

COMMENTARY

Growing Our Own Rural, Remote and Aboriginal Health Workforce: Contributions made, approaches taken and lessons learnt by three rural Australian academic health departments

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Abstract

Aims: This paper describes the investments made, approaches taken and lessons learnt by three rural Australian academic health departments engaged in the delivery of the Health Career Academy Program (HCAP). The program seeks to address the under-representation of rural, remote and Aboriginal populations within Australia's health workforce.

Context: Significant resources are directed towards rural practice exposure for metropolitan health students to address workforce shortages. Fewer resources are directed towards health career strategies that focus on the earlier engagement of rural, remote and Aboriginal secondary school students, those in Years 7–10. Best practice career development principles highlight the importance of earlier engagement in the promotion of health career aspirations and in influencing secondary school student career intentions and uptake of health professions.

Approach: This paper describes: delivery contexts; the theory and evidence that has informed the HCAP; program design, adaptability and scalability; program focus on priming the rural health career pipeline; program alignment to best practice career development principles; enablers and barriers confronted in program delivery, and lessons learnt to inform rural health workforce policy and resourcing.

Conclusion: There is a need to invest in programs that seek to attract rural, remote and Aboriginal secondary school students to health professions if Australia is to develop a sustainable rural health workforce. A failure to invest earlier undermines opportunities to engage diverse and aspiring youth in Australia's health workforce. Program contributions, approaches and lessons learnt can inform the work of other agencies seeking to include these populations in health career initiatives.

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KEYWORDS

health career academy program, health workforce, rural health career pipeline, rural, remote, Aboriginal, secondary school students

1 | INTRODUCTION

A range of strategies have been implemented to address Australia's rural, remote and Aboriginal health workforce shortages. These include rural and remote practice exposure for health students from regional and metropolitan centres and strategies focused on attracting rural, remote, and Aboriginal populations into health professions.^{1,2} Evidence suggests that both approaches can influence the uptake of rural practice post-registration.¹⁻⁴ However, "few will understand the life and the needs of rural and remote communities better than those from these communities, including Aboriginal and Torres Strait Islander communities."⁵

Whilst significant investments are directed towards practice exposure,¹ less resources have been directed towards career strategies focused on the engagement of rural, remote and Aboriginal secondary school students in Years 7-10. Career development principles highlight the importance of engaging these students earlier in their career decision-making stages to build career aspirations, influence career intentions and contribute to professional pathway uptake.^{6,7} A failure to engage earlier detrimentally impacts capacity to prime the nation's health career pipeline with rural, remote and Aboriginal participants who are more likely to return to their communities to practice post-registration.²⁻⁴

Three rural Australian academic health departments have invested in the development, adaptation and implementation of a health career initiative to address the under-representation of rural, remote and Aboriginal populations in Australia's health workforce, the Health Career Academy Program (HCAP). The HCAP seeks to: engage secondary school students earlier in their career decision-making stages; afford students an opportunity to explore the range of health career pathways available; expose students to practicing health role models and health students undertaking rural and remote placements; and facilitate student exploration of local/regional employment opportunities.⁸

This paper will describe: delivery contexts; the importance of priming the rural and remote health career pipeline; the theories that have informed the HCAP; program design, adaptability and scalability; program alignment to best practice career development principles; enablers and barriers confronted, and; lessons learnt to inform rural, remote and Aboriginal health workforce policy and resourcing.

2 | DELIVERY CONTEXT

Challenges associated with the development of a sustainable rural, remote and Aboriginal Australian health workforce are well-documented. These include geographical and professional isolation; under-resourcing; cultural complexities^{1,9}; and the current divide between rural communities and universities with carriage of health professional education, including a focus on attracting metropolitan students to health degrees in preparation for practice in larger centres and acute models of care.⁵

The University of Sydney University Departments of Rural Health located in Broken Hill and Lismore and Rural Clinical School located in Dubbo have invested since 2007, 2017 and 2018, respectively, in the design, adaptation and implementation of the HCAP across far west, western and the north coast regions of New South Wales. These departments are funded through the Commonwealth Government's Rural Health Multidisciplinary Training (RHMT) Program and are located within lower socio-economic status regions with a higher representation of Aboriginal people.¹ The aims of the RHMT Program include the provision of effective rural training experiences for health students, development of an evidence base for the efficiency of rural training strategies and contribution to increasing the number of rural origin health and medical students.¹⁰

Whilst these departments share similar challenges, they also experience unique features associated with geographical location; demography; the presence of existing networks, relationships, and partnerships; resource accessibility; cultural diversity; and the health workforce development opportunities available to them. This necessitates a degree of HCAP flexibility and adaptability in ensuring program acceptability and contextualised approaches to program co-design and implementation.⁸

3 | PROGRAM FOCUS ON PRIMING THE RURAL AND REMOTE HEALTH CAREER PIPELINE

Health career pipeline literature is increasingly informing Australian health workforce policy and the role of RHMT funded departments.¹ Health career pipelines aim to address the under-representation of marginalised

populations within health professions and have been described as ‘a pipeline from primary to secondary to postsecondary education, and finally to professional training’.¹¹ Australian investments in health career pipeline models have predominately focused on addressing medical workforce shortages.¹² Whilst of importance, this policy approach fails to extend career pipeline opportunities to rural, remote and Aboriginal students aspiring to allied health and nursing careers.

The National Rural Health Association stated that ‘it is critical to maximise the number of kindergartens to 12th grade level youth in [rural] communities that are informed about, choose to prepare for, and are successful in entering health professions training programs’.¹³ Earlier engagement is considered critical in recruiting these individuals into the next stages of the rural health workforce pipeline. The HCAP seeks to engage secondary students from Year 7 to 10 in health career development and aspiration building strategies and to maintain this engagement across their secondary school trajectory.

4 | CAREER DEVELOPMENT THEORIES

There has been a growth in the number and type of strategies seeking to influence senior secondary school student (Years 11–12) uptake of health careers. These strategies include School-Based Apprenticeships and Traineeships,¹⁴ cadetships and recent initiatives such as the National Aboriginal and Torres Strait Islander Health Academy.¹⁵ However, the theoretical frameworks that inform these strategies can be poorly defined within the literature. As stated by Austin et al. ‘career theory and practice are inextricably related’.⁶

The HCAP has been informed by career theories relevant to program contexts including strengths-based, appreciative inquiry, aspiration building and career complexity theories.^{6,7,16} Strengths-based approaches employed in the HCAP aimed at enhancing student confidence to aspire to their career of choice, increase student motivation towards their career development and support students in establishing networks with peers, health professional and student role models, and community leaders.⁶ Appreciative inquiry acknowledges the importance of solutions development in overcoming career barriers that include geographical isolation, poorer socio-economic status and educational attainment, separation from family/support networks and cultural circumstances.^{3,6,7}

Career aspiration theory identifies a correlation between lower socio-economic status and student capacity to aspire to professional occupations as ‘capacity to aspire is not equally distributed because of social, cultural, and

economic resources available to diverse groups’.⁶ Career complexity theory acknowledges the interplay between internal and external influences that can impact student career aspiration and attainment.¹⁷ Internal influences include a student’s abilities, aptitude, interests, beliefs, values and cultural norms. External influences are those that occur beyond the students control and include family and life circumstances, socio-economic status and family/peer expectations.⁸

In responding to these theories, the HCAP seeks to provide secondary school students with opportunities to engage with rural, remote and Aboriginal health role models to acquire an understanding of the obstacles confronted and the real-world solutions drawn on to address them. The HCAP links students to a number of tertiary pathways, scholarship opportunities, and student support services located within their universities of choice.

5 | PROGRAM DESIGN, ADAPTABILITY AND SCALABILITY

The HCAP was initially designed and delivered in Broken Hill, far west New South Wales Preliminary pilots of the program were narrow in scope, focused on nursing career pathways and student exposure to traditional hospital services. Participant feedback informed program expansion to include medicine and allied health academies and broader exposure to a range of health and social services within the region.⁸ These program experiences were drawn on to inform program transferability and scalability.¹⁸

The three departments have co-designed and adapted the HCAP in collaboration with school and industry partners to enhance program alignment to school curriculum requirements, health industry needs and to ensure RHMT program parameters are addressed.^{1,19} The program integrates career education and information sharing, exposure to health services and role models, and clinical skills and health literacy sessions.

Program activities are tailored to account for growth in student maturity across their school trajectory. Each Department delivers the program over multiple years, and for various lengths of time. For example, The Broken Hill and Dubbo Departments tailor their programs to provide students in Year 7 with an introductory information day relating to health careers, undertake a hospital tour and engage in clinical skills sessions focused on blood pressures, temperatures and blood glucose levels. Health literacy sessions focus on health-promoting behaviours. Students in Year 10 visit health care locations such as Aboriginal Community Controlled Health Services, the Royal Flying Doctor

Service and non-government organisations, these activities are half to full-day events annually. Year 10–12 students are engaged in advanced career discussions to inform school electives and career pathways decisions. These participants engage in clinical skills sessions such as suturing, plastering and cannulation.

All secondary school students, Aboriginal and non-Aboriginal, expressing an interest in health careers can engage with the Broken Hill and Dubbo Departmental programs across Years 7–12, and can participate multiple times across a delivery year. The Lismore Department has adapted the program to specifically focus on Aboriginal student participation and engages students in half-day careers activities that are delivered onsite within the rural health academic department multiple times during a year, with the ability for students to attend every year. Consultations are underway to explore the introduction of outreach activities to relevant health industry sites. Program adaptability is of importance because ‘it is rare for interventions to remain unchanged as they are scaled up’. Adaptability is required to respond to contexts and the organisational, financial and human resources available.¹⁸

6 | PROGRAM ALIGNMENT TO BEST PRACTICE CAREER DEVELOPMENT PRINCIPLES

Best practice career development principles for students from lower socio-economic status⁶ and Aboriginal and Torres Strait Islander backgrounds⁷ have been described in the literature and include: career development strategies that commence at an early age; contextualised strategies; the integration of career activities within school curriculum and industry practices; accessible career development opportunities; strategies that are underpinned by Aboriginal and Torres Strait Islander leadership, cultural safety and responsiveness; institutional commitments to equity and community partnerships; ensuring the right people are providing the right health career advice; embedding school based health career strategies within comprehensive health career pipeline models, and; program evaluation to enable student experiences to inform adaptations and tracking of participant career trajectories.^{6,7}

Whilst the HCAP is targeted towards secondary school Years 7–12, the Broken Hill Department has endeavoured to strategically and theoretically connect their program to a suite of health service strategies delivered directly on primary school campuses through health professional role model exposure. Resource limitations and alternative health service models in Dubbo and Lismore have limited

the capacity of program leaders in these communities to extend the reach and impact of the HCAP to younger participants.

Best practice strategies reflected in the HCAP include: program adaptation to context; delivery across Year 7–12; academic, health service, and industry partnerships; and program intent to locate the HCAP within a rural, remote and Aboriginal health career pipeline. The approaches adopted within the HCAP contrast with alternative career strategies that can; be externally driven by health agencies or universities; be one-off events within communities; lack longer term commitments; fail to engage with theoretical and evidence-based approaches to career development; be poorly connected to local and regional health and school education stakeholders; and have limited local leadership and ownership.

7 | PROGRAM ENABLERS AND CHALLENGES

Identified program enablers include: place-based approaches to health career development; theoretically informed strategies; program leaders who are located within regions with capacity to leverage local relationships and networks across mainstream and Aboriginal health and education sectors; redistribution of department resources to support program delivery; knowledge sharing across departments; built in adaptability to improve program acceptability and efficiency; and program embeddedness within rural academic health departments with carriage of health workforce development and linkages to a range of health services and higher education institutions.

An important enabler across all departments is Aboriginal leadership of the three programs. Current program leaders are from Arabana, Bundjalung, Paakantji, and Yaegl cultural groups. Aboriginal leadership is a critical feature in ensuring cultural expertise, knowledge and worldviews inform program design and delivery and the promotion of culturally safe and responsive approaches. These leaders have extensive knowledge of health career pathways and lived experiences of the challenges confronted by Aboriginal students and families in aspiring to and attainment of health careers.

Identified program barriers include: limited access to financial and human resources to ensure program sustainability; limited federal and state health policy and resourcing focused on priming the rural, remote and Aboriginal health career pipeline; school education and health professional turnover in communities, necessitating the re-establishment of relationships between program leaders and key stakeholder agencies; lack of formal linkages between schools, universities,

and health industries to ensure a comprehensive health career pipeline approach; challenges in tracking secondary student transition into higher education programs and professional practice, including practice locations postregistration.

Participant feedback is drawn on to inform program improvements. A small body of research has been undertaken on the program;²⁰ however, challenges exist in accessing research funding and the academic staff required to undertake longitudinal evaluations of program impact and workforce outcomes. There is a need to understand which strategies are acceptable and effective if we are to address 'gaps in the Australian rural health research evidence base [which] threaten to leave holes in Australian health policy'.²¹

8 | LESSONS LEARNT

Important lessons have been learnt in the design, adaptation and implementation of the HCAP. The importance of establishing and maintaining trusting and credible relationships with students, schools, health industry and community partners is considered a key feature in enabling program co-design and continuity of engagement.²² The contextualisation of the program is considered necessary to support place-based responses that are more likely to meet the needs of rural, remote and Aboriginal communities.²³

The consistency of HCAP leaders has also been identified as being of importance. The role of local leaders in understanding the contexts in which the program is being implemented, their advocacy for student participants in relation to their career pathway aspirations and re-distribution of RHMT program funds to enable HCAP delivery is significant. HCAP leaders acknowledge their advocacy role at the student, community, health and education systems levels. The World Health Organization describes advocacy as a 'combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program'.²⁴

Advocacy efforts undertaken by HCAP leaders are required to: highlight the challenges confronted by rural, remote and Aboriginal students in the attainment of health professions; draw attention to potential solutions to these challenges; illuminate the importance of earlier engagement of secondary school students; influence internal and external resource distribution to the program; and to inform health workforce policies. HCAP leaders are sensitive to the importance of community participation and co-operation for these advocacy efforts to avoid paternalistic approaches and to ensure the aim

of advocacy efforts is focused on redressing imbalances that contribute to the current health workforce challenges experienced.²⁵

9 | CONCLUSION

There is a need for policy and resource investments in programs that seek to attract rural, remote, and Aboriginal secondary school students to health professions. If Australia is to develop a comprehensive approach to the development of a sustainable rural, remote and Aboriginal health workforce, and inclusive health career pathways, the integration of the HCAP within this pathway is required. A failure to invest earlier in career decision making stages undermines opportunities to transition diverse and aspiring youth into the nation's future health workforce. Program contributions, approaches and lessons learnt can inform the work of other agencies seeking to engage these populations in health career initiatives and the development of a sustainable and fit-for-purpose rural, remote, and Aboriginal health workforce.

AUTHOR CONTRIBUTIONS

Debra Jones: Conceptualization; writing – original draft; methodology, writing – review and editing. **Kathryn Naden:** Conceptualization; writing – original draft; methodology; writing – review and editing. **Denise Hampton:** Conceptualization; writing – original draft; methodology; writing – review and editing. **Emma Walke:** Conceptualization; writing – original draft; writing – review and editing; methodology. **Susan Parker Pavlovic:** Conceptualization; writing – review and editing. **Siobhan Graham:** Conceptualization; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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ETHICAL APPROVAL

Ethics approval was not required for this Commentary Paper. The First Nations intellectual knowledge shared to inform this publication is reflected in authorship.

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