NATIONAL RURAL HEALTH ALLIANCE INC.

Supplementary Submission

in response to the Productivity Commission Position Paper,

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

November 2005

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This Submission is based on the views of the National Rural Health Alliance, but may not reflect the full or particular views of all of its Member Bodies.

Health care reform and the health workforce

Discussions about the need for major reform of Australia's health system have been increasing in intensity for some time. While all acknowledge the very high quality of the existing system, it is facing unprecedented and accumulating stresses that require urgent action to position it to retain its quality and ability to serve the Australian population into the future. It is particularly significant that the Council of Australian Governments (COAG) has taken up this issue, that the Treasurer referred the important issue of the health workforce to the Productivity Commission, and that these two pieces of work are now synchronised.

The Alliance was pleased to be involved in the Commission's recent roundtable on Productive Federalism which signifies the institution's growing commitment to micro-economic reforms in the health care sector as a potential source of economic and social improvement. The Commission's more detailed work on the health workforce is clearly a major component of this broader task. As the Position Paper says (p xviii):

> *Many of the changes required to improve health workforce arrangements could only occur as part of broader health policy reform, including to the funding of health care in Australia.*

The Alliance supports the wider moves to reform Australia's health care system, in the belief that such reform has the capacity to benefit health consumers in rural and remote areas. It is even possible that health care reform could be of greater relative benefit to people in non-metropolitan areas because some of the current deficiencies (eg poor continuity of care; the logistical, financial and health outcome costs of intergovernmental uncertainties), as well as the developing stresses (population ageing, increasing chronic disease burden) arguably have a greater impact on patients and their families in those areas than in the major cities.

The Alliance will continue to support the current moves to health reform while ever it appears likely that the reform will not jeopardise a set of 'non-negotiable' principles. These include that reform must lead to:

- improvement in the equity of access to services and the distribution of health professionals in rural and remote areas so as to help secure improved health outcomes;
- improvement or at least no reduction in patient safety and in the quality of services in rural and remote areas; and
- that the benefits of reform, including any potential cost savings made, must be reinvested in health with a fair proportion (at least 30 per cent) going to rural and remote health.

The prospect that productivity changes could lead to savings in current health expenditure leads to the potentially valuable option of re-directing more of the current spending to health promotion and early intervention, including to programs of those sorts to meet the special requirements of people in rural and remote areas.

It is the Alliance's hope and expectation that the current health reform work being led by the Commission and COAG is about effectiveness and sustaining the future of our health system, not an exercise to reduce costs in the sector in the short-term.

General comment

The Council of the National Rural Health Alliance has just held its annual face-to-face meeting (28 October-2 November), which provided the opportunity for it to consider some of the issues raised in the Productivity Commission's Position Paper. On behalf of the 24 national organisations that are Member Bodies, Council therefore wishes the Commission to take the following matters into consideration as it prepares its final report.

Rural proposals
The NRHA generally supports the Paper's recommendations relating to the health workforce in rural and remote areas, and including its consideration of Indigenous health issues (draft proposals 10.1, 10.2, 10.3 and 11.1). It is critical to keep in mind that urban models of service delivery and workforce competencies and structures are very rarely appropriate for rural and remote health systems. So the NRHA would wish any reforms consequent upon the Commission's work to be very explicit about giving separate consideration to what is appropriate for rural and remote areas, and for Indigenous communities.

In relation to draft proposal 10.2, the NRHA is pleased to see the comment on p 175 that workforce innovations in rural and remote areas should be evaluated for their possible applicability across the general health workforce. Rural workforce innovation is partly driven by factors that increasingly characterise the health workforce as a whole – scarcity of trained personnel and of funds, and a requirement for flexible response to varied local situations – and this sense might usefully be included in proposal 10.2 or 10.3.

In relation to draft proposal 10.2, second dot point, the NRHA would like the Commission to consider amending the wording to read 'consider necessary health care competencies and major job redesign opportunities specific to rural and remote areas'. The NRHA is developing an approach which emphasises the need to have a defined set of primary care core competencies incorporated into training for all primary care health workers. In the case of interventions such as for accidents that will occur in remote areas, the competencies would be designed to enable each level of worker to assess a patient, stabilise him or her, and refer up to the next level of competence indicated for the condition. Such competencies would also enhance the flexibility of workers, for example by training paramedics to extend their skills to health promotion.

It is not clear why evaluation has been particularly stressed in relation to rural workforce issues. The NRHA argued in its first submission for a more general assessment of the range of innovation that has been trialled in the last decade or so (in relation to workforce developments and models of service delivery), to see how the health system as a whole could be improved. The general failure to share knowledge, experience and learning across jurisdictional boundaries needs to be addressed, and not just for rural programs (although it is true that they are of the greatest parochial interest to the Alliance!).

In relation to draft proposal 10.3, the NRHA would like to see a wider selection of incentives examined for relative efficacy. This should reflect the Paper's discussion on pp 177-80. A most important possibility is that of providing a greater number of salaried positions in rural and remote areas, which can be directly compared to the suggested incentives of enhanced MBS rebates or practice grants. Given the increase in female part-time GPs in rural areas, for example, the practice-as-business model may be increasingly less suitable. A variation is the provision of part-time salaried positions with permission to engage in some private practice. The role of communities and local government in providing things like infrastructure support to health professionals to reduce business risk and anxiety about 'lock in', and provide enhanced amenities for such professionals, is another important incentive that addresses other quite critical health worker concerns affecting attraction and retention that are broader than that of pure remuneration.

The NRHA supports draft proposal 10.3's suggested assessment of the longer-term effectiveness of regionally based education and training. If, as we anticipate, the assessment results are favourable, the NRHA would like to see further investment in educating health workers in rural and remote settings. Consistency in rural undergraduate scholarship and placement programs across all disciplines would be highly desirable, given the developing importance of multidisciplinary teams in rural and remote health delivery.

General proposals
In terms of the Paper's overall proposals, the NRHA has the following comments.

- The NRHA agrees with others (eg the AMA release of 29 September) that the Paper has paid insufficient attention to the very real difficulties inherent in the Commonwealth/State relationship on health system responsibilities and funding.

    - It would be open to the Commission to make a finding that it or another body needs concurrently to consider all key aspects of health policy reform, including funding[1]. It is arguable that the kind of workforce reforms and productivity gains the Commission is suggesting will be difficult to realise without wider reform, as the Commission itself suggested on p xviii, quoted above.
    - At its recent meeting the NRHA Council reasserted the urgent necessity of improving dental and oral care services in rural and remote areas. One factor needing to be addressed is that the number of dentists being educated (a federal issue) has been in decline since the 1940s. However, the situation is arguably worse because of Commonwealth/State disagreement over responsibility and funding for dentists.

- The NRHA welcomes the focus on workplace innovation and job redesign, and the systemic impediments to GPs' delegation of routine tasks to appropriately qualified, but more cost-effective, health professionals.
    - It will be important for national bodies such as the proposed advisory health workforce improvement agency and the accreditation agency to respond quickly where the benefits of change to enhance flexibility and efficiency can be demonstrated.
    - For rural and remote conditions, and particularly where the Indigenous population is preponderant and needs culturally appropriate services, a range of job redesign

[1] We recognise the current work of the House of Representatives Committee on this.

possibilities would need to be provided (rather than one recommended model) since conditions in rural and remote communities can vary so widely.
- The NRHA agrees that changes to the MBS and to some aspects of registration are likely to encourage delegation.

- Despite some reservations (as above), the NRHA believes that there is considerable merit in approaching workforce requirements, education and training accreditation and professional registration nationally. Such a streamlining would assist the quick implementation of, for example, education and training changes that would need to follow from job redesign or workplace innovation changes.

- The NRHA would like to see some clearer discussion of arguments about whether the creation of other health worker positions (eg p171) and delegation of more routine procedures to them constitutes 'a lower level of quality' of service. The rural community rightly wishes to receive the same high quality of health care as other Australians. The trialling of new health worker positions largely in rural areas is sometimes seen by rural Australians as expecting them to settle for less. The Commission could perhaps expand the discussion on p169 to clarify these issues.

- The Paper pays relatively little attention to the need to integrate community (particularly consumer) views in the policy discussions and new processes it envisages, although it does specify that the proposed national health workforce improvement agency should have consumer representatives. The NRHA Council believes strongly that such community/consumer representation is critical to processes such as changing workforce balance, and health worker skills and competencies requirements. There can also be a community role in policy setting about rationing of service provision (eg across specialisms, between prevention and treatment etc), which would affect most of the workforce issues discussed in the Paper. Community participation in health service planning and management at the local level would build the knowledge and skills base for providing advice at higher levels of government, as well as improving aspects of local health service delivery.

- The Paper has not taken up the recommendation in the NRHA's original submission on encouraging 'managed self-care' by health consumers, with its benefits for more effective use of the health workforce, and more economic and social participation by the individuals whose health is improved, particularly where chronic disease is concerned. Given the greater costs of health servicing in rural and remote areas, particularly for acute and chronic conditions, the NRHA Council emphasized at its recent meeting that considerable productivity gains and health system savings could flow from an emphasis on prevention.

- On the arguments supplied, the NRHA is cautious about the proposal to move to a block funding model (pp 180-183). The concept of governments having to 'be explicit about minimum levels of access and service quality that must be met in rural and remote areas, and to provide funding commensurate with achieving those care levels' (p 181) could have merit, providing community consultation is honestly involved in the specification process. Reservations about the model as described include the complexity of the number and type of service providers that would be involved, and the ability of most of the types of organisations

suggested to manage such diversity, including quality, safety and indemnity issues; whether the true, higher cost of service delivery in rural and remote locations as compared to metropolitan can be clearly enough calculated so that contracts could safely be determined by 'the lowest level of subsidy' (p180); and whether the level of cost savings would be significant (has the extent of overlap and duplication in rural areas been accurately mapped so that likely savings could be estimated?).

- The NRHA is gratified to see the Paper's reference to regional development as the most cost-effective and sensible long-term solution to health and other rural and remote workforce challenges.

NRHA
11 November 2005