Commissioners Mike Woods and Robert Fitzgerald
Productivity Commission

Health Workforce Study

Comments to Position Paper - Rural and Remote Workforce Issues

Dear Commissioners

Nganampa Health Council provides primary health care and health program delivery across the Anangu Pitjantjtajara Lands in the extremely remote and isolated northwest of South Australia.
We operate 9 clinics and an aged care 16 bed respite facility in these indigenous communities. The organisation has a committed staff of health professionals and is nationally recognised as a best practice examplar for Aboriginal Community Controlled Health services.

Workforce issues are extremely difficult in remote indigenous communities. Don't anyone underestimate them, they are the single most significant management challenge.
The key important aspects in recruiting and retaining staff that we have built into our organisation structure are:

1. A fabric of appropriate Aboriginal health worker training programs plus structured in house upskilling for nurses and doctors plus extensive professional development opportunities for all staff through specific leave and allowance entitlements .
2. Orientation - ongoing and at various levels - OH&S related, Clinical, Administrative, Cross Cultural
3. Suitable and secure housing and transport in remote communities
4. Personal safety - community and management support and follow up to incidents
5. Attractive remuneration package
6. Attractive leave arrangements contracted in.
7. Locum replacement staff to ensure staff absence doesn't pass added burden to remaining staff
8. Support for multi nurse work environments. (in lieu of single nurse stations)

And even with this framework in place we have trouble finding skilled, competent staff to cover the positions.

In terms of the Position Paper section on Rural and Remote Workforce I would like to offer the following comments:

1. A funded structure for remote patient access to hospital and specialist services does exist. It is called PATS (Patient Assisted Transport Scheme) and was moved from federal to state responsibility in the 1980's. This scheme fails to give the intended equity of access for remote patients because it is severely underfunded. It has been underfunded since the early 1990's and little consideration has been given for rising travel and accommodation costs. (Note for example that if a patient uses own vehicle to travel to the nearest hospital, reimbursement for the vehicle and fuel is a total of 15 cents per kilometre)
2. Medicare access is limited for remote organisations because it is dependent on the GP actually seeing the patient. In our organisation 2.5 FTE doctors provide care for all residents of the AP Lands. This is an area of over 100,000 square kms. Necessarily over half their consultations are held by phone with Community Health Nurses at the particular remote worksite. None of these phone consults can be billed under the HIC's current Medicare arrangements.
3. IT networks across remote Australia are extremely fragile. Currently our organisation has an IT structure that links all our remote sites by satellite. The technology does not permit us to develop PIRS (Patient Information Recall Systems) due to bandwidth limitations on satellite transmissions. This network limitation means that our health professionals are disadvantaged in their ability to call up patient records and to maintain efficient patient recall systems. A strong frustration for the remote practitioner.
4. Establishment of regional tertiary level educational environments has been a very positive development in recent years. The establishment of the Centre for Remote Health in Alice Springs and the GP's Vocational Training Program have both been strongly supported by our staff.

If you would like any further information please contact me on 08 8954 9041

Yours sincerely

Chris Masters
Health Services Manager

24th October 2005