Submission from the Centre for Remote Health

(a joint Centre of Flinders University and Charles Darwin University)

in response to the Productivity Commission Position Paper,

***Australia's Health Workforce* (September 2005)**

At a broad level, we support the notion of overall reform of the health care system. Much of the variability across jurisdictions of service provision, workforce conditions and patient access is a result of the lack of clarity of responsibility for health care across different levels of government. Many of the structural problems related to health workforce would be more easily overcome with a single level of government being accountable and responsible for health care delivery. The efficiencies could well be invested to help overcome the current and future workforce problems, particularly in rural and remote areas.

We are gratified to note the Commission's recognition that remote areas, which are fundamentally different demographically, socially and epidemiologically to rural areas[1], have higher health needs and lower level of health resources.

We support the call for a stronger evaluation culture to be developed. We do not believe that the primary problem in rural and remote primary health care service development is lack of innovation. There have been many pilots, demonstrations and trials. The problem is the failure to garner knowledge through appropriate evaluation of initiatives, in order to enable the establishment of evidence-based PHC service delivery models, sustain and systematise these initiatives over time and transfer successful programs to other jurisdictions. Some of this research is currently under way through the Australian Primary Health Care Research Institute.

We are cautious about recommendations in relation to use of telemedicine and robotic technology in the absence of adequate workforce in remote Australia. In other word, even if the ICT infrastructure were up to speed, these technological advances are welcome as an adjunct to appropriate numbers of appropriately trained health professionals, not as a substitute for them.

The Commission suggests a number of structural changes which should increase efficiency and consistency across jurisdictions and professional groups. Some of these measures should also facilitate the development of job redesign that educates cadres of new health professional disciplines.

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[1] Wakerman J 2004 Defining Remote Health. Australian Journal of Rural Health 12:210-214.

The establishment of nurse practitioners is an important step in providing another level of health professions and should be strongly supported. However, we appreciate that the initial need for registration as a nurse and the length of nurse practitioner training are disadvantageous in solving remote workforce issues.

We agree that another cadre of generalist professionals could be developed that has a shorter time from initial training to preparedness to working in remote areas and allows an increased number of local people to be educated. One approach is to define a bundle of competencies that a primary care practitioner needs. In this way there may be multiple training pathways to a common end point. This approach would be particularly effective in remote areas where there are limited numbers of health professionals in any one remote community. For example there are a number of current pilot programs where paramedics are being trained in health promotion and prevention. On the other hand Aboriginal health promotion officers in remote communities could be trained in extended clinical skills. Thus, as well as the possibility of a generic primary care practitioner course, there may be other different starting points for different professions, all with the same end point that relates to the defined bundle of competencies. Government should support the development of further pilot programs that train ‘physician assistants’ and evaluated trials of generic primary health care workers, particularly in remote areas.

We are very supportive of initiatives to strengthen the low level of interprofessional education in Australia. Remote areas exemplify the need to work in a strongly multidsicplinary fashion. This should commence with education at an undergraduate level.

The issue of closer alignment between industry needs and university courses is supported. We are unconvinced that transfer of funding from DEST to DOHA will achieve this goal. Responsiveness of educational institutions is complex and often needs to take place at a jurisdictional level (in the absence of national reform) and also to the needs of professional groups. One good example of this is the Flinders University Remote Health Practice program. The Remote Health Practice Program, comprising the Graduate Certificate, Graduate Diploma and Master of Remote Health Practice awards, is the first multidisciplinary postgraduate program to prepare health professionals for working in remote areas. The remote practitioner needs to understand health and disease at a population level, as well as deal with clinical emergencies. In response to the broad range of skills and knowledge required in remote regions, the program has a strong public health content as well as an extended clinical practice component. The content is multidisciplinary, except for the practice topics which are profession specfic.

The success of the postgraduate program is due in large part to a symbiotic relationship with professional bodies and close links with health services and remote communities. There are agreements between the university and a number of health services at a state and regional level which support service staff to undertake the course. This not only better prepares remote staff, but also acts as a recruitment & retention incentive. There are a number of lessons learnt from this experience that may be useful.

- Respect for practitioner knowledge by academics
- Explicit and appropriate values
- High quality academics with strong service links
- Appropriate length of lead time
- Strong institutional links between university & both relevant professional organisations and health services
- A receptive university
- Location
- Ongoing engagement and industry-responsive development
- Value of joint appointments between universities and health services.

In relation to training, the report notes the growing evidence that rural origin is the best predictor of future rural practice.[2] There are a number of rural undergraduate schemes for medical and now allied health students to increase rural exposure and education. Because responsibility for different professional groups lies with different levels of government, some students receive higher levels of support with, for example, student placement programs than others. We would like to see a recommendation which would lead to standardisation of a high level of support to undergraduates of all health disciplines with respect to undergraduate scholarships and student pacement programs.

In conclusion, the health needs and social context of the 30% of Australians living in rural Australia and the 3% living in remote Australia are specific and require specific, tailored responses. It is vital that consumers and professionals from both rural and remote Australia have a seat at the table with respect to the structural changes, largely supported, which are envisaged. In this way, our needs may be better met. We need to build on the many innovative programs and instituions that have grown from the pressing needs in the bush. The regional universities, university departments of rural health and rural clinical schools are central to meeting the health workforce needs of the future in non-metropolitan Australia and should be strengthened to meet this growing challenge.

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[2] Wearne SM & Wakerman J Training our future rural medical workforce [editorial]. Medical Journal of Australia 2004; 180 (3): 101-102.