National Rural Health Commissioner: Policy Options to Improve Access, Distribution and Quality of Rural Allied Health Services

Submission from the Centre for Rural and Remote Mental Health, University of Newcastle and collaborators in rural mental health.

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Introduction

Rural health outcomes including mental health outcomes are persistently poor despite relatively similar prevalence. Rural people face distinct environmental, economic, social, technical, demographic and geographic challenges. Current approaches based upon metropolitan assumptions are not working well in rural areas. We applaud the intention of the Commissioner to develop a Commonwealth policy and investment response for Australia's rural allied health workforce that is informed by Aboriginal and Torres Strait Islander understandings of health and wellbeing (community control, connection to country, respect of Elders and local decision making). This intention is consistent with the Orange Declaration on rural mental health [1]. The declaration outlines ten problems and proposes ten solutions for improving rural mental health and wellbeing. We acknowledge that effective use, support and development of the allied health workforce is essential to improve equitable access to care and rural health outcomes. The submission is written with a community development stance and aims to strengthen the stated intention of the discussion paper.

This community development approach fits closely with ten-solutions proposed in the Orange Declaration for improving rural mental health and wellbeing. The authors call for

- whole-of-community, placed-based and contextually relevant, evidence-informed, co-designed plans and strategies;
- holistic and integrated models of healthcare and community wellbeing;
- increased State and Federal government funding to support longer program time-frames to fully trial and evaluate innovative strategies;
- further research and strengthened data collection;
- and leveraging digital technology to increase efficiency

We expect that the commissioner will receive many submissions from the various University Departments of Rural Health (UDRHs) and others across the country and we will not duplicate their evidence. Rather, we wish to emphasise the principles of developing more effective rural service models. Then, using the allied health workforce expertise of several network members we will address some areas of allied health workforce development and sustainability that may not be fully considered by others.

We agree strongly with many parts of the paper including the pipeline approach, the need for a comprehensive allied health workforce dataset, though we would strongly advocate for the use or extraction from existing Commonwealth and other datasets (e.g. National Registration and Accreditation Scheme/AHPRA). We support the use of and investment in telehealth in both service provision and clinician support activities including supervision but note that they should complement and support the local workforce and services not supplant them. It is critical that workforce developments recognise the importance of addressing the rich variety of rural contexts and the importance of adopting a systemic and not a piecemeal and disjointed approach as if often the case. Developments need to be based on evidence and the Medical Research Futures Fund may provide opportunities to obtain that evidence in a consistent and dynamic fashion.

We note that AHPs in rural and remote areas inevitably operate over a wider scope of practice than those in city settings and so the ideas or a rural generalist AHP has some merit. Perhaps this is best understood in the light of local needs, practitioner, competence and the mechanisms available for supervision, support and governance. Stepped-care approaches are particularly popular in the mental health field but it is clear that one size will not fit all communities and contexts and so a flexible approach is needed.

We agree that for effective change in the quality, access and distribution of rural allied health workforce, dedicated structured leadership is required. However, we believe this structured leadership, needs to be situated at the local level (or at least regional) level. Hence, we think the proposed Integrated Allied Health Hubs (IAHHs) have merit. IAHHS of sufficient size, critical mass and economies of scale could adopt the 'whole-of-person' approach that we are advocating for and in this capacity provide essential allied health workforce supports such as cultural orientation and training, professional mentoring, interdisciplinary and discipline-specific CPD and career development/planning supports. However, such an approach needs to build upon and not duplicate local primary care services which are the core services in rural and remote communities.

We are unable in the time and with available resources to provide a comprehensive response to all the issues in the Discussion paper. Our expertise-base in rural mental health and wellbeing forms the basis of our comments even when not explicitly mentioned.

Detailed feedback

We focus on four key issues that are either poorly understood, have been given insufficient attention or are missing:

1. an over-emphasis on the grow-your-own health training system;
2. an over-emphasis on extending placement length during training;
3. the need to develop the proposed framework to strengthen support to newcomer workers and increase rural career pathways and opportunities; and
4. the need to strengthen understanding of the social and personal dimensions of attraction, recruitment and retention.

These four issues particularly three elements of the discussion paper: 2 - Introduction of Rural Origin Selection Quotas, 3 - Structured Rural Training and Career Pathways (MMM2 – 7) and the stated policy intention to support early-career AHPs to stay working rurally.

1. An over-emphasis on the grow-your-own health training system, in particular, the secondary school to undergraduate training stage and rural origin students.

While we believe there is merit in setting rural origin student quotas for University courses, especially for Aboriginal and Torres Strait Islander people and for a 'grow your own' rural allied health training approach (supported by the availability of allied health TAFE and university courses in regional locations), the emphasis on rural origin students and the secondary school to undergraduate training stage limits the development of the rural allied health workforce. Most notably, it restricts opportunities for meaningful rural training/employment experiences for urban-origin allied health students (including overseas students training in Australia) as well as for working AHPs (especially early and late-career) who are interested in and temperamentally suited to rural/remote practice [2]. The rural origin and rural training policy focus in the Discussion Paper assumes that graduates' employment choices are simple and can be easily influenced, we believe that employment choices are highly complex and influenced by a mix of organisational, career development and personal /social factors which change over the life course. This is supported in a recent rural workforce retention study on early career allied health professionals that found rural origin had limited influence on turnover intention and life stage was the primary determinant [3]. Additionally, the 'rural training creates rural jobs' policy focus ignores the realities of the globalised workforce which is highly mobile and individuals will likely hold many positions and be life-long learners coming in and out of education and training across their career. This workforce mobility is supported by early data from a Nursing and Allied Health Graduate Outcome Tracking study, currently being undertaken by Newcastle and Monash Universities, which found that while at graduation rural origin may influence rural employment, over time intention to practice rurally increases for both urban and rural origin graduates [4].

With respect to the 'grow your own' health training system policy, flexible training opportunities should be made available to rural residents across the life course including part-time training/placements for mature-age students, as well as clearly-articulated career pathways from TAFE to University (both undergraduate and postgraduate). Given the financial barriers rural residents commonly face undertaking professional training, health services (public and private) should be funded to offer allied health traineeships. Trainees would work as allied health assistants while undertaking an allied health bachelor's degree. Such traineeships would include supervised workplace training, clinical placements and the participating universities) would need to provide culturally appropriate support and be able to address barriers to learning. We believe that the NSW Aboriginal Mental Health Workforce Training Program https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/aborig-mh-wrkforce-prog.aspx is a scalable model for both Aboriginal and Torres Strait Islander people as well as for the general rural population with some minor modifications [5]. We do caution that for a full understanding of multiple incentives, including financial ones a proper analysis of the financing flows, mapping of barriers and incentives for the workforce is required [6].

2. An over-emphasis on extending rural placement length during training.

We assume that the focus on extending rural placement length for students has been selected because it has proved effective in improving the rural medical workforce, in particular, GPs in the primary care setting. We argue that caution needs to be taken in applying the same approach to improving rural allied health workforce, as there are significant differences between medical and allied health training pathways and associated with this student age and life stage.

In the medical workforce, given the broad shift to graduate-entry medical schools, the average age of students on entry is 22 years, followed by 4 years fulltime medical training and 3-5 years of specialist training, so qualified medical professionals are on average 29-31 years. This compares with allied health, where the students are usually 18-19 years on entry to university health science courses, and length of courses is between 3-5 years, so allied health graduates are on average 21-24 years old. Cosgrave identified the importance of life stage on rural-based early career AHPs retention and discussed stages of adulthood and agreed characteristics - young adulthood (career advancement, the pursuit of social activities and pair-bonding) and middle adulthood (stability, settling down, family and work focus) [3]. While there is considerable debate about the chronological ages relating to life stages, young adulthood is generally associated with late teens to early-to-mid-twenties and middle adulthood begins in the late twenties. Place attachment has also been identified as strengthening at the beginning of middle adulthood and linked to the place in which the person is living at the time [7]. We agree that social and personal dimensions are important influences in attraction and retention to rural practice, but believe that their strongest influence is later in early adulthood and at the beginning of middle adulthood – i.e. in mid-late 20s. For the medical workforce this critical period occurs during training, while for the allied health workforce it most commonly occurs in the early career years.

There is also newly emerging evidence in rural medical education questioning the extent of the influence of extended longitudinal placements on employment choices. Malhi et al. [8] argue that choice by medical graduates to practice rurally is complex, and while rural placements influence and longer placements have more impact, rural practice choice is more likely a result of the effects of ‘accumulated rural experiences overtime’ including rural origin, clinical experiences that support relationship-based learning (between patient–student, student-teacher and student–community [9]) and cultural and personal satisfaction with rural living/lifestyle.

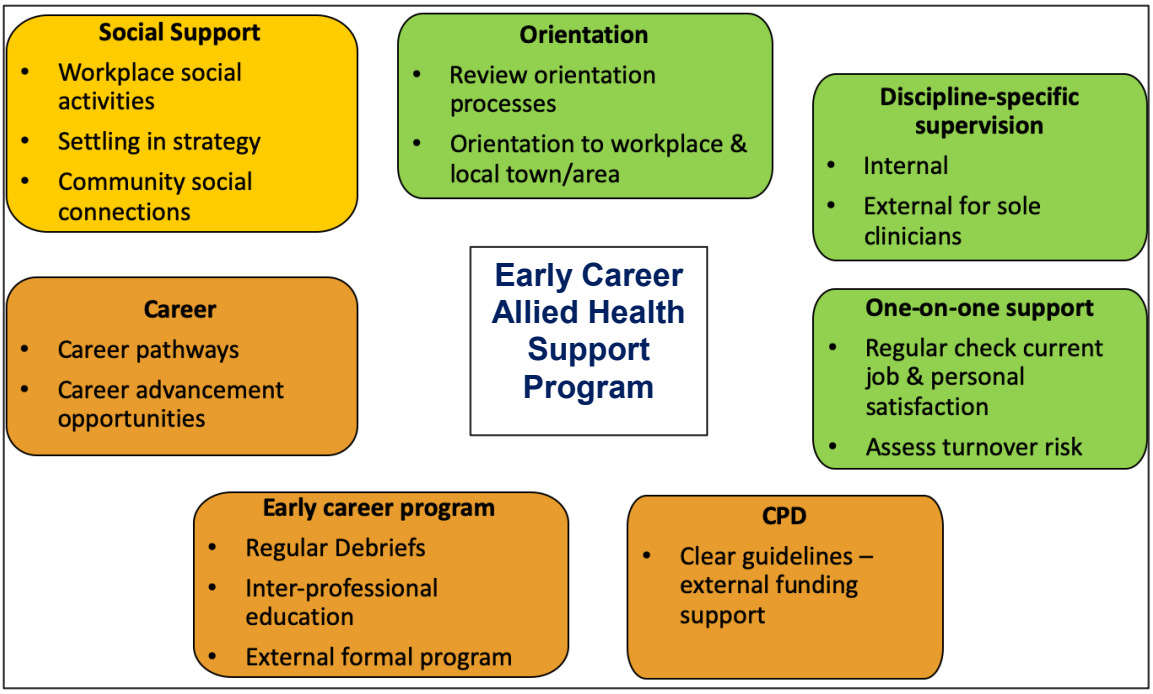
We agree that rural practice choice is complex and believe that extending allied health rural placement length should not be the main focus, especially for undergraduate allied health students given their early adulthood life-stage. This also acknowledges evidence that undergraduate allied health students’ prefer short duration placements given they undertake more paid employment than medical student [10,11]. We argue the policy focus for rural allied health placements in training instead needs to focus on resourcing health services to provide high-quality relationship-based learning that supports students to develop a strong understanding of the role of social contexts and social determinants on health/wellbeing of rural patients and communities. We support the proposed extension of the John Flynn Program to allied health students to support the development of relationships in, and connections with, rural communities.

3. A need to strengthen the workforce components of the proposed framework and to develop policies that support successful adjustment to rural practice and rural living and increased rural-based career opportunities.

We agree, given the importance of life stage on rural practice choice (see 2. above), that policy levers are needed to better support early career AHPs to stay working rurally. The Discussion Paper argues that a lack of supervision and support in the workplace contributes to high-turnover of early-career AHPs. We agree that the adjustment for early-career AHPs requires a 'big leap' and newly graduated health professionals need structured workplace support to help them to successfully adapt to rural practice, as well as regular discipline-specific supervision to support them to become confident and competent clinicians. However, we think a more holistic approach is needed, that addresses orientation needs, CPD, career development and planning and social connection (especially for newly-arrived AHPs with limited social networks who may be unfamiliar with Australia's rural environment). For the development of strategies for career development and planning, we believe that the Victorian Government Allied Health Career Pathways Blueprint is an excellent resource that could be adopted broadly https://www2.health.vic.gov.au/health-workforce/allied-health-workforce/allied-health-career-pathways-blueprint.

The essential elements of an early career allied health support program (ECAHSP) are captured in the figure below. This program has been developed and is being implemented by East Grampians Health Service in Victoria as part of a research partnership project with the University of Melbourne, Department of Rural Health trialling a whole-of person retention improvement framework for rural allied health workforce http://www.sarrahconference.com/3345. While some aspects of the ECAHSP are workplace-specific, the proposed IAHHs could contribute to many aspects of the program.

Figure 1.Whole-of-person support program for early career allied health workforce - East Grampians Health Service



4. A need to strengthen understanding of the social and personal dimensions of attraction, recruitment and retention and to develop policies that support the development of social connection and belonging for newcomer workers in rural communities.

Increasingly over the last decade, the strong influence of social and personal determinants on rural health workforce retention has been identified [2,3,12]. This includes a range of social factors which have different influences over time: for attraction–rural familiarity and/or interest; for retention –social connection and place integration, community satisfaction and participation and fulfilment of personal aspirations [13]. However, to date, most research has focussed on the more high-status health professions (for example, doctors, dentists and pharmacists) and on identifying and meeting individual-level needs. In comparison, the retention of allied health professionals needs solutions that can respond to both the needs at individual and at workforce levels. Cosgrave et al [13 argue that there is a need for a strengthened conceptual framework of social and personal determinants of retention and the identification of the factors that health services and/or rural communities can influence, that are amenable to change(for example, social connection) as opposed to those that are not (for example, life-stage influences and life-course events).

The social connection and belonging dimension of rural health workforce recruitment and retention needs a whole-of-community approach involving health services, local councils, local community groups, businesses, schools and others. Communities need to be resourced to work together to identify what attracts (and detracts) professionals to work in their town/region and use this information to develop place-based strategies across the life course to attract, recruit and retain a professional workforce. An example of such a “whole of community” recruitment and retention initiative is currently occurring in Shepperton, Victoria,

where the Local Council is leading a ‘Great Careers, Happen Here’ campaign (Council contact Fiona Le Gassick - Manager and Marketing & Communications).

Given the importance of meeting social needs, there is also strong argument for the creation of local coordinator positions in rural towns to: implement place-based workforce development strategies; provide individual support to newly-arrived health professionals to assist them (and their family members) to settle in; and to coordinate activities for both new workers and students on placement to socially connect with local people and groups. An example of a very successful recruiter and retention coordinator position is currently operating in Marathon, Ontario Canada and this may be a replicable model. The model is co-funded by local health service, the major employer in town (mine) and the local council. Key aspects of the Marathon Model associated with its success are:

1. the position is a community asset - supported by the incumbent being contracted by the local council,
2. the position is customer-service focussed and works very flexible hours (contract based on hours);
3. the incumbent was a non-local who has successfully adjusted and adapted; and
4. one who has strong local networks.

We recommend trialling this recruitment and retention coordinator model in rural communities across regional, rural and remote towns (MMM3-7) for a 5-7 year period to fully evaluate its effectiveness

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