Tool 08:

Effective models of workforce engagement

08

Effective models of workforce engagement

This section includes exploration of various innovative approaches to engaging the workforce in Australia and may be applicable in some remote locations. Two of the models presented are in various stages of implementation in the remote Project Communities. Given further time and resourcing it is anticipated that the current Project would benefit from further testing of these models in these two communities.

Exploration of models

Scarcity of a health workforce in remote and very remote Australia has resulted in the introduction and piloting of schemes that address the lack of workforce. This Section of the Toolkit offers an outline of five such models and looks at both the key factors in the potential success of those models and the barriers. While most of these models cross several industries, for this exercise, the analysis will focus on their application in the health industry and the disability sector, in remote areas.

Pacific Australia Labour Mobility (PALM) Scheme

The PALM scheme is an initiative by the Australian Government to facilitate job opportunities for individuals from nine Pacific island countries, and Timor-Leste, in the Australian aged care sector.[1] Participants can work in Australia for a minimum of one year, with the option to extend their stay for up to four years.[1] This program aims to address workforce shortages while providing valuable employment opportunities and experience for Pacific job seekers.

Key factors to success

A review of PALM initiatives across both the health and disability sector has identified several key factors resulting in its success. These include:

- Executive and management support for the program.
- Ensuring that the host organisation is enthusiastically engaged in the model, and, where possible, is a larger scale provider so that workers can be 'clustered' and thus be better supported.[2]
- Where possible, include other industries that provide ancillary health services e.g. cleaning, catering or maintenance, so that the number of participants in one location can be expanded, thus maximising the attraction of the model.[2]
- An understanding of any cultural practices or issues.[3,4]
- Adequate workplace supervision for participants, including the allocation of 'buddies' in the Australian workplace.[3,4]
- A degree of experience in a similar role e.g. previous training in a similar role in their country of origin or additional support for those without formal employment experience.[3,4]
- A comprehensive induction prior to commencing in the Australian workplace environment.
- Ensuring participants understand the nature of the role and program, both from an academic and physical perspective.[3,4]
- The model works well in industries such as health, where there is a workforce shortage rather than those where there is limited opportunity for job growth e.g. manufacturing industry.[5]

Potential barriers

While the PALM model provides significant benefits to areas of workforce shortage, there are some barriers that are common across various initiatives. These include:

- A lack of support for the program in some Australian workplaces.
- Miscommunication between participating organisations.[3,4]
- Placing participants in very small facilities with no connection to an overarching larger organisation for support can be problematic, or alternatively[2]
- Placing only a few participants in a location or moving participants frequently between wards or facilities reduces their satisfaction with the model.[2-4]

Model in practice

The Australian Pacific Training Coalition and the Pacific Labour Facility worked with a PALM labour hire Approved Employer (AE) to deliver a Certificate III in a relevant discipline to 40 students from Suva.[22,23] The program involved blended training arrangements: it was delivered for 12 weeks in Suva and then followed by a supervised work placement for the remaining 10 weeks on site in one of nine Australian aged care facilities.

Unfortunately, poor communication between the AE and the Host Employer meant that some facilities did not have a formalised dedicated workplace supervisor. This issue was compounded by some of the Host Employer facilities not being receptive to the pilot.

Despite these setbacks, overall, the experience was positive with 38 of the participants completing the course.

Designated Area Migration Agreements (DAMA)

A DAMA is a formal arrangement between the Australian Government and a Designated Area Representative (DAR); usually a state or territory authority or a regional body such as Local Government or Chambers of Commerce, allowing access to a greater number of overseas workers than standard migration programs. DAMAs are structured as a two-tier framework:

- Tier 1: An overarching five-year deed of agreement (head agreement) with a regional representative.
- Tier 2: Individual labour agreements tailored to employers within the parameters set by the head agreement. This flexibility enables regions to respond effectively to their specific economic and labour market needs.

Employers are required to apply for endorsement from the DAR. Once approved, the business then nominates and sponsors skilled and semi-skilled overseas workers for certain occupations, including health. An important requirement of a DAMA is that employers must provide evidence of genuine attempts to employ Australian workers first. Participants employed under a DAMA may be currently living overseas or may be already in Australia but have visas that are soon to expire.

Key factors to success

- Prioritising of regional visa processes.[6]
- Having a DAR that is experienced in employment via DAMAs.[6]
- Concessions can include the level of experience, age, salary, and command of the English language.
- While it is up to the employer as to whether they collaborate with a registered migration agent, this can contribute to the success of the program.[7]
- As with the PALM model, employing a critical mass of staff in a community, across a range of industries ancillary to aged care, can contribute to the success of the model.[7]
- Allows for a wider range of occupations than regular visas.[8]
- Participants employed under a DAMA can include those already working in Australia whose visa may soon expire or who may soon cease to comply with normal working visa requirements e.g. age.[7]
- Participants must live and work in the area sponsored under the DAMA i.e. fly-in, fly-out (FIFO) workers are not eligible.

Potential barriers

- DARs must be cognisant of the potential for a higher risk of exploitation and therefore must have the capacity and organisational maturity to manage the complexities involved in supporting workers sponsored and employed through a DAMA.[6]

Model in practice

East Kimberley Chamber of Commerce and Industry have a DAMA with the Federal Government for the provision of overseas workers from a range of industries including the health and aged care sector.[26] An Aged Care facility located in the area, with a range of workforce gaps, were successful in their application for a labour agreement initially for two participants who were currently working in two separate Australian capital cities, with one soon to exceed the allowable age for a regular visa (45 years of age).

These were the first of many DAMA participants for that facility. Within 12 months of the first two, all 17 of their vacant positions, ranging from nursing and personal care workers, to catering and administrative services, were filled.

Hybrid tertiary training and pathway to homeownership

This innovative project model seeks to establish a collaborative working group composed of health service providers and educational institutions to develop a hybrid tertiary training program, specifically for Indigenous Australians. This initiative aims to:

- Facilitate access to recognised health qualifications for students.
- Create a defined pathway to homeownership, promoting community stability and economic empowerment. By integrating education and financial stability, this model enhances opportunities for local residents.

It is anticipated the hybrid model will provide assistance for Indigenous community members to more easily access financial assistance to apply for a loan and purchase a home, while providing them with appropriate support to make that a reality i.e. financial, legal and negotiation assistance and education.[9] The initiative will see the Pathway to Home Ownership model that has been established in the East Kimberley through the Wunan Foundation, combined with a tertiary training model.

The Project will provide Indigenous Australian people with access to health-related courses while working in the health industry in the area. Participants would be provided with rental accommodation that would evolve into them working towards home ownership of the property.

Key factors to success

- Using a co-design approach to construction to ensure homes meet the actual needs of the community.
- Participants would be required to be enrolled and completing a health-related tertiary course while working at a local health facility to be eligible.

Potential barriers

- Having key individuals leave the area or cease involvement can seriously impact both the success and longevity of the program.
- Ensuring adequate mentoring and support throughout the program is a vital component of it succeeding.

Model in practice

The proposed model in the West Kimberley community is partly based on a successful one that was implemented in there by the Wunan Foundation – The Pathways to Home Ownership Program.[9] The program facilitated and supported home ownership for members of the community. Through the program, eligible community members were able to access assistance with financial planning and ongoing mentorship through the home ownership process, with the program collaborating with both clients and financial institutions to assist with successful negotiation of the home ownership process.

To qualify, community members had to satisfy the following requirements:

- A steady job for a minimum of 12 months.
- Little or no other debt.
- Have a deposit to the value of 5–10% saved.
- Provide evidence of good banking conduct.

Recognition of lived skills for employment in aged care

The RPL initiative focuses on creating a process to recognise lived skills within remote communities and promote local workforce participation in the aged care sector. This framework will:

- Acknowledge and validate the unique skills and experiences of individuals.
- Support the employment of local residents in aged care roles, thereby strengthening community ties, enhancing service delivery and contributing to the sustainability of services.

Key factors to success

- Participants must be willing to remain working at the organisation for the length of the training course, thus providing a consistent workforce.
- Having a specific training provider for all participants ensures that the nuances of participant requirements in that specific community, can be addressed.
- Provides employment for local community members who are more likely to remain employed in the health sector within that community.

Potential barriers

- Participants would be required to commit to the length of the training course and to their ongoing employment during that period.
- The importance of sourcing and maintaining mentors for participants would be paramount.

Model in practice

In the community of Menindee, a program providing training from an RTO (de-identified at the request of the provider), to train students in a health-related discipline, will be trialled. The aim of the program is to provide the required training, with experiential learning being recognised as well as any formal qualifications. Four participants have been signed up to commence in July 2025 with three of these identifying as Indigenous.

For participants, this program means being able to achieve appropriate qualifications while securing employment in a local health organisation. The ability to do this without the program is limited given the constraints for them in gaining employment in their local community, as well as accessing the necessary training despite barriers such as transport and funds for course fees.

Participants will be mentored right through the training process; from providing all the essential paperwork for employment and training to assistance with study and gaining the necessary practical skills associated with their roles.

Fly-in, fly-out clinical staffing

FIFO models rely on staff moving in and out of a community to provide services where there is a workforce shortage. These can take a variety of different forms:[10]

- Specialist outreach services where it would not be conceivable to have that discipline of clinician permanently in a remote or very remote location.
- 'Hub and spoke' model where outreach services are provided to a variety of locations from one central location.
- Orbiting staff who move around between a few specific communities, negating the need for repeated orientation.
- Long-term positions where a cohort of practitioners provide services on a regular basis (e.g. month on, month off).
- Short-term locum or agency staff who attend a location as a once-off occurrence.

Each has its own advantages and drawbacks.

To address clinical staffing shortages in remote areas, a FIFO model that recruits a regular cohort of clinicians to work at remote facilities is usually the best option for sustainable and high-quality care.

Key features include:

- Clinicians are compensated at rates comparable to those offered by nursing agencies.
- This arrangement ensures continuity of care, as clinical staff are consistently present.
- By using direct employment, aged care organisations avoid the additional costs typically associated with temporary staffing.

Key factors to success

- A well-functioning effective permanent staff cohort with a good relationship with, and being held in high regard, by the community.[11]
- Adequate infrastructure including accommodation and information technology.[11]
- Prior knowledge of the community and/or the organisation or good orientation to the same.[11]
- FIFO staff being supportive of the local health workforce.[12]
- Remuneration that reflects the associated travel and living-away-from-home costs.[13]

Potential barriers

- Constant loss of corporate knowledge in addition to repeated need for on-boarding and induction processes, thus leading to unsustainable pressure for permanent staff.[11]
- Address the immediate, short-term health needs but lead to lack of continuity and do not 'value-add' in the longer term.[11]
- High staff turnover can lead to decreased quality of care and an increased risk of errors.[11]
- A poorly planned FIFO solution can result in a time-consuming drain on existing permanent services and staff.[10]
- Relies on staff being able comfortable to be separated from their usual lifestyle for significant periods of time, potentially resulting in limited social support and social dislocation, as well as the associated health risks.[13]

Model in practice

One organisation that extensively uses a FIFO workforce is the Royal Flying Doctor Service (RFDS). This includes providing regular FIFO general practitioner (GP) and nurse-led clinics, mental health clinics and dental services.[14] These services are often provided 'beyond normal medical infrastructure' where demand or capacity to house a permanent service is not viable, and there is no access to the medical benefits schedule.[14]

One specific example is the provision of the Rural Women's GP Service by the RFDS.[15] This service provides a choice of a female GP in communities where there is only a male permanent practitioner. These female GPs attend these communities for years, negating the need for constant orientation of new staff and engender trust from the community normally only achieved through having a long-term practitioner.

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