AUSTRALIA RURAL HEALTH EDUCATION NETWORK
SUBMISSION TO THE
PRODUCTIVITY COMMISSION
STUDY INTO THE HEALTH WORKFORCE

November 11th 2005

The Australian Rural Health Education Network [ARHEN] is the national secretariat for the 10 University Departments of Rural Health and the Monash School of Rural Health. ARHEN provides the following comments for the Productivity Commission's Study into the health workforce.

ARHEN welcomes recognition of the shortage and mal-distribution of the health workforce. Coupled with the baseline shortage, the current health workforce is strained to near capacity limit. Poor retention and recruitment rates in rural and remote areas place further burden on both the workforce and the community in which they live and work.

The health of rural Australia has long been recognised as not enjoying the same level of health and well being as urban Australia. Similarly, our Indigenous people endure a standard of health and wellbeing significantly lower than non Indigenous Australians.

ARHEN calls upon the Productivity Commission, through this review process, to identify and recommend enhancements to existing programs and where necessary new programs and activities that will result in improved access to a well trained and prepared health workforce for rural Australia.

ARHEN believes that the disparity between health science undergraduate scholarships, supports and placement programs is becoming increasing untenable in our current workforce shortage. Models of care are increasingly moving to care being delivered and managed by an inter-professional team. However, the continued non productive talk between commonwealth and state health departments on who is responsible for nursing and allied health students and workforce allows for an environment that disadvantages the training and recruitment of these much needed nursing and allied health professionals.

It is well recognised that having a rural background and/or a rural placement experience during training are strong predictors of health students and graduates joining the rural health workforce. While the Commonwealth is to be commended on many of its rural health initiatives, it is critical that the core programs for rural and remote health science education and research [UDRH, RCS and regional universities] receive further investment to enable increased education and training in a non metro environment.

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ARHEN welcomes the notion of improving workforce arrangements in context of broader health policy reform, including to the funding of health care in Australia. It needs to be pointed out that although accountability, public protection and management of financial risks have been identified as important issues at the start of the PCWS, very little is offered in relation to these points to those who seek to address the health workforce issues.

While ARHEN supports the National Health Workforce Strategic Framework, our experience highlights the uncoordinated and at times 'problem passing' nature of the current health system arrangements. For example, the NHWSF calls for action in Oral Health as a priority – however limited action has been undertaken at Commonwealth or State level. ARHEN has sought funding for Dental Academics to be employed by each UDRH to support local dentists, train dental undergraduates and better inform other health care providers on oral health. This was direct workforce proposal to meet a very real and serious health care need - however this was not supported by the Commonwealth Dept of Health and Ageing.

The Productivity Commission has set the challenge 'to identify the combination of reforms that best progress greater efficiency and effectiveness in the training, distribution, and regulation of the health workforce, while preserving accountability, public protection and management of financial risks' [Victorian Government Dept of Human Service, 2005. p1]. This is a daunting task that needs a coordinated approach, transparency about agendas of all the stakeholders, and good knowledge on what is taking place in other states in Australia and overseas.

Although the submission proposes a new approach, it is difficult to identify the elements that make it so unique. It is a pity that the Productivity Commission in its workforce report has largely ignored the existence of the federally funded workforce initiative that resulted in the formation of University Departments Of Rural Health [UDRH]. These UDRH are coordinated through ARHEN and have started to address rural workforce issues and community capacity building. A comparable rural initiative exists in the USA since 1972 (Weiner, Rickets III, Fraher, Hanny, & Coccodrilli, 2005).

ARHEN believes that workforce shortages will continue unless immediate and broad training initiatives are in place that address health workforce training and preparation. While freedom of movement will result in skilled overseas trained workers [OTW] being part of the health workforce – ARHEN does not support recruitment of OTW at the expense of investment in local training and recruitment. As you have stated: *at a minimum, Australia should aim to produce sufficient numbers of health workers to meet future care needs, without unsustainable reliance on overseas trained professionals.*

While health workforce training is complex and involves multiple tiers of government, universities, VET sector, professional colleges and associations. Training improvements are needed now to provide a balance to the ever decreasing health workforce. Changes required include increased places for tertiary training places; improved and simpler articulation opportunities and processes between tertiary and VET sector; increased rural experience during training; increased training in rural areas and rural health to be included in all health workforce training. We also believe there is a

significant amount of work still to be done in addressing the disparity between demand and the number of available training places.

ARHEN supports the further recognition and development of Aboriginal Health Workers [AHW]. AHW training is predominately in the VET sector with limited and uncoordinated articulation into the tertiary sector. To enhance better career options for Indigenous people and to increase Indigenous participation in the health workforce, the issue of articulation needs urgent attention. ARHEN/UDRH are positioned to undertake activity to progress this issue.

ARHEN recognises the need for greater flexibility in course development and development of 'courses' to meet the needs of an ever changing health system. It is recognised that not all disciplines will be available in all rural and remote locations. With the development of alternative health workforce positions/entities – a better distribution and use of health workforce will be attainable. ARHEN and UDRH are positioned to progress research and training to extend and/or broaden the competencies of qualified health workers already living in rural and remote areas.

The UDRH are also positioned to expand opportunities for inter-professional education and training of a 'new-look' health workforce and for building effective inter-professional teams. There is now a substantial base of research evidence that shows improvements in interprofessional practice in a wide range of health care contexts can lead to significant improvements health outcomes.

In recent years, other developed countries such as the US, UK and Canada have recognised the importance of developing interprofessional education (IPE) programs and improving interprofessional practice (IPP). Recognition of the need for better collaboration and communication amongst health professionals and systems has taken an integrated and pervasive approach in the form of mandated education and training policy initiatives and very substantial long-term government funding commitments to facilitate associated program and curriculum redevelopment.

We welcome this recognition of the need for interprofessional teaching and learning but are concerned that there is little in the Paper to guide positive change to address these needs. To this end we recommend that Draft Proposal 5.2 be amended to read as follows:

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provided independent and transparent assessments of:

- *Current and developing interprofessional education programs both in Australia and overseas;*
- *Opportunities to improve health workforce education and training to include interprofessional or multidisciplinary approaches (including for vocational and clinical training); and*
- *The means by which such changes may be introduced into current courses and curricula, and the implications for accreditation requirements and the like.*

There are a number of very promising pilot and other interprofessional projects taking place in this country. However, they are taking place in the context of a policy vacuum and are thus destined to

be of limited impact and sustainability. We rural health professional academics, who are in many cases responsible for the development of IPE initiatives, believe that the Productivity Commission's view is overly optimistic about the current status of IPE and IPP in this country. While the importance of interprofessional learning and practice is slowly becoming evident at some levels, mostly within the areas of applied health care education, training and practice, it appears that the greatest barrier is a lack of institutional support and commensurate strategic planing. The future development of effective IPE and IPP will require fundamental policy change and funding support. It is essential to call this urgent need to the attention of health authorities and education providers at the highest administrative echelons.
Discussion with Scotland and England highlight the fact that a system based on single disciplinary practice creates barriers to information flows that not only can compromise patient care, but are also very wasteful in terms of resources as the same information is collected and recorded over and over again.

ARHEN would support the establishment of a national council to provide for more systematic and integrated consideration of opportunities to better align training and course / workforce design. UDRH membership and recognition of an inter-professional workforce would be a valuable asset to such a council.

ARHEN supports better evaluation of workforce programs and supports the Commissions proposition to initiate a series of cross program evaluations to ascertain what is likely to be most cost-effective in improving the accessibility, quality and sustainability of health workforce in rural and remote Australia. The established regional and remote academic infrastructure for training and research – UDRH- are well placed to provide research and evaluation into health workforce training and service model development.

UDRH have already undertaken research into issues relating to recruitment and retention of the rural health workforce. This work has shown that targeting professionals during stages of their careers when they are more likely to be willing to work in rural or remote areas is successful, and that the provision of more regionally-based training opportunities also increases recruitment and retention in rural and remote areas.

The last decennia has seen a steady growth of Australia's rural population. Almost 50% live now outside the five biggest cities, and some rural towns are predicted to grow by 30-40% over the next 25 years (O'Leary, 2004). The downside is that there is a recognised inequity in health compounded by poor access to health services in rural areas compared with metropolitan areas. For example, risk factor studies in the Greater Green Triangle region showed that the levels of cardiovascular disease risk factors are very high. In addressing these inequities, new models of care need to be developed, however, the Productivity Commission's Workforce Study (PCWS) failed to recognise important issues that are likely to impact on the viability of these models. Issues that have been ignored include:

- → The federal initiative that lead to the establishment of UDRH;
- → Workforce and health service activities initiated by the UDRH;

- → Problems UDRHs face due to costs and attracting students. The inequity of funding limits their full potential, and additional state funding will assist in addressing rural workforce and health inequities. There are anomalies in fund allocation for the provision of accommodation for students of the different disciplines who are on rural placement. This makes it more difficult to place, for example, physiotherapy students in rural areas then students that have chosen podiatry or medicine;
- → Rural workforce needs and demographic trends are more pressing than noted in the PCWS; Conservatism of some organisations that deliver health services;
- → Self-centred interests of some of the representatives of disciplines that make up the health workforce and their professional organisations;
- → Issues of tension, accountability, delegation and competence in cases where new models of care (e.g., use of multi-skilled assistant practitioners or interprofessional collaboration) were piloted (Mackey & Nancarrow, 2005; Rushmer, 2005; Rushmer & Pallis, 2003; Wakefield, 2000);
- → Progress made by states such as South Australia and Western Australia in the recruitment of overseas trained professionals, recognition of some of their qualifications, and the provision of training or supervision where needed; and
- → Lack of funding for developing and testing new models of care.

Comment on PC Draft proposals

- Draft proposal 3.1: supported
- Draft proposal 3.2: supported
- Draft proposal 4.1: supported – UDRH membership
- Draft proposal 5.1: not supported
- Draft proposal 5.2: supported – amended as above – recognition of Inter-professional training and UDRH membership
- Draft proposal 5.3: supported in part – increased funding for training recognisant of need for costs relevant to true cost for regional and remote training
- Draft proposal 6.1:
- Draft proposal 6.2: support a national approach to the assessment of overseas trained health professionals
- Draft proposal 7.1: supported
- Draft proposal 7.2: supported
- Draft proposal 7.3: supported
- Draft proposal 8.1: supported
- Draft proposal 8.2: supported – recognition of AHW and RAN
- Draft proposal 9.1: Supported – UDRH membership
- Draft proposal 9.2: supported
- Draft proposal 10.1: highly supported
- DRAFT PROPOSAL 10.2: supported
- DRAFT PROPOSAL 10.3 : supported – recognition of UDRH
- Draft proposal 11.1: supported

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