Northern Australia Workforce Development

Following a referral on 12 October 2022 from the Minister for Northern Australia, the Hon Madeleine King MP, the Joint Select Committee on Northern Australia will inquire into and report on Northern Australia's workforce development.

Submissions closing date: 09 December 2022.

Terms of Reference

The Joint Select Committee on Northern Australia shall inquire into and report on workforce development in Northern Australia, considering the impediments to building the economic and social infrastructure and workforce needed to support economic development, with particular reference to:

a. trends in Northern Australia that influence economic development and industry investment including population growth, economic and business growth, workforce development, infrastructure development, and Indigenous economic participation;
b. impediments to building the economic and social infrastructure required to support industry and business to expand and create regional jobs;
c. challenges to attracting and retaining a skilled workforce across Northern Australia; and
d. empowering and upskilling the local Indigenous population.

Response:

This response is a collective response from the three Rural Workforce Agencies (RWAs) focused on Northern Australia:

- **Rural Health West** – RWA for Western Australia
- **RWA NT** – RWA for the Northern Territory, and
- **Health Workforce Queensland** – RWA for Queensland.

Rural Workforce Agencies

- The Rural Workforce Agencies (RWAs) are funded by the Australian Government Department of Health to deliver a range of activities to address the access, quality and sustainability of the rural primary health workforce. Rural Workforce Agencies operate in each state and the Northern Territory and for more than 25 years have delivered a comprehensive range of health workforce programs and services in rural and regional Australia.
  In doing so, RWAs has established and maintained collaborative working arrangements and networks with key health workforce stakeholders in rural and regional Australia. These stakeholders include Aboriginal Community Controlled Health Services, Primary Health Networks (PHNs), local communities and local health services, university medical and health faculties, Rural Training Hubs, jurisdictional health departments and other key organisations.
- Rural Workforce Agencies have a unique track record and experience in supporting communities and working with stakeholders to address health workforce shortages, and to assist the rural health workforce. Rural Workforce Agencies are not-for-profit agencies whose singular focus is on ensuring remote, rural and Aboriginal and Torres Strait Islander communities have access to highly skilled primary health care professionals when and where they need them, now and into the future.
- RWAs are uniquely placed to understand local community's health workforce needs - including conducting an annual health workforce needs assessment – and to work with communities to explore and identify innovative workforce models to support improved access, quality and sustainability of health workforce, to support improved health outcomes.
- The environment in which RWAs operate is not static. It is in constant flux as rural and remote communities shift, change and often contract in response to myriad factors including environmental challenges, economic downturns, decreases in essential service provision, increasing regional centralisation and declining local populations . Accordingly, responses by RWAs must be flexible and nimble and be based on a detailed knowledge of the individual needs of each community within their jurisdictions.
- This detailed knowledge at a local community level is part of a jurisdictional-wide strategic approach to health workforce recruitment and retention. RWAs have collected and analysed data on rural workforce demographics through minimum data sets for more than twenty years. This data provides a rich picture of the changing patterns of workforce practice, the age of practitioners, workforce turnover and retention and provides the most comprehensive and consistent national picture of rural workforce currently available. RWAs are mature organisations with a wealth of detailed knowledge, experience and expertise in understanding the needs of rural and remote communities and the challenges of delivering a workforce to meet those needs.

Impediments to building the economic and social infrastructure – lack of access to primary care

- A lack of access to primary care (including General Practice services) stifles economic development[1].

[1] General practice: service or business? InSight+ , 5 December, 2022.

- Access to primary health care is a fundamental core service requirement for all communities to support economic and community development – and to allow communities in Northern Australia to grow and flourish.
- Powerful evidence suggests that primary care, can produce a range of economic benefits through its potential to improve health outcomes, health system efficiency and health equity[2], and forms part of the fundamental infrastructure service baseline to allow economic sustainability, economic development and growth.
- Critical shortage of housing and health infrastructure are real impediments to delivery of primary care in Northern Australia
- Safe work conditions and adequate support for rural and remote health care are critical to the sustainability of primary care in Northern Australia.

Status of primary care workforce – fragile, especially in rural and remote Australia

- The primary care landscape can be viewed as mostly providing viable and sustainable services – and this deserves to be acknowledged and celebrated.
- The service landscape is not a monoculture – but rather a mosaic of private, public, not for profit and mixed model service providers and models.
- It can be argued that access to services has improved over the last 25 years, although access has improved more in urban areas – with a net increase in relative disparity.
- It can also be argued that provision of GP and primary health services is in a fragile state and increasing challenged. There are some regional and remote localities that increasingly are unsustainable for private practice. We see growing examples of market failure in smaller, remote population communities.
- Increasingly primary care is defined by maldistribution issues (rather than macro supply issues) and challenges of subspecialisation (small scale and subspecialisation are not aligned).
- These macro comments and arguments are not mutually exclusive.
- A large number of rural and remote towns remain highly dependent on overseas trained doctors
- There is significant staff burnout in small rural practices and Aboriginal Community Controlled Organisations (ACCOs).
- Without a clearer trajectory of training pathways and future careers, history suggests we are unlikely to establish a sustainable workforce required to underpin accessible, high quality and sustainable health services for rural and remote Australian communities.
- Despite numerous initiatives over recent decades, persisting rural allied health workforce challenges remain a key factor limiting access to allied health services in rural and remote communities. Nationally, the rural allied health literature describes multiple factors that contribute to high turnover/low tenure of allied health professionals.

Potential Solutions – primary care workforce

Indigenous primary health care workforce

- Indigenous health workers are critical and essential to the economic development of Northern Australia. Further investment is required to support local community engagement and development that supports empowering and upskilling local Indigenous people and Indigenous organisations, and that supports training pathways for Indigenous doctors, Indigenous Allied Health Professionals and Indigenous Allied Health Assistants.

[2] Building the economic case for primary health care, © World Health Organization 2018.

Address disparities in remuneration

- Address the significant disparities in remuneration for rural GPs and GP registrars vs (state employed) hospital based rural doctors as a priority attraction strategy. This is also an issue for allied health and nursing.

Nuanced policy responses

- Our collective experience across Australia over more than 25 years indicates the requirement for nuanced not blanket policy response. If policy change is made to address Northern Australia workforce issues, it has implications for other rural and regional workforces. (i.e. not mutually independent workforces)
- Every policy change has unintended consequences (and often there is insufficient consideration of the implications of one policy change to the wider policy environment, and the resultant practical impact in communities). The RWAs would welcome the opportunity to assist with input to, and review of any policy changes to provide a perspective of the likely change to practice, and outcome for Northern Australia.

New place based models of care and funding – to drive community development and economic growth

- The solutions to address rural health workforce issues will require application of non-traditional models of health care provision (in the Australian context) including: health care teams, and hub and spoke models of care delivery, that enable rural communities no longer rely on a general practitioner/rural generalist resident in each and every town. Northern Australia represents an unique opportunity to pioneer and put into practice innovation that meets requirements and supports communities to grow and thrive.
- Funding models that support blended funding across health, disability and aged care are required to meet smaller population and community needs.
- Collective RWA experience demonstrates an increasing focus on a holistic approach to improve GP retention by key players within the health workforce space delivers results. Non-monetary incentives to retain rural GPs are increasingly being considered, such as supports for their families, orientation and integration and mechanisms to increase connectedness to the rural community. Future investment into data capabilities to evaluate retention supports and collaboration across health workforce stakeholders will be key to further development of rural health workforce strategies.
- Local planning must include Local Hospital Networks, PHNs, Rural Workforce Agencies and community representatives – particularly Indigenous people and community organisations. Workforce and service plans must be endorsed by all parties with funds pooled and distributed accordingly. Recognition that socioeconomic factors and the role of other sectors such as housing, education, infrastructure and transport are taken into account in service planning in the region. Specific funding for this for this place-based resource intensive work is needed and Rural Workforce Agencies are well placed to undertake this work within their jurisdictions.

Core requirements

- Fundamental focus on delivering improved access, quality and sustainability of primary care. See Appendix A that describes key issues, strategies and desired outcomes for access, quality and sustainability of primary care.
- Adequately trained and prepared health professionals for remote practice
- Access to housing and supporting health infrastructure
- Safe work conditions.

In addition to this response, we look forward to the opportunity to participate in hearings or consultations that may occur as part of the Joint Select Committee on Northern Australia. Please find our contact details below:

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Appendix A: Access, quality and sustainability of primary care

	Access *Improving access and continuity of access to essential primary health care*	Quality *Building workforce capability*	Sustainability *Growing the sustainability of the health workforce*
Key issues	• Shortages of GP, nursing, allied health, and Aboriginal & Torres Strait Islander health worker/practitioner workforce in remote and rural Northern Australia • Inequitable distribution of health workforce • Lack of or inadequate infrastructure (ICT, physical) • Insufficient funding for workforce and services in priority locations • Long distances to travel to access services/lack of locally available services • Lack of affordable and appropriate transport to access services • Lack of suitable housing for health professionals • Limited/lack of services available after hours • Cost of services/lack of bulk billing services impacting on populations of lower socioeconomic status • Lack of culturally safe health service options in some rural communities • Health literacy around health service access and availability	• Skill mix of workforce not aligned to local needs • Lack of experienced, long stay workforce • Care is episodic rather than comprehensive, continuous and person-centred • Workforce not equipped to deliver culturally appropriate health care • Low representation of First Nations people delivering health care • Difficulty accessing quality professional development and clinical upskilling • High representation of early career graduates in allied health • Challenges to training and developing a local workforce • Lack of mentoring and leadership opportunities • Barriers to expanding or utilising full scope of practice • Workforce data and patient information is siloed	• Ongoing challenges for recruiting and retaining health workforce • High turnover of health professionals in remote and rural communities • Limited pipeline of locally trained workforce • Decline in interest in rural health, general practice and primary care as career choices • Lack of end-to-end training in remote and rural communities, preventing the development of required community-based skills • Inefficient and fragmented care due to high visiting/outreach models • Vulnerable and non-viable workforce models including: o Challenges to the viability of private health services in remote and rural areas including cost of living, distances to travel, income of clients, access to workforce and economies of scale. o Current fee for service general practice models in remote and rural areas does not support sustainability o Current models don't support 'Easy Entrance, Gracious Exit' of workforce creating financial, administrative and work/life balance burdens • Lack of workforce retention due to: lack of access to continuing professional development, professional isolation, burnout due to lack of relief, poor housing and accommodation, high cost of living, spouse/family and lifestyle considerations • Concerns for the mental health and well-being of the workforce due to climate and natural disasters such as floods, droughts, fires, as well as the impacts of the COVID-19 Pandemic

	Access *Improving access and continuity of access to essential primary health care*	**Quality** *Building workforce capability*	**Sustainability** *Growing the sustainability of the health workforce*
Strategies	• Employ targeted recruitment support and retention packages to priority communities, including locums • Continue to build evidence through collation of workforce data to inform workforce planning • Assist health professionals with relocation grants and incentives • Support clinical and leadership development • Promote the increased use of virtual and digital tools including telehealth • Streamline processes for patients to access transport subsidies • Develop innovative workforce models to support community need and increase workforce capacity (generalist models) • Ongoing workplace cultural training and embedding culturally responsive practices to support culturally responsive services • Encourage interprofessional collaboration and communication • Advocate for further policies and activities to attract health professionals to remote and rural areas	• Strengthen the First Nations health workforce training pipeline to support culturally responsive health service delivery to First Nations people • Better utilise the Aboriginal and Torres Strait Islander Health Practitioner role including its role in delivering services to complement activities undertaken by First Nations Health Workers • Support to commence vocational training in health-related studies, close to home • Organisational support to access continuing professional development • Provision of scholarships and bursaries to support upskilling aligned to community need • Organisational support for staff to undertake leadership training at all levels • Encourage activities that support role development and enhancing scope of practice for all professions • Support commissioning of providers that embed cultural, clinical, and organisational orientation and training in their organisations to support transitions to rural practice • Support succession planning to ensure a continuous pipeline of strong clinical and administrative leaders • Increase workforce capacity through workforce redesign to deliver quality multidisciplinary care • Shared patient records across organisations to support quality care • Shared workforce data across organisations to assist with workforce and service planning at the local level	• Offer rural immersion opportunities to attract students into rural health careers • Support rural high school visits to create interest in a rural health career • Work with universities to identify and prioritise students interested in rural health practice for long term placements and to expand support of remote and rural student placements in Northern Australia and first jobs • Availability of end-to-end training in regional and remote sites, for all professions • Collaborate at the local level to support essential worker accommodation solutions • Support navigator and liaison roles to promote better system integration, coordination and collaboration • Investigate blended funding workforce models to support financial viability and skills retention • Work within priority communities to assess and develop innovative workforce models that expand scope of practice and that consider emerging health workforce roles • Family support opportunities including schooling and childcare for children, employment opportunities for partners • Prioritise collaborative, place-based workforce and service planning with communities in order to meet community need • Encourage local health professionals and community members to mentor and support students on long term placements • Availability and promotion of mental health and wellbeing services for the remote and rural health workforce • Advance practice sustainability by expanding the types of professions in remote and rural practice that can access MBS items
Desired outcomes	• Increased supply of primary care workforce to priority areas • Improved availability of appropriate infrastructure to support health service requirements • Increased utilisation of virtual and digital tools to support health service delivery • Increased availability of affordable and appropriate transport to access health services • Increased availability of appropriate housing for health professionals • Increases in technology and financial supports for health professionals • Greater understanding of services and access to affordable primary care within communities • An endorsed overarching vision for primary care (state and federal)	• An experienced and capable workforce that is responsive to local needs • Increased availability and continuity of quality primary health care services • Increased availability of quality training, close to home • Work environments that enable staff to work to the top of their scope providing workforce satisfaction and quality care • Increased capability of the health workforce to deliver culturally appropriate health care • A greater cohort of clinical and administrative leaders in remote and rural communities • Workforce data is accessible and supports workforce planning at the local level • Patient information is accessible across organisations to support quality care	• Greater numbers of future workforce taking up careers in rural health • Greater numbers of the medical workforce choosing general practice • Higher rates of health workforce retention in remote, rural, and regional areas • Health service delivery is optimised through improved system integration, coordination and collaboration • Workforce models are developed to meet local need and support viability and sustainability of services • Developing the future workforce to address maldistribution and local need.