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SUBMISSION

To the Joint Select Committee on Northern Australia

By

Greater Northern Australia

Regional Training Network

(GNARTN)

&

The Remote Health Project

(RPH)

This paper does not necessarily reflect the views of the GNARTN and or Remote Health Project partner government and funding agencies.

HealthWorkforce AUSTRALIA
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Contents

Executive Summary

Addressing health issues of Northern Australia are uniquely challenging. A proportion of the population is scattered in remote and rural areas; international borders are nearby and disease patterns in the north are frequently different from those of Southern Australia. Sustaining a skilled health workforce is challenged by location, access to education for children, community, cultural, accommodation and cost issues. Without attention, these health services and workforce issues could present an impediment to the growth of Northern Australia.

The success of industry development in Northern Australia must be underpinned by the good health and of its citizens and supporting health services. In particular, a coordinated, cross-jurisdictional approach is needed for successful health service delivery in Northern Australia. Health strategy and service delivery needs to be supported by quality health professional education and training. A coordinated approach to health could also benefit the whole of Australia economically by providing a health professional training hub for students within the Asia-Pacific Economic Cooperation (APEC) region.

Two agents of change, established in the past three years in Northern Australia; the Greater Northern Australia Regional Training Network (GNARTN) and the Remote Health Project (RHP), have demonstrated that cross jurisdictional partnerships provide a mechanism to drive coordination, co-investment and productivity in health professional training and the wider health system. Multilateral partnerships, supported by appropriate governance structures, can drive improved health outcomes by reducing duplication, improving productivity and developing the health workforce to meet the needs of the communities in Northern Australia.

To this end the GNARTN Council has proposed to the jurisdictional Health Authority Chief Executives of WA, NT and QLD that they sponsor a Health Round Table to inform health policy and strategic development in line with the Joint Senate Committee's terms of reference.

Effective collaboration assists health professional and health executives to reduce costs and link systems and services; health professional and patients then see no barriers as they move across northern Australia in response to community needs.

GNARTN proposes that:

- A healthy population with appropriate access to health services is critical to the sustained economic development of Northern Australia in the next 30 years. Achievement of this must be supported by a fit-for-purpose health professional training system embedded within Northern Australia's health system infrastructure.

- That a Health Round Table be convened by the Health Department Director Generals of Western Australia, and Queensland, the Chief Executive Northern Territory Health Department and their Executive Representative to inform the Joint Select Committee's strategic priorities related to the health needs of Northern

Australia and the significant economic benefits that could be gained by positioning Northern Australia as the Health Workforce training hub within the APEC region.

- Increased productivity and efficiency can be achieved through the harmonisation of policies, investment and the legislative and regulatory enablers that facilitate Northern Australia Health Professional training pathways.

- The development of a sustainable health service for Northern Australia is dependent upon access to workforce training and skill development, affordable and suitable housing, quality education for children and cultural and community incentives that entice and sustain the health workforce.

- Opportunities to enable jurisdictional leadership in the provision of specified health services. By way of example cancer specialty services for the North located at Darwin in the Northern Territory or Tropical Diseases in Queensland.

- A Greater North Health Group is resourced via a multilateral agreement between the State jurisdictions and the Commonwealth to enable shared investment in health workforce planning and development, service planning, health infrastructure and enhanced telehealth systems.

- Considerable opportunity to recruit, orientate and retain the health workforce can be achieved by joined up Northern Australia approach.

Introduction

High quality and equitable healthcare, health services and health professional training must be considered a priority area in the proposed development of Northern Australia and its mineral, energy, agricultural, tourism, defence and other industries. A skilled, suitably-trained and qualified health workforce is critical workforce infrastructure that needs support and development.

Currently,

> '*there is a big divide between the health of metropolitan Australia and that of Australians living in rural and remote areas. There is also a dichotomy in terms of the health services available. In essence, if you live in rural or remote Australia your health will on average be poorer, and your access to health services more limited, a trend which worsens with increasing remoteness.*'[1]

The particular health challenges of Northern Australia need to be met by a unique workforce trained for the emerging health needs of Northern Australia. Northern Australia's health organisations and agencies have been at the forefront of addressing and managing the impact of Northern Australia's unique health issues. The knowledge held by this group - the lessons learned, and solutions developed by people who are embedded as service providers - must inform strategies to ensure health gains for future population. Unlocking this knowledge and connecting the appropriate people is crucial to ensure a cost effective and robust health system.

The 'New Normal'

The factors driving health reform, and including the recent economic crisis, have created what Henry et al (Accenture 2011)[2], describe as the 'New Normal' in the publication, *Cross Jurisdiction Collaboration: New models for State, Regional and Local Governments*.

That is, the operating environment of government entities has changed to such a degree that traditional individual responses alone are unable to address the changes and challenges they face. Central to the theme of cross-jurisdiction models, such as GNARTN, is the notion that the new model will address a specific problem or opportunity.

The objectives for any such collaboration are

1) improving effectiveness – *better government services at the same cost*

2) enhancing efficiency – *reducing costs associated with providing a service*; and/or

3) creating new capabilities – *developing new models of care and service delivery not currently provided within current jurisdictions*

4) reducing duplication – identifying and sharing worthwhile projects and initiatives.

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[1] Health Workforce Australia, 2013, National Rural and Remote Workforce Innovation and Reform Strategy.

[2] Michael Henry and Daniel McClure, 2011, Cross-Jurisdiction Collaboration: New Models for State, Regional and Local Government, Accenture Consulting (www.accenture.com)

Collaboration in Northern Australia: Greater Northern Australia Regional Training Network (GNARTN) and the Remote Health Project (RPH)

The historical and bureaucratic fragmentation of Northern Australia is noted in the findings of Dale (2013) in the paper titled '*Governance Challenges for Northern Australia*'[3] where it states;

> *'There is little governance connectivity across the north…and, by and large, the three jurisdictions tend to manage common issues in isolation' (p11),*
>
> and furthermore;
>
> *'Governance in northern Australia is centralised to Darwin, Perth, Brisbane and Canberra, This centralisation has historically meant that there are quite fragmented approaches to governance among regions within the north' (p13).*

The specialised health service needs of Northern Australia have driven the development of two Australian Health Ministers Council-endorsed cross jurisdictional initiatives – the Remote Health Project in 2011 and the Greater Northern Area Regional Training Network in 2012. These organisations were established to address issues such as inequities in health service delivery and funding in northern jurisdictions, poorer health outcomes for rural and remote populations, and health workforce mal-distribution and shortages.

RHP had its origins in the 2011 establishment of a group by the Director Generals and Chief Executive Officers from the NT, WA, QLD and SA. The group's brief was to identify 10 core initiatives to improve the capacity of State Governments to deliver health services, thereby improving health outcomes in northern and remote Australia.

The 10 initiatives (see Appendix 2) sit within four key themes: Workforce, Collaborative Service Planning, Enhanced Telehealth and Defraying Infrastructure.

GNARTN was established in 2012 by the Australian Health Ministers Advisory Council (AHMAC) to support Health workforce training. GNARTN works in cross-jurisdictional collaboration with public, private and community-controlled health sectors north of the Tropic of Capricorn to;

a) develop the best coordination of clinical workforce, and clinical education and training effort, and

b) build the capacity of health services and health service delivery across the rural and remote region of Greater Northern Australia.

The GNARTN Council has strategic decision-making power over GNARTN annual work plan processes. Membership of the Council comprises Director Generals (DG) and/or their executive nominated representative, and representatives from each of following: the Regional Training Networks of QLD, NT, and WA; key Indigenous persons nominated by the jurisdictional DG/Chief Executive; Health Workforce Australia; and co-opted experts at the discretion of the Chair. Funding is provided through Integrated Regional Training Networks (IRTN) in each jurisdiction through HWA.

[3] Dale, A, 2013, Governance challenges for northern Australia, Cairns, James Cook University.

GNARTN and the Remote Health Project, through GNARTN's governance structure, have demonstrated the benefits to jurisdictional partners by maintaining a focus on building capacity for a rural generalist health workforce. The organisations also have established mechanisms to support the effective communication and coordination of investment such as telehealth using an across-sector and cross-jurisdiction partnership approach between QLD, NT and WA. Demonstrated benefits and achievements of GNARTN and the Remote Health Project can be found in Appendix 2.

The Way Forward: Appropriate governance and funding models to support lateral integration

Key to effective and productive cross-jurisdiction collaboration is an appropriate governance structure and a focus on the four 'P's – policy, programs, production and provision:

- **Policy**: *to achieve desired outcomes by an authorising legislature*;
- **Programs:** *to address policy directives;*
- **Production:** *of those human resources, processes, systems and facilities required to develop or appropriately manage programs*; and,
- **Provision:** *which are the combination of processes, systems and transactions that ultimately deliver services*.

A key learning from both GNARTN and the Remote Health Project is that, while many health professionals willingly serve on cross-jurisdictional advisory and reference groups, their first priority is to their respective organisations. GNARTN and the Remote Health Project have created a mechanism that supports the establishment of new cross-jurisdictional models, and have developed a platform for sharing ideas to improve remote health service delivery[4]. This prototype model (Appendix 3) can enhance and maintain horizontal, cross-jurisdiction activity, support the traditional vertical/jurisdictional funding and governance arrangements, support development and up-skilling of the rural/remote health workforce, and identify unique elements important to rural and remote health service delivery.

Northern Australia Health Alliance or Round Table

GNARTN and the Remote Health Project, have a network within Northern Australia to foster collaboration between organisations to achieve improved health outcomes. It is recommended that a Health Round Table, hosted by the State Health Department leads of WA, NT and QLD, inform strategic priorities related to the future health needs of Northern Australia and consider the possibility that significant economic benefits could be gained by positioning Northern Australia as the Health Workforce training hub within the APEC region.

[4] See Appendix 4 – GNARTN Program Logic model

Northern Australia as a Health Professional Training Hub to the APEC region

A significant economic benefit could be realised by positioning Northern Australia as a training hub for health professionals for Australia's near neighbours (eg: Papua New Guinea, Solomon Islands, Timor and Indonesia). This goal is well-aligned with the present commitment to develop Northern Australia and set conditions for innovation.

APEC economies see that improving health is important to improve workforce productivity and participation and requires a whole-of-government approach.

> *'APEC economies are committed to providing their communities with access to quality universal health coverage as an investment in their future socio-economic well-being and as a key contributor to the comprehensive wealth and productivity of the economy'.*[5]

This commitment via APEC to universal health coverage is a significant part of the business case to support the development of Northern Australia as a health professional training hub. Currently the tertiary education sector generates around $15 billion per annum for Australia, making it the largest export earner after resources[6].

Strong economic growth is projected in the global tropical zone as described by the "State of the Tropics"[7] project. In 1980 the Tropical zone accounted for less than 15 per cent of global Gross Domestic Product (GDP). In 2010 this figure increased to greater than 19 per cent and is growing.

Development and maintenance of effective rural/remote health services and an appropriately-trained and supported rural/remote health workforce in northern Australia is a key pillar for sustainable growth and economic and social development of northern Australia.

GNARTN and the Remote Health Project, or a similar adequately-resourced northern Australian collaboration, provides a vehicle to implement initiatives aimed at improving health outcomes and health system performance in northern and remote areas. GNARTN has demonstrated that, by having a governance mechanism to enable partnership in northern Australia, significant efficiencies can be achieved with limited additional investment.

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[5] Third High Level Meeting on Health and the Economy: A Model for a Sustainable Healthcare System Bali, Indonesia, 24-25 September 2013, 'The Double Burden' Across APEC Economies, Submitted by James Cook University, 2013/HLM-HE/010a.

[6] Universities Australia website http://www.smartestinvestment.com.au/campaign/key-facts/

[7] See http://stateofthetropics.org/wp-content/uploads/Project-Overview_Final1.pdf

Appendix 1: The Remote Health Project

BACKGROUND

The *'Remote Health Project'* arose from recognition that the four participating jurisdictions (Queensland [QLD], Northern Territory [NT], South Australia [SA] and Western Australia [WA]) shared common challenges in delivering high quality, sustainable health services in northern and remote communities and, in collaboration, can take practical steps to address a number of significant issues.

The project commenced in late 2011 when senior officers from the four jurisdictions started working together to determine a set of actions that would lead to health service and workforce improvements for the northern and remote areas of Australia.

The Remote Health Project leadership is shared between the partner DGs, and is supported WA Country Health Service (WACHS) Executive Director Primary Health and Engagement (EDPHE) Melissa Vernon, as chair of the working group.

THE REMOTE HEALTH PROJECT: INITIATIVES

Workforce – Recruitment and Retention

1. Introduce a 'single brand' for remote health employment. Such branding enables a collaborative approach to recruitment, more effective promotion of remote opportunities (especially for overseas recruitment) and facilitation of the portability of employment opportunities between jurisdictions. This branding should be compatible with Health Workforce Australia (HWA) international recruitment initiatives.

2. Jurisdictions agree to a consistent approach to protect the remote health employment brand that is consistent human resource managements practices and processes across the north. Important to this protection is collaborative adoption of common orientation, support and mentoring approaches.

Collaborative Service Planning

3. Within each remote community, development of a single Health Services Plan (HSP) developed by formal (contractual relationships) local alliances comprising Medicare Locals (MLs), Local Health Networks and other providers (e.g. NGOs, private).

   HSPs should be based on cross-jurisdictional agreement on core services provisions for remote communities (as per the NT Core Functions of Primary Health Care). Core services should highlight agreed priorities such as maternal and child health, chronic disease and mental health. This specification of core services will have implications for collaborative health education and personnel training requirements in remote locations.

4. Develop and implement a package of non-monetary and monetary incentives / enablers to promote collaboration in the development and implementation of the HSPs.

Workforce - Training

5. Establish a Darwin- based Medical Pre Vocational Training Centre with a focus on enabling and coordinating junior doctor experience in remote locations.

6. Extend to other jurisdictions the Pathways to Rural and Remote Orientation Training – PaRROT, a primary health care approach to chronic disease. The focus of PaRROT is to reorient the workforce from acute to primary health care through e-learning techniques.

7. Further develop and broadly implement an enhanced role for ATSI Community Workers in remote Aboriginal and Torres Strait Islander communities who can;

    • Assist coordination of services to best meet community need and work with the community, families, consumers and carers.

    • Support the development of increasing self responsibility and self care. Navigate the health system and services on behalf of the community and consumers.

    • Navigate the community and consumers on behalf of the providers to enable best possible take up and use of the service.

    The establishment of these roles should enable a more defined role for Aboriginal Health Workers in clinical service provision.

8. Provide training and support across remote locations in a cross-jurisdictional collaborative approach to assist ATSI Health Workers attain the requisite competency standards for national registration.

Enhanced Telehealth

9. Jurisdictions will progressively develop and implement cross-jurisdictional provision of telehealth services in remote communities to improved services to those communities and support remote branding and e-learning for health personnel.

Defraying Infrastructure

10. Jurisdictions will move to a more uniformly appropriate design and construction of housing and clinics in remote settings. It is proposed this approach be based on work recently completed by Office of Aboriginal and Torres Strait Islander Health (OATSIH).

Appendix 2: Snapshot of GNARTN & Remote Health Project Cross-Jurisdiction Achievements 2013

Project Title	Objectives	Deliverables/Outcomes
Health Workforce Data Project: Understanding Clinical Placement Activity in Greater Northern Australia (GNA)	• Identify clinical placement activity in GNA • Commence a process to inform future discussions on measures of clinical capacity within the context relevant to GNARTN • Provide advice to IRCTN's regarding potential opportunities to grow clinical placement capacity at jurisdictional level • Collect and collate data to inform the development of a GNA Clinical Placement Enhancement Strategy	Key learnings/recommendations from the study related to: • Capacity for remote clinical placement • Enhancement of rural and regional clinical placement • Articulation of existing capacity • Innovative approaches to improving access to clinical placements • Support for enhanced capacity and learning from current practice • Relationship with universities and health service infrastructure • Engagement of non-government organisations and the private sector • Flexibility of scheduling clinical placements • Jurisdiction-specific policy framework to support clinical placements • New models of supervision
Rural and Remote Generalist: Allied Health Project	The aim of the project was to support the development of clinical training models for allied health professions that meet the needs of northern Australian health services, and rural and remote communities in particular, by mapping and describing the clinical tasks that are or could potentially be safely skill shared within multi-disciplinary teams. Rationale: There is currently no published comprehensive description at the task level of the clinical requirements of rural or remote practitioners from allied health professions. This has been a significant limitation to the development of rural and remote-specific clinical training programs and resources, and generalist models of care in allied health teams.	The primary deliverable for the project was a comprehensive task list describing the clinical tasks undertaken by rural and remote allied health professionals in the project sites, and of those, which are most appropriate for inclusion in a skill-sharing model of care. Project summary findings were: • Delivery of clinical tasks and functions by more than one profession is relatively common in current rural and remote allied health practice (45% of clinical tasks are delivered, at least in part, by more than one profession). • One hundred and twenty-seven (127) of the 337 tasks identified in the aggregated task list were assessed to be appropriate for skill-sharing between two or more allied health professions, assuming training, clinical governance and all other requisite supporting processes were implemented. Skill-sharing was most commonly proposed to be modest expansion of existing scope of task delivery / skills rather than larger-scale re-orientation of practitioners' skills sets and scope of practice in the service. • The project findings show clusters of related tasks that are identified as appropriate for skill-sharing in rural and remote allied health teams. The clusters are logical groupings for translation into clinical training programs for rural and remote allied health professionals. Thirteen clusters are proposed; Activities of daily living (ADL) and function; Mobility and transfers; Prevention of foot morbidity in high risk groups; Children's development; Cognition & perception; Communication; Psycho-social; Fatigue, sleep and energy conservation; Pressure care, skin and wounds; Diet and nutrition; Neuro-musculoskeletal and pain; Cardiovascular fitness & exercise tolerance; and Continence assessment and basic intervention. • The generalisability of the task list to other services and settings was tested in a small review activity. The review

		activity found that the task list represented the clinical tasks undertaken by physiotherapists, dietician/nutritionists and podiatrists relatively well. Greater variation in clinical tasks was noted for social work. No occupational therapists participated in the review. • Greater potential for use of the allied health assistant workforce is evident in the project findings. Less than a third of potentially delegable tasks are currently delegated by project site teams. Although not a primary focus of the project, information on delegation was an opportunistic product of the methodology employed.
A model for improving Continuing Professional Development for Aboriginal and Torres Strait Islander Health Workers	• Develop a model to identify, track and record education and training, and professional development needs of Aboriginal and Torres Strait Islander Health Workers across GNA • Develop and implement a plan to disseminate the model across all jurisdictions • Support clinical training and ongoing professional development of Aboriginal and Torres Strait Islander Health Workers	Developed by GNARTN and the NT Health Department for cross-jurisdiction dissemination: • Development of a self-directed Personal Portfolio of Training and Continuing Professional Development for Aboriginal and Torres Strait Islander Health Workers and Health Practitioners • Development of a group training package based on the Personal Portfolio of Training and Continuing Professional Development focussed on: - Training options and pathways for Aboriginal and Torres Strait Islander Health Workers/Health Practitioners - Planning Continuing Professional Development with reference to the Aboriginal and Torres Strait Islander Health Practice Board of Australia, and using a 5 Step Reflective Practice Process integrating the 5 Domains of The Aboriginal and Torres Strait Islander Health Worker Professional Practice Framework (Providing culturally safe health care; Delivering health care in a holistic way; Caring for the community; Leading and developing self and others; Practicing in a professional and ethical way) - developed by the National Aboriginal and Torres Strait Islander Health Worker Association – NATSIHWA, and HWA - Developing and maintaining an up-to-date resume, and - Keeping accurate records of training and Continuing Professional Development
Consultation for the establishment of a GNA Universities Network	• Identify and work collaboratively on common clinical education and training issues relevant to development of the health workforce for GNA	• Initial meeting convened via teleconference involving - Notre Dame University - Curtin University - Flinders University - Charles Darwin University - Batchelor Institute of Indigenous Tertiary Education - Centre for Remote Health Alice Springs - Mount Isa Centre for Rural and Remote Health - James Cook University - Central Queensland University • Planned convening of the network in Darwin – end March 2014
Convening of a one-day workshop 'Supporting the development of Aboriginal and Torres Strait Islander Health Practitioners in Far North Queensland'	• To provide a forum for discussion by key stakeholders to progress the development and establishment of the Aboriginal and Torres Strait Islander Health Practitioner workforce in Far North Queensland – Hospital and Health Services (HHS's) and Aboriginal Medical Services (AMS's)	• Workshop convened - Morning session for Aboriginal Medical Services - Afternoon session for Health and Hospital Services, Queensland Health Topics included: - Current climate for the Aboriginal and Torres Strait Islander Health Worker Workforce - Aboriginal and Torres Strait Islander Health Practice Board of Australia - Utilising Aboriginal and Torres Strait Islander Health Practitioners in AMS's and HHS's - Issues associated with training, employment and ongoing CPD for Health Practitioners - Summary of issues, priorities, next steps and building an ongoing discussion forum to support organisations
An options analysis on the	• To identify a potential framework/option that ensures	• Development of an options analysis paper for discussion and endorsement by GNARTN Council as to further planning and

development of a 'Centre for Prevocational Medical Education and Training for GNA'	integration and consistency for medical education and training, and therefore allows more efficient and effective planning and provision of education, training, support and pastoral care to all prevocational medical trainees.	development across GNA
The Remote Health Project – Guidelines for planning in remote communities	• The Guidelines finalised for use in March 2013, and formally published by Queensland Health in July 2013, are being used as determined by jurisdictions. • For example QLD is using the guidelines to guide integrated joint service planning in partnership with the Apunipima community; SA has made the guidelines available to Country Health Services; and WA is working to integrate the guideline principles into the WACHS planning approach.	• The establishment of collaborative joint community joint health service plans that can be used to allocate services and funding based on evidenced need and need the need expressed by local communities. • The development of culturally-appropriate services • Reduction in duplication and service gaps. • Identification of outcome based performance measures
PaRROT – Pathways to Rural and Remote Orientation and Training	Overview: The PaRROT web-based program provides training which includes orientation, induction and professional development of pre-recruitment, new and existing employees working in primary health care settings. Addressing the domains of prevention, early detection and management, the focus is in providing a comprehensive primary health care approach to chronic disease. Objective: To make the PaRROT online platform available for use across jurisdictions, with capacity for upload of additional jurisdiction-specific resources and tools	• Cross-jurisdiction Working Group established • Analysis of jurisdictional content/resource needs in progress • Development (in progress) of a cross-jurisdictional business model to develop, maintain and sustain PaRROT including: - Establishment of a cross-jurisdictional Working Group - Alignment of current PaRROT content with GNA jurisdictional needs - Automated enrolment processes - Guidelines for use of all materials - Resourcing to provide support functions of enrolment, participant support and learning recognition, including development of additional learning modules - Program monitoring and data collection required by all jurisdictions - Management of intellectual property and copyright of materials as required - Communication management

Potential 2014 GNARTN Projects for discussion/endorsement by GNARTN Council

Project Title	Brief Description
Mapping advanced procedural and non-procedural clinical placement capacity in GNA	To conduct a needs analysis on the number and locations of advanced procedural and non-procedural skills training post.
Phase 2 - Rural and Remote Generalist: Allied Health Project	To map resources/ training packages against clinical task clusters identified under GNARTN RRG: AH project Identify gaps with the view to jointly development training and resources.
Workplace-based peer review of clinical supervision practice	To develop and pilot a peer mentoring support system for clinical supervisors in rural and remote context
Phase 1: Rural and Remote Nurse Clinical Placement Project	Undertake a stock take of existing programs / projects which have be trialed to support training of nurses in rural and remote
Towards a near neighbors strategy: investigating opportunities for increasing clinical placement capacity	This project will identify what is currently occurring across disciplines regarding clinical placement activity with near neighbors, and will highlight the strengths, weaknesses, opportunities and threats through a SWOT analysis to inform the development of a feasible growth strategy for clinical placement with near neighbors

Appendix 3: Background Information on GNARTN & Remote Health Project

Establishment of Greater Northern Australia Regional Training Network (GNARTN)

The Council of Australian Governments (COAG) announced a number of health workforce reforms at its 29 November 2008 meeting, several of which focused on clinical education and training. These reforms are being progressed by the Commonwealth statutory authority, Health Workforce Australia (HWA).

The Australian Health Ministers' Conference (AHMC) meeting of 22 April 2010 provided endorsement for HWA to establish, as one of these bodies of work, Integrated Regional Clinical Training Networks (IRCTNs). The purpose of the IRCTNs is to promote access to clinical placements, facilitate reporting of clinical training activity, strengthen collaboration between stakeholders, and source new placement opportunities.

On 9 May 2011, HWA distributed draft funding agreements to jurisdictions to support the development of RTNs throughout Australia and, in July 2011, jurisdictional representatives at the HWA Jurisdictional Policy Committee supported the establishment of the Greater Northern Australia Regional Training Network (GNARTN).

In August 2011, the Australian Health Ministers Conference (AHMC) endorsed the establishment of the GNARTN. The purpose of the GNARTN is to address the clinical education and training issues of the Northern Territory and the northern rural and remote areas of Western Australia and Queensland.

Establishment of the Remote Health Project

The *'Remote Health Project'* arose from recognition that the four participating jurisdictions (Queensland, Northern Territory, Western Australia, South Australia) a) shared common challenges in delivering high quality, sustainable health services in rural and remote communities, and b) through collaboration can take practical steps to address a number of issues that are significant and unique to rural and remote Northern Australia.

The project commenced in late 2011 when senior officers from the four jurisdictions started working together to determine a set of actions that, if implemented, would lead to health service and workforce improvements for the northern and remote areas of Australia. The Western Australian Director General has led the project on behalf of the four jurisdictions.

With ministerial support, the four jurisdictional Director Generals (DGs) approved the development and implementation of 10 cross-jurisdictional initiatives. Two representatives from each jurisdiction oversee the project implementation via the *Remote Health Project Steering Group*. Each jurisdiction is leading the implementation of one or more initiatives.

GNARTN & REMOTE HEALTH PROJECT: as effective Mechanisms Supporting Development of the Health Workforce and Health Services Across Greater Northern Australia

GNARTN and the Remote Health Project provide mechanisms with appropriate structures and a high level of governance including the Director's General, Western Australia, Northern Territory and Queensland, and/or their representatives, and key government and non-government stakeholder executives. GNARTN and the Remote Health Project provide:

- Mechanisms to effectively support, drive and develop cross jurisdiction collaboration across Greater Northern Australia;
- A vehicle to successfully implement initiatives aimed at improving health outcomes and health system performance;
- Opportunity to establish new models service delivery and approaches to clinical training and workforce support needed to support the economic and social development of rural/remote northern Australia;
- Enablers to recruit and retain an appropriate rural/remote health workforce to provide quality care
- Enablers to increase access to health services with an appropriately trained and skilled rural/remote workforce

Policy Context

Health Defined

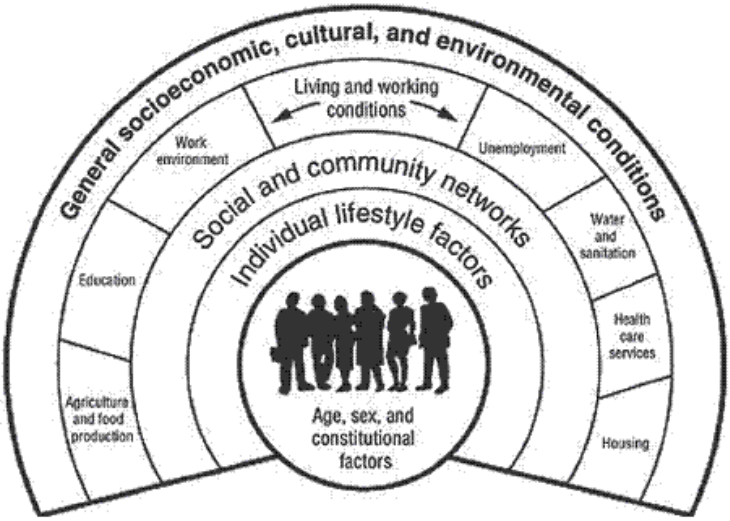
1) A biomedical or clinical view of health focuses on the absence of presence of disease.
2) A more holistic concept of health is 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 1946).
3) An Aboriginal and Torres Strait Islander view of health is 'not just the physical wellbeing of the individual but the social, emotion and cultural wellbeing of the whole community. This view of health takes a whole-of-life approach and can include the cyclical concept of life-death-life (National Aboriginal Health Strategy Working Party 1989).

While definitions of health continue to be debated and medical research continues to study the causes of disease, there is heightened awareness of the broader social, economic and environmental conditions that contribute to disease – the conditions into which people are born, grow, live, work and age (WHO 2011[8]).

Determinants and Gradient of Health: A person's health and wellbeing result from a complex interplay between biological, lifestyle, socioeconomic, societal, cultural and environmental factors – or broad causal pathways that affect health (Figure 1). Furthermore, health status

[8] WHO 2011, Social determinants of health, http://www.who.int/social_determinants/en/, Viewed 22 January 2014

within a population typically follows a gradient, with overall health tending to improve with each step up the socioeconomic ladder (Kawachi et al 2002[9]).



The Health of Australians: Rural and Remote Northern Australia

Overall Australians enjoy one of the highest life expectancies in the world, but some Australians experience poorer health[10]:

- Aboriginal and Torres Strait Islander people generally fare worse on a number of health measures, for example, life expectancy is about 12 years shorter than for other Australians and access to and use of health services is often lower
- Where there is increased social disadvantage comes less healthy lifestyles and poorer health
- The further people live away from major cities, the less health they are likely to be.

'There is a big divide between the health of metropolitan Australia and that of Australians living in rural and remote areas. There is also a dichotomy in terms of the health services available.
In essence, if you live in rural or remote Australia your health will on average be poorer, and your access to health services more limited, a trend which worsens with increasing remoteness.'[11]

Health Reform & Need for Change

Health Workforce Australia (HWA)[12] was established in 2010 as an initiative of the Council of Australian Governments to work across the health and education sectors and address the

[9] Kawachi I, Subramanian SV & Almeida-Filho N, 2002, A glossary for health inequalities, Journal of Epidemiology and Community Health, 56:647-52.
[10] Australian Institute of Health and Welfare, 2012, Australia's Health, Series No. 13, Cat. No. AUS 156, Canberra: AIHW
[11] Health Workforce Australia, 2013, National Rural and Remote Workforce Innovation and Reform Strategy.
[12] Health Workforce Australia 2011: National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015

challenges of providing a skilled, flexible and innovative health workforce that meets the needs of the Australian community, now and into the future. The National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 (Framework) supports a national call to action for workforce reform that will involve and link the health and education sectors. Factors driving health reform and change include:

- Population growth, ageing pop, people living longer
- Growing burden of chronic disease
- Poor state of Indigenous health and gap in life expectancy between Indigenous and non-Indigenous people
- High and unrealistic expectations of health services
- A paradigm shift in ways of thinking about workforce design and planning is required
- Efforts at State/Territory level have often been constrained by jurisdictional and sectoral boundaries and focused at the micro level of the system
- Sustainability will require re-balancing health services
- Need for more cost-effective, efficient workforce –particularly evident in rural/remote
- Need to refocus on wellness, prevention and primary health care

The alignment of thinking regarding workforce innovation and reform with key directions in health service reform and priorities will ensure that national health workforce reform efforts complement and support major health system priorities and reform efforts already underway. Better understanding of how the workforce can be developed to meet need and improve the outcomes valued by consumers and carers will contribute to future innovation and reform strategies across the education and health sectors. These strategies will need to be implemented in a way that acknowledges the need for health and education systems to continue to deliver services, while at the same time moving towards new approaches**.**

Guiding principles for implementation of the Framework are:

- Work from a community, individual and carer needs perspective.
- Involve the community, consumers and carers in service system design, health workforce planning and evaluation.
- Align with the intent and actions of 'Closing the Gap' in the planning and implementation of national health workforce innovation and reform.
- Address the expansion of existing roles or creation of new roles in ways that ensure the quality and safety of care is improved.
- Address workforce issues in ways that recognise Australia's social and cultural diversity and promote equity of access and outcomes across communities, geographic areas and age groups.
- Recognise the importance of informed personal choice and self-management.
- Recognise and support members of the community, including volunteers and unpaid carers, in the provision and delivery of health services.
- Facilitate collaboration: across all levels of government and with regulatory bodies, accrediting bodies and professional associations; in partnership with education providers across the education continuum - schools, Vocational Education and Training (VET), universities, colleges and workplace based trainers; with the private sector, the not for profit sector and the community-controlled sector.
- Build health services research and evaluation into all workforce and service redesign initiatives.

- Build and disseminate the evidence base for successful health workforce innovation and reform.
- Ensure mechanisms for accountability and evaluation are planned and systematically undertaken to ensure progress towards the implementation of this Framework is monitored and reported

Priority Populations and Domains

The key priority populations and domains reflect the areas of innovation identified in strategic health workforce plans of Commonwealth, State and Territory governments, and Aboriginal and Torres Strait Islander Community Controlled health service sectors. Priority population groups include: • Aboriginal and Torres Strait Islander peoples • Older people • People living with chronic diseases • People living with mental health problems	Priority domains include: 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 2. Health workforce capacity and skills development - develop an adaptable health workforce equipped with the requisite competencies and support that provides team-based and collaborative models of care 3. Leadership for the sustainability of the health system - develop leadership capacity to support and lead health workforce innovation and reform 4. Health workforce planning - enhance workforce planning capacity, both nationally and jurisdictionally, taking account of emerging health workforce configuration, technology and competencies 5. Health workforce policy, funding and regulation - develop policy, regulation, funding and employment arrangements that are supportive of health workforce reform

There are many similar issues facing all participating jurisdictions in regard to both the provision of clinical education and training and the recruitment and retention of an appropriate clinical workforce. The purpose of cross-jurisdiction collaborations such as GNARTN and the Remote Health Project is to a) develop the best coordination of clinical workforce, and clinical education and training effort, and b) build the capacity of health services and health service delivery across the rural and remote region of Greater Northern Australia.

GNARTN Scope

The primary role of the GNARTN is to drive collaboration, advocacy and support to increase clinical education and training, clinical placements and workforce initiatives across the geographical area. The GNARTN is proactive, action-focussed and needs-based. It

operates within the contractual boundaries and the directives provided by the jurisdictions Director Generals and Chief Executive Officer. A key objective of the GNARTN is to draw on existing clinical workforce initiatives, such as those provided by HWA, to enable better coordination, communication, collaboration and consistency across the GNA area.

GNARTN Functions

The initial primary functions to be addressed by GNARTN include:

- Addressing Obstacles to Inter-jurisdictional Clinical Placements;
- Aboriginal and Torres Strait Islander Health, Clinical Education and Training, and Workforce Development; and
- Development of the rural generalist workforce and general specialist workforce to facilitate enhanced clinical education and training and clinical placement options.

Over time and as capacity/resources allow, GNARTN may explore the following functional domains:

- Shared approaches to the implementation of HWA work programs;
- Sponsorship of best-practice clinical education and training research and innovations;
- Development of a common clinical placements planning approach;
- Sharing of clinical placement capacity to facilitate cross-jurisdictional placements;

Future investments for consideration/exploration/investment may include:

- Development of a common Workforce Planning Methodology;
- Development of a Greater Northern Australia (GNA) workforce strategy;
- Development of a GNA Aboriginal and Torres Strait Islander workforce strategy;
- Development of a GNA recruitment strategy; and
- Building health workforce across the GNARTN geographical area.

GNARTN Model of Cross Jurisdiction Collaboration

The factors driving health reform and the current economic crisis has created what Henry et al[13] (Accenture 2011), authors of Cross Jurisdiction Collaboration: New models for State, Regional and Local Governments, have described as the 'New Normal'. That is, the operating environment of government entities have changed to the degree that traditional responses alone, are insufficient to address the changes and challenges they face. Central to the theme of cross-jurisdiction models such as GNARTN, is the notion that the 'new model' will address a specific problem or opportunity. The objectives for any such collaboration are 1) improving effectiveness, 2) enhancing efficiency, and/or 3) creating new capabilities. In short:

- improving effectiveness in government means 'better government services' at the same cost
- improving efficiencies entails 'reducing the costs associated with providing a service', and

[13] Michael Henry and Daniel McClure, 2011, Cross-Jurisdiction Collaboration: New Models for State, Regional and Local Government, Accenture Consulting (www.accenture.com)

- creating new capabilities requires 'developing new services not currently provided within current jurisdictions'.

There are a number of things that should be considered when government entities are planning for cross-jurisdiction collaboration (Henry et al, 2011). This includes consideration of the public service value chain:

- Policy – principles and directives put in place by an authorising legislature to achieve desired outcomes and conditions
- Programs – the service, product or regulatory initiative designed to fulfil the policy directives, goals and outcomes
- Production - human resources, processes, systems, materials, facilities that factor into the development and management of a program
- Provision – combination of processes, systems and transactions that ultimately deliver services or regulates an entity.

Best practice for cross-jurisdiction collaboration established from analysis of 80 domestic and international cases provides valuable reference for GNARTN's forward planning, as does consideration of the common pitfalls found in cross-jurisdiction collaborations (Henry et al, 2011).

BEST PRACTICE	SUPPORTING EVIDENCE	IMPLICATIONS
Provide the leadership critical to define power-sharing early	• Each entity has one vote, regardless of the population of population size • Divide power through centres of excellence – each entity owns different services based on which service has the capacity to deliver	• The division of power plays a critical role in the effectiveness of any collaborative model • Final approval from each entity forces collaboration early in the discussion • Consider what can/does the entity want to give up in terms of power • Determine/make explicit what level of authority the resulting regional institution will exercise
Create a structural process to evaluate collaboration opportunities	• Entities commission studies to evaluate where collaboration can be implemented and/or the feasibility of a proposed partnership • Research and lessons learned from past mergers provide a tested approach to implement collaborative models	• A structured process is essential to determine if a service should be contracted or shared – develop a business case, roles and responsibilities, and a comparative analysis and conduct a bidding process
Engage key stakeholders at all levels	• Discuss the proposed changes with key stakeholders	• Involve key stakeholders at the onset to ensure sense of ownership and inclusion in

	• Provide information/education on the benefits and impacts of the new model	decision-making • Keep key stakeholders engaged to ensure that they move parallel to the goals of collaboration
Establish benchmarks or metrics to track outcomes of collaboration models	• Collaboration contracts may require entities to provide benchmarks to measure project impacts • Set a target service level agreement as part of the contracting process	• Data can prove success and may open doors for further collaboration opportunities
PITFALLS TO AVOID	**SUPPORTING EVIDENCE**	**IMPLICATIONS**
Undefined roles and responsibilities	• Entities form coalitions around specific causes without giving significant thought to the collaborative structure • Impact may be limited if cross-jurisdiction entity is focused on one subject • Joint power agreements are less effective since they are created and focused on a specific issue	• Roles, responsibilities and purpose must be clearly defined in any collaboration model • Single-purpose collaborations will be unable to address other services that may be dependent on their own • Joint power arrangements do not provide a good solution for larger coordination on development
Buy-in is not gained from key stakeholders	• Collaboration across governments tend to occur to address a crisis, but when the crisis disappears, so does the initiative • Communicate to key stakeholders the opportunity cost of not addressing the issue immediately	• Understand how and when to market regionalism to local entities as they may be afraid of losing local power and the cultural fabric of their local region
Perception of another layer of government	• Regional entities were created without an increase in power or funding to implement their initiatives	• Collaboration models will fail without the proper infrastructure in place (power, FTE's, Mission Statement etc)
Unfunded regional bodies	• Cross-jurisdiction entities may fail due to minimal or unfunded initiatives	• Ensure proper channels of funding or build in plans to identify and secure sustained financial resources

Organisational Domain	Driving Forces For Collaboration	Restraining Forces of Collaboration
Purpose	• 'Felt need' to collaborate • Common goal • Willingness to address other agency's interests or cross-agency goals vs local organisational goals	• Divergent goals • Focus on regional or local agency concerns • Lack of goal clarity • Not adaptable to interests of other organisations
Structure	• Formalised structure for coordination (eg liaison roles) • Formalised processes (meetings, deadlines, agendas) • Sufficient authority of participants • Role clarity • Dedicated assets (people, resources) for collaboration	• Impeding rules or policies • Inadequate authority of participants • Inadequate resources • Lack of accountability • Lack of formal roles or procedures for collaborating
Lateral mechanisms	• Social capital (interpersonal networks) • Effective communication and information exchange • Technical inter-operability • Combined training events	• Lack of familiarity with other organisations • Inadequate communication and information sharing
Incentives	• Collaboration as a prerequisite for funding or resources	• Competition for resources • Territoriality • Organisational level distrust and lack of mutual respect
People practices	• Respect for other parties' interests, expertise, roles, perspectives • Perseverance/commitment	• Lack of competency • Arrogance, hostility, animosity
From Hocevar, Thomas & Jansen (2006), *Building Collaborative Capacity: An innovative Strategy for Homeland Security Preparedness* (Ed.) *Innovation Through Collaboration*[14]		

[14] Hocevar, Thomas & Jansen, 2006, Building Collaborative Capacity: An innovative Strategy for Homeland Security Preparedness (Ed.) Innovation Through Collabortion

Appendix 4 GNARTN LOGIC MODEL

Overview

- The overall aim of the GNARTN program is to develop the best coordination of clinical workforce, and clinical education and training effort across the Northern territory and the northern rural and remote areas of Western Australia and Queensland

- The Health Workforce Australia (2011) National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 informs and is a key driver for the strategic direction and work of GNARTN

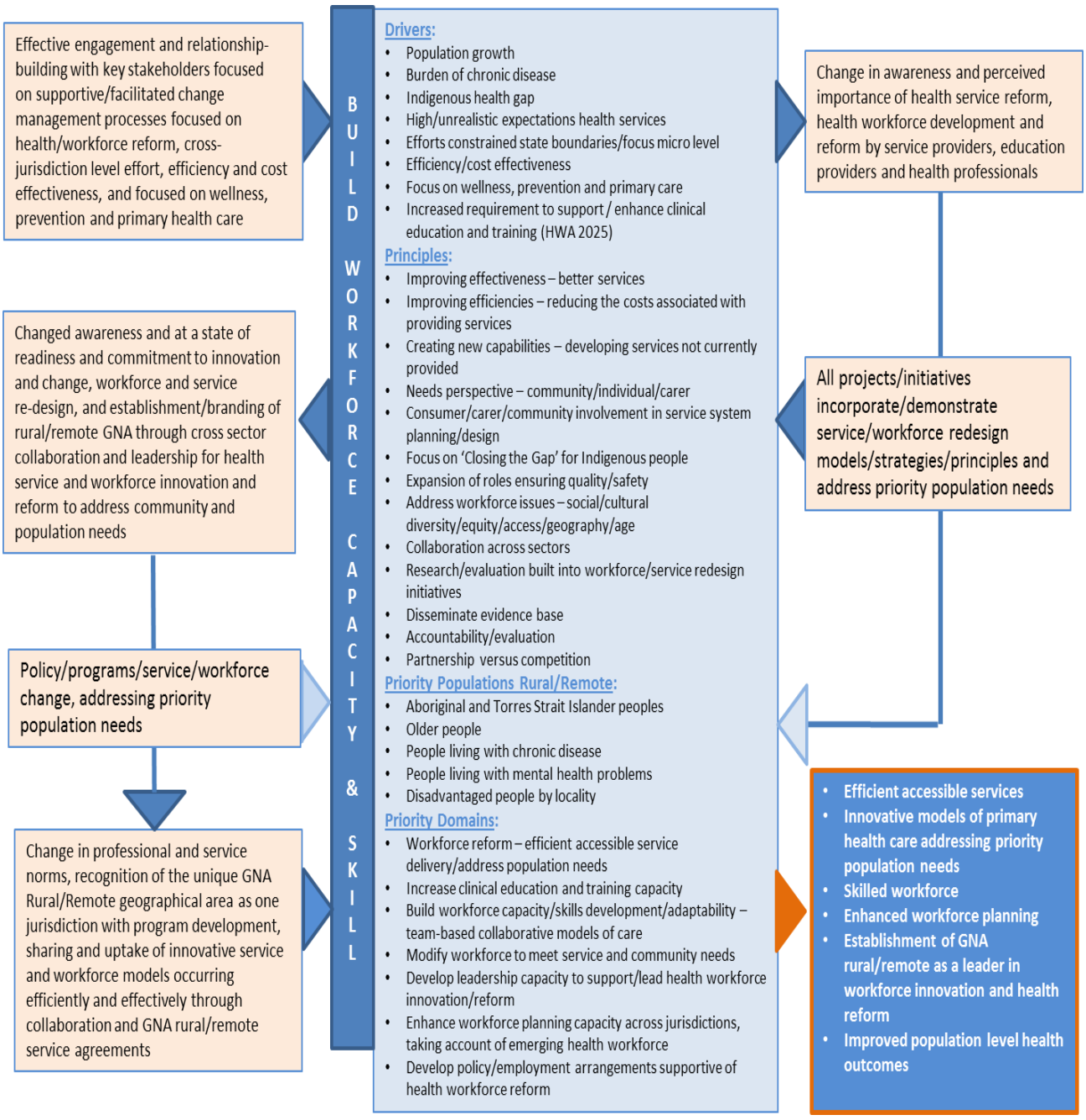
- This logic model depicts the identified investments within and across jurisdictions to end 2013 and 2014/2015, as well as performance benchmarks and short, medium and long-term outcomes

- The primary focus to end 2013 is on the initial primary functions for GNARTN as outlined in the Terms of Reference and endorsed by the Council (refer 'Functions' above)

- The model signifies the commencement of cross-jurisdiction partnership, collaboration, advocacy and support for clinical workforce initiatives across the geographical area

- The visionary planning for GNARTN includes the initial primary functions to end 2013 and the broadening agenda of other functional domains to end 2015, inclusive of appropriate strategic planning and evidence-base to ensure successful program delivery

GNARTN Program Hypothesis



Potential mechanisms of influence and advocacy may include:

- Building clinical workforce capacity and skills across rural/remote GNA
- Facilitating and supporting the development of GNA leadership for clinical education and training, and health workforce innovation and reform across jurisdictions
- Advocating for the adoption, implementation and evaluation of clinical education and training innovation and reform initiatives at the local service level across jurisdictions
- Facilitating and supporting joint rural/remote cross-jurisdiction initiatives and projects

- Mediation of HWA, agency and sectoral interests in clinical education and training and workforce reform initiatives and activities

Assumptions

- GNARTN works at strategic and operational levels to influence outcomes (both are equally important)
- Federal and State Government policy positions support and encourage GNARTN investment in workforce development initiatives
- The program area is adequately resourced, and there is the staffing capacity to implement the logic model effectively across jurisdictions and agencies
- There are funds and resources available to support GNARTN to invest in workforce change and development initiatives
- GNARTN and agency/health staff have the knowledge, skills, confidence and capacity to work in this program area. There is adequate investment in the professional development of teams/staff working on cross-jurisdiction collaborative strategies and projects
- Stakeholders provide appropriate advice in ways that meet GNARTN objectives
- Cross-jurisdiction agencies/services are willing to work with the GNARTN model and work towards the establishment of cross-jurisdiction health workforce models
- Evidence-base for GNARTN's interests is strong enough to support the development of innovative interventions and strategies