Mark Cormack
Chief Executive Officer
Health Workforce Australia
GPO Box 2098
Adelaide SA 5001

Dear Mr Cormack

Thank you for the opportunity to comment on the Health Workforce Australia Rural and Remote Workforce Innovation and Reform Strategy.

As you know, the AHHA is the independent peak membership body and advocate for the Australian Public and not-for-profit health sectors and national voice for universally accessible, high quality healthcare in Australia.

The AHHA commends the development of a national workforce strategy to guide future needs, reforms and initiatives to improve the health care services of rural and remote communities. The AHHA has been vocal in support of National Health Reform that means all Australians will have equitable access to the health care where they need it, and this is particularly important where maldistibution of health services and health workforce exist in rural and remote communities. The current funding designated by the Commonwealth to address rural workforce shortages and maldistribution and train and support more GPs, specialists, nurses and allied health professionals for rural areas is welcome.

There is a concern that this may not be translated into real changes on the ground for people in communities without better integration of services, better investment in the types of services and skills needed in rural and remote areas and a health workforce that is trained and skilled in coordinating and collaborating care across traditional boundaries and disciplines.

In June 2011 The AHHA hosted a ground breaking National Health Reform (NHR) Simulation and Master Class which brought together senior people with current and recent experience in the healthcare system to participate in a 'road test' of the new environment which will be created by the NHR Agreement. The aim was to identify opportunities and challenges around its implementation. The Report on the Simulation is available at http://ahha.asn.au/publication/policies/national-health-simulation-and-masterclass.

There were a number of critical issues identified in the Simulation that indicated a need for expanded and changing health workforce roles, and these are very relevant to rural and remote services. The AHHA supports expanded roles where there is adequate preparation, training and ongoing support for health professionals who may not undertake procedures or case management as frequently as colleagues in metropolitan hospitals and health services. Better outreach networks for rural areas would need to be established to develop and sustain expanded or unique roles in the rural health workforce.

The burden of chronic disease is increasing, particularly in rural areas. The Australian Bureau of Statistics has reported continued increase in the age profile in rural areas. Health workforce

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in rural areas in both Medicare Locals (ML) and Local Hospital Networks (LHN) will need to establish a strong case management capacity, particularly for the most complex patients with multiple co-morbidities, including the training and appointment of case managers to coordinate care. Greater utilisation of programs such as Hospital in the Home will require specialised resources and trained staff and health professionals with greater capacity, skills and confidence to support and encourage patients for self-managing.

To promote widespread use of the patient controlled electronic health record (PCEHR) and encourage multi-provider access, including GPs and specialists, National performance agencies will need to foster health improvement within a learning environment by training health professionals and allowing provider access to clinically meaningful data and feedback about their patient care practices. This is the key to improving quality as practitioners who are collecting the data can also recognise the overall purpose for its collection. Similarly rural hospitals and small health facilities will need health professionals who can use technology and manage data.

Better health care in rural and remote areas depends on people working together effectively. MLs and LHNs currently being established in rural areas will require immediate support to build leadership capabilities and provide organisational improvement and governance support to assist cultural change.

Good outreach networks, including education networks, leaders and managers in rural and remote areas with the capacity to bring people together, and good governance and support for rural hospitals and health services are the key ingredients in addressing attraction and retention of health professionals. Skills in leadership and integration of care, including interdisciplinary work, are also essential for better provision of services to Aboriginal and Torres Strait Islander people and building the capacity and opportunities for development of skilled Aboriginal and Torres Strait health professionals and other health workers.

University Departments of Health and Rural Clinical Schools have provided unique and positive contributions to exposing students to rural communities and have significantly supported local and visiting health professionals in their education and professional development. Such departments also help build and sustain rural communities and keep them rich with knowledge and engagement. AHHA believes there is further opportunity to grow these entities with the proviso that there is a continued expansion and strong emphasis on all health professions.

Attendees at the Simulation hosted by AHHA in June 2011 recognised that governments need to facilitate the development of more effective skills for undertaking joint evidence-based population health planning within both LHNs and MLs, and this is particularly important for rural and remote health services and healthcare. This function must be supported by the provision of clinically relevant datasets at the local level and planning could be facilitated by the creation of joint population health planning groups. Health professionals and health managers are the best people to undertake this role in conjunction with representatives of their communities. This requires a workforce with skills to both plan for population health and engage others in that planning. This will not be achieved with continued reliance on short term locums who do not have community knowledge or engagement.

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The Multi-purpose-Service model is an excellent example of a multi-governmental pooled funding arrangement in rural communities and should continue to be utilised as a resource. In 2009 AHHA formed a National Multi-purpose Services working group which supports the recommendation of the National Health and Hospitals Reform Commission (Reform Commission) to expand the Multi-purpose Services program nationally, as a delivery strategy for integrated rural health services.

Over the last 17 years, Multi-purpose Services have been able to survive the multiple challenges thrown at them by extraordinary economic, social, technological, educational and political change. They are a sustainable model of integrated health service delivery based on basic population health planning and primary health care service delivery models. They have enabled smaller rural and remote communities to retain basic services and expand those that are relevant to local communities.

The most obvious feature of Multi-purpose Services across Australia is they provide structural, funding and legal mechanisms that have been established to secure local services in accordance with community expectations. Innovation in service design and delivery has been possible and is attributable to the ability to pool funds, design services, deliver flexible services and forge strong local relationships.

In successful Multi-purpose Services, staffing policies encourage more role sharing and role expansion across all aspects of their operations. Some of this is through formal learning; for example, a physiotherapist undertaking up-skilling to have a basic set of competencies in occupational therapy or podiatry, or training non-clinical staff to be able to provide a range of flexible hotel and domestic services. In this way, staff can fill gaps in services across settings and make them more viable in small communities; but this is likely to happen only if there is a strong culture of valuing staff, training and development and career development planning and opportunity.

From the Multi-purpose Service working group's observations, there are different approaches in each State however, Community Service (Victoria) is an example where the traditional models of health care service delivery have been challenged, where the range and number of services offered to the community increased considerably, and the service achieved growth in its funding base. For example Alpine Health (Victoria) achieved significant growth and expansion in service delivery in response to community needs made possible from pooled funding that could be used to enable flexible use of its workforce. Under the Multi-purpose Service model, Alpine Health was able to turn around from the edge of financial insolvency to a strong financial base.

The AHHA supports continued resourcing of Community Health Services by enabling other local health service providers, such as MLs or Aboriginal & Torres Strait Islander medical services to commission services from the Community Health Services. There is significant benefit from ensuring community health professionals continue to engage directly in the community and maintain and develop skills in new models of care and home based care to reduce hospital admissions. Community based health professionals are well placed to enhance professional linking for patients and should be empowered to do so.

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Commonwealth and State governments need to provide new funding initiatives to incentivise integrated care. This could be expedited through nationally consistent clinical practice guidelines to foster integrated care across LHN-ML boundaries, resulting in patients being treated in more appropriate settings in the primary, community and secondary care services. This requires skilled health professionals who can effectively integrate care and work in a team effort across multiple services.

Finally, the Commonwealth and States need to facilitate up-scaling of outcomes of workforce pilots and sharing of best practice at the local level with a view to achieving improved outcomes.

If you have any further questions on the above please contact Ms Maggie Crowley – Director, Policy Networks & Communication on (02) 6162 0780 or by email at mcrowley@ahha.asn.au.

The AHHA has a Rural and Remote Policy Network which is multi-disciplinary and cross jurisdictional. AHHA looks forward to working with HWA to build on the issues raised in this paper. Could we meet with you in the near future to discuss these issues further?

Yours sincerely

Prue Power
Executive Director
28 October 2011

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