can contribute even more than is currently the case to the nation's economic and cultural life. They provide valuable skills, experience, time and other resources, especially in rural areas where they are in greater proportion and where a palpable and valuable sense of community is built on the skills and energies of locals.

For initiatives relating to child and adult oral health to succeed in rural and remote areas it is essential that the measures in place to redistribute the oral health workforce are effective and quickly build parity in access to private and public oral health services for country people. Rural oral health teams are needed for preventive oral health as well as restorative dentistry. Given their higher rates of decayed, missing and filled teeth, country people must receive the services they need as a matter of urgency.

Q7: What new job roles are being recruited for, and in where is this recruitment taking place (e.g. specific sectors, regions or states).

The work of DisabilityCare Australia has the capacity to augment the financial basis for allied health positions in rural areas. Allied therapy assistants could help here as they can be based locally. In the new system spearheaded by DisabilityCare Australia there will be an important place for local case managers or care coordinators who can work with the support of the specialised and more centralised interdisciplinary rehabilitation or care team that may be based regionally.

Actions for the Community Services and Health Industry Skills Council (CS&HISC)

Q8: What supportive actions from government, CS&HISC and/or other agencies would help your organisation to perform its role(s) more effectively?

http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/positions/nrha-priority-recommendations-17-june-2013.pdf

Given the expanded role that allied health professionals can play in integrated health, aged and disability care, existing programs should be expanded and new initiatives introduced for encouraging more allied health providers to work and live in rural and remote areas. The additional resources expected to be available in both the disability and aged care sectors will help underpin such efforts.

The Alliance calls for additional program funds and a flexible approach to telehealth which includes store-and-forward services as well as real-time consultations. These additional services should be underpinned by broader MBS items and appropriate training and support for the clinicians involved. The new programs would support interactions between and among doctors, nurses and midwives, allied health professionals and Aboriginal Health Workers. Uses will include health monitoring, video consults, interim reviews between consultations and professional supervision sessions.

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.

Q9: Is there anything new or different in terms of content and approach you would like to see in EScan 2014?

Information on training pathways, demographic changes and new workforce structures with analysis on how they are expected to improve quality of services and health outcomes in rural and remote locations.

Other comments

The Vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia. The Alliance has a particular commitment to equal health for country and city people by the year 2020.
The Alliance is working to meet this commitment in four ways:

1. by improving knowledge and understanding of the health and wellbeing of people in rural and remote areas;
2. by being an effective advocate on issues affecting the health of rural people;
3. by working in collaborative relationships, including with our 34 Member Bodies; and
4. by ensuring the Alliance continues to be an effective, sustainable and ethical organisation. (Extract from 2013 election campaign, Shine a Light on Rural and Remote Health http://www.ruralhealth.org.au/advocacy/election).

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