

TEMPLATE FOR WRITTEN SUBMISSIONS

Rural and Remote Health Workforce Innovation and Reform Strategy

Health Workforce Australia (HWA) was established in 2010 in response to the Council of Australian Government's (COAG) National Partnership Agreement 2008 that acknowledged Australia needed

"a new single body working to Health Ministers that can operate across both the health and education sectors and jurisdictional responsibilities in health is critical for devising solutions that effectively integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training." ¹

HWA has been commissioned by the Australian Health Ministers' Advisory Council (AHMAC) to develop a Rural and Remote Health Workforce Innovation and Reform Strategy for Australia.

The Rural and Remote Health Workforce Innovation and Reform (RRHWIR) Strategy aims to provide national guidance on future needs, reforms and initiatives to improve the health care services of those in rural and remote communities.

The RRHWIR Strategy will be a complementary document to Health Workforce Australia's *National Health Workforce Innovation and Reform Strategic Framework for Action* and the *National Training Plan*. It will seek to:

- promote better utilisation of existing workforce;
- support optimal use of skills and workforce adaptability;
- build workforce capacity for responding and adapting to changing demands in rural and remote communities.

The development of the RRHWIR Strategy and Implementation Plan will be informed by an extensive consultation process during September and October in 19 metropolitan, regional, rural and remote locations. Input into the Strategy can be provided by attending a consultation workshop or by making a written submission.

The submission template is provided below. The questions have been developed based on the five Domains for Action contained within the draft Background Paper, which is available online at: www.hwa.gov.au/wir/ruralandremote.

The Draft Strategy and Implementation Plan will be provided to the HWA Board in April 2012 and it is anticipated that it will be presented to AHMAC in the first half of 2012.

¹ COAG (2008) *National Partnership Agreement on Hospital and Health Workforce Reform*. Schedule B p.16

Written submissions are due no later than Friday, 28 October 2011.

Please complete your submission and return, preferably in a Word.doc format to HWA via:

Email:

ruralandremote@hwa.gov.au

OR

Regular Mail:

Health Workforce Australia

GPO Box 2098

Adelaide SA 5001

WRITTEN SUBMISSION

to **HEALTH WORKFORCE AUSTRALIA** to provide comment on
the **RURAL AND REMOTE HEALTH WORKFORCE INNOVATION AND REFORM**
STRATEGY

Name of stakeholder / organisation making this submission: Services for Australian rural & Remote Allied Health (SARRAH)

Name and position of the author of this submission: Rod Wellington Chief Executive Officer (CEO)

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The comments provided in this submission are from the perspective of (please tick those that apply):

- Education providers to the health workforce
- Health service managers
- Health workforce planners
- Health workforce researchers
- Indigenous health services planners and providers
- Rural and remote health services planners and providers
- A regulatory body
- A professional group(s)

Services for Australian Rural and Remote Allied Health (SARRAH), is nationally recognised as the peak body representing rural and remote allied health professionals.

SARRAH represents professions including, but not limited to: Audiology, Chiropractics, Dental

and Oral Health, Dietetics and Nutrition, Diabetes Education, Exercise Physiology, Genetic Counselling, Health Promotion, Medical Radiation Science, Occupational Therapy, Optometry, Orthoptics, Osteopathy, Pharmacy, Physiotherapy, Podiatry, Prosthetics and Orthotics, Psychology, Social Work, Speech Pathology and Sonography.

A consumer group

A carer group

Government

Non-government (not for profit)

Non government (private, for profit)

Other
(Please specify).....

Confidentiality

The information provided in this submission will be presented as part of a Report to the HWA Board and the Rural and Remote Expert Reference Group. Individual submissions will be made available to members of the HWA Board on request. HWA does not intend to publish the submissions received or the Report on the submissions.

The Report will consist of aggregated, de-identified information and will be used to inform the final Rural and Remote Health Workforce Innovation and Reform Strategy.

Thank you for your participation.

CONSULTATION QUESTIONS:

PLEASE PROVIDE YOUR FEEDBACK BY RESPONDING TO THE CONSULTATION QUESTIONS BELOW.

These questions have been developed based on the five Domains for Action contained within the draft Background Paper, which is available online at: www.hwa.gov.au/wir/ruralandremote.

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.

Key lessons from the literature:

- Promote, value and support generalist practice across all professions
- Expand existing roles
- Develop new roles, such as support and assistant roles
- Sustain what has worked in the past, such as GP proceduralists
- Address attraction and retention of health professionals through a range of initiatives

Introduction:

Services for Australian Rural and Remote Allied Health (SARRAH) commented on the earlier National Health Workforce Innovation and Reform Strategic Framework for Action (Framework) and welcomes the opportunity to contribute to the discussion of the Rural and Remote Health Workforce Innovation and Reform Strategy (RRHWIR).

SARRAH appreciates that the RRHWIR is the next step following the strategy document 'Healthy Horizons'. Health Workforce Australia (HWA) noted that this is a national strategy for rural and remote health, which is part of its current Workplan approved by the Australian Health Ministers Advisory Council. The observation is made that there are not workforce shortages, but there is misdistribution of the existing workforce. Whatever the case, rural and remote Australian communities continue to be disadvantaged when comparing standards of health and wellbeing to metropolitan communities.

SARRAH wishes to continue to be included in these discussions as allied health professionals are significant providers of health care in rural and remote communities. In addition allied health professionals are innovators and as a generally younger workforce than medicine and nursing, provide opportunities for role expansion that may address skill shortages in retraining the allied health workforce in rural and remote areas across Australia.

The comments listed in the Consultation summaries^{2,3} from the Canberra workshop on Thursday 8 September 2011 and the Albury –Wodonga workshop on Wednesday 14 September 2011 are endorsed by SARRAH. Many of these are not repeated as it is taken that the points have been noted by HWA.

Questions:

1.1 In what ways (if any) would health workforce roles and responsibilities need to change to improve the accessibility of health services or to support appropriate models of care in rural and remote settings?

SARRAH again acknowledges the establishment of the Australian Health Practitioner Regulation Agency and HWA as bodies that can operate across the health and education sectors, and also the consultation process. These were positive major outcomes stemming from the National Health Workforce Strategic Framework (2004) but SARRAH is still frustrated at the slow progress in regard to developing a vision for the health of rural, regional and remote Australians. In 2004 this was that *people in rural and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities*⁴. In order for this to be achieved it was agreed that there needs to be health equity such as provision of appropriately trained (and more equitably remunerated) health workers *in sufficient numbers at the right place at the right time*.

Retention of health professionals is the key in improving access to health workers in rural and remote areas and this was recognised in 2010 by the World Health Organisation (WHO)⁵. The WHO Global Policy Recommendations have four domains. These are: *Education, Regulatory, Financial incentives and Personal and professional support*. Each of these recommendations applies as equally to allied health professionals as to medical professionals. In some instances this is already occurring. For example, an improvement in the Education domain is evident with some targeted admission policies in education programs, location of health professional schools outside of capital cities, and exposure of students to rural experience; however these policies need to expand to more areas and professions. In addition, access to continuing or postgraduate training is less accessible. There is less progress being achieved for allied health professionals within the other recommendations although SARRAH is currently finalising a proposal seeking funding from the Commonwealth Government to establish a mentoring program (see Section 2.5).

² Health Workforce Australia. Rural and Remote Health Workforce Innovation and Reform Strategy. Consultation summary Albury-Wodonga: Wednesday 14 September, 2011.

³ Health Workforce Australia. Rural and Remote Health Workforce Innovation and Reform Strategy. Consultation summary Albury-Wodonga: Wednesday 14 September, 2011.

⁴ Healthy Horizons: A Framework for improving the health of rural, regional and remote Australians

⁵ World Health Organization (2010) Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations (page 3).

Generalist practice necessitates advanced skills in some areas of practice; not a *watering down of skills* and this requires further training or up-skilling particularly in speciality areas of practice and in management/leadership. Rural and remote clinicians need to be 'specialist generalists'.

There is a need to increase funding for the development and delivery of programs such as SARRAHs highly successful Indigenous Diabetic Foot (IDF) program. The IDF program model can be replicated in such areas as the establishment of an Indigenous Oral health project to improve oral health and dental care for Aboriginal and Torres Strait Islander people in rural and remote communities. The IDF program is based on up skilling local workers, working in partnership with health professionals to achieve good health outcomes for clients and communities.

Changes needed in health workforce roles and responsibilities in rural and remote areas include increased access to advanced (postgraduate) clinical training and recognition that multi-professional health teams are often standard practice in these areas. These team practices are in many rural and remote allied health services and include primary healthcare such as the IDF program, prevention initiatives and chronic disease self management. This emerges from necessity where remoteness and the lack of *same profession* colleagues mean that clinicians must be less *siloe*d than their medical counterparts. It has been said that rural communities have *low volume but high complexity* health issues. The College of Rural and Remote Medicine acknowledges generalist/specialist practice and skills of medical practitioners in remote & rural areas and *the need to develop a broad range of skills*. This also applies to allied health professionals, but it is not supported by appropriate funding. The lack of rights to directly refer to some medical specialists is another limiting factor which in some instances can be very disadvantageous to rural and remote residents.

1.2 What are the major issues facing health workers that impact on productivity and their capacity to deliver services in ways that best meet community need?

It is often stated that the need is for a health system with workforce design and planning that works backwards commencing from identifying the health needs of communities and consumers. SARRAH has stated previously that the *devil will be in the detail*. Health workforce data is still needed on the rural and remote allied health workforce although here have been some developments. There is a need to develop an allied health evidence database to inform strategies for workforce development and reform funding. The collection of allied health workforce and service delivery data, especially in rural and remote areas across Australia is urgently required. Workforce data must be collected on a national and regular basis using a consistent methodology including both registered and self-regulating allied health professionals comparing supply with demand.

More research is needed in rural and remote communities generally and in specialist populations such as Australia's children, the future workforce. In an Australian Government

publication, *A Picture of Australia's children 2009*, there has been development of specific indicators to monitor the performance of systems and services available to children and their families but there are still a number of data gaps⁶. Children with disabilities and other conditions in rural and remote communities (including Aboriginal and Torres Strait Islander people) who need the services of allied health professionals are severely under-resourced due to lack of a skilled workforce and funding barriers to service provision. Access to postgraduate training (up-skilling) in a number of specialist areas is limited in rural and remote communities. With the welcome initiatives to increase undergraduate student numbers there are now many more student health professionals *in the pipeline*, but there needs to be attention given to them emerging as new graduates requiring a career path. This is a major issue that impacts on both recruitment and retention of rural and remote health professionals.

Another productivity gain to best meet community health service needs is to create flexible funding models linked to the needs of individual communities allowing for responsive health care services to be delivered and is essential to addressing access issues.

Further productivity gains could be made by minimising regulatory complexity thereby allowing clinicians to practice their clinical specialties. To maintain a risk minimisation approach it may suffice to fund supporting structures such as intake systems or administrative support.

1.3 What strategies have already been successful in reforming workforce roles and responsibilities to better address need?

The main strategies in reforming workforce roles in rural and remote allied health services are the support for allied health managers, allied health assistants and greater opportunity through increased places of rural and remote scholarships to undertake studies in health professions. The success of the scholarships is very evident but there is over-subscription of the allied health scholarships generally, in particular with undergraduate and postgraduate rural and remote students.

The work undertaken in workforce redesign and increased scope of practice in various jurisdictions has resulted in rural communities receiving some services they previously did not have access to. However implementation of this strategy needs to be undertaken within a risk management framework, ensuring that services are provided by workers with the appropriate skills and support to achieve good health outcomes. Further national funding is required to support allied health professionals in rural areas to take up extended scope of practice roles, as a cost effective measure to increase local community access to services.

The provision of postgraduate training in rural Victoria was an extremely successful project. The Australian Government Funded - *Building Capacity in the rural workforce: a paediatric physiotherapy training program* proved to be a powerful recruitment and retention

⁶ Australian Institute of Health and Welfare (2009). *A Picture of Australia's Children 2009*. Cat. No. PHE 112. Canberra: AIHW.

strategy⁷. This was shown to have improved children's services, in some areas non-existent previously, in rural communities while providing a career path for young health professionals (workforce retention strategy). The model, equivalent to early medical specialist training (registrar level), was described by a rural medical specialist thus: *The strength of this model is that the driver is the University, the administrator is the health service (Hospital) and the providers are a combination of the University, the Hospital and Community services.* This requires further funding but the model could be applied to a number of allied health professions.

1.4 What strategies show enough promise that they could be considered for broader implementation?

Academic positions for allied health professionals in University Departments of Rural Health (UDRH's) have been shown to enable quality workforce data collection, promoting research and development of training programs such as mentioned in the previous section. The recommendation is to expand the UDRH program to cover all rural and remote Australia. UDRH resources should be enhanced with core funding for allied health academics on staff, con-joint appointments of academic/clinical staff, training of clinical supervisors and support of allied health clinical placements (accommodation, transport and support).

Strategies to support allied health professionals also need to be aligned to realistic expectations in relation to managing demand. The number of allied health professionals in rural areas per head of population is less than their metropolitan counterparts. However there is not always a vacant position. Consequently there is a need for workforce data supported with funding options to address gaps, particularly in communities where health outcomes are already poor.

1.5 What new or novel strategies could be considered in relation to reforming workforce roles to increase access?

Develop opportunities across all health professions, not only medical practice, for allied health professionals in the public health system particularly and in primary care in regard to more equitable remuneration, recognition of speciality skills and acknowledgement of leadership roles in rural and remote areas.

Consideration should be given to the Scottish model where local positions provide interprofessional support for students, new graduates and more established professionals under the *AHP Practice-based Education* program. The Scottish *Facilitation Programme* should also be considered as a cost-effective method of supporting the emerging workforce and assisting in the retention of existing staff
<http://www.scotland.gov.uk/Resource/Doc/344745/0114735.pdf>

⁷ Williams E, Morris M (2009). Australian Government, Department of Health and Ageing, National Rural Primary Health Project *Building Capacity in the Rural Physiotherapy Workforce: A Paediatric Training Partnership*. The University of Melbourne

1.6 Are there potential barriers (e.g. organisational, industrial, professional) to achieving change in this domain? What are they? How could they be overcome?

Traditionally the medical profession has received double the remuneration of allied health professionals, are paid incentives to work in rural and remote areas and are paid while training as interns and registrars. Changing this will threaten 'territories' but if this was addressed even in part it would be more attractive for allied health professionals to work in rural and remote areas, with less attrition.

1.7 Are there things in rural and remote communities that could be built on to seed or speed innovation and change in models of care and the workforce reform needed to support them?

It is important to ensure priority is given through Council of Australian Governments (COAG) initiatives and the range of Australian health care reforms such as Medicare Locals to ensure that there is improved access to allied health professional services for Aboriginal and Torres Strait Islander people to assist in 'closing the gap'.

In addition consideration of some of the innovative multi-professional and interprofessional service models that have developed in many areas could guide innovation in other spaces. The discussion paper notes hub and spoke models for medical services – such models have successfully provided sustainable allied health services in areas where local services cannot be sustained, and should be considered in such circumstances.

1.8 Any other comments or suggestions:

DOMAIN 2

Health workforce capacity and skills development

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

Key lessons from the literature:

- Increase initiatives to attract more Aboriginal and Torres Strait Islander people and more people of rural origin to the health workforce
- Sustain the benefits of exposure to rural practice during training programs
- Provide culturally appropriate training and continuing professional development for the whole health workforce
- Adequately prepare students and staff for working in regional, rural and remote areas
- Develop curricula, teaching approaches and articulated programs throughout the continuum of education that build and develop generalist skills in all disciplines
- Implement interprofessional learning throughout the continuum of education
- Retain and support workplace supervisors and mentors
- Improve access to continuing professional development for all health roles
- Use technologies, such as simulation and distance technologies, for training and up-skilling
- Build capacity for rural health research

Questions:

2.1 What could be done at the undergraduate level to encourage people to take up health careers in rural and remote settings?

Some strategies to encourage allied health professionals to take up careers in rural and remote settings are shown to be effective as mentioned in section 1.1.

It is well documented in medical literature and evident in allied health research⁸ that lack of career path and access to postgraduate professional development restrict recruitment and cause attrition of workers. The increased number of allied health professional students in the 'pipeline' is a well-informed generation who know where the 'best' jobs are, those which have opportunities for career development and fair remuneration. There is inequality for a rural and remote allied health professional which contributes to the misdistribution of the health workforce.

In marketing rural and remote health career options there is an inequality when competing with a metropolitan health service. This is seen clearly at career/job shows for profession

⁸ Williams E, D'Amore W, McMeeken J (2007) Physiotherapy in rural and regional Australia. Australian Journal of Rural Health (2007) 15, 380–386

specific groups. There is a significant cost associated with sending a rural representative to these type of marketing forums, more so than their metropolitan counterpart. The cost of travel and often marketing collateral can generally be prohibitive.

The development of education options to allow students to train within their own communities has been embraced by some professions, but less by others. Active encouragement for Universities to provide such options should be considered as a strategy to attract and retain students in rural communities, and broaden the opportunity for mature aged students to enter health professional training. For example an allied health assistant may continue working and living in their rural community while training to be a Physiotherapist. The role of the UDRH network in supporting such education arrangements is very important.

2.2 What are the major issues in educating and training and supporting the workforce in rural and remote settings?

Sustainability of funding for academic and clinical training, including post-graduate, remains the major issue for educating and training. There are experienced allied health clinicians in rural and remote areas that do not have the opportunity to pass on their knowledge and skills as there is no support for postgraduate training. This means there is poor succession planning creating gaps and fragmentation when the clinician retires or leaves.

2.3 What are the major issues facing health workers in rural and remote settings in relation to continuing professional development, access to mentoring and support and clinical supervision?

A major issue is the lack of infrastructure support in regard to maximising the opportunities offered by technology. Another is funding for academic expertise for development of courses relevant to the rural and remote workforce (see Section 1.3).

Fewer allied health professionals per head of population often means the demand for services is even more significant. This can result in allied health professionals not always accessing professional development even when it is available due to workload pressures.

2.4 What strategies have already been successful in addressing these issues?

New electronic communication technology is revolutionising education and it is no longer necessary to be in the same room as a lecturer. However, funding is required for the development of information and communication technology in relation to education and training systems for allied health professionals practising in rural and remote Australia. This would include professional support policy guidelines and training packages which utilise videoconferencing facilities. Barriers also exist with bandwidth which is a major issue in using technology in some areas throughout Australia.

An additional strategy may be to mandate professional development for all allied health professionals similar to nursing professionals. This would require employers to treat professional development as standard practice in workforce planning.

2.5 What strategies show enough promise to be expanded?

Mentor programs have been shown to be successful in instances at a professional and state level to support people in the health workforce⁹. Funds are needed to implement a national rural mentorship program which provides comprehensive orientation and support for new graduates, those new to rural practice and practicing rural allied health professionals. The program should also include support for new and existing mentors and supervisors. In addition, the program needs to include funding for both the mentor and the mentee to participate otherwise there is little support by employers particularly in times of staff shortages.

2.6 What new or novel strategies could be considered?

SARRAH provides no additional comment at this time.

2.7 Are there potential barriers to achieving change in this domain? What are they? How could they be overcome?

SARRAH provides no additional comment at this time.

2.8 Any other comments or suggestions:

SARRAH provides no additional comment at this time.

⁹ Occupational Health Australia: Mentorlink. <http://www.mentorlinklounge.com/> accessed 20 Oct 2011

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.

Key lessons from the literature:

- Strengthen and support leadership capacity throughout the system
- Prepare the rural health workforce for their leadership role in smaller communities
- Enable front line clinical leaders to implement reforms
- Develop leadership programs that are relevant to the non-urban context
- Acknowledge and support Aboriginal and Torres Strait islander leadership within the health system
- Enhance social capital in rural communities through cross-sectoral leadership

Questions:

3.1 What are the major challenges facing health leaders and health service managers in rural and remote settings?

Workforce shortage remains the single major challenge facing health leaders and health service managers in rural and remote settings. These items are very well covered in the summary reports from the HWA Canberra and Albury-Wodonga Consultation workshops referenced in the Introduction.

3.2 What strategies have already been successful in addressing these?

SARRAH provides no additional comment at this time.

3.3 What strategies show enough promise to be expanded?

SARRAH provides no additional comment at this time.

3.4 What new or novel strategies could be considered?

SARRAH provides no additional comment at this time.

3.5 How could the system better support and empower Aboriginal and Torres Strait Islander people to be leaders at all levels within the health system?

SARRAH provides no additional comment at this time.

3.6 Are there potential barriers to achieving change in this domain? What are they? How could they be overcome?

SARRAH provides no additional comment at this time.

3.7 How would you strengthen and support leadership capacity throughout the health system?

SARRAH provides no additional comment at this time.

3.8 Any other comments or suggestions:

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.

Key lessons from the literature:

- Plan for a health workforce that is based on local need and context
- Move beyond simply planning for existing professional groups
- Collect and use appropriate data that reflects regional, rural and remote contexts

Questions:

4.1 What are the major issues that need to be taken into consideration in planning the health workforce for rural and remote settings?

SARRAH agrees with the views raised at the Consultation workshop in Canberra particularly the following points:

- o There is a lack of focus on allied health professionals in workforce planning and a lack of job security for allied health professionals which have implications for future planning.
- o Insufficient data systems to capture information required for workforce planning.
- o Planning needs to involve the consideration of the available (and planned) support for recruitment/retraining of practitioners, including supervision, continuing professional development (CPD), local infrastructure (e.g. housing, education, transport availability and work-life balance).

4.2 What strategies have already been successful in addressing these?

The Queensland Rural Generalist Training pathway may assist planning, through the provision of a clear link to workforce outcomes, e.g. though guaranteed placements and good opportunities at the end. This model is applicable to medical practitioners only but similar pathways could be developed for allied health professionals.

4.3 What strategies show enough promise to be expanded?

Increasing the flexibility of registration and accrediting bodies to meet specific rural conditions, for example to allow broader scopes of practice and cross-disciplinary training, will provide more coverage across rural and remote communities.

4.4 What new or novel planning strategies could be considered?

SARRAH agrees with the views raised at the Consultation workshop in Canberra particularly the following points:

- o Look at new ways to measure why people leave areas (sources of dissatisfaction), to enable better predictions to inform planning, as well as uncovering areas to address in retention such as spousal satisfaction measurement.
- o Need to incorporate improvements to facilities and available CPD opportunities into planning, as workers cannot be successfully brought into these areas without these in place.
- o Impact of new technologies, such as telehealth services and digital imaging should be considered for the impacts it has on health workforce needs.
- o Plan for peaks and troughs in workforce numbers, for example at holiday times and fly-in fly out (FIFO) communities. Perhaps an expansion to the allied health component of the Commonwealth Government's Nursing and Allied Health Rural Locum Scheme may be considered.
- o Need for a national blueprint for workforce needs.
- o Need broader consideration at the planning stage of what type of health system we actually want. There is currently a focus on curative aspects, when more focus should be on prevention and health promotion. A shift in funding and planning towards this approach needs to occur.

4.5 How would you suggest that current data collections and data collection methods about workforce be improved to better capture an accurate picture of the rural and remote workforce?

An urgent need exists to explore more effective ways to interrogate national data sets on rural and remote settings. Also allied health data is currently lacking and should also be a specific focus. Data collections need to begin at the level of Medical Colleges and representative organisations (e.g. Medical Board of Australia). This data can be used to look at where the gaps in service provision exist. SARRAH notes that the Pharmacy Board of Australia is doing a survey with their registrants and this may provide a model for other professions. Workforce data health by Professional Associations, particularly for self-regulating professions, should also be considered.

Another need is to include qualitative data from local communities about their health requirements, to establish their needs on the ground and complement traditional data collection methods. This should be a role for Medicare Locals as part of their population

health planning functions. In addition, qualitative information about allied health practitioners intention to retire, leave or stay and why is also urgently required.

Finally training organisations in the different sectors need to establish better links between each other and to assist in broader health worker planning. This could be driven by local leaders.

4.6 What support is required to assist local planners?

SARRAH provides no additional comment at this time.

4.7 Who could or should be working together to improve local planning capacity?

Planning needs to be more bottom up, from community level, empowering local community ownership. To support this approach a national framework should be adopted, so a plan can be drawn up with input across sectors.

Whilst local shire councils have little funding to provide local health care, Medicare Locals must have the capacity for local health planning. However, the level of funding for Medicare Locals for this activity is currently unconfirmed. Local Hospital Networks, community representatives, health practitioners and other stakeholders will also have key roles to play in local health planning.

4.8 Any other comments or suggestions:

Different approaches towards planning should be considered for different areas. What is working now needs to be considered in determining an appropriate approach however this does not mean that one size fits all concept should apply.

DOMAIN 5

Health workforce policy, funding and regulation

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

Key lessons from the literature:

- Support rural and remote workforce flexibility with appropriate health and education policy, funding mechanisms and regulations
- Develop registration requirements that accommodate isolated practitioners and maximise the supervisor workforce outside urban areas
- Use policy and funding levers to support, value and encourage generalist practice and increase flexibility in course and training site accreditation

Questions:

5.1 What if any regulatory, policy or funding barriers are there to achieving a flexible and sustainable rural and remote health workforce?

SARRAH supports the points above but notes that the greatest barrier for rural and remote allied health professionals in the policy, regulation, funding and employment is the overall lack of a national rural health policy and a 'voice' in the political arena. Another barrier is the equity gap in funding of health professions thus creating a two tiered or hierarchical health system.

An example is the funding of Patient Assisted Travel Schemes (PATS) which does not include Specialist allied health professional services in rural and remote Australia and access to services provided by allied health professionals not otherwise available. SARRAH supports the appointment of an Allied Health Professional to the Australian Health Ministers' Advisory Council taskforce to develop a set of national standards for PATS recommended in the Community Affairs Senate Committee Report in 2007.

5.2 Can you suggest any strategies to address these?

To address the first barrier, the SARRAH members support the development and implementation of a national rural health policy, one that is underpinned by a rural and remote health plan. The development and implementation process would be more equitable with representation from allied health professionals. This would be achieved with the appointment of a national Chief Allied Health Officer to sit alongside the Chief Medical Officer and Chief Nurse positions within the Commonwealth Government department of

Health and Ageing. This new position should develop policies which contribute towards implementing a multi professional approach to delivering health services across Australia.

A policy to ensure that allied health professionals are represented on boards of Local Hospital Networks and Medicare Locals at all levels of governance both at a clinical and corporate level. Skills based boards of management should be appointed and supported by education and training programs that will assist in developing skill sets on sound governance practices. Medicare Locals in rural and remote areas must also have strong financial support with funding that is flexible and commensurate with meeting responsibilities and local community health needs.

The second barrier is unequal remuneration or incentives such as that available to medical practitioners. This needs to be addressed for the health workforce if the workforce shortage in rural and remote allied health professionals is to be alleviated. The first step could be financial reward for the increased responsibility of extended scope practice and incentives for health professionals who develop specialty skills and expertise. This could be in areas that complement medical specialties and which are targeting national health priorities in primary health care, prevention of chronic disease and rehabilitation.

5.3 What strategies have already been successful in addressing these?

SARRAH provides no additional comment at this time.

5.4 What strategies show enough promise to be expanded further?

In order to improve the health of rural and remote Australians, there needs to be expansion and simplification of access to Medicare. Reform to Medicare, through the expansion of the primary health care items needs to better reflect the health needs of rural and remote Australians and the capacity of private allied health professionals to deliver services. This could include an increase to the funding rebate for the number of consultations allowed per patient, including item numbers for access to allied health professions currently excluded (e.g. Pharmacy), and a rebate for allied health services delivered via videoconferencing. Also consideration of more flexible access to Medicare funding where private allied health professional services are not viable but public services could expand capacity with funding. While such arrangements are available for communities of 7,000 or less, there are still gaps for larger communities.

It is important to ensure that allied health professionals who are providing health care services to individuals are included in the roll out of the e-Health strategies including the allocation of identifier numbers, access to electronic clinical records and trialling e-systems in rural and remote settings.

5.5 What new or novel strategies could be considered?

Ensure priority is given through COAG initiatives and the range of Australian health care reforms such as Medicare Locals to improve access to allied health professional services for Aboriginal and Torres Strait Islander people to assist in closing the gap.

5.6 Any other comments or suggestions:

ADDITIONAL INFORMATION:

- What are some of the most innovative and successful health workforce reforms that you have been a part of? (Please list your top three).
 1. Developing and administering the allied health stream of the Nursing and Allied Health Scholarship and Support Scheme.
 2. Developing the Indigenous Diabetic Foot Program.
 3. Developing a toolkit 'Transition to Remote and Rural Allied Health Practice'.
- Do you give permission for HWA to follow up with your organisation to obtain further information about these reforms?

Yes
- Do you have any other comments or advice about the development of the Strategy?

No

Written submissions are **no later than Friday, 28 October 2011**.

Please submit via email (preferably in a Word.doc form), to ruralandremote@hwa.gov.au or print and send to HWA at the address detailed above.

Health Workforce Australia thanks you/your organisation for taking the time and effort to provide input into the strategy and for providing your perspective and advice.

Further information about the work of HWA is available at www.hwa.gov.au.

Thank you for completing this submission to Health Workforce Australia.
