ACRRM RESPONSE TO ISSUES RAISED IN THE PRODUCTIVITY COMMISSION ISSUES PAPER

THE HEALTH WORKFORCE

JULY 2005

INTRODUCTION

The Australian College of Rural and Remote Medicine (ACRRM) welcomes the opportunity to submit comments on the Productivity Commission's Issues Paper on the Health Workforce, May 2005.

ACRRM was founded in 1997 as the peak professional body for rural and remote medical education and training. Central to ACRRM's activities, and to the issues raised in this submission, is the understanding that rural and remote medical practice is a distinct specialty of medicine, requiring appropriate specialist training, support and ongoing professional development. ACRRM's core function is to determine and uphold the standards that define and govern competent, unsupervised rural and remote medical practice.

The ACRRM membership is principally based in RRMA 4-7 and therefore embodies the current rural and remote medical workforce. Rural and Remote Medicine is based on the need to provide a particular breadth and depth of service and care to rural communities. Its expression, in terms of workforce, goes beyond the basic quantification of practitioners that has, to some extent, limited the delivery of appropriate services.

In terms of a functional rural and remote health workforce, ACRRM will be highlighting in this submission, the need to look beyond numerical and FTE accounting processes for the rural workforce, and to look instead at the regional and, especially, local capacity to deliver relevant services. This concept relies on appropriate numbers of adequately trained personnel across a co-ordinated team of professions.

Health workforce definitions should include the concept of "effective workforce", in terms of numbers and mix of personnel, twinned with an operational capacity to deliver services where they are required and the training and skills to practice safe and high quality care. If one of these elements is diminished, then capacity to deliver appropriate care to rural communities is critically limited.

UNDERSTANDING THE TASK

The Commission is examining the pressures facing the health workforce and as part of that process, has developed an Issues Paper as a preliminary report to COAG. The Issues Paper is also intended as a catalyst for review and response by organisations with an interest in health workforce and as an opportunity to gather views on policy issues, potential workforce solutions and systemic constraints and challenges.

The process is intended to achieve the best outcomes from the community's investment in the health workforce and promote a more responsive and cost effective result. In particular, the study has focused on:

- Factors that affect the supply of, or demand for, health professionals;
- The current structure and distribution of the health workforce and its efficiency and effectiveness;
- The efficacy of health workforce planning and its linkages to health services planning and the education sector;
- Workforce-related policy measures that would health ensure efficient and effective delivery of quality health services in an environment of demographic change, technological advances and rising health costs; and
- ***The particular health workforce needs of people in rural, remote and outer metropolitan areas, and of Indigenous Australian.***

KEY ISSUES

In terms of the points raised in the Productivity Commission Paper, the principal issues that influence the rural and remote workforce are as follows:

- Policy and program commitments for the whole length of time required to train the health workforce
- Finding the means to address key gaps in the skills mix
- Balancing training and support approaches that cover both medical and health workforce
- Ensuring that the public- private divide does not unnecessarily inhibit effective use of the workforce
- Modelling the importance of service to rural and remote Australia in every aspect of workforce recruitment, training and support.

ACRRM SUMMARY

In terms of the discussion of issues, the following summary of points indicates the areas that ACRRM considers to be particularly worthy of emphasis:

- The concept of the interrelated team is an important one, in situations where options are reduced by distance and isolation. The appropriate health workforce mix, supported by relevant training, professional development and support options creates a functional health workforce in terms of the delivery of rural and remote medicine.

- The clear identification of gaps in health workforce teams is integral to well co-ordinated rural workforce – in terms of key functionality that is lost through the absence

of particular professionals. Examples include the loss of a rural proceduralist or the absence of a qualified theatre nurse.

- Well qualified and trained workforce can be limited in its function by excessive restrictions in terms of portability and transferability of qualifications and privileging. ACRRM strongly supports regulatory activity that provides safe and high quality practice, however redundant bureaucracy should be examined.

- The application of incentives, training and support mechanisms presently available to doctors, are ineffective similar measures are applied to ensure the workforce of other health professions is assured. The rationale underpinning workforce differences in this regard should be examined.

- Notwithstanding that the key generational issues should be examined and understood, it is ACRRM's experience that a properly marketed program to rural origin and rurally orientated students can provide a significant and sufficient workforce.

- In view of the particular needs of rural and remote Australia, the numbers of education and training places for Australians needs to be reviewed in order to ensure sufficient doctors with the extended skills base required for rural and remote medicine.

- Rural and remote doctors have a skills base beyond that of general practice.

- Systemic constraints that limit their capacity to practice between public and private sectors and between hospital and community settings should be examined.

- The investment in workforce recruitment and skills development for rural Australia is often confounded by service closures and contractions that limit the use of skills across the workforce team and discourage the attainment of such skills by younger doctors.

RURAL AND REMOTE MEDICINE

ACRRM has recently developed a very detailed position on rural and remote medicine that provides an important perspective for the Productivity Commission study. As part of its application for the recognition of Rural and Remote Medicine as a specialty discipline by the Australian Medical Council, ACRRM has produced evidence based discourse on the needs of rural and remote Australia in terms of its health workforce and a rationale for policy and program development. Key extracts are detailed below.

The latter part of ACRRM's submission provides an overview of issues with the potential to guide the Commission in their consideration of recommendations for health workforce support in rural and remote Australia.

DEFINITION OF RURAL AND REMOTE MEDICINE

Rural and Remote Medicine is the specialty that focuses on securing optimum patient and community health outcomes utilising a particular range and depth of knowledge, skills and attitudes not common to any other medical craft group to achieve the desired outcomes within the parameters of practice imposed by rural and remote environments.

Rural and Remote Medicine operates on a unique paradigm of primary, secondary and tertiary medical care, with increased individual responsibility owing to relative professional isolation, geographic isolation, limited resources and special cultural and sociological factors.

A specialist in Rural and Remote Medicine requires a broad understanding of diagnosis, treatment and management from the perspective of a number of medical and surgical disciplines and applies these skills along the continuum of care from primary presentation to secondary and sometimes tertiary care. Practitioners are able to adapt and build their skills in response to the health needs of a diverse range of rural and remote community settings and the degree of isolation from other health services and resources.

The defining characteristics of the specialty are the specific content, context and consequent complexity of the discipline.

CONNECTIONS WITH OTHER DISCIPLINES

Rural and Remote Medicine is a specialty that takes a broad range of consulting room practice responsibilities to meet the demands of the rural and remote context and combines them with sets of skills and expertise from a number of relevant specialties. Rural and Remote Medicine shares content with Obstetrics, Emergency Medicine, Surgery, Psychiatry, Public Health, Internal Medicine, Paediatrics, Radiology, Anaesthetics, Ophthalmology, Pathology, Gerontology, ENT, Aboriginal and Torres Strait Islander Health and General Practice, and also requires a working knowledge of many allied health fields such as podiatry, social work, physical and occupational therapy. It applies to all age groups and covers all symptoms and presentations.

The breadth of the specialty also extends to its interrelationships with both medical disciplines as a whole and with individual professional settings. The rural medical practitioner must be capable of working in a variety of clinical settings and be confident in leading multi-disciplinary and multi-professional health care teams whose members may be physically distant from each other.

WORKING CONTEXT

There are three key issues in this area:

1. Recognising the difference between health profiles and community needs in metropolitan and rural Australia; and
2. Recognising the right of rural community members to be able to access, locally and to a high standard, the care that they require. Equity of access is an abiding principle that should underpin the consideration of both workforce provision and service delivery.
3. Understanding the cost effectiveness, nationally, in terms of morbidity and mortality from lack of onsite services. The small marginal cost of providing extra services in an existing facility. The lack of attractiveness of a facility that does nothing in terms of attracting doctors to rural areas and there is the overall cost inefficiency to the community of transferring people out. Despite the fact that hospitals are being closed on the grounds of economics, there is little valid data to support this case at the present time.

The practice of Rural and Remote Medicine is shaped by the nature and patterns of mortality and morbidity across rural and remote Australia and internationally. The health status of

Australians in rural and remote regions is substantially poorer than that of their urban counterparts and there is a link between remoteness and decreasing levels of health for both Indigenous and non-Indigenous people.[i] [ii] They have more risk factors for disease and suffer more ill-health. They are likely to die from one to three years sooner. Even excluding exceptionally high rates among rural/remote Indigenous people, death rates remain 10-20% higher[**]. Death rates due to cancer, cardiovascular disease, respiratory disease and injury, the four major causes of death, are all higher or substantially higher.[iii]

There is considerable congruence between patterns of health disadvantage, morbidity and health risk behaviours in rural and remote Australia and those in other countries (both developed and developing). This is particularly true of indigenous populations. Additionally, many of the defining features of rural morbidity and mortality reflect:

- the distinct lifestyles, environment and industries of rural and remote communities;
- the larger indigenous populations and the consequent the need for competency in Indigenous Health and an understanding of its implications for medical practice;
- the distinct culture of rural and remote communities;
- the different expectations of the doctor's role and the doctor-patient relationship; and
- isolation from specialist centres and technology balanced by the rollout of cheaper "mini technology".

It has been found that rural Australians overwhelmingly preferred to have medical services provided locally rather than to have a means provided by which they might access healthcare services in cities as demonstrated at Figure 1 below.[iv] [v] Shrapnel and Davies generally found rural people prefer working with familiar people.[vi] Other studies have identified rural consumer preferences for medical care from a practitioner they know and feel comfortable with, and who can provide continuity of care[vii]. There is evidence suggesting that many rural people will avoid required specialist treatment rather than travel to a city to receive it.[viii] [ix]

WORKFORCE RESPONSE

There is considerable evidence that rural and remote medical practice entails a unique model and therefore pattern of medical care. Urban solutions can be inappropriate and counter-productive for rural and remote Australia.

The Australian Medical Workforce Advisory Committee has recognised and highlighted the difference between rural and remote medical practice patterns and other un-referred forms of generalist practice. As a result, it calculates Australian workforce needs with specific adjustments for the different urban/rural medical practice patterns (including the amount of specialist-type services that specialists in rural and remote medicine perform). It states that:

> "In small rural centres, other rural areas and remote areas, the majority of day-to-day medical care in the hospital and non-hospital setting is provided by GPs. This includes primary care, in-patient care and most procedural care (obstetrics, anaesthetics, operative obstetrics, general surgery, trauma, medical emergency and other matters such as endoscopy and radiology). These GPs are also likely to be providing non-clinical medical services, including in public and population health, administration including

[**] *This figure is for non-Indigenous people under 65, this adjusts for the distorting effects both of older people moving to cities for aged care and for the higher death rates among Indigenous people.*

hospital administration, and activities associated with running Divisions of General Practice. There is also a wider expectation on the individual doctor by the community to act as health advocate and more generally take a leadership role in the community." [x]

This finding reflects the practice of Rural and Remote Medicine rather than General Practice. The term "GP" has been used in order to highlight that these doctors provide primary as well as secondary care. However, the explanation of the additional breadth and depth of their practice was also felt necessary to differentiate these rural medical practitioners from General Practitioners who would not hold these skills or responsibilities.

The key distinguishing features of the practice patterns of Rural and Remote Medicine practice includes:

(i) Complexity of care provided, including procedural and other advanced medicine that in urban settings would ordinarily be the province of a separate medical craft group;
(ii) Diversity of roles and settings including hospitals and other community health facilities;
(iii) Extensive practice of distance based professional collaboration between the rural and remote medical practitioner and other specialists in the provision of shared care, skills transfer or education; and
(iv) Longer working hours and on-call responsibilities of rural medical practitioners.

ACQUIRING A UNIQUE RANGE OF CLINICAL KNOWLEDGE AND SKILLS

Workforce strategies need to encompass the time and resources for the rural medical workforce to attain and maintain an appropriate range of skills. This incorporates core primary care services but their delivery typically involves a higher degree of complexity. It extends to a wide range of additional services many at more advanced levels and involving modified delivery models to those in urban practice. They include:

- diverse service areas ordinarily the province of other specialties, including: aged care, rehabilitative care, post-operative care, palliative care, mental health care, radiology and obstetric ultrasound and public health;

- special skills associated with care provision locally without immediate access to comprehensive medical care network, (e.g. tele-consulting, working with non-specialist nurses and health workers, performing procedures without advanced medical technologies);

- services associated with common problems, presentations and conditions of rural and remote communities that may be considered relatively unusual in urban contexts (e.g. managing envenomation, stabilization of common farm injuries); and

- secondary care provided as an essential part of medical care in a rural and remote context including performance of basic obstetric, surgery and anaesthetic procedures.

These core Rural and Remote Medicine skills incorporate many of the identified essential skills of generalist and specialist care. Its core competencies extend beyond those of modern General Practice into a range of areas usually associated with other specialties (e.g. fracture

and complex injury treatment, emergency care, use of ancillary equipment such a x-ray, ultrasound, slit lamp, aged care, mental health care, post-operative care).

They also incorporate skills that are distinct to rural and remote delivery models including tele-consultancy and working without advanced medical facilities/specialised auxiliary support staff such as radiologists, specialist nurses and the like.

Practitioners of Rural and Remote Medicine require advanced diagnostic, therapeutic and clinical management skills that in urban areas are generally the province of specialists and sub-specialists. These skills build on what have been defined as core areas outlined above, but are in practice learned and performed in parallel as required in the training/practice environment. The key areas encompassed by this domain are in obstetrics, obstetric ultrasound, surgery, anaesthetics, mental health and population health.

CONCLUSION

In order to understand, and plan for the support of the rural and remote workforce it is necessary to factor in the scope of practice for rural doctors, which is distinguished from that relevant to other specialists/sub-specialists by virtue of the remote context where services are provided with minimal medical technologies, and by the less reductionist nature of the rural doctor's expertise. Delineating the extent of their role and capacity and an appreciation of when to refer are therefore critical aspects of competent practice. Innovative models for specialist/generalist cooperation are also becoming an increasingly important and unique practice feature. The professional relationships between specialists, rural and remote medical practitioners and health professionals in the provision of care, exemplify the unique nature of Rural and Remote Medicine in terms of its breadth and depth and the context in which it is delivered.

The all-encompassing nature of Rural and Remote Medicine means that teamwork models, which include multi-skilled nursing and allied health professional staff, as well as hospital and other health service infrastructure are a key feature of the clinical model which further differentiates these skills from those performed by both un-referred care providers and specialists in urban environments.

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[i] AIHW (2002) *'Australia's Health 2002'. AIHW Cat No. AUS 25. Canberra.*
[ii] Wainer J. (1998) Rural Women's Health *Australian Journal of Primary Health Interchange* 4(3) Special Issues: Women's Health, LaTrobe University
[iii] AIHW (2002). Opp Sit.
[iv] Humphreys JS et al. (1997). Opp Sit.
[v] RDAA (2003). *'Viable Models of Rural and Remote Practice: Stage 1 and Stage 2 Report'*. Canberra.
[vi] Shrapnel, M, Davies, J. 'Impediments to Rural Prosperity: A Social Perspective'. Paper presented at the 24th ANZRSAI Annual Conference, Hobart. December 2000.
[vii] Humphreys JS. (1997). Opp Sit.
[viii] Veitch PC, Sheehan MC, Holmes JH, Doolan T, Wallace A (1996). 'Barriers to the use of urban medical services by rural and remote area households'. *Aust J Rural Health* 4:104-110.
[ix] Keleher H, Ellis J (1996). 'Rural People utilising city hospitals: issues for service provision'. *Aust J Rural Health* 4:111-150.

[x] AMWAC (2000) '*The General Practice Workforce in Australia: Supply and Requirements 1999-2000'*. AMWAC Report 2002.2. Sydney.