AMSANT Submission: Consultation 1, October 2023

Unleashing the potential of our workforce: Scope of Practice Review

The Aboriginal Medical Services NT (AMSANT) is the peak body for Aboriginal community controlled health services (ACCHSs) in the Northern Territory (NT). AMSANT is the largest provider of comprehensive primary health care to Aboriginal people in the NT and represents 12 full member organisations (ACCHSs) and 13 associate members across the Territory. Our members work right across the NT from Darwin to the most remote communities. Our member services provide comprehensive primary health care in a complex cross-cultural environment, working with resilient Aboriginal communities with very strong culture and connections to country but also with very high rates of complex chronic diseases, poverty, overcrowded housing and homelessness.

At this first stage of consultation, AMSANT is providing only brief comments and will provide a more detailed and formal submission at one of the other three consultation periods.

Examples of multidisciplinary collaboration.

The ACCHS sector provides an excellent example of strong multidisciplinary collaboration. We employ a wide range of health professionals, including Aboriginal health practitioners (AHPs) and workers (AHWs), nurses (practice nurses, remote area nurses, nurse practitioners), midwives, doctors, allied health, social and emotional wellbeing (SEWB) staff, family support workers, youth workers, Aboriginal liaison officers (ALOs), drivers and others. Cultural safety and Aboriginal leadership are core components of our model of comprehensive primary health care service delivery.

For clinical primary health care services, funding is from both grant and Medicare funding.

Enablers

Remote primary health care manuals

Nurses and AHPs can diagnose and treat a wide range of conditions without speaking to a doctor using the remote primary health care manuals (also known as the CARPA Manuals), which are gazetted so they can be legally used in Aboriginal primary health care clinics by trained health professionals including AHPs, nurses and doctors. These manuals have been in existence in their current format since 1992, although the manuals have increased in the number of areas they cover (in addition to the Standard Treatment manual, there are also manuals covering Women's Business, and Procedures and Medicine Management). The CARPA Manuals have clear indications for when a doctor should be called. This system has served remote Aboriginal primary health care well for many years and is also used in less remote locations such as Darwin to good effect. The Manuals enable nurses and AHPs to undertake interesting, varied work within their scope of practice and the CARPA guidelines. This type of model could be used outside of Aboriginal primary health care.

Excellent systems of orientation, mentoring and upskilling are required for this system to work safely in Aboriginal primary health care. Although the standard of clinical service delivery is generally high, as noted below, it is hard to sustain these systems in the face of very high workforce turnover.

Financing models: Health Care Homes.

The Health Care Homes trial supported ACCHSs with a financing model that rewarded services for the complexity of care they provided, regardless of which professionals provided the care. It recognised the highly complex care that ACCHSs provide that is not well remunerated by the Medicare system. Several ACCHSs participated in this Health Care Homes trial and, unlike private general practice where a high proportion of practices did not complete the trial and the number of patients enrolled was much less than predicted, there was only one ACCHS that dropped out and patient enrolments largely met expectations. This model built on the strength of ACCHSs and was well accepted. Unfortunately, the trial ended with no opportunity for services to continue with this financing model. There are, however, definite opportunities to build on this trial. While private general practice may require more developmental assistance to be ready to implement such large-scale change, AMSANT believes that ACCHSs could be at the forefront of the implementation of new financial models

Benefits

The current system allows multidisciplinary teams to provide care to very remote communities using professionals working to the top of their scope of practice.

Aboriginal Health Practitioners have a much wider scope of practice in the NT than in other jurisdictions. This allows them to work alongside nurses as equals.

Risks

The ACCHS sector is in a workforce crisis with unsustainable rates of staff turnover, particularly for nurses. The work is challenging with a mixture of infectious diseases that is often associated with poverty in low-income countries (e.g., rheumatic heart disease) and where some of the highest rates of chronic diseases such as diabetes are found in the world. Communities are very remote with staff often required to provide emergency care to very sick patients for hours before retrieval aircraft get there.

There is a risk that 'working to the top of scope' could drift into staff providing care outside their competence, particularly when health services are very short of staff, and it may be a matter of taking staff who don't yet have the right training /experience or closing a clinic because of a lack of staff. This is an ever-present risk given the severe workforce shortages the sector is experiencing.

Aboriginal communities, both remote and urban, deserve highly skilled staff including general practitioners. We do not want working to the 'top of the scope of practice' to mean that one profession can be substituted with another profession just because of workforce maldistribution. We also do not want there to be an acceptance of the status quo of severe maldistribution of the workforce with the risk of staff working outside of their scope of competence because of shortages and high turnover.

The current workforce crisis is partly as a result of a lack of workforce planning and effective policies to improve maldistribution of the workforce over decades. This will not be solved by workforce substitution or other reforms focusing solely on scope of practice. This crisis requires concerted effort by Governments across multiple levels.

There must be investment in orientation, support and mentoring of less experienced health professionals working in challenging environments. This is currently undertaken by services with little centralised support apart from participation in intensive academic courses such as the Masters of Remote Primary Health Care. Whilst these courses are useful, we also need greater funding for emergency courses and shorter courses (including online components) in other key areas such as

chronic disease and child health, which are suitable to more rapidly upskilling clinicians in our environment.

Although AHPs have a wider scope of practice in the NT than in other jurisdictions, the numbers of AHPs are declining. The failure of the educational system to provide effective bicultural education has meant that it is an extremely difficult path for many Aboriginal people to achieve a Certificate IV level of competence, particularly when so much of the training offered occurs outside of the remote communities in which they live. Reform of the educational system and adult literacy/numeracy services are needed. In the interim of this reform occurring, however, other pathways into health careers that do not necessarily require this level of educational attainment are needed to ensure that Aboriginal and Torres Strait Islander people have access to a variety of career options within health services. Aboriginal people can work as community workers and public health staff (with training in contact tracing, etc.) for example; they can also be supported to learn a variety of technical skills that would greatly assist other clinicians, such as venipuncture or point of care testing without having to reach a certificate IV level. Many Aboriginal people work in SEWB, administration, and emerging areas such as disability. All these areas require training pathways. This is an area AMSANT will expand on in future submissions. AMSANT will also address other areas, such as technology as a support to working to full scope of practice, in upcoming consultation rounds.

References

Russell D , Zhao Y et al, (2017). Patterns of resident health workforce turnover and retention in remote communities of the Northern Territory of Australia, 2013–2015, Human Resources for Health volume 15, Article number: 52