Submission

to

Productivity Commission
Health Workforce Study

from

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Australia has very high standards of healthcare when measured in terms of maternal and perinatal mortality and in terms of access to high standard gynaecology healthcare services all of which are underpinned by world class standards in healthcare research.

If, as this paper suggests Australia is to see changes in the provision of obstetric and gynaecology services as part of wider changes in the healthcare sector, it is important that standards of healthcare are not compromised, that we do not 'throw the baby out with the bath water'….or into it, as some current crusaders would have us do.

The paper highlights the importance of good data bases for measurement of healthcare services. National data sets should be funded, promoted and facilitated across the healthcare sector, private and public. As in many issues discussed in this paper, the fragmentation of health service delivery between Commonwealth and State systems unnecessarily complicates establishment of national data collection. Data collection should include health care outcomes, feedback from the community as a whole as opposed to feedback from special interest groups alone, and workforce monitoring nationally, not just in terms of numbers overall, but of distribution and age profiles of the workforce. Trends over time would be clear to see, hopefully prompting faster response to workforce fluctuations than we have seen in recent years where maternity service provision in particular is facing a major challenge in rural areas.

Provision of rural obstetric health services is becoming more challenging as standards and services expected by the community rise and the lifestyle and safety standards expected by health care workers and their families change. Low population density and large distances make it impossible to provide the same range of services for rural women as those that are available in large metropolitan centres. With careful planning, and recognition of the factors which are dissuading healthcare workers from providing maternity healthcare services, it should still be possible to provide high standard care which is acceptable at community level to the majority of rural families. It will never be possible to provide every woman with their ideal maternity care choice, just as it is impossible at the outset of pregnancy to predict with 100% accuracy just who will require referral for tertiary level care.

In a rural context, encouraging training to maintain a broad skill base is important: midwives should still maintain general nursing skills, general practitioners should be given training and financial incentives to maintain procedural skills, and specialists should be supported to provide a broad range of gynaecology and obstetric services. A major change in the medical landscape in recent years is the expectation of doctors and their families that they will have time off work when they are not on call, and that they will work fewer hours than previous generations were prepared to do. Safety concerns also urge more sensible work practices than those of the past. One consequence of this is that solo general practitioner towns will likely soon become a thing of the past, as will health services reliant on single practitioner specialist services. Lessening the impact on the community of the inevitable consolidation of medical services in particular towns is greater public access to motor transport to attend services away from their home base. Greater portability of the technology which supports health services and good roads and air service possibilities also enable more ready provision of 'out clinics' by regional health services and general practices.

The safe future provision of maternity services in rural Australia should focus on:

1. Identifying centres large enough to support specialist services where a group of specialists can have a workload sufficient to maintain their obstetric and gynaecology skills, and to share on call support services for junior medical staff, general practitioners, hospital emergency services and midwives.
2. Where geographic isolation and population density is such that it is not possible to sustain a large enough team of specialists to meet the above criteria, then the on call team should include procedural general practitioners skilled in operative obstetrics, lessening the on call demands on the specialists. No regional obstetric and gynaecology service should be expected to run without at least two resident specialists, and then only with the support of out of town specialists to provide locum holiday and weekend relief on a regular basis.
3. Within regions, in towns insufficiently large to support a resident specialist service, low risk obstetric services should still be possible where they can be supported by a team of midwives and general practitioners, preferably with sufficient hospital resources to provide operative intervention when needed. Where Caesarean Section facilities are not possible, then transfer policies, transport arrangements and patient consent procedures need to be very comprehensive and monitored closely to ensure safety standards and community expectations continue to be met.

It should be possible to build a picture of the healthcare workforce which would be needed to support such a framework for maternity services even given variations due to population shifts.

Issues which need to be confronted to ensure that the workforce is there are:

1. Make it attractive to work in rural hospitals: provide funding to help local health services provide accommodation assistance, to provide onsite childcare facilities, to provide employment officers in local health services to help partners of healthcare workers find local employment, to encourage flexible roster arrangements and to provide financial incentives beyond those offered in major population centres. Differential MBS fees weighted for rurality/remoteness should definitely be considered in support of general practitioners and specialists working outside metropolitan centres.

2. Promote rural training bases for general nurses who want to become midwives, and ensure that this is not a financial burden to them.

3. Promote rural training bases for general practitioners to obtain procedural skills in obstetrics, anaesthetics and paediatrics. Promote part time training to enable continuance of general practice whilst obtaining additional skills. Provide financial incentives for procedural practice that recognise the extra time and commitment required to maintain skills: the Commonwealth Government has already moved in this direction. A particular training avenue which should be promoted and financed more enthusiastically is the Advanced Diploma in Obstetrics for general practitioners: this is potentially a source of medical practitioners with a broad and useful range of skills to help support rural health services outlined in 1-3 above.

4. Fund rural senior registrar obstetric and gynaecology training posts and an administrative position to oversee the establishment and maintenance of the posts. Opportunities for specialist trainees to broaden their training with overseas experience are becoming more difficult to find. Rural areas could provide an alternative working environment for such trainees, but funding and indemnifying the work can be problematic. Senior registrars could ease the on call burden of

local practitioners; help update knowledge of local practitioners, and might in some instances, lead to commitments from the trainees to stay in the rural workforce. A national training indemnity scheme, covering training in both private and public sectors across the country would be a boon to all involved in the extremely important work of training the rural workforce.

5. Look seriously at how the anxiety associated with fear of litigation amongst all health care workers providing maternity services can be ameliorated. This is being addressed at some levels including better risk management strategies and education, some legal reforms including statute of limitations revision, and better support for healthcare workers subjected to allegations of negligence, but the process of dealing with patient complaints is still lengthy and stressful. For all concerned, there should be mechanisms which lead to speedy resolution of issues relating to patient discontent. The process should be simple in outline, involve a minimum of agencies/personnel, and have an endpoint which leads to speedy patient recompense where it is deemed due, specific recommendations to the health service to any changes that should be considered to minimise the risk of similar complaints in the future and an apology on behalf of the health service and where indicated, the health care workers, to the patient or his/her family. If there has been no breach in the quality of health care provided this should be clearly spelt out to the aggrieved parties. There should be no means of recourse the courts beyond any tribunal dealing with the above. There should be a limited time frame from the initiation of the complaint to resolution, in which the process must be complete.

6. Simplify and minimise medical indemnity cover across the private and public health sectors. Again, some improvements have occurred, but it remains a financial difficulty, particularly for new practitioners setting up practice, and when looking to find locum relief cover for general practitioners and specialists working in the private health sector in rural areas.

   Promote work practices that encourage teamwork. This is particularly so in maternity service provision. The current divisive debate about midwifery versus medical maternity care is unnecessary: both midwives and medical personnel are essential to provision of quality maternity care. The focus should be on continuing involvement of both general practitioners and midwives in promotion of safe and community friendly care. It is important that whilst looking to ways to increase midwifery input into antenatal care, and lessening the lifestyle demands on general practitioner obstetricians does not lead to lessening of the skill base of general practitioners supporting maternity services. It is also important that any changes to maternity care patterns do not adversely impact on midwives by creating unnecessarily stressful working patterns with respect to lifestyle or burdens of responsibility.

   The complex state and federal funding of health services creates difficulties in promoting the teamwork outlined above: midwifery services are largely funded by state health services, and outpatient medical services are met through Medicare payments and private fees. Ways to simplify combined antenatal services with medical and midwifery personnel who are not driven by cost shifting exercises by local health services should be explored; particularly where at present antenatal care is in the hands of general practitioners and specialists providing clinic care in the private sector. In the private hospital sector it is almost impossible to involve midwives working in private hospitals in antenatal care as there is no mechanism for hospitals to be funded for midwife involvement in antenatal care services. Whilst well established procedural general practitioners are often strongly in

favour of the current system of separate outpatient and inpatient care settings, it is possible that future generations of procedural practitioners may prefer to work in maternity care clinics in conjunction with their midwifery colleagues, with shared responsibility for antenatal, intrapartum and postnatal care. Funding arrangements and provisions to maximise continuity of care before, during and after pregnancy must be considered if such care frameworks are to be of maximum benefit to the community.

7. Continue to expand the role of rural clinical schools in nurse and medical student training, enabling students to spend longer in rural communities during training.

8. Beware of the limitations of 'clinical best practice protocols' as a method of simplifying health service provision. The evidence bases for many so called best practices are seriously flawed, and what is deemed best practice today may not be shown to be best practice tomorrow. Reducing health care provision to a series of recipes is to oversimplify the complexities of human health and disease. It is better to focus on training well skilled professionals able to modify their practice over time as the evidence base evolves from good research and population data collection.

9. Continuing support of indigenous health care worker training is imperative to improving the level of healthcare awareness in Aboriginal communities. Sustaining links between individual communities and visiting health care services over time, with stable personnel, may also help promote health consciousness amongst communities.

10. Where overseas trained health personnel are needed to support rural health services, they must be given appropriate orientation to the Australian work environment, given ongoing support in adjusting to life and work in rural communities, and be expected to maintain ongoing medical practice review and education as would be expected of local graduates. The mechanisms to ensure this are not currently in place but could be easily facilitated through the medical colleges for medical practitioners at least. Local health services and medical practices looking to employ overseas graduates should have access to straight forward pathways and rules which outline the process. Where a time frame will leave health services and practices stretched in the interim, there should be well organised and funded locum services in place. This should be long term goal in the provision of rural health services: to have well organised and audited locum services available as there will likely always be a high degree of mobility amongst health care workers in rural areas and the hunt for stop gap measures whilst the next long term appointee can be found is an ongoing stress on services and personnel.

11. Create one national framework for monitoring health service needs and outcomes, training the workforce and supporting the workforce. Have national medical and nursing registration and standards. Use state bases to monitor the situation locally, but minimise the duplication of data collection and synthesis, the need for endless discussion between states and Commonwealth as to how and who is going to do what. Make training schemes national and facilitate movement between training bases when trainees or health services require it. Do not complicate the matter by having precious training funds and personnel diverted into 'tendering processes'. Have national audit bodies to oversee the efficient expenditure of tax payer funded training fees as now happens through the Australian Medical Council with the accreditation process for Medical Colleges. Such a body would be in a position to identify apparent best practice training

schemes and disseminate the information throughout the healthcare training network.

12. Accept that on a head for head basis, rural health service provision will inevitably be more costly than that for metropolitan populations.

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