**TEMPLATE FOR WRITTEN SUBMISSIONS**

**Rural and Remote Health Workforce Innovation and Reform Strategy**

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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.

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

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

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:

**Exercise and Sports Science Australia (ESSA)**

Name and position of the author of this submission:

**Gregg Orphin, Chair, ESSA National and Rural and Remote Committee**

Contact person (name and title):

**Dr Ian Gillam, Industry Development Officer, ESSA.**

Contact details (telephone and email): (03) 9885 6033

**Ian.Gillam@essa.org.au**

**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)**
**Exercise and Sports Science Australia**.....

☐ 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.**

## Contents

**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.

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## 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

**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?

Allied Health Professionals (AHPs) provide discipline-specific services as members of primary health and secondary care teams. AHPs not only provide the most effective discipline specific outcomes, but these are also cost effective for the health care system and patients, wherever they may live. Rural and remote (R&R) patients, including indigenous Australians, will have their health needs better served by those professionals most qualified to deliver appropriate interventions and advice, when compared to generalist health professionals, such as Remote Area Nurses, Aboriginal Health Workers and allied health assistants. By increasing the understanding of general practitioners (GPs) and nursing staff as to the important role AHPs can provide in the management of chronic disease, the health outcomes of R&R Australians, who have been shown to have a higher incidence of chronic disease than those in the larger cities, can be improved.

The majority of government health funding for rural and remote health, has been given historically to medical professionals including GPs, nurses, medical specialists and hospital staff. AHPs, and in particular Accredited Exercise Physiologists (AEPs), have been

provided very limited funding or government support, yet they are encouraged to set up R&R practices, and travel to remote areas to provide their services.

Since the federal recognition of the Accredited Exercise Physiologist as a discrete allied health profession in January 2006, the profession has been increasingly recognised by GPs and other health professionals. Since July 2009, AEPs have been the 6th most utilised allied health profession in providing Medicare services to patients with chronic disease, and in the group management of patients with Type 2 diabetes, AEPs were the most commonly used allied health group.

The HWA paper on "Rural and Remote Health Workforce Innovation and Reform" seems to be more of the same, ie, providing funding to GPs and nurses and encouraging them to become "generalists" to deliver an increasingly wide range of services, which would normally be provided by AHPs. Increasing the scope of practice and the range of services to be delivered by general practitioners and nurses, only reduces the time available to deliver the services for which these professionals have been specifically trained. AEPs are 4-year university qualified AHPs who specialise in the delivery of exercise, lifestyle and behavioural modification programs for the prevention and management of chronic diseases and injuries. It is unreasonable to expect that GPs or nurses would acquire a similar level of competency by completing short courses in exercise physiology and its related disciplines, even if there were incentives to up-skill in this professional area (and many others), so as to broaden their scope of practice.

Exercise and Sports Science Australia (ESSA) is also particularly concerned with the proposal to extend the scope of practice and the required service delivery for GPs and nursing staff, especially when it involves providing advice on physical activity and lifestyle interventions. Such a proposal would actually limit the opportunities, and act as a disincentive for AEPs to establish practices in R&R Australia.

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?

A major issue for AHPs, and especially AEPs, is the poor understanding that many primary health care professionals (GPs, Remote Area Nurses, Aboriginal Health Workers) have of the skills and abilities of AHPs to treat patients with a broad range of chronic diseases. This lack of understanding limits referrals to AHPs and therefore access to their services. AHPs have historically been provided with little if any financial, structural or administrative support to establish practices in R&R Australia (for further comments see Domain 5). There are also only limited continuing education opportunities for R&R AHPs, which significantly affect these health professional's ability to update their skills and knowledge (for further comments see Domain 2). There are also currently, very limited opportunities for mentoring, student supervision and locum support. These provide major barriers to

practitioners when considering establishing practices in R&R areas, as these barriers significantly reduce service availability and productivity.

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

The DoHA paper "Closing the Gap" (2008), as outlined in the current "Rural and Remote Health Workforce Innovation and Reform Strategy" (RRHWIR) paper, outlined a number of strategies to support R&R health practitioners. However, these initiatives have "*almost entirely, but not exclusively, been directed at the medical profession"* and not to AHPs. The incentives included

*"financial incentives, bonded scholarships, a HECS Reimbursement Scheme, Rural Locum Placement program, non-financial incentives for overseas trained health professionals and medical graduates and other forms of incentive or assistance" (RRHWIR, p 10)*

As these strategies have not been made available to AHPs, it is not surprising that without these strategies and support services, there is a paucity of AHPs, including AEPs, in R&R areas. The current RRHWIR paper provides only more of the same, with support continuing to be directed to GPs, nurses and aboriginal health workers and not AHPs. ESSA believes this is extremely disappointing and it recommends that the priorities outlined in the RRHWIR paper, need to be expanded to AHPs.

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

The proposed strategy to use the new high speed National Broadband Network to deliver telehealth services to R&R areas of Australia is a promising development. However, the recent announcement of the $620 million telehealth initiative by the Gillard government, only provides rebates for video consults provided by doctors and nurses. Again the important role AHPs play in reducing the burden of chronic disease has not been given adequate consideration in this initiative.

The effectiveness of nurses to use telehealth consultations to deliver exercise interventions to manage chronic disease has recently been shown to be ineffective. A recently published study in the prestigious medical journal, "*The Lancet*" (Andrews et al, *The Lancet,* June 25, 2011), clearly showed that a walking-based exercise program of 150 min/week delivered by nursing staff, failed to improve blood glucose control in patients with Type 2 diabetes. In comparison, the paper showed that an intensive dietary intervention program, delivered by dieticians, improved blood glucose control, emphasizing the need for trained AHPs to deliver effective lifestyle interventions.

The finding in the study by Andrews et al (2011), that an exercise intervention was ineffective to reduce HbA1c in type 2 diabetics is contrary to most other studies. When an

exercise intervention was delivered by exercise physiologists to patients with Type 2 diabetes, the efficacy of exercise to improve blood glucose control, the intervention was shown to produce significant clinical outcomes (Dunstan DW et al. *Diabetes Care 25:* 1729, 2002; Pedersen B. K and Saltin B.. *Scand J Med Sci Sports*: *16 (Supp 1):* 3, 2006; Church et al, *JAMA: 304*: 2253, 2010). Indeed the change in HbA1c attributed to regular exercise interventions, which were supervised by exercise physiologists are comparable to that seen in patients with Type 2 diabetes taking Metformin, the medication of choice for insulin resistance (Pedersen B. K and Saltin B. *Scand J Med Sci Sports*: *16 (Supp 1):* 3, 2006).

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

ESSA strongly recommends and encourages HWA to provide similar support programs for AHPs as were previously recommended to GPs and nurses in the DoHA paper "Closing the Gap" (2008) paper. This includes financial incentives, bonded scholarships, a HECS reimbursement scheme, rural locum placement program, non-financial incentives for overseas trained health professionals as well as increasing access to continuing education programs for AHPs. Such support would encourage AHPs and in particular AEPs, to establish practices in R&R Australia, so exercise physiology services can be provided to improve the health of all individuals, irrespective of where they live.

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?

Barriers to change could include lack on infrastructure that facilitates inter-professional practice and lack of professionals in R&R areas. Incentives for AHPs commencing and continuing practice in R&R areas similar to those available for GPs and nurses and, with increased AHPs involvement in R&R areas, continued strategic development of infrastructure to promote inter-professional practice have the potential to overcome these barriers.

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?

The recent developments in primary health care, such as the new Medicare Local network and the National Preventive Health Agency should assist in developing more comprehensive and integrated primary and secondary health programmes such as those in preventive health, the management of chronic disease, and aged care. It is hoped that the development of such programmes, will increase the engagement of AHPs to provide their services as part of these programmes.

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?

A number of regional universities in Australia (eg Charles Sturt University, University of Wollongong, Southern Cross University and James Cook University) provide the undergraduate and postgraduate programmes required to train new exercise physiologists. These universities recruit a significant number of their students from regional Australia. The provision of scholarships that encourage students to return to their local R&R communities, HECS reimbursements, or assistance to them to establish their practice in these areas, could be extremely cost effective.

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

Access to continuing education and professional networks are the most significant issues. For cost effectiveness, professional organisations such as ESSA mostly run continuing education courses in the capital cities. The attendance by R&R AEP practitioners at these continuing education courses, often requires significant additional costs related to travel, time off work, accommodation costs and meals, which is a significant disincentive. In

addition, there are personal, family and community costs, which also act as significant barriers to practicing AEPs in R&R areas attending continuing education courses. Therefore equitable alternatives are greatly needed to facilitate the continuing education of R&R health care professionals. Furthermore, without the network of peers and mentors and access to readily available education resources, which are often taken for granted in metropolitan areas, R&R AHPs come under increased pressure when presented with difficult or complex cases.

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?

The major concerns for R&R AEPs are access to professional education opportunities, limited professional networking and mentoring opportunities and general issues related to professional isolation. The major issue for R&R practitioners is the cost associated with attendance at continuing education courses. Attendance at these continuing professional development courses is essential as this is required to maintain the practitioners' professional accreditation. Development of mentoring, peer, and inter-professional networks is also important. Development of incentive packages for experienced practitioners, who are providing mentoring and clinical supervision for inexperienced AEPs, also need to be considered. Increasing these opportunities may encourage graduates or inexperienced practitioners to start a practice in R&R areas.

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

ESSA has recently commenced a range of strategies to support AEPs working in R&R areas of Australia. These include: establishing the National Rural and Remote Committee to ensure the national body is aware of the issues affecting these practitioners, developing online or podcasting continuing professional development opportunities, support for attendance at CPD courses and conferences. Options on how to establish an effective on-line mentoring programme is also currently being discussed.

2.5 What strategies show enough promise to be expanded?

The strategies outlined above in section 2.4 are currently being monitored and evaluated. Cost to the national professional body (ESSA) is a significant barrier to providing adequate support that fully addresses the needs of R&R practitioners, so support from DoHA to assist with the development of these programmes, would enhance the effectiveness and accessibility of these strategies.

2.6 What new or novel strategies could be considered?

Video conferencing is certainly an option to increase the opportunities to expand continuing education and professional network initiatives; however the cost, from ESSA's perspective,

is prohibitive. Webinars, similar to those provided by the ATO for small business owners, could also provide a option with the impending advent of the National Broadband Network.

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

The cost associated with implementing some of these strategies is a significant barrier and additional funding or infrastructure support would help to overcome this barrier.

2.8 Any other comments or suggestions:

## 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?

The major challenges facing health leaders in the R&R sector are related to the reduced medical and allied health workforce. This includes AHPs, who can initiate and develop effective health programmes across a wide geographical area and to diverse ethnic and socioeconomic groups, including Indigenous Australians. Challenges also exist in retaining the existing health workforce, by providing adequate continuing education and professional support networks across all sectors for R&R practitioners. Furthermore, there are insufficient incentives to encourage experienced AHPs to provide mentoring or student supervision which is important for the future development of the health workforce in R&R Australia. Mentoring and student supervision come at a significant cost to the AHPs business, as it results in a loss of time and income, and for the community, reduced availability and access the services provided by the AHP.

3.2 What strategies have already been successful in addressing these?

These challenges have not yet been sufficiently addressed within the allied health sector for R&R practitioners, which limits my ability to provide effective comment.

3.3 What strategies show enough promise to be expanded?

The new health reform agenda, including the Medicare locals may provide increased opportunities for AHPs to provide input to broad based primary and secondary health programmes, based on the needs of their particular community. This should provide

increased financial support, increased opportunities for inter-professional networking and continuing education.

3.4 What new or novel strategies could be considered?

Extending support strategies similar to those available for primary health care professionals to AHPs should increase their availability in R&R areas, increasing patient accessibility and in turn reducing the burden of chronic disease on the healthcare system.

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?

I am unable to comment on this.

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

Communication of, and access to, strategies offered by DoHA to assist AHPs seems to be an issue, which may flow on from the lack of professional networks within the sector. Establishing peer and inter-professional networks may improve communication and therefore access to supportive strategies.

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

Leadership is an area that is often absent within many university programs in the health sector, and to obtain these skills often requires additional studies in unrelated disciplines. Furthermore, the notion of leadership appears to be undervalued in many health professional accreditation systems, as there is not sufficient compensation provided to AHPs to take on leadership, mentoring or student supervision roles in the health care sector. Changing this practice should change the capacity for leadership within the health system.

**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?

The important service that AHPs can provide within R&R communities is partially acknowledged within the current HWA paper, by the comment that there should be an "expansion of the role for physiotherapists" (page 38, para 1). However, accredited exercise physiologists have a broader scope of practice, with a primary focus on the treatment and prevention of chronic disease, which is generally not the domain of physiotherapists, who are primarily involved in the acute management and rehabilitation of injuries. Therefore, I would suggest that support for AEPs would be more suitable to provide AHP services to R&R communities. With the high incidence of chronic disease in R&R and Indigeneous Australians, AEPs are best qualified to provide exercise and lifestyle couselling necessary to treat individuals with a wide range of chronic diseases, and AEPs also have the ability to work in the areas of injury prevention and management.

ESSA strongly believes AEPs would provide an important range of services that are required to improve the health of R&R Australians and believe that should financial support and adequate assistance be provided to its members to set up practices in R&R areas, there could be significant impact on the health and well being of R&R Australians.

4.2 What strategies have already been successful in addressing these?

These have previously not been sufficiently addressed within the allied health sector for R&R practitioners, which limits my ability to provide comment.

4.3 What strategies show enough promise to be expanded?

I am not aware of any strategies and hence cannot provide comment.

4.4 What new or novel planning strategies could be considered?

I am unable to comment on this.

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?

Data collection should focus on determining the number of AEPs in R&R Australia, the number and type of services provided, the health conditions for which services have been provided and their impact on the health of R&R Australians, especially those in "at risk" and disadvantaged populations. Data on the efficacy of AEPs in delivering health outcomes within primary health sector and the demand for these services, should also be monitored.

In the event, that initiatives are provided in the areas outlined above, the above data would provide a baseline, to determine the impact on the health of R&R Australians, which could be used to determine the cost effectiveness of the funding provided to support these initiatives.

4.6 What support is required to assist local planners?

With an increased understanding of the roles of AHPs in R&R areas, planning needs to take into account the rate of chronic disease and the aging population at the local level.

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

GPs and AHPs should be working together to evaluate and determine the optimum arrangements for managing an effective workforce that can deliver effective health services to R&R communities.

4.8 Any other comments or suggestions:

## 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?

As outlined within the HWA paper and the issues I have raised above, there are significant challenges and barriers to providing health services in R&R areas, especially for AHPs, which have previously not been provided with sufficient financial or professional support by DoHA.

AHPs, such as AEPs, are generally located in small private practices in the larger regional towns of R&R Australia. However, these practitioners will often have limited practice infrastructure and facilities, and may often be required to travel significant distances to service other practice locations and clients to ensure their practice viability. The lack of practice infrastructure will often result in significant barriers for effective communication, inter-professional network development, and AHPs' ability to supervise or mentor students, who may wish to increase their experience to work in R&R Australia. This not only affects the viability of the current practitioners, but also reduces their ability to see clients, assist inexperienced practitioners, and develop new practices in R&R Australia.

5.2 Can you suggest any strategies to address these?

As outlined above in section 1, the barriers outlined in 5.1 above need to be addressed by providing adequate financial, professional and infrastructure support to AHPs in R&R areas.

5.3 What strategies have already been successful in addressing these?

At the present time adequate strategies have not previously been put in place to support AHPs to sustain viable practices in R&R areas.

5.4 What strategies show enough promise to be expanded further?

There is no data to comment on this at the present time.

5.5 What new or novel strategies could be considered?

As previously mentioned, extending the regulations, policies and funding that relate to primary health care professionals to those AHPs involved in the prevention and treatment of chronic disease will assist in overcoming these barriers. Essentially this comes down to the facilitation of inter-professional practice, rather than the generalisation of the health workforce, as proposed in this paper.

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).

  Exercise is Medicine

  Medicare Locals

  HEAL project

- 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?

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**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.**

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