General Practice and Primary Health Care Northern Territory (GPPHCNT)

Response to the Productivity Commission Position Paper: Australia's Health Workforce

General Practice and Primary Health Care Northern Territory (GPPHCNT) is the peak body for the Territory's general practice and primary health care sector, and provides recruitment and support services for rural and remote GPs, support for GP Divisional programs, and policy and advocacy on primary health care issues.

GPPHCNT is closely involved in GP workforce issues in the NT, and in issues relating to multidisciplinary primary health care teams, so wishes to comment on the position paper with particular reference to remote and Indigenous health workforce issues.

General comments

An adequate, well skilled and supported, and sustainable general practice and primary health care workforce is critical to the health of Australians. This workforce must be trained and skilled to deliver patient centred care which is evidence-based, and which utilises advances in information management/information technology to support high quality service delivery.

GPPHCNT supports the Productivity Commission's general approach around improving incentives and creating more effective processes and frameworks within which specific workforce initiatives can be developed and implemented. GPPHCNT is also strongly supportive of multidisciplinary primary health care team approaches, and therefore supports suggestions in the Commission's report which adopt such an approach, such as creation of stronger incentives within the MBS for the delegation of tasks (eg to nurse practitioners, practice nurses and Aboriginal Health Workers). We also support the recommendations relating to the provision of regionally-based education and training opportunities in rural and remote areas; and the exploration of 'block-funding' models to support desired levels of services in particular communities or regions.

GPPHCNT also 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, with several provisos as outlined below. A single national multidisciplinary accreditation agency for university based education and training and post graduate training has the potential to enhance the multidisciplinary nature of primary health care service delivery, and to achieve consistency in health professional registration processes. 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.

However, it needs to be taken into account that health workforce issues differ markedly across and within Australian jurisdictions. While many health workforce issues would benefit from greater national co-ordination and consistency, there is no "one size fits all" approach. The primary health care workforce recruitment and retention issues, and their determinants, faced by remote Aboriginal communities in the NT (and in similar demographic areas such as northern WA, northern SA, and northern Queensland), are very different from the issues experienced in urban, outer metropolitan, and even rural communities elsewhere. Tailored approaches are needed for particular situations; therefore we advocate a system which enshrines regional flexibility within a nationally consistent framework.

Despite some relevant and interesting proposals put forward by the Commissioners with regard to the general domain of health workforce, the sections on rural/remote practice, Indigenous health workforce, and special needs groups need to be strengthened. The claim that the general proposals of themselves (an advisory health workforce improvement agency, an independent council to assess health workforce education and training models, integrated workforce reform via uniform registration standards, complementary reform of registration arrangements, and improved funding-related incentives through Medicare) will improve the rural and remote and Indigenous health workforce issues is probably partially true, but far stronger proposals are required to bring about genuine progress in these areas.

Rural and Remote Health Workforce issues

In relation to rural and remote health, it will be important that the proposed Workforce Improvement Agency has a clear brief to specifically address rural and remote workforce issues. There should be a specific section within the new Agency to focus on rural and remote, as there should also be on Indigenous health workforce. There should be no possibility that these areas are dealt with as after-thoughts or are tacked on to other programs and strategies. They need to be dealt with specifically and directly, albeit within a coordinated framework looking at the entire health workforce picture.

The claim on p. LVI that the range of health services that can be viably offered within in smaller rural and remote communities is essentially limited is highly contestable. While it is difficult to recruit people to tough, isolated positions with few colleagues in the field and limited supports, it is far easier to attract and retain the wide range of health care professionals necessary in rural, remote and Indigenous health practice where there is a functional, adequately resourced and supported primary health care team in place.

A new Workforce Improvement Agency must focus on investigating and evaluating models of health care delivery in rural/remote communities, establishing what works best for client outcomes, benchmarking the range and depth of health workforce requirements to meet needs, and then working to achieve the appropriate funding mechanisms to ensure that the public and private sectors can deliver the appropriate workforce range and levels to meet community needs and produce effective health outcomes. A special time-limited section of this Agency should be set up to evaluate the appropriate models of service delivery that would underpin the workforce benchmarks. An agreed model(s) of service is required to work out which health care providers are required and in what numbers to deliver appropriate health care to a given population with an established morbidity profile.

States and Territories will need to fund and provide adequate services and workforce, and Medicare will require reform to ensure communities are provided with the range of services required (as supported by evidence base) to produce health outcomes.

Indigenous Health Workforce

The suggestions in this section of the paper are reasonable as far as they go; that is: widening of scope of practice for some professions, increased training opportunities for Indigenous students in health care roles, improved remuneration in the field. However, far stronger and more specific recommendations are required from the Productivity Commission in order to bring about serious change and definitive improvements to health outcomes through workforce initiatives. Again service delivery modelling and workforce benchmarking are critical. It is necessary to determine the morbidity profile of the community, the agreed model of health service delivery, and the workforce required to deliver the services that will meet community need and produce positive health outcomes. The proposed Workforce Improvement Agency should be tasked with answering these questions and setting the necessary parameters and guidelines that need to be met by those with responsibility for health service funding and delivery.

Here it is critical that the Productivity Commission acknowledges the National Framework for Aboriginal and Torres Strait Islander Health (1994), its key principles and recommendations. The Primary Health Care Access Program (PHCAP) must also be noted in terms of its role in developing Aboriginal primary health care services over the last 5 years and its effect on Aboriginal health workforce levels and range. PHCAP funding from the Commonwealth has slowed down in the past 12 months, but the program remains the most logical means of expanding the Aboriginal health workforce via funds pooling between the Commonwealth and the States within a community controlled health framework.

GPPHCNT agrees with your assessment that funding mechanisms are “a pervasive influence on the health workforce”. The Fee For Service, private practice model under the MBS has failed to deliver equitable access to general practice services and quality care for Aboriginal people throughout Australia (and for other disadvantaged groups) and there is a need for alternative models. In Aboriginal health, these models are based on salaried health professionals working as part of multidisciplinary teams in organisations that are large enough to deliver consistent access and quality care.

GPs in remote Aboriginal primary health care teams

GPPHCNT has explored and documented the factors that enable successful recruitment and retention of GPs to remote Aboriginal primary health care, and summarises these below for the attention of the Commission. These issues could be addressed by the proposed Workforce Improvement Agency.

Aboriginal people need to be able to access qualified GPs who are resident in the community, and who work within multidisciplinary teams with clearly delineated roles for all practitioners. The role required of the GP is diverse, encompassing individual clinical care, and other activities, including education, administration, and public health activities and programs. Salary packages and terms and conditions of employment should be more attractive than those offered in capital cities, and should not create any impediment to recruitment and retention of GPs. Strategic and

collaborative approaches to setting remuneration levels across the medical profession, based on realistic assessments of political issues, work values, practitioners' views and circumstances, and equity and health outcomes data, are warranted.

A comprehensive range of support services is required. Key requirements are a single employer for each primary health care team, with expertise in health service delivery; the primary health care team must be well supported with management, financial, human resource, IM/IT, and public health support; there should be support from a senior medical officer; and there should be clear delineation of roles and responsibilities within the PHC team, and established practice standards for each team member.

The clinic infrastructure and equipment must be adequate; adequate housing must be made available; and effective locum support is required.

The preparation of GPs to work in Aboriginal health, particularly in remote areas, needs to begin during their early education and training, and continue through post-graduate training, into specific preparation programs prior to the commencement of work. Effective orientation and induction programs for all GPs and other members of the PHC team are required. GPs need access to quality Continuing Professional Development and other educational opportunities to support them to remain on the vocational register.

Effective family support programs are needed, along with support for GP well-being. The health service in which the GP is employed needs to provide an educational and learning environment. All GPs need to be supported by, and have ready access to consultation with a network of secondary and tertiary care specialists.

A number of government initiatives over recent years have made a considerable contribution to supporting recruitment and retention of GPs in Aboriginal health in remote settings. However, more still needs to be done, in particular:

- The government must, as a priority, address the need to reduce the gap between GP incomes and the incomes of other specialists. In addition, there needs to be increased support for specific financial incentives for GPs to work in rural and remote areas.
- Improved funding for Aboriginal primary health care services is needed, to enable them to offer more competitive conditions for GPs.
- Further reforms are needed in the way Australia deals with OTDs, as outlined in our previous correspondence to the Commission.
- Non financial incentives, such as preferential access to education and training, are needed to attract Australian GPs into areas of need.
- Initiatives to address GP recruitment and retention need to be complemented by initiatives to promote and support the Aboriginal health worker, nursing, and allied health professions.

Special Needs Areas (eg mental health, disability, aged care)

Although a focus on each of these areas may be beyond the scope of the Productivity Commission in this work, an attempt at least needs to be made to elaborate mechanisms for addressing workforce needs in these areas. For example, in the area of aged care there needs to be a focus on needs based planning to determine the required workforce to meet a particular community's needs (or the communities needs). The major requirement is that the services and associated

workforce have a clear evidence base regarding what the services can be expected to achieve in terms of health outcomes. Unfortunately the current funding mechanisms are based on service demand rather than service need, and this results in service inequity and limited access for less empowered sections of the Australian community. The Productivity Commission should address this issue of service planning based on 'demand' as opposed to 'need', and the associated effects on workforce provision – otherwise we will perpetuate the focus of services on the 'worried well' rather than more genuine need where service inputs could produce stronger cost and social benefits.

Nurse practitioner issues

GPPHCNT is highly supportive of the role of nurse practitioners in the context of the multidisciplinary primary health care team. The NT has considerable positive experience of working with highly skilled and experienced nurses. Many of these, predominantly in a remote setting, are able to prescribe/order/refer under established guidelines such as the CARPA manual and within a framework that sees the GP/District medical officer ultimately responsible for patient care.

GPPHCNT strongly believes that the nurse practitioner profession should be conceived and developed as an integral part of the workforce in all areas, not only in areas of workforce shortage. In particular, nurse practitioners should not be seen as an acceptable substitute for GPs, especially in rural and remote areas; but rather the role should be developed as a key part of the multidisciplinary primary health care team, in all areas.

GPPHCNT also believes that the profession of nurse practitioner needs to be clearly defined, and that nurse practitioners must be adequately trained and qualified for extended practice, accredited, registered, and supported with comprehensive guidelines and protocols to ensure that safety and quality in the health care system is maintained. There needs to be clear delineation between GPs and nurse practitioners. As part of this process, issues relating to clinical governance, prescribing, referrals, and pathology need to be carefully worked through.
The potential impact of the development of the nurse practitioner role on other professions, including GPs and Aboriginal Health Workers, must also be considered,

We believe that each State/Territory is tackling this issue and each is taking a different approach, and support the need a consistent approach across States and Territories. The proposed Workforce Improvement Agency should examine these issues and develop a way forward.

Unfortunately, in spite of the important work that they do, Remote Area Nurses still have poorly defined legal and professional status. Remote Area Nurses should be recognised 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. 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.