National Rural and Remote Health Workforce Innovation and Reform Strategy

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Executive summary

Vision
A rural and remote Australia with an appropriate, skilled and well supported health workforce that meets the needs of the local community.

Principles
Health workforce policy, planning and development for rural and remote communities should:
1. Be focused on building the capacity for person-focused and responsive health care with an emphasis on individual and community need at a local level.
2. Give priority to the further development of the Aboriginal and Torres Strait Islander health workforce.
3. Acknowledge that there are a number of differences between the rural and the remote environments which affects the application of training, policy, funding and planning.
4. Build the health system’s capacity for the provision of culturally safe care.
5. Promote evidence-based workforce reforms that support workforce retention, full and expanded scopes of practice, generalism and flexibility within a framework of quality and safety for consumers.
6. Build on successful local workforce innovations, particularly those that show promise for national scalability.
7. Place an emphasis on building health literacy, consumer engagement and greater capacity for health prevention and self-management.
8. Maximise the use of effective technology where it supports delivery of quality healthcare in rural and remote areas.

Priority recommendations
1. Develop the rural and remote workforce in alignment with current health reform initiatives through:
   • promoting better use of existing roles
   • redesign of existing roles
   • creating new roles on the basis of consumer need.
2. Support and enhance the growth of education, clinical training and career opportunities in rural and remote Australia.
3. Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future.
4. Plan for the optimal use of skills and adoption of workforce innovation and reform, by developing appropriate planning and modelling approaches for the rural and remote health workforce.
5. Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.

Strategic actions
To support attainment of the priority recommendations, a number of actions have been identified under the National Health Workforce Innovation and Reform Strategic Framework for Action (2011-2015), domains for action.
Implementation

Health Workforce Australia (HWA) will collaborate with key stakeholders to drive the adoption and implementation of the National Rural and Remote Health Workforce Innovation and Reform (RRHWIR) Strategy. Implementation will require national coordination across government, higher education, regulatory bodies, employers, industry, the professions, the private and the not-for-profit sector.

Background to the strategy

National Rural and Remote Health Workforce Innovation and Reform Strategy

The mortality gap between rural and remote areas and major cities continues to be high in Australia. This mortality gap is influenced by the higher death rates of Aboriginal and Torres Strait Islander people and by higher death rates among young adults living outside major cities. Between 2004 and 2006 there were 4,600 ‘excess deaths’ outside major cities, from coronary heart disease (20 per cent of excess deaths), ‘other’ circulatory disease (17 per cent), chronic obstructive pulmonary disease (9 per cent), motor vehicle crashes (8 per cent) and suicide (4 per cent).

Rural and remote areas of Australia also experience shortages of skilled health workers. In 2006 the ratio of full-time equivalent (FTE) medical specialists to population in major Australian cities was four times higher than the ratio in remote and very remote areas. Important regional variations are also seen in the availability of nurses and midwives who form 50 per cent of the health workforce nationally. The maldistribution in medicine, dentistry and allied health is a global problem. This is highlighted in the World Health Organisation (WHO) report, ‘Increasing access to health workers in remote and rural areas through improved retention’ and its evidence-based recommendations relating to education, regulation, financial incentives and personal and professional support.

Health Workforce Australia’s (HWA) task has been to develop a National Rural and Remote Health Workforce Innovation and Reform (RRHWIR) Strategy that offers a comprehensive course of action to address workforce issues for rural and remote areas and identify key innovations and reforms with potential for national application.

The purpose of the National RRHWIR Strategy is to provide a suite of strategic actions for adoption at national, jurisdictional, and agency level to add value to what is already underway, and to facilitate productivity improvements and workforce flexibility.

Development of the National RRHWIR Strategy

The development of the National RRHWIR Strategy has been informed by:

- The development of a background paper that included a review of the literature on rural and remote workforce issues and reforms (nationally and internationally), and a scan of efforts already underway in Australia.
- A call for written submissions.
- National consultations in rural, remote, regional and major urban settings.
- Consultations with peak government agencies which influence policy and program development nationally in the health, education and regional development sectors.
- Consultations with the health profession registration boards under the Australian Health Practitioner Regulation Agency (AHPRA).

An Expert Reference Group (ERG) was established to guide the development of the National RRHWIR Strategy and to provide feedback on early and final drafts.

All of these sources have informed the content and direction of the National RRHWIR Strategy.
The National RRHWIR Strategy provides advice on what is necessary to address the challenges facing the health system in rural and remote Australia for:

- Commonwealth, State, Territory and local governments.
- Health service providers.
- Employers.
- Private and non-government sector.
- Higher education.
- Training sector.
- Health professional registration and accreditation agencies.
- National agencies focused on health reform.
- Consumers.
- Professional bodies.
- Unions.
- Student and trainee workforce.

The National RRHWIR Strategy does not provide advice on operational rural and remote workforce issues, organisational key performance indicators or service delivery in isolation from linkages to health workforce reform.
Implementation of the National RRHWIR Strategy: next steps

HWA will collaborate with key stakeholders to drive the adoption and implementation of the National RRHWIR Strategy. This will involve building the evidence, including planning, research and evaluation, and providing this information to assist governments and key decision makers in rural and remote areas to deliver the changes needed to meet the challenges facing this workforce.

Addressing the challenges facing the rural and remote workforce cannot be achieved in isolation. It will require national coordination across government, higher education, regulatory bodies, employers, industry, the professions, the private and the not-for-profit sector.

Almost all health systems are dealing with costs growing at unsustainable rates that are not being matched by a rise in revenue. Adoption and implementation of the National RRHWIR Strategy will support increased capacity through productivity gains, workforce redesign and where identified, increased workforce numbers. HWA recommends current and emerging rural and remote workforces and workplaces adopt the National RRHWIR Strategy.

If implemented, the National RRHWIR Strategy will support the development of a sustainable, flexible, skilled workforce to deliver a more integrated system, providing safe effective person centred care, in rural and remote Australia.

Introduction

Setting the scene

Health Workforce Australia (HWA) was established in 2010 as a national health workforce agency through the 2008, National Partnership Agreement on Hospital and Health Reform, 2009/10-2012/13 (NPA). HWA drives a strategic, long-term program which addresses the future challenges of providing a skilled, flexible and innovative health workforce. The reforms are needed to address workforce shortages and to ensure Australia’s health workforce can meet increasing demands for services resulting from an ageing population, increasing levels of chronic disease and community expectations.

Policy context

The following key policy foundations form the context for HWA’s work:

1. National Partnership Agreement on Hospital and Health Workforce Reform (2009/10-2012/13)

The NPA outlines the workforce reform initiatives agreed by governments to improve health workforce capacity, efficiency and productivity. These include funding, planning and coordinating clinical training across all health professions; supporting health workforce research and planning; improving international recruitment efforts; and progressing new workforce models and reforms.

2. Health Workforce 2025: Doctors, Nurses and Midwives (volumes 1-3)

Health Workforce 2025: Doctors, Nurses and Midwives (HW2025) (volumes 1 and 2) provides long-term, national workforce projections and presents the best available planning information on Australia’s future health workforce. HW2025 finds that without nationally coordinated reform Australia is likely to experience limitations in the delivery of high quality health services. This is a consequence of workforce shortages and maldistribution, inefficiencies and insufficient capacity in the training system, and continued reliance on poorly coordinated skilled migration to meet essential workforce requirements.
HW2025 volume 3 examines individual medical specialities in Australia. The key findings are:

- The number of medical specialists is increasing but the workforce is not evenly distributed.
- There are not enough general practitioners and some other medical specialists in regional and rural Australia.
- Some medical specialities are more popular than others from a career perspective.
- A growing trend toward specialisation and sub-specialisation means there isn’t enough generalists.

HW2025 volume 3 identifies the issues and opportunities to build a medical workforce that is able to sustainably service the health needs of the Australian community. The next steps involve seeking national agreement on the actions identified, progressing outcomes through collaboration and consultation, and implementing the results across the health and higher education sectors.

HW2025 identifies a range of policy directions covering workforce reform, training, immigration and geographical distribution that can be adopted to deliver a more sustainable health workforce.

Health Ministers have identified that the main policy levers to address the shortfall in the health workforce identified in HW2025 are innovation and reform, immigration, training capacity and efficiency, and workforce distribution.

In November 2012, Australian Health Ministers agreed to the following comprehensive set of policy responses to the findings of HW2025:

- Responding to the projected nursing workforce imbalance.
- Progressing workforce redesign.
- Aligning training and workforce need.
- Establishing a National Medical Training Advisory Network.
- Driving efficient and effective training.
- Addressing industrial barriers and enablers to workforce reform.
- Addressing legislative barriers and enablers to workforce reform.
- Streamlining clinical training funding.
- Considerations for achieving national self-sufficiency.

HWA will lead and/or support the implementation of these policy responses, consistent with its approved work plan, budget and organisational principles of building evidence, providing leadership and working in collaboration.

This work will underpin and influence the future adoption and implementation of the National RRHWIR Strategy.


The National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015, approved by Health Ministers in August 2011, provides an overarching national policy platform to guide health workforce reform. HWA aligns all of its programs and initiatives with the five domains for action identified in the framework. The five domains are the essential areas for activity for the development of a sustainable health workforce for the future.
4. Other policy links

The National RRHWIR Strategy will be a complementary document to the National Strategic Framework for Rural and Remote Health released by the Commonwealth in 2012, which ‘promotes a national approach to policy, planning, design and delivery of health services in rural and remote communities’\(^\text{10}\). The National RRHWIR Strategy draws on the high level directions advocated in this framework.


The National RRHWIR Strategy is an important development, given the recent release of the Senate, Community Affairs References Committee report ‘The factors affecting the supply of health services and medical professionals in rural areas, August 2012’ and release of the House of Representatives Standing Committee on Regional Australia report ‘Cancer of the bush or salvation for our cities? Fly-in, fly-out and drive-in, drive-out workforce practices in regional Australia’ in February 2013.

The National RRHWIR Strategy will also complement both the National Maternity Services Plan 2010-2015, (which has a focus on increasing access to maternity services, particularly for women in rural and remote locations) and the ‘Building a 21st Century Primary Health Care System: Australia’s First National Primary Health Care Strategy’ (which guides current and future policy and practice in the Australian primary health care sector).

The National RRHWIR Strategy will be cognisant of the review of Australian Government health workforce programs that has been released. The review, announced as part of the 2012-13 budget, focused on analysing the appropriateness, effectiveness and efficiency of programs in terms of meeting key health workforce objectives and priorities, including emerging workforce issues. Broader health workforce challenges, including those identified in HW2025 has been considered by the review.

The National RRHWIR Strategy will support the implementation of measures to ‘close the gap’ between health outcomes for Aboriginal and Torres Strait Islander people and other Australians. The National RRHWIR Strategy has also been developed with regard to the wider context of health reforms currently taking place in Australia, and in particular the establishment of Medicare Locals and Local Health Networks (LHNs) as outlined in the National Health Reform Agreement signed in August 2011.

Medicare Locals are a key component of the Australian Government’s health reform agenda, and have been established as regional primary health care planners to drive improvements in primary health care. Medicare Locals are working collaboratively with general practitioners, other primary health care providers, LHNs, National, state and territory rural health workforce agencies and communities to better integrate and coordinate the delivery of health care services, including workforce planning.

The National RRHWIR Strategy also acknowledges and aims to support and enhance current and future rural and remote health workforce reforms and programs undertaken by Commonwealth, state and territory health departments; National, state and territory rural health workforce agencies and networks; professional associations; and peak bodies.
The rural and remote context

There are a number of frameworks and definitions used to describe and classify rural and remote areas in relation to health service provision.\(^1\)

The term rural and remote, as defined by the Australian Bureau of Statistics (ABS) Australian Standard Geographical Classification Remoteness Area parameters, covers inner regional, outer regional, remote or very remote geographical areas.\(^2\) This classification system is adopted for the purpose of the National RRHWIR Strategy.

Within these classification categories, communities vary considerably from larger, more closely settled population centres, to small populations dispersed over large areas.\(^3\) These differences have significant impacts on the capacity to deliver and access health services and the nature of the workforce required to deliver them.

It needs to be emphasised that whilst the rural and remote sectors have some issues in common, there are also some stark differences. The biggest, for example, is the relative absence of medical practitioners in remote areas. Remote health is predominantly reliant on the core workforce of Aboriginal and Torres Strait Islander health workers, and practitioners and remote area nurses (RANs) with support from a range of multi-disciplinary health professionals across the fly in fly out (FIFO) and drive in drive out (DIDO) allied health and medical professions.

The rural and remote health workforce

The understanding of health workforce in this National RRHWIR Strategy has been drawn from the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 and consists of the following roles:

- Clinicians and practitioners in various disciplines that may be nationally regulated, partially regulated, self-regulated or unregulated.
- Support workers in clinical and non-clinical roles.
- The preventative and health promotion workforce.
- Health service managers.
- Health planners, administrators and researchers.
- Health educators and trainers.
- Health students.
- New or emerging health disciplines.
- Voluntary and unpaid carers.

Outside of metropolitan areas the concept of the health workforce can be much broader and the roles and responsibilities of health, community services, schools, police and correctional services, local government and children’s services are often, by necessity, shared.

Across Australia the health workforce and the community services sector together are growing faster than the all-industries rate but the rural and remote sectors are facing significant skills shortages. To fill such gaps, rural and remote communities are heavily reliant on international health professionals (IHPs), short-term placements, visiting staff, FIFO and DIDO workers, and the student/trainee workforce.
Key issues affecting rural professionals, and to an even greater extent remote health professionals, and their families include:

- Isolation.
- Community expectations.
- The needs of the individual and their family.
- Extensive travel to provide services in the course of work.
- Limited professional, occupational and educational opportunities.
- Filling multiple roles.
- Long working hours and travel time.

Proportionally and numerically the Aboriginal and Torres Strait Islander health workforce is small. This presents many challenges for the Aboriginal and Torres Strait Islander health workforce and Aboriginal and Torres Strait Islander access to culturally safe health care.

The available data indicates that in Australia in 2008, there were 153 Aboriginal and/or Torres Strait Islander medical practitioners (about 0.2 per cent of the total workforce). In 2011 there were an estimated 218 Aboriginal and Torres Strait Islander medical students. The Northern Territory had the highest proportion of Aboriginal and Torres Strait Islander medical practitioners (1.2 per cent). They were on average about 3.5 years younger than non-Indigenous practitioners and a higher proportion (45 per cent) were female.

There were 2,212 Aboriginal and/or Torres Strait Islander nurses employed in Australia, representing about 0.8 per cent of nurses. Tasmania and the Northern Territory had the highest proportion of nurses and midwives who identified as Aboriginal or Torres Strait Islander, at 1.4 per cent.

The available data on Aboriginal and Torres Strait Islander health workers and practitioners is limited. The 2001 and 2006 census periods show the number of health workers increased from 916 to 1,012 (10.5 per cent). In 2006, 32 per cent worked in major cities or inner regional areas and 48 per cent reported working in either remote or very remote regions.

There is wide variation in Aboriginal and Torres Strait Islander health worker and practitioner roles, definitions, scopes of practice, education standards and career pathways, which has contributed to limited career development opportunities for Aboriginal and Torres Strait Islander health workers and practitioners. There is a limited pipeline of new trainees and large numbers of long-term vacant positions. Further, there is inadequate workforce information and a lack of coordinated planning for the workforce. Improved health workforce data collection for information, analysis and planning is a key work area for HWA.

In addition there are low numbers of Aboriginal and Torres Strait Islander people in the allied health workforce. As a result of this, Indigenous Allied Health Australia supports the promotion of allied health careers amongst Aboriginal and Torres Strait Islander people.

The rural and remote health workforce is also ageing and in some professions retiring earlier than their city counterparts. The ageing of the health workforce has serious implications for sustainable health service delivery and for the supervision and mentoring into the future of trainees and new graduates. This issue is affecting the health workforce throughout Australia but is even more pressing in rural and remote areas.
Commonly reported barriers to the delivery of sustainable health services in rural and remote Australia include:

- A lack of rural and remote specific policy and context at the planning and funding level.
- Inadequate allowance for the contextual differences between rural and remote and ‘mainstream’ service delivery.
- The complexity of Commonwealth, state and territory and inter-jurisdictional and inter-sectoral policy, regulation and planning.
- Funding models that may not adequately allow for the specific challenges faced in rural and remote areas, such as the additional costs and travel time over vast distances to provide services (for health professionals) or receive them (for consumers).
- The counterproductive aspects of traditional ways of working and hierarchies which, when they occur, can limit productivity.
- The maldistribution of the rural and remote workforces.
- High rates of burnout and turnover in the health workforce.
- A lack of detailed workforce data on specific professions for rural and remote areas, in particular the allied health professions.
- Shortages in infrastructure, supervision and support to accommodate the training of more health students and early career professionals in rural and remote settings.
- The rigidity of professional demarcations that can limit innovation in roles and scopes of practice to better meet consumer and community need.
- The lack of flexibility in some educational programs, professional and industrial groups and accreditation bodies.

In spite of these barriers, the rural and remote health workforce, researchers, educators and professional associations have been at the forefront of workforce innovation and reform.

The case for change in rural and remote

There is a big divide between the health of metropolitan Australia and that of Australians living in rural and remote areas. There is also a dichotomy in terms of the health services available.

In essence, if you live in rural or remote Australia your health will on average be poorer, and your access to health services more limited, a trend which worsens with increasing remoteness.

People living in rural and in remote areas are more likely to report certain chronic diseases such as arthritis, bronchitis and osteoporosis. They have a lower incidence of cancer with the exception of head, neck and lip cancer and melanoma which is attributed to the increased prevalence of smoking, excessive alcohol consumption and exposure to the sun. They are also 10 per cent more likely to have a mental disorder at some point in their lifetime, more likely to have a substance abuse disorder (usually alcohol), more likely to smoke, more likely to be classified as overweight and more likely to have untreated dental problems.
Aboriginal and Torres Strait Islander people form a large percentage of some rural populations especially the more remote communities (26 per cent) than they do in the cities (1 per cent). The majority (68 per cent) of Aboriginal and Torres Strait Islander people live outside major cities. When compared with other Australians, Aboriginal and Torres Strait Islander people have higher hospitalisation rates for cardiovascular diseases (1.7 times); three times the rate of diabetes; higher rates of respiratory disease (with hospitalisation rates for Aboriginal and Torres Strait Islander children aged 0-4 years almost twice the rate for other Australian children); worsening rates of end-stage renal disease; twice the rate of hospitalisation for mental health problems; and higher rates of hospitalisation for injuries and poisoning.

The life expectancy gap between Aboriginal and Torres Strait Islander people and other Australians has narrowed, but it has not closed. Some 70-80 per cent of the mortality gap is attributed to chronic disease. The death rate ratio for people aged 35–44 years is significantly higher for Aboriginal and Torres Strait Islander males (5 times) and females (5.4 times) than for other Australians. The death rate of Aboriginal and Torres Strait Islander men due to ‘external’ causes such as injury, accident and suicide is more than three times the rate for other Australian men aged 25-44 years. Aboriginal and Torres Strait Islander children aged 0-14 years die at twice the rate of other Australian children.

Encouraging and supporting participation in the health workforce by the Aboriginal and Torres Strait Islander population and focusing strongly on its development and retention must be a priority in future health workforce reform. HWA has undertaken work to strengthen and sustain the Aboriginal and Torres Strait Islander health worker workforce to deliver care in response to the known burden of disease in Aboriginal and Torres Strait Islander communities. The Growing Our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker Project (May, 2012), makes 27 recommendations that inform the development of policies and strategies to strengthen and sustain the Aboriginal and Torres Strait Islander health worker workforce in response to the known burden and distribution of disease in the Aboriginal and Torres Strait Islander population. HWA is supporting an implementation plan based on these recommendations.

When it comes to trying to address these problems, rural and remote areas of Australia still continue to experience shortages of skilled health workers. These relatively poor health indicators will not improve for rural and remote Australia unless action is taken.

HW2025 documents significant variations in the availability of doctors, nurses and midwives in the different regions of Australia. In particular, for doctors, modelling of the current workforce according to location highlights the disparity in their distribution in relation to where the population resides. Projected future growth in medical graduates is unlikely to make significant inroads into relative geographical equity under current policy settings. Agreement on desired distribution of the workforce, coupled with enhanced policy measures to achieve this distribution, is urgently required to ensure the current opportunity arising from significant growth in graduates is not forgone.

A further challenge is the expected increase in older people as a proportion of the population living in rural and remote areas. Consequently the demand for aged care services will increase over the next 40 years. This raises concerns about the provision of informal care as well as the sustainability of the workforce in general, and the health and aged care workforce more specifically, in rural and remote areas.

The mental health sector is also already experiencing increasing demands for services. One in five Australians experience symptoms of a common form of mental disorder (anxiety, affective or mood disorders, substance use disorders) in any 12-month period, while about 45 per cent of Australians will experience a mental disorder during their lifetime. This is exacerbated in rural and remote locations where access to specialist supports and services is limited.
Changes in rural industries can also affect the availability of the health workforce. One example of this is the current Australian mining boom. Positive health related impacts identified over the longer term in mining communities include improvements in health service (e.g. a mining company bringing in a physiotherapist) and improved transportation links and infrastructure\textsuperscript{45}. However, this can also generate workforce pressures, including:

- The flow-on effects of sudden population growth are likely to place further demand on health services and reduce the ability to attract and retain health workers.
- Increased demand for housing and rising costs is affecting health professionals, whose salaries cannot cover market rates (housing rental increases as high as 400 per cent have been documented)\textsuperscript{46}.
- Increased competition for finite labour affects the recruitment and retention of health professionals, where health sector wages and conditions are unable to compete with the mining sector.
- Other service-related impacts that include higher levels of alcohol and other drugs consumption in already vulnerable communities\textsuperscript{47}; a skewing of the population to high-risk age groups, such as males 25-44 years\textsuperscript{48}; and the need for health providers to service a greater variety of cultures and language groups, as skilled workers are imported to meet mining industry shortages\textsuperscript{49}.

Australia’s health system is highly reliant on IHPs to provide health services to the community. For example, the proportion of international medical graduates is significantly higher in rural and in remote areas where 41 per cent of all doctors have trained overseas (up to 70 per cent in some communities). HW2025 highlights the likely ongoing demand for employment of IHPs, at least in the short to medium term, as part of a comprehensive strategy to meet projected health demands.

**If action is not taken**

Failure to innovate and reform the systems that prepare and support the rural and remote health workforce could mean:

- A mismatch between the types of skills available and the needs of individuals and communities.
- Reduced capacity to retain the experience and skills of our existing health workforce.
- A further reduction in the potential to attract new entrants to the rural and remote areas.
- Reduced access to culturally appropriate services in rural and remote areas.
- An increase in avoidable deaths or loss of functionality.
- Further pressure on an already stretched system, at a time when the number of trainees coming through is projected to increase considerably as the supervisor workforce ages and exits the system.
- Worsened inequalities in access to health services.
- No improvements in gaps in the life expectancy and quality of life of rural and remote community members.
- Consumers avoiding or rejecting necessary care due to distance and cost.
- An inadequate continuity of care, leading to decreased outcomes and increased costs to the system and to the consumer.
Time for action – introduction to the National RRHWIR Strategy domains

The purpose of the National RRHWIR Strategy is to provide a set of options for adoption at national, jurisdictional and organisational level, to add value to what is already underway, and to facilitate shifts to a more effective way of working in the future.

The National RRHWIR Strategy, if adopted and implemented, will support the development of a sustainable, flexible, skilled workforce to deliver a more integrated rural and remote workforce providing high quality services.

The National RRHWIR Strategy is aligned with both the content and the policy directions arising from the HW2025 and the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015, approved by Health Ministers.

Through the consultation process, five priority recommendations were developed to align with the five domains of the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015:

1. Health workforce reform for more effective, efficient and accessible service delivery.
2. Health workforce capacity and skills development.
3. Leadership for the sustainability of the health system.
4. Health workforce planning.
5. Health workforce policy, funding and regulation.

Each chapter that follows is introduced through the five domains of the framework and the five priority recommendations.

Under each domain, up to six strategic actions are identified.
Domain 1

National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 domains for action

- Health workforce reform for more effective, efficient and accessible service delivery.
- Health workforce capacity and skills development.
- Leadership for the sustainability of the health system.
- Health workforce planning.
- Health workforce policy, funding and regulation.

National RRHWIR Strategy priority recommendations

- Develop the rural and remote workforce in alignment with current health reform initiatives through promoting better use of existing roles, redesign of existing roles and creating new roles on the basis of consumer need.
- Support and enhance the growth of education, clinical training, and career opportunities in rural and remote Australia.
- Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future.
- Plan for the optimal use of skills and adoption of workforce innovation and reform by developing appropriate modeling approaches for rural and remote workforce planning.
- Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.
Domain 1 – health workforce reform for more effective, efficient and accessible service delivery

Reform health workforce roles to improve productivity and support more effective, efficient and accessible service delivery models that better address population health needs.

Changing models of care, the multifaceted nature of service delivery, the need for workforce flexibility and the increasing demands on health service providers require commensurate efforts in workforce development and reform.

In broad terms, workforce reforms and innovations to improve efficiency, effectiveness and support access to new models of care include:

- Models of care that are person-centred and developed from community, consumer and carer need perspective.
- Supporting work to ensure health professionals work to full scope of practice, expanding scopes of practice, and the introduction of new categories of staff, in particular assistant roles where appropriate.
- Models of care based around eHealth and telehealth applications.
- Reconfiguring health systems to provide more community and home-based care.
- Promoting and supporting the role of generalist practitioners across all health professions.

There is already considerable effort underway through the Commonwealth and in every state and territory, as well as the private and not-for-profit sectors, to develop models of care, service delivery methods and workforce roles that better meet the unique needs and address the different circumstances faced by rural and remote individuals and communities. Examples of this include efforts to reduce the impact of distance through the increasing use of information and communication technology (telehealth and eHealth).

Key to this domain will be identifying existing efforts and facilitating widespread implementation, as well as identifying new workforce innovations that support accessible service delivery.

A particular priority is the development of a workforce that has the capacity to work across the whole continuum of care from acute to community-based and population-based interventions. Another priority is the recognition that in many remote and very remote communities it is the same people who are required to provide all of these different aspects of health care. Similarly, workers in health, law enforcement, emergency services, child protection and education, need to work collaboratively more frequently in remote communities.

Stakeholders consulted in the course of the development of the National RRHWIR Strategy acknowledge the positive impacts of these initiatives; however note the possibility of unintentional negative consequences for the long-term rural and remote workforce. For instance, there are concerns that the emerging lack of parity in terms and conditions granted to the FIFO and DIDO workforce (and short-term relief workers) in comparison to the local workforce, making the attraction and retention of staff even more difficult. Due to dispersed populations and economies of scale there is also a need for greater flexibility and innovation by local providers across a range of sectors to ‘join up’ resources to improve recruitment and retention in rural and remote areas. Medicare Locals may play a role in addressing these issues through using flexible funding to address primary health care service gaps identified through population health needs assessments.

The following strategies are designed to support current efforts to:

- Promote workforce capacity.
- Increase the proportion of the health workforce that chooses rural practice.
- Increase access through the development of service delivery models that better address the needs of rural and remote communities and individuals.
### Domain 1 strategic actions

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<th><strong>Visiting health workforce</strong></th>
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| 1.1 | Identify and promote best practice models for the coordination and integration of visiting locum and FIFO/DIDO health providers with local services, taking into account:  
• The impact of the developing dependency on locum or FIFO/DIDO services on the stability of the permanent local health workforce.  
• Locum health professional recruitment, training and support.  
• The mobilisation of technology for rural and remote support.  
• Coordination of the outreach health workforce. |

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<td>Identify successful initiatives and activities that contribute to health workforce recruitment, retention and orientation and expand across all health professions where appropriate.</td>
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<th><strong>Innovative workforce models</strong></th>
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| 1.3 | Support and implement new and existing workforce models that enable:  
• Full scopes of practice and appropriate expansion of scopes of practice to achieve optimal use of skills, skill mix and workforce adaptability.  
• The expansion of generalist roles in all relevant health professions.  
• The expansion or development of health assistant and support roles, where appropriate.  
• Coordinated care between health and related services including law enforcement, emergency services, child protection and education.  
• A growth in community and home-based care. |
Domain 2

National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015

domains for action

- Health workforce reform for more effective, efficient and accessible service delivery.
- Health workforce capacity and skills development.
- Leadership for the sustainability of the health system.
- Health workforce planning.
- Health workforce policy, funding and regulation.

National RRHWIR Strategy priority recommendations

- Develop the rural and remote workforce in alignment with current health reform initiatives through promoting better use of existing roles, redesign of existing roles and creating new roles on the basis of consumer need.
- Support and enhance the growth of education, clinical training, and career opportunities in rural and remote Australia.
- Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future.
- Plan for the optimal use of skills and adoption of workforce innovation and reform by developing appropriate modeling approaches for rural and remote workforce planning.
- Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.
Domain 2 – health workforce capacity and skills development

Develop an adaptable health workforce equipped with the requisite competencies and support to provide team-based, inter-professional and collaborative models of care.

Working in rural and remote settings provides health workers with a much broader set of challenges, both personally and professionally, than working in large regional and major metropolitan settings. Education and training programs must match the needs of rural and remote communities as well as the complexity and challenges of living and working in them. Appropriate and contemporary education around the culture, health and wellness needs of Aboriginal and Torres Strait Islander people must also be a core part of preparing all health professionals for practice. Concurrently there must be a continued focus on supporting and developing of the Aboriginal and Torres Strait Islander health worker and practitioner workforce.

Higher levels of teamwork and interprofessional practice are a necessity in rural and remote settings. Until recently, the training programs of most health professions have occurred within traditional professional boundaries where students have limited or no exposure to the language and knowledge base and service offering of other professions. The teaching of common professional skills such as communication, clinical leadership, cultural awareness and respect, person-centred care and ethics through interprofessional training, provides opportunities for students to ‘learn with, from and about each other to improve collaboration and the quality of care’52. A significant part of the preparation of the rural and remote health workforces must include developing the skills and abilities to work in teams and with colleagues at a distance.

There is growing national and international evidence suggesting that exposing students to positive rural and remote health practice is an effective strategy for increasing the recruitment and retention of health professionals, and that students educated in a rural setting are more likely to remain and work there. Some rural and remote health providers have gained Registered Training Organisation (RTO) status as way of growing their own entry-level assistant and administrative workforce from people who live locally and are committed to working locally. The now well established Rural Clinical Schools for Medicine, rural campuses of University Schools of Nursing and Midwifery and University Departments of Rural Health (UDRHs) provide excellent examples of ways to support both students and their supervisors. Likewise there are an increasing number of learning and support programs aimed at improving rural and remote training opportunities, through access to new communication technology for rural and remote health students and workers.

There is debate amongst stakeholders about the effectiveness of compulsory rural placements for students who do not express an interest in rural practice. However, there is acknowledgement of the insufficient infrastructure and support for those choosing an elective clinical placement in many parts of rural and remote Australia. There is also a recognised need among stakeholders to rebalance the perception of some health graduates that rural and remote careers and lifestyle are of lesser professional, personal and economic value.

There are a number of medical scholarships available to students wishing to work in rural and remote areas that then bond them to periods of rural service. The impact of the bonding period on later intentions to work in rural and remote settings is addressed in a study commissioned by the Department of Health and Ageing in relation to the Australian Government’s medical workforce distribution programs and policies53. Stakeholders have suggested that these scholarship schemes need to be available to all health professions on an equal basis and that efforts must be made to reduce the reported stigma of gaining university entry on a bonded scholarship, by promoting these scholarships as prestigious.
The difficulty in accessing continuing professional development (CPD) locally is a major issue for the rural and remote health workforce. Stakeholders suggest that the current support provided for CPD by the government, employers and some professional associations does not take into account the costs and service delivery consequences of the compulsory national registration standards requirements for all registered health professions. In particular those workers in very remote and isolated settings, who have a specific need for face-to-face and online CPD opportunities. Many stakeholders who live and work in rural and remote areas note that conferences, workshops and forums are often metro-centric, and state that their access to them is limited by the availability of funds and changes to rostering to accommodate absence from service.

There is support from all health professions to address the inequities in the resources provided to medical students as compared to those provided to nursing and allied health professionals.

Just as the rural and remote health workforce is ageing so too is the academic research and teaching workforce required to produce the next generation of researchers and health professionals. Achieving and maintaining an adequate critical mass of teachers, supervisors and researchers with expertise in rural and remote practice, where there is already low numbers, requires specific attention.

### Domain 2 strategic actions

#### 2.1 Supporting the Aboriginal and Torres Strait Islander health worker and practitioner workforce

Build on existing initiatives that promote and support the Aboriginal and Torres Strait Islander health worker and practitioner workforce, including those that:

- Support Aboriginal and Torres Strait Islander health workers choosing to proceed through the pathway to national registration.
- Recognise and promote the Aboriginal and Torres Strait Islander health worker and practitioners workforce and its ongoing development and professionalisation.
- Develop career pathway programs for Aboriginal and Torres Strait Islander health workers and practitioners (including articulation pathways into other health professions).

#### 2.2 Clinical placements

Build on existing effort to increase clinical placements in rural and remote areas across all health professions by:

- Ensuring appropriate levels of support are provided to all students on clinical placements in rural and remote locations.
- Supporting the growth of training posts across existing and new settings and developing educational opportunities in rural and remote Australia through:
  - developing national guidelines for rural and remote clinical placements that promote improvement in the quality and coordination of placements
  - increasing and improving simulation modalities
  - targeted models of supervision, including interprofessional models.
- Implementing models of student-led clinics that provide access for rural and remote communities and education opportunities for students.
### 2.3 Recruitment and retention

Promote innovative health student recruitment and retention models in rural and remote communities by:

- Enabling regional hospitals to act as hubs for training and research to expand internship, residency, registrar and trainee positions in rural and remote communities.
- Evaluating for broader applicability a rural preferential recruitment scheme, or similar programs, for graduating health students.
- Supporting the development of rural entry schemes available to medical students of rural or remote origin across all relevant health professions.
- Implementing a national campaign that builds on existing programs to promote the skills, experience and professional benefits to be gained from a career working in rural and remote health.

### 2.4 Education and training

Implement learning models that promote interprofessional learning and:

- Build on existing efforts to promote cultural respect, competency and safety in all health professional education courses.
- Identify competencies required to work in rural and remote areas.
- Provide family, peer and intra-group support to Aboriginal and Torres Strait Islander students across the educational journey.
- Develop programs for Aboriginal and Torres Strait Islander students and rural youth in their high school and pre-university years that articulate with university level courses to prepare them for careers as health professionals.
- Build on existing efforts to develop training networks between tertiary teaching hospitals and rural and remote sites.
- Support teachers, supervisors and researchers with expertise in rural and remote practice.

### 2.5 Continuing professional development

Undertake a range of targeted initiatives aimed to support and develop the existing rural and remote health workforce, including:

- Identifying and facilitating clinical partnerships to enable health professionals from rural and remote locations to undertake work placements in metropolitan settings to familiarise them with new treatments and technologies, and strengthen working relationships and networks.
- Identifying and supporting opportunities to increase access, reduce duplication of effort and promote interprofessional CPD delivery in rural and remote areas.
### National RRHWIR Strategy priority recommendations

- Develop the rural and remote workforce in alignment with current health reform initiatives through promoting better use of existing roles, redesign of existing roles and creating new roles on the basis of consumer need.

- Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future.

- Plan for the optimal use of skills and adoption of workforce innovation and reform by developing appropriate modeling approaches for rural and remote workforce planning.

- Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.

### National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 domains for action

- **Health workforce reform for more effective, efficient and accessible service delivery.**

- **Health workforce capacity and skills development.**

- **Leadership for the sustainability of the health system.**

- **Health workforce planning.**

- **Health workforce policy, funding and regulation.**
Domain 3 – leadership for the sustainability of the health system

Develop leadership capacity at all organisational levels to support and lead health workforce innovation and reform.

Research indicates leadership affects people, their satisfaction, trust in management, commitment, individual and team effectiveness, the culture and climate of organisations, and ultimately, individual and collective performance. While other factors are influential, leadership plays a central role in mobilising people towards a common goal and outstanding health outcomes.

Recognising and supporting distributed leadership from everyone with the capacity and desire to lead for improvement is particularly important in rural and remote areas where there is often a high turnover among those in designated leadership positions. Ensuring a broad base of leadership capacity will help counter the negative effects of such turnover including:

- Organisational instability.
- A lack of continuity in relationships.
- Difficulties developing the trust required from staff and the community to carry out long-term plans and initiate change.

Formal and de facto health leaders in small rural and remote communities face different pressures to their metropolitan and large regional counterparts, often having a higher community profile, less personal privacy and higher expectations of their availability and capacity for short-term responsiveness to local issues. Aboriginal and Torres Strait Islander leaders and health workers/practitioners may also face additional family and kinship issues, with extra sensitivities and even higher expectations of availability and accountability to their communities.

For all rural and remote health leaders, these issues are compounded by a general lack of access to mentors, training and networking opportunities. Leadership and management development courses, national networks, forums and conference opportunities tend to be only accessible in metropolitan centres. Barriers to participation by rural and remote health leaders include: prohibitive travel distances; heavy workload; insufficient backfill; and a lack of support (financial and otherwise) to enable attendance.

HWA is developing Health LEADS Australia; an Australian health leadership framework that will define the leadership capabilities required of health leaders, create a common language around health leadership and embed an agreed approach to health leadership in early career training and education and in accredited continuing development.

Leadership development opportunities for Aboriginal and Torres Strait Islander health leaders that acknowledge the additional challenges faced and build on cultural leadership paradigms relevant to health are limited. HWA is working with senior Aboriginal and Torres Strait Islander health leaders to explore the meaning, principles and practice of Aboriginal and Torres Strait Islander leadership relevant to health and to propose appropriate forms of leadership development.

The five strategies in the leadership domain of the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 are relevant to rural and remote health leaders and will assist in developing leadership capacity at all organisational levels to support and lead health workforce and other key areas of innovation and reform. These strategy outcomes are consistent with the objectives of the Australian Commission on Safety and Quality in Health Care (ACSQHC) and will improve the quality of health decision making, service planning, patient care and community health outcomes.
## Domain 3 strategic actions

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<tr>
<td><strong>3.1</strong></td>
<td><strong>Aboriginal and Torres Strait Islander health leadership</strong></td>
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<td></td>
<td>Support initiatives that recognise and encourage Aboriginal and Torres Strait Islander health leaders including recognition of prior learning and experience to enable access to all leadership development opportunities and advancement into postgraduate leadership courses.</td>
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<td><strong>3.2</strong></td>
<td><strong>Rural and remote focus</strong></td>
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<td>Build on existing work to ensure health leadership programs and initiatives demonstrate specific application and relevance to rural and remote health.</td>
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<td><strong>3.3</strong></td>
<td><strong>Leadership development</strong></td>
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<td>Develop and improve the current and future rural and remote health workforce access to leadership, mentoring, networking, training and development opportunities and ensure continuing value through:</td>
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<td>• Protected professional development time.</td>
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<td>• Online services from universities, VET institutions, professional colleges.</td>
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<td>• Involving local community leaders in leadership programs with health professionals.</td>
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<td>• Interprofessional learning and reflection.</td>
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<td><strong>3.4</strong></td>
<td><strong>Learning resources</strong></td>
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<td>Develop practical and effective learning resources for the rural and remote health workforce that incorporate online techniques to support leadership development.</td>
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<td><strong>3.5</strong></td>
<td><strong>Strategic management</strong></td>
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<td>Identify strategic management skills relating to:</td>
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<td>• Change management.</td>
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<td>• Program and project management.</td>
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<td>• Innovation and teams.</td>
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<td>Incorporate into leadership development opportunities for the rural and remote health workforce.</td>
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Domain 4

**National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 domains for action**

- Health workforce reform for more effective, efficient and accessible service delivery.
- Health workforce capacity and skills development.
- Leadership for the sustainability of the health system.
- Health workforce planning.
- Health workforce policy, funding and regulation.

**National RRHWIR Strategy priority recommendations**

- Develop the rural and remote workforce in alignment with current health reform initiatives through promoting better use of existing roles, redesign of existing roles and creating new roles on the basis of consumer need.
- Support and enhance the growth of education, clinical training, and career opportunities in rural and remote Australia.
- Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future.
- Plan for the optimal use of skills and adoption of workforce innovation and reform by developing appropriate modeling approaches for rural and remote workforce planning.
- Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.
Domain 4 - health workforce planning

Enhance workforce planning capacity, taking account of current and emerging health needs and changes to health workforce configuration, technology and competencies.

Current planning models often work on the assumption that health service delivery will occur in existing facilities by existing professional groups. There is a need to develop planning models that look beyond traditional professional demarcations and organisational structures, and allow planning across different health professions and health settings especially in rural and remote planning.

Rural health service models need to be based on integrated care that is specific to a rural or remote location and impact on the methodology and processes for rural workforce planning and recruitment and retention strategies. Rural workforce planning methodology involves examination of the health profile of the community, the level of geographic isolation of the location, existing service infrastructure and the available workforce and their specific skill sets.

Stakeholders suggest there may be benefits in developing planning models that include the workforce across all services in the community. Where skills and resources are scarce and worker numbers limited, greater efficiencies can be found by sharing across sectors. This can occur between public, private and NGO health and aged care services and by looking to the education, housing, police and community/volunteering sectors to identify opportunities to share and coordinate resources. Stronger linkages are also required with the mining, tourism and farming industries, whose workforce can create rapid population increases in small rural communities affecting the demand on health services.

Recent reports into the Australian health workforce highlight the complexities encountered in planning health services in rural and remote areas.

The Productivity Commission in its report on Australia’s health workforce noted the importance of developing health workforce policies for rural and remote areas on a ‘whole-of-workforce’ rather than profession-by-profession basis. Similarly, the National Strategic Framework for Rural and Remote Health acknowledges that a multi-pronged approach is needed to actively address the mal-distribution of the health workforce.

HW2025 shows that there is a continuing maldistribution of the medical workforce and potential future challenges for the distribution of the nursing and midwifery workforces. It further highlights that while there is a role for national aggregate planning of the health workforce, there is also a need to enable service (or local) level planning. This is to ensure that the health workforce roles and models of service delivery will best meet the needs of consumers and be responsive to regional planning requirements. The analysis in HW2025 is the first step only. Further work will be undertaken on:

- Geographic health workforce planning. This will take into account the service-level planning that is required to determine an appropriately skilled health workforce for regional, rural and remote Australia.
- ‘Health Workforce 2025 - Selected Health Occupations’ project. This will bring together available information to describe the existing size and characteristics of 41 professions. Activity measures that can be used to estimate demand for services will also be examined for each profession.
- Health Workforce 2025 – Oral Health project. This will provide a descriptive study of the oral health workforce including workforce numbers, characteristics, sources of supply and movements out of the oral health sector, as well as supply and demand projections for selected parts of the registered workforce.

HWA has also developed a National Statistical Resource (NSR), which brings together health-related workforce, training and activity data, which is used for HWA’s workforce planning and projections and can be used by jurisdictional workforce planners.
The NSR has two components:

1. The health workforce data tool which contains accurate data about supply and demand in Australia’s health workforce. Users can access the National Health Workforce Dataset and Clinical Training Dataset and create their own tables, maps and graphs.

2. The health workforce planning tool which projects the health workforce needed to meet the nation’s healthcare requirements.

The health workforce planning tool can be used to undertake health workforce supply and demand projections by each state and territory to identify potential gaps and oversupply in Australia’s health workforce at local and national levels. The planning tool will help all levels of government and health service organisations carry out detailed workforce planning. The tool uses shared methodologies and datasets to achieve greater data quality and integrity.

Stakeholder feedback suggested that there is currently a lack of expertise and experience in health workforce planning and modelling in Australia, particularly with reference to the rural and remote context, as well as a shortage of local level planners and clinical coders. This feedback identified some key elements required of effective health workforce planning specific to rural and remote areas. This included:

- Identifying the health needs of the community.
- Benchmarking workforce planning models through the identification of successful models in rural and remote areas and their specific skills mix characteristics.
- New service models, workforce roles, intersectoral relationships and multi inter- and trans-disciplinary professional care.
- Changes in service delivery, such as existing telehealth opportunities and digital imaging advancements.
- Future health workforce expectations and career preferences.
- Peaks and troughs in workforce numbers caused by personal leave and local seasonal environmental factors.
- The impact, contributions and needs of industries such as mining and tourism.
- The composition of the workforce supply including permanent resident workforce, registrars and trainees, students, visiting health professionals, international health professionals and the locum workforce.
- The unique burden of disease, and levels of unmet need, demand and supply, in very remote communities and Aboriginal and Torres Strait Islander communities.

Further support and training is required to ensure there are people with the requisite workforce planning skills. Poor literacy in health workforce planning limits the ability of managers to use data effectively. There are also concerns that current workforce related data collections do not accurately document the number of Aboriginal and Torres Strait Islander people in the health workforce or what roles they perform. Without the capacity to accurately count and record this part of the workforce it will not be possible to plan for future development and support.

Stakeholders also suggested the need for a greater understanding of the intentions and motivations of the rural and remote workforce. It was noted that knowing how many and what kind of rural and remote health workers exist represents only part of the picture necessary to plan for and support them. Planning to meet community needs requires an understanding of not only the size, demographic and epidemiological profile of communities, but also the many determinants of health status, health system performance, and community expectations and preferences. An example is the Medical Schools Outcomes Database (MSOD) longitudinal tracking, which is a nationally coordinated project for tracking medical students through medical school and into prevocational and vocational training.
## Domain 4 strategic actions

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<th>4.1</th>
<th>Aboriginal and Torres Strait Islander health data</th>
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<td>Support and develop existing efforts to collect, improve and share accurate information on Aboriginal and Torres Strait Islander health needs to inform local, regional and national workforce planning and to be incorporated into national health workforce initiatives.</td>
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<th>4.2</th>
<th>Workforce data and planning toolkit</th>
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<td></td>
<td>Build on existing work to develop nationally consistent rural and remote health workforce data collection, workforce planning toolkits and supportive resources for Medicare Locals, Local Health and Hospital Networks, National, state and territory rural health workforce agencies and health services (including Aboriginal Community Controlled Health Services) to assist with workforce planning and development.</td>
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<th>4.3</th>
<th>Rural and remote health workforce modelling</th>
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<td>Support and expand on existing effort to develop appropriate modelling approaches for rural and remote health workforce planning and build local capacity to interpret and use the outputs.</td>
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<th>4.4</th>
<th>Community development and engagement</th>
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<td>Build on and improve community access to health literacy resources to enable effective and meaningful engagement in local level health workforce planning.</td>
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<th>4.5</th>
<th>National rural and remote health workforce survey</th>
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<td>Build on existing work to develop a national longitudinal qualitative survey of rural health workers’ expectations, career aspirations and intentions in relation to rural and remote practice.</td>
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Domain 5

**National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 domains for action**

- Health workforce reform for more effective, efficient and accessible service delivery.
- Health workforce capacity and skills development.
- Leadership for the sustainability of the health system.
- Health workforce planning.
- Health workforce policy, funding and regulation.

**National RRHWIR Strategy priority recommendations**

- Develop the rural and remote workforce in alignment with current health reform initiatives through promoting better use of existing roles, redesign of existing roles and creating new roles on the basis of consumer need.
- Support and enhance the growth of education, clinical training, and career opportunities in rural and remote Australia.
- Support leadership at all organisational levels to ensure sustainability of the health system and responsiveness to the health needs of consumers now and into the future.
- Plan for the optimal use of skills and adoption of workforce innovation and reform by developing appropriate modeling approaches for rural and remote workforce planning.
- Support and enhance the industrial and legislative framework to promote and facilitate the implementation of workforce reform policy to sustain and build the rural and remote health workforce.
Domain 5 – health workforce policy, funding and regulation

Develop policy, regulation, funding and employment arrangements that support health workforce reform.

What works for metropolitan Australia does not always work in rural and remote parts of Australia. Medicare rebates for allied health services, for instance, are tied to a referral from a general practitioner. In places where there is no ready access to a GP, allied health services become inaccessible.

In order to address this disparity in the applicability of policy decisions to rural and remote areas compared to metropolitan areas, it has been suggested by stakeholders that a rural and remote ‘ruler’ be applied across all health workforce funding, policy and regulatory decisions to measure their impact on rural and remote communities. An example of this is the Commonwealth’s Regional Australia Impact Statement which is included in all Cabinet submissions and describes the likely impact, positive or negative, of any new submission on Australia’s regions, particularly where the impact will vary by location or differ in rural and remote areas compared to metropolitan centres.

To meet the needs of both rural and remote communities, the health workforce has to be flexible in relation to the location and scope of the work it does; often the health workforce must travel long distances to deliver services. However, stakeholders report that they can be constrained by current service delivery models, and by policy, industrial, regulatory and funding arrangements. A one-size-fits-all approach does not account for the unique challenges facing those who work in rural, remote, and in particular very remote settings. These factors are accelerating retirement intentions, reducing the capacity to retain staff, and therefore reducing access to services for the community.

The standards set by the accreditation bodies for health services and health professional education and training programs, are sometimes perceived as metro-centric, by those attempting to provide services or educational placements in rural or remote settings. For example, prescribing certain numbers and types of staff without reference to setting can mean that training places cannot be established, or funding levels tied to the achievement of accreditation (e.g. some specialist medical placements, some GP incentive payments) cannot be accessed. Student and trainee placement opportunities are also limited as a result of the requirements of some accrediting bodies.

Some stakeholders believe there is a need to clarify the requirements of the National Boards in relation to compulsory CPD and reconsider their feasibility for health professionals in rural and remote settings. In addition, because of the differences in distance and travel required and the costs of CPD, registered health professionals require different resources and supports to maintain the currency of their knowledge and the safety and quality of their services. The review of definitions of practice by some National Boards provides an opportunity to consider appropriate definitions for rural and remote settings and determine what constitutes practice in relation to mentoring or supervision roles.

The creation of the National Registration and Accreditation Scheme (the National Scheme) has positively supported the mobility of the health workforce for those professions covered under the National Scheme. However, the full realisation of this benefit is constrained by the continuing differences in legislation and regulation between jurisdictions that affect the practice of health professionals. For example, there are considerable differences in state and territory legislation providing for the prescribing, dispensing, supplying and administering of medicines. Further, the state and territory legislation may not reflect the endorsements provided by the National Boards to undertake these activities, which results in health professionals being unable to practice their full scope.

Inconsistencies in practice that affect workforce mobility also exist for those professions not covered by the National Scheme and consideration should be given to additional mechanisms that address workforce mobility and maldistribution issues.
Health Ministers have identified that the main policy levers to address the shortfall in the health workforce identified in HW2025 are innovation and reform, immigration, training capacity and efficiency, and workforce distribution. As part of HWA’s policy response to HW2025, it will work with key stakeholders to agree a co-ordinated process of review of relevant Commonwealth, state and territory legislation to identify barriers and enablers to flexible use of the workforce. This will identify where there may be opportunities to nationally harmonise relevant legislation where such changes would make a material contribution to workforce productivity and distribution. HWA proposes the initial focus of this work will be on state and territory drugs and poisons and radiation safety legislation which have been identified through recent workforce reform initiatives as limiting opportunities for reform.

HWA will also analyse state and territory health workforce industrial arrangements (government and non-government employers) to identify barriers and enablers to workforce reform. This will enable the development of a set of common goals, principles and conditions that reflect the current and future requirements of the health workforce and workplace, with the overarching aim of boosting productivity, supporting the generalist workforce, retention and job satisfaction. This could provide jurisdictions and employers with reform options for incorporation, on a voluntary basis, into their enterprise agreement development processes. Considering the size and importance of the nursing workforce, HWA proposes to highlight, as priorities, specific issues relating to the nursing workforce when providing advice and recommendations to Ministers.

There is a consistently held view in the rural and remote workforces, that IHPs are a valuable and under-supported asset to these communities. Nevertheless, barriers exist to enable the full use of this valuable supply of workers. The length of time to obtain visas, the difficulty level of the English language proficiency exam, and the processes and waiting times involved in meeting the requirements of some professional bodies, all limit the availability of health professionals and the attractiveness of Australia as a work destination. HWA’s international health professionals program has a mandate to address these issues.

The role of resource industries in rural and remote areas need to be considered to see where there may be links and potential areas for support. There may be the potential for developing private and public sector partnerships that could assist rural and remote communities with the funding of health services and infrastructure. The findings of the House of Representatives Standing Committee on Regional Australia report ‘Cancer of the bush or salvation for our cities? Fly-in, fly-out and drive-in, drive-out workforce practices in regional Australia’ in February 2013 also provide useful guidance in this regard.

Stakeholders suggest that challenges remain in relation to multiple funding sources across the state or territory and federal levels or between portfolios of government. There is a need for more flexible funding arrangements in rural and remote services, so that funds can be applied locally in response to local need and local skill availability, and to allow funds to be pooled between the public, private and non-government sectors. For instance, the part-funding of a speech pathology position by both education and health in a small community can mean that neither department is able to provide an attractive full-time position, resulting in patient needs remaining unmet. Better-coordinated planning and funding could avoid this outcome. Flexible funding is also likely to provide a better environment for workers, allowing more creative individual responses to recruitment and retention issues. Recent moves at Federal, state and territory levels to reduce the number of program-specific funding pools through broad-banding and outcome-based funding and the development of flexible funding pools, may assist small organisations in rural and remote settings at both the application and reporting stages. Medicare Locals are well positioned to support the local allocation of funds with a focus on community need based assessment.

In the feedback received during the development of the National RRHWIR Strategy, the Australian Standard Geographic Classification - Remoteness Areas (ASGC-RA) system, was often perceived to lead to anomalies and inequities in specific funding and incentive programs. This was also raised under recommendation 8 in the Senate Inquiry ‘The factors affecting the supply of health services and medical professions in rural areas’. As part of the DoHA review of workforce programs, the use of the ASGC-RA for the distribution of workforce incentives has been examined. This process has included extensive stakeholder consultation.
The efforts of professional bodies and state and territory governments to promote rural generalist pathways in medicine demonstrate the effectiveness of realigning incentives so that they reward generalist careers. There is now broad agreement that they have national applicability, and that their appropriateness for other health professions is worthy of further investigation. HWA, in collaboration with state and territory health departments, is developing a national framework to support national implementation of the rural generalist model.

### Domain 5 strategic actions

#### 5.1 Policy and legislation

Promote and facilitate the implementation of policy that supports workforce reform by:

- Building on existing work to implement a rural and remote health workforce impact assessment across state/territory government policy proposals.
- Identifying barriers and enablers across Commonwealth, state and territory legislation to support a flexible health workforce.
- Consolidating and improving appropriate funding streams and arrangements to improve community access to quality health care.

#### 5.2 Registration

Support and implement workforce reform efforts relevant to the national registration process by:

- Building on existing work by National Boards to review definitions of ‘practice’ in the context of the rural and remote health workforce.
- Harmonising legislation and regulation to ensure health professionals have the capacity to work to their full scope of practice.
- Encouraging National Boards to review their supervision requirements to enable inter-professional supervision models and the retention of supervisors in rural and remote settings where this is appropriate.

#### 5.3 Recruitment, retention and re-entry

Expand on existing work to implement coordinated policy initiatives specific to rural and remote health workforce recruitment, retention and re-entry that:

- Identify accommodation, workload and organisational needs and supports.
- Identify existing incentives and how best to coordinate and promote them.
- Facilitate the development of the role of Medicare Locals in supporting funding models appropriate to areas with small population bases, where ‘fee for service’ business models are not viable.
- Collaborate with private sector, non government and non-health organisations to develop strategies to address health workforce maldistribution and develop business models that improve the sustainability of the health workforce.
- Develop appropriate flexible, affordable, locally delivered programs to assist health professionals in rural and remote areas in re-entering the workforce.

#### 5.4 Industrial

- Analyse state and territory health workforce industrial arrangements (government and non-government employers) to identify barriers and enablers to supporting workforce reform and the promotion of interprofessional and generalist workforce models in rural and remote settings.
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40 AIHW (2011). The health and welfare of Australia’s Aboriginal and Torres Strait Islander people: an overview 2011. Cat. no. IHW 42. Canberra: AIHW. p. ix

41 AIHW (2011). The health and welfare of Australia’s Aboriginal and Torres Strait Islander people: an overview 2011. Cat. no. IHW 42. Canberra: AIHW. p. 65

42 AIHW (2011). The health and welfare of Australia’s Aboriginal and Torres Strait Islander people: an overview 2011. Cat. no. IHW 42. Canberra: AIHW. p. ix


55 Lost in the Labyrinth Report on the inquiry into registration processes and support for overseas trained doctors, House of Representatives Standing Committee on Health and Ageing

56 This is consistent with the Australian Health Ministers policy response to the findings of HW2025 (November 2012) which included the need to address industrial barriers and enablers to workforce reform.