AUSTRALIAN RURAL & REMOTE WORKFORCE AGENCIES GROUP

# Australian Rural and Remote Workforce Agencies Groups Response to the Productivity Commission Position Paper: Australia's Health Workforce*

## General Comments

ARRWAG welcomes the opportunity to provide further input into the work of the Productivity Commission in exploring new and better ways to deal with the health workforce challenges currently affecting the Australian community.

ARRWAG is broadly supportive of the proposals put forward in the position paper and considers the work of the commission a 'step in the right direction'. ARRWAG is supportive of some of the general directions, namely:

- Recognition of the vital importance of working to improve the supply of an adequate and appropriate health workforce.
- Acknowledgement of the additional complexity of providing healthcare in rural and remote communities.
- A more national approach to accreditation of the health workforce.
- Reducing the number of agencies involved in accreditation, training and workforce projections.
- More careful definition and agreement of roles within the healthcare workforce.

ARRWAG and its members welcome the wide-reaching discussion of issues relating to rural and remote communities, but would take a more optimistic view than is offered in the position paper where it is suggested that "in the face of such loss of critical mass in these smaller communities, the range of service that can be viably delivered on site will necessarily shrink. The implications for this study is that there are limits on the degree of improvement possible." (Page LVI).

While the challenges and limitations need to be acknowledged, these statements suggest a degree of inevitability that is not conducive to seeking real improvements.

With advancing technology and current levels of prosperity in Australia, a more ambitious and optimistic approach should be encouraged. It should also be recognised that any improvements to health services will support the development of rural and remote communities. A professional health workforce may also encourage other professionals to remain or consider living in rural or remote communities.

Finally, ARRWAG wishes to point out that the position paper does not sufficiently recognise the impact of the large numbers of Overseas Trained Doctors (OTDs) who serve rural and remote communities around Australia. While it does recognise the high proportion of OTDs, it fails to suggest how to make a more efficient and effective use of this workforce or how better support can be provided.

It is currently recognised that OTDs represent between 30-40% of the medical workforce in rural and remote communities. However, what is less well recognised is that almost all the doctors recruited to RRMA 4-7 areas in the last five years have been trained overseas. This means that as the doctors who have remained in communities for decades retire, the proportion of OTDs will become more and more pronounced unless there is a significant increase in the numbers of Australian trained doctors choosing to work in rural and remote Australia.

OTDs work in some of the most demanding environments and generally do so with minimal support from the Australian taxpayer. While Australian graduates have benefited from subsidised medical training and a range of initiatives designed to attract doctors to rural and remote areas, OTDs have often entered these communities with very limited support or induction programs.

Considering the minimal cost to the Australian community in training and developing these professionals in the past, a relatively small additional investment in training and support would ensure better and more appropriate use of this available workforce.

# Comments on rural and remote workforce issues

The following section provides more specific comments on the draft proposals or discussion points in the Position Paper but is limited to those which are most relevant to the rural and remote medical workforce:

### Meeting the needs of rural and remote areas (Draft Proposals 10.1 and 10.2)

ARRWAG supports the inclusion of provisions that consider the unique requirements of the rural and remote health workforce in all broad institutional health workforce frameworks. Such arrangements acknowledge the fact that rural and remote Australia has unique needs.

However, it is imperative that planning for workforce requirements occurs in the context of a defined 'need' in rural and remote communities. Historically, service planning is based on 'demand' rather than 'need' and this has led to inequity and limited access for the more disadvantaged and less empowered segments of the community. The health disparities between rural and remote communities compared with city and urban communities has been well documented and decisions about workforce planning in these areas should be based on such information.

It is also important that mechanisms are put in to place to ensure that the "provision to consider the particular workforce requirements of rural and remote areas" results in better outcomes. Unless there are mechanisms and incentives, there is a danger that these provisions become a 'tick-the-box' exercise and fail to achieve real outcomes.

Should the new Health Workforce Improvement Agency become the preferred mechanism, it must have a role in investigating and evaluating models of health care delivery in rural and remote communities. This means determining the best outcomes for the community, benchmarking health workforce requirements to meet needs and morbidity profiles, and then developing the appropriate funding mechanisms. 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. This role would be supported through representation of stakeholder organizations, including ARRWAG, that have experience in addressing these issues.

Finally, models of healthcare delivery need to take into account that specific skills may need to be provided in addition to the standard training programs in order to prepare healthcare professionals for rural and remote communities. Such models also need to recognise the additional complexity of providing adequate training to those already working in rural and remote communities. Service delivery models will only be successful if the required training and supervision can be provided.

**National Health Workforce Improvement Agency (Draft proposal 10.2)**
Draft proposal 10.2 (with reference to 4.1) provides only a broad outline of the role of the National Health Workforce Improvement Agency and therefore the comments provided below are intended to outline operational principles only.

ARRWAG acknowledges there is merit in establishing such an agency, particularly if the agency is successful in:

- Reducing the number of agencies and the complexity of current funding and accreditation arrangements.
- Achieving greater national consistency in standards and accreditation.
- Improving quality of care and achieving greater portability of qualifications across jurisdictional boundaries.
- Linking workforce projections with training and educational opportunities more directly.

However, ARRWAG's support for this proposal is cautious and dependent on the detail of the proposed structure. In particular, ARRWAG has reservations about the ability of the proposed National Agency to:

- Avoid becoming a superstructure that achieves little tangible outcome in improving health outcomes or better management of the health workforce.
- Encourage innovation. The proposed structure follows a 'top down' approach while innovation is generally generated from a 'bottom up' system.
- Deal adequately with lobby groups, union representatives and interest/stakeholder groups.
- Effectively deal with industrial issues.
- Successfully address the needs of rural and remote communities or other special needs groups without creating a whole range of 'sub agencies' – thus resulting in a system much like the one that exists presently.

Finally, the magnitude of change proposed through such an agency requires much more examination and consideration before it can be evaluated successfully. Should the plans for the National Health Workforce Improvement Agency proceed, ARRWAG would encourage the Productivity Commission to provide more detail on the proposed structure and the terms of reference for comment and discussion.

**Job redesign opportunities specific to rural and remote areas (Draft Proposal 10.2)**

The current model, where primary care is overseen by a general practitioner, is the preferred model for ARRWAG and its members. In this model the doctor may take overall responsibility for the care that is provided by a team of health professionals with a range of specific skills and is most likely to result in quality outcomes.

- **Nurse practitioner roles**

ARRWAG is supportive of the role of nurse practitioners in the context of the multidisciplinary primary health care team. 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.

However, 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.

ARRWAG also believes that the profession of nurse practitioner needs to be clearly defined. 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 of roles between GPs and nurse practitioners to ensure that all parties are clear as to who has ultimate responsibility. 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 for a consistent approach across States and Territories. The proposed National Health Workforce Improvement Agency should examine these issues and develop a way forward.

Finally, it needs to be recognised that substituting one health professional for another will not do anything to address the real issues around workforce availability and distribution. The difficulties with attracting sufficient numbers of health professionals to rural and remote communities are not limited to any particular group of health professionals. As a result, changing the roles of any professional group may do little to address the current workforce shortages.

- **Redesign through improved clinical protocols**

ARRWAG strongly supports the development of improved clinical protocols – particularly where these are developed in line with a clear evidence base. However, the inherent dangers of such programs mean that quality may be eroded over time for the following reasons:

  - These protocols could result in a de-facto role substitution resulting from the belief that health care can be reduced to a set of protocols which can be supervised and provided by less qualified professionals. As a result, care may be less holistic and more fragmented.

  - Professionals whose roles have expanded would need to be adequately trained and monitored to ensure that the roles were carried out appropriately. Both training and monitoring or credentialing of the roles will prove expensive. More importantly, once a healthcare professional has been practicing a particular role it will be difficult to withdraw credentialing. Without sufficient monitoring this in turn could result in diminished quality of care and introduce a level of risk the community may not be prepared to accept.

Where a doctor is available to provide supervision, other healthcare professionals will be able to expand their roles and take a broader role in providing care.

**Undergraduate Workforce Planning – ensuring a workforce supply for rural and remote Australia (Draft Proposal 9.2)**

ARRWAG agrees that all workforce planning initiatives should include planning for the rural and remote workforce. However, numerical planning for a rural and remote workforce will not be able to address the problem of recruiting and retaining staff to work in these areas. An increase in health professionals graduating from a particular program may or may not have an impact on the number of those professionals working in the areas where they are needed.

The position paper acknowledges some of these issues but does not go far enough in recognising the difficulties associated with recruiting and retaining professionals in these areas.

ARRWAG believes that an important longer-term approach to addressing this problem is to create incentives for undergraduates to become health professionals in rural and remote communities.

In its recent Federal Budget Submission, ARRWAG outlined a number of recommended scholarship and incentive schemes that should apply to undergraduate medical students. These schemes provide opportunities for students to 'try out' living and working in rural communities, as well as creating incentives for graduates to take up positions in rural areas. Both types of schemes should be an integral part of planning for undergraduate training programs.

In addition, ARRWAG would support further rural incentives and scholarships for nurses and allied health professionals. This would be a means of encouraging all healthcare professionals to work in rural and remote areas and provide the necessary support to GPs. Adequate professional support is an important factor in attracting and retaining GPs to work in rural and remote areas.

**Cost-effective use of resources in rural and remote Australia (Draft proposal 10.3)**

ARRWAG supports a cross program evaluation exercise that assesses the use of financial incentives and coercive approaches to boost workforce supply in rural and remote areas. Assessing which programs are the most effective is an essential part of being able to build on those approaches which do deliver positive outcomes.

However, in addition to an evaluation of past and current programs, a framework of principles to guide decision-making needs to be developed for future programs. For example, cost effectiveness should not be the only factor that determines the success of a program. Many programs seeking to address medical workforce shortages in rural and remote Australia may indeed be cost intensive, but if they are improving the quality and accessibility of health services in rural and remote Australia, they should be evaluated as successful because they provide an important benefit to those communities. In some cases they are even fundamental to ensuring that these communities survive.

As highlighted by the AMA in its submission to the Productivity Commission, "We should be seeking service excellence in all geographic areas. Unit costs are undoubtedly related to the frequency of services provided so lower volume rural practice faces a cost disadvantage. The funding of rural health services needs to reflect this reality. Government should ensure that when services cannot be provided proximally, patient access is not denied for logistic or financial reasons".

Another example might include a statement about the level of commitment to infrastructure and services in rural and remote communities. This could be similar to the community contracts entered into by other organisations that wish to make a firm commitment to a level of service for rural and remote Australia.

- **Regionally based training programs**

ARRWAG believes that regionally based education and training should be provided wherever possible.

However, it may be necessary to differentiate between different types of training. For example, providing quality undergraduate training programs in regional areas may not always possible. In some jurisdictions, such as the Northern Territory or Western Australia, geography would make it difficult to establish university campuses that are accessible to all without diluting the quality of the programs. In other cases, the ability to recruit academic staff and provide adequate infrastructure may place limitations on what can be provided.

On the other hand, up skilling programs and continuing education programs should be delivered without the requirement to take healthcare workers out of their work context for extended periods and so may need to be provided in regional, rural or remote locations.

- **Retention strategies - cost-effective utilisation of the current workforce**

Retention issues pertaining to the current workforce appear to be given very little attention in the Position Paper.

ARRWAG believes that the most cost-effective means of ensuring an adequate workforce supply in rural and remote communities is to work on retaining those health professionals who are already skilled and experienced in working in these contexts. This needs to be taken seriously and funded appropriately.

Retention strategies need flexibility because situations differ between individuals and the communities in which they work. A retention strategy that is successful in one community will often need to be adjusted to reflect local conditions in order for it to be successful in a markedly different community.

Part of the complexity of ensuring better retention rates also stems from the needs of the healthcare professional's spouse and/or family. Family issues will weigh heavily in the decision-making processes of any healthcare professional contemplating work in a particular community. Although physical isolation is one of the most easily recognised problems in this regard, social isolation, lack of educational or professional opportunities and lack of infrastructure may be equally strong determinants in a family's decision to live in a rural or remote community. Although little can be done to directly address some of these factors, the experience of Rural Workforce Agencies and others has shown that doctors and their families will cope with some of these pressures more effectively if they are given the appropriate support.

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