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Australian Government
Productivity Commission
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Dear Commissioner,

Following the publication of your position paper on "Australia's Health Workforce" (21 September 2005) and the round table meeting that you had in Alice Springs, attended by the Central; Australian Aboriginal Congress, the Aboriginal Medical Services Alliance NT (AMSANT) now provides this submission to clearly outline our views on a number of unresolved issues.

Overall AMSANT supports the approach that you have taken focusing on improving incentives and creating more effective processes and frameworks within which specific workforce initiatives can be developed and implemented. It is our experience that the critical issues have been left on the table unresolved for more than a decade and we fervently hope that the new structures that you are proposing be established along with the abolition of existing structures may create the capacity in the system to address the hard issues.

In particular AMSANT supports the establishment of the proposed national workforce improvement agency and the health workforce education and training council along with the abolition of AMWAC and AHWAC. A single national multidisciplinary accreditation agency for university based education and training and post graduate training would enhance the multidisciplinary nature of service delivery, especially in primary health care services. Such a body would further assist in the process of achieving national registration process across health disciplines. Finally, the establishment of the proposed independent review body (subsuming existing committees) to advise on services to be covered by the MBS and on referral and prescribing rules is a welcome suggestion.

There are, however, several areas where AMSANT believes the Commission needs further information in order to make some additional recommendations that we believe could make a significant difference to the workforce issues we are confronting in Aboriginal health in the Northern Territory.

Funding mechanisms for health care services

AMSANT agrees with your assessment that funding mechanisms are "a pervasive influence on the health workforce". The Fee For Service, private practice model has failed to deliver equitable access to general practice services and quality care for Aboriginal people throughout Australia and there is a need for alternative models based on salaried health professionals working as part of multidisciplinary teams in organisations that are large enough to deliver consistent access and quality care. We believe that the model of Aboriginal community controlled primary health care has major advantages over the traditional private practice model and our model can deliver better access, better quality, better health outcomes, better recruitment and retention of health professionals and other advantages (see attachment 1 the paper delivered to the recent national workshop organised by the Australian Primary Health Care Research Institute "**Aboriginal Community Controlled Comprehensive Primary Health Care : better access, better service provision and greater health gain per dollar?")**

Aboriginal community controlled health services are funded in a "mixed mode" model that always includes a grant plus Medicare fee for service. This allows a static funding element based on the health services client population and a dynamic funding capacity giving the service the capacity to respond to visitors and unexpected increased morbidity. The Primary Health Care Access Program (PHCAP) is an important existing funding model developed by AMSANT that potentially has broader implications, especially in rural and remote areas. The funding model in the PHCAP includes a capitation grant plus access to Fee For Service Medicare and overcomes the disadvantages of the funding model of the Aboriginal Coordinated Care Trials (CCT). We have attached a copy of the AMSANT submission to the Senate Inquiry into Medicare (attachment 2), a paper presented at the Australian Health care Summit 2003: "Universalising the Universal Health scheme. Lessons from the Aboriginal health financing reform campaign" (attachment 3) and a paper on the PHCAP in the NT (Attachment 4). These papers contain more detailed information on funding issues for your consideration, including the advantages of the PHCAP over the CCT funding model.

In addition to the innovative funding model the PHCAP is also about supporting the development of Aboriginal community controlled health services as the appropriate organisational structure for the delivery of primary health care to Aboriginal people. AMSANT believes that this model will deliver better access, quality of care and health outcomes for our people. The 4 key elements for the success of this model include:

1. Effective governance with adequate training of health boards
2. Effective management with every service requiring a CEO or Director with the necessary level of management qualifications and/or experience.

3. Economies of scale and adequate funding. The PHCAP benchmark is around $2000 per person but there is also a requirement that the health service population is large enough to ensure that economies of scale can be best utilised to achieve the critical mass of resources needed for a successful and sustainable service.
4. The recruitment and retention of an appropriately skilled workforce including public health expertise to advise on evidence based services and programs and establish data collection systems against core performance indicators. This enables a service to evaluate its effectiveness over time and participate in a continuous quality improvement process.

A significant number of Aboriginal community controlled health services do not have all of these elements and are therefore struggling to deliver accessible, quality services that are able to report on key performance indicators. AMSANT believes that it is important to focus on the services that are working and understand what the critical factors in this success are rather than dwell on the services that are struggling. The key issue is that where the model of Aboriginal community controlled primary health care is working to its optimum it is a better model than the private practice model working to its optimum.

Rural and remote issues

1. GP recruitment and retention

AMSANT has continued to advocate that for the medical workforce the principal problem is maldistribution and not an absolute lack of doctors. AMSANT supports your view that "shortage cannot be defined" as there is no methodology that would enable us to agree on an ideal GP to population ratio based on health outcomes (see attachment 5 for further discussion of this issue). Given that maldistribution is the principle problem for GPs then strategies need to include:

- Financial incentives benchmarked against the average annual income of GPs in capital cities such that remuneration is at least 20% higher in areas of need. Since the changes to Medicare under Medicare plus there is evidence to suggest that average GP incomes in the capital cities have increased by about $80 000 (David Brand, consultant reviewing the Rural and Remote General Practice Program: personal communication, October 2005). If this is correct then GP incomes in the NT are no where near what is needed to attract GPs away from capital cities and your recommendation that government more carefully considers the impact of policy decision on rural and remote health is welcome.

- Non Financial Incentives such as bonded scholarships, preferential access to specialist training and geographic provider numbers (see attachments 2,3 and5 for further details)

- Salaried GPs as part of Multidisciplinary teams in grant funded primary health care services (see attachment 1 for a fuller discussion of this and other issues that

impact on the recruitment and retention of GPs)

- International Medical Graduates (IMGs). We have attached the Congress position paper on Overseas Trained Doctors for your information (attachment 6). Since that was written there have been significant improvements however there are still some key outstanding issues. There needs to be recurrent funding provided through the GP training consortium for training IMGs on the 5 year scheme to FRACGP level (see attachment 7). In addition, selected IMGs who have passed their AMC part 1 in their country of origin should be able to access a scholarship to assist them to live in Australia for a period of 3 to 6 months prior to them sitting the part 2 examination. This assistance should be linked to them agreeing to take up training positions in the rural stream of the GP training program in areas of need and then working a further 5 years after achieving FRACGP status. After this, as with the 5 years scheme, they should be granted permanent citizenship and the freedom to practice anywhere in Australia. This would create a powerful incentive for IMGs to achieve FRACGP status and work in areas of need.

2. Nursing issues

Your position paper makes it clear that for nursing, unlike the other professions, the problem is not primarily one of maldistribution but an absolute lack of nurses in Australia. In spite of continued advocacy AMSANT has been frustrated by the lack of progress that has been made to ensure that there are sufficient undergraduate nursing places available for on site training in public hospitals in the Northern Territory, especially in Central Australia. AMSANT was of the view that the Centre for Remote Health, a University Department of Rural Health, should have devoted a large part of its resources to undergraduate nursing and not post graduate training programs but this did not occur and the nursing shortage at Alice Springs Hospital is partly a result of this failure. There is very clear evidence that rural origin students are much more likely to work in rural areas and thus undergraduate nursing training needs to be available in all regional centres across Australia. The training places need to be further decentralised away form the capital cities. This situation is an example of the problem that you have highlighted in your position paper – the current mismatch between the university places funded by DEET and the needs of the health system for health professionals. However, AMSANT is not sure that your proposed solution – to transfer responsibility for the allocation of funding to the DoHA, is going to address this problem. A mechanism needs to be found to enable the health service providers, not the DoHA, to influence these decisions as occurs in the VET sector.

In terms of the debate about nurse practitioners and practice nurses there is a need for the issue to be resolved. What is very clear is that the current largely unregulated manner in which recently graduated nurses can go and begin practise in remote Aboriginal communities as “Remote Area Nurses” is unsafe and needs to be phased out as soon as possible. Unfortunately, in spite of the important work that they do, Remote Area Nurses still have poorly defined legal and professional status. It seems that the way forward to

overcome this problem is to recognise Remote Area Nurses as part of the broader nurse practitioner workforce because if there is a place in the Australian health system, in all geographic locations, for nurse practitioners such practitioners should also work in remote areas. Whether generalist nurse practitioners can simply be up skilled to work in remote areas or whether they need a completely separate training and registration process to work in remote areas as "Remote Area Nurses" is not entirely clear and there are different views on this within AMSANT. What is clear is that workforce substitution should not occur because of the inability to recruit GPs rather we should be exploring substitution between GPs and nurses to achieve greater efficiencies across the entire health system. On the other hand, if the national debate is resolved around the need for practice nurses, and not nurse practitioners, then this is the model that should be applied in remote areas as well with GP supervision in all locations. Perhaps there needs to be a combination of both. AMSANT's main concern is that whatever model is accepted nationally needs to be applied in rural and remote areas. We do not want a second tier health system developed for rural and remote areas simply so that access can be achieved at a lower standard of care. We expect a similar standard of primary health care across the entire health system and this requires multidisciplinary teams with clear role delineation. The proposed workforce improvement agency will need to resolve these issues through a careful and objective analysis of the arguments and evidence.

3. Geographic specialisation

The issue of geographic specialisation is a complex one and impacts on all health professionals, and again, there are different views on this within AMSANT. AMSANT has had a view that all health professionals, once they complete their mainstream training, should be capable of working in all parts of Australia with all ethnic groups, including Aboriginal people. There are already a large number of specialist medical colleges and adding geographic specialisation has the potential to expand this considerably. It is not clear that such a move would assist us to recruit and retain a GP workforce in the NT and it is possible that it would diminish the pool of doctors who believe they have the necessary skills to come and work in rural and remote areas and with Aboriginal people. For these, and other reasons, historically AMSANT has not supported the establishment of a specialist medical college in Aboriginal health or rural and remote medicine. However, we again recognise the complexity of the issues involved and differences of opinion within our own membership on these issues. There is a need for an independent body, such as the proposed national workforce improvement agency, to carefully consider the pros and cons of the issues and evidence and then make a definitive decision. Such a decision should also be applied across all disciplines.

Aboriginal health

The issues we have been discussing up to now will greatly assist us to recruit and retain the necessary workforce in Aboriginal health, even though in your position paper these issues are rightly discussed in the broader context of funding and rural and remote health. AMSANT believes that the proposed new national structures are also of critical importance to Aboriginal health but it is imperative that the interests of Aboriginal

community controlled health services are adequately represented in the governance arrangements for these new bodies.
There are, however, other issues that need to be addressed beyond what has been outlined in your position paper. Rather than outline them all again AMSANT commends to the Commission "the National Aboriginal and Torres Strait Islander Workforce Strategic Framework". This Framework has been endorsed by AHMAC and we believe that the Commission should specifically make reference to this including the need for it to be fully implemented.

We hope that these additional comments are of assistance to the Commission. We believe that your final report is going to be very important and should make a significant contribution to our workforce needs. Please contact us if you would like further information or clarification on any points that we have made.

Yours sincerely,

Pat Anderson
Executive Officer

Attachments

1. "Aboriginal Community Controlled Comprehensive Primary Health Care : better access, better service provision and greater health gain per dollar?" paper delivered by the Central Australian Aboriginal Congress to the Australian Primary Health Care Research Institute Workshop, Melbourne, October 2005**.**

2. Rosewarne, C., Boffa, J. & Anderson P. 2005 'Universalising the Universal Health Scheme: Lessons from the Aboriginal Health Financing Reform Campaign'. Health Issues, Journal of the Health Issues Centre, Issue 82, Autumn 2005. This paper expands on the paper presented by Pat Anderson CEO AMSANT to the Australian Health Care Summit 2003 Canberra. 'Policy initiatives that really improve the health system for Indigenous Australians: The Northern Territory experience and the Primary Health Care Access Program (PHCAP'. at http://www.amsant.com.au/amsant/documents/Aus_Health_Summit_03_Pat_%20Anderson.doc.

3. Aboriginal Medical Service Alliance N.T. (2003). Bulk billing and Aboriginal health: a submission to the Senate Inquiry into Medicare. Retrieved June 3, 2004, from http://www.amsant.com.au/amsant/documents/senatemedicare.doc & http//www.aph.gov.au/senate/committee/medicare_ctte/fairer_medicare/submissions/sub157a.doc.

4. Rosewarne, C, and Boffa, J. 2004, 'An analysis of the Primary Health Care Access Program in the Northern Territory: A major Aboriginal health policy reform', *Australian Journal of Primary Health*, 10 (3): 89—100.

5. Boffa, J. Is there a doctor in the house? *Aust. & NZ J of Pub Health*, Vol. 26, no. 4, 2002: 301-304.

6. Central Australian Aboriginal Congress. *Overseas Trained Doctors at Central Australian Aboriginal Congress Position Paper February 2004*, CAAC, Alice Springs, retrieved from http://www.caac.org.au

7. AMSANT Internal Memorandum on GP and IMG training in the NT, November 2005.