Attachment 1

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRIG)	Australian Psychological Society (Rural and Remote Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

Attachment 2

Inquiry's Terms of Reference

The factors affecting the supply and distribution of health services and medical professionals in rural areas, with particular reference to:

(a) the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres;

(b) the effect of the introduction of Medicare Locals on the provision of medical services in rural areas;

(c) current incentive programs for recruitment and retention of doctors and dentists, particularly in smaller rural communities, including:
  (i) their role, structure and effectiveness,
  (ii) the appropriateness of the delivery model, and
  (iii) whether the application of the current Australian Standard Geographical Classification – Remoteness Areas classification scheme ensures appropriate distribution of funds and delivers intended outcomes; and

(d) any other related matters

Attachment 3

The Health Workforce

Submission to the

Productivity Commission

National Rural Health Alliance

and

College of Medicine and Health Sciences, Australian National University

August 2005

This Submission is based on the views of the National Rural Health Alliance and the College of Medicine and Health Sciences at the ANU, but may not reflect the full or particular views of all of the Member Bodies and individuals in those agencies.

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Recommendations

1. A heavy reliance on the free market system for health professionals results in an under-supply in rural and remote areas that has serious health, social and economic consequences for people in those areas. Governments must continue to be involved in some management of this market.

2. Consideration of the health workforce provides an opportunity for the Productivity Commission to commend greater national focus on 'managed self-care' by health consumers through a range of structured programs. Such work would enable a more flexible and effective use of the available workforce, and have substantial national economic benefits as well as direct health benefits for individuals.

3. The Commission should encourage the health sector to continue to research and debate a number of matters under the general head of 'role re-definition' or changing scopes of practice for health professionals in Australia, in the context of the primacy of safety and quality for the health system.

4. The Australian Government should re-commit to not actively recruiting health professionals from poorer nations; and commit to training more than enough health professionals for its own needs.

5. There needs to be continued attention to the various means by which, as a nation, we can provide support and recognition for international health graduates who choose to work here, as well as the means by which they become included in certification, quality and safety assurance systems. There should be a national approach to training, recruitment and skills assessment for overseas professionals, with the Australian Government having overall responsibility.

6. State and Federal Ministers for Health and Higher Education should liaise with higher education institutions on the inclusion of greater amounts of inter-professional education, rural placements and joint professional placements in undergraduate health curricula.

7. It will remain important to recognise that in Australia the GP is at the heart of primary care and that the GP will normally be the key member of the multidisciplinary health care team. Work should continue to evaluate and consolidate rural and remote general practice programs, to promote their uptake in general practice, and to continue to adapt and adopt them as program models for use in nursing, allied health and other disciplines.

8. National, State/Territory and local governments need to work closely together on aspects of health workforce supply and demand, with a particular eye to areas where their collaboration can enhance outcomes, avoid duplication or avoid contrary pressures (and so 'unintended consequences').

9. A workforce strategy specifically for rural and remote areas should consider further expansion of the number and scope of University Departments of Rural Health and

Rural Clinical Schools; means by which a greater number of new health graduates could be encouraged to spend some of their time in rural or remote communities; and providing additional incentives to health professionals to work in salaried positions in the public sector.

10. Governments should be encouraged to see investment in social and physical infrastructure (eg community facilities and networks, education, roads, and IT), especially in rural and remote areas, as determinants of health, as well as of the supply and demand for the health workforce (and for other workers). They should see successful rural development as the best medium-term program for the recruitment and retention of workers to country areas.

11. Demand and supply for workers is determined in large part by the structure of the health care system. With 'health reform' on the agenda, further consideration must be given to having one level of government responsible for health services, with funding transfers between the jurisdictions, acceptable accountability measures, and effective management in the regions themselves.

Introduction

This submission is in three parts. The first (above) lists some priority recommendations. Other recommendations are in NRHA publications on some of the specific topics covered in this submission.

The second part deals with general health workforce issues, beginning with the global situation and moving to a brief discussion of ways in which Australia's health workforce will be impacted by changes in health funding and remuneration that seem likely to occur. Given the mission and work of the NRHA, there is an emphasis on rural and remote aspects of these topics.

The third part of the submission, at Appendix 1, deals briefly with a number of mainstream health workforce issues, each of which relates to a particular health professional group.

The NRHA has a number of published articles on aspects of the rural and remote health workforce, all of which are available on its website at www.ruralhealth.org.au

General health workforce issues

The global context

Internationally there have been fundamental changes over several decades in the labour forces of developed countries. There has been a major rebalancing with respect to skilled vs unskilled workers, the mix of skills, full-time vs part-time workers, and the gender mix. Since earlier failed experiments in centralised workforce planning in some western countries, including Australia, this rebalancing has almost all taken place within a free-market context. Training institutions and individuals seeking work have had to read market signals, with all the imperfections ('externalities') associated with such a situation. There have been some long leads and lags.

This is the background to the current situation in which there is a worldwide shortage of health professionals across the board. Major increases in demand have been driven by consumers' expectations for health services, by their perceptions of what health services can do for them (especially in the later stages of life), by increasing technological capacity, and by the ageing of populations. Changes in consumers' expectations have included stronger (and entirely legitimate) demands from people in rural and remote areas to a level of access to health services that is similar to that of people in the major cities. The supply of skilled health professionals has failed to keep pace with this increased demand. The decisions of markets and governments have not resulted in global balance.

An assessment of what governments ought to do about this undersupply of health professionals should not accept uncritically the increasing demand for the services of such professionals. In the circumstance where the supply of public services is necessarily limited by what is politically and economically possible through the tax system, it is not practicable for governments to meet all consumer demands for 'health' or, for that matter, for education,

recreation, transport or housing services. Despite this fiscal constraint, Australia has had no explicit and planned system of rationing health services; it has been done through queuing and pricing, and through unplanned service shortages to which the under-supply of staff has contributed.

In terms of how much additional investment is warranted in the services of particular groups, the health sector represents a particular case: some of the services of professionals can (and should) be supplemented by activities of the individual patients themselves; and some of the services of some professionals can be replaced by the services of other providers. To date few explicit national decisions about such workforce issues have been made.

Global considerations of supply and demand for the health workforce consistently raise these same two basic issues. In general terms the first is just how much health care is warranted for any particular individual, given competing demands for resource allocation and the capacity of most consumers in many circumstances to care for themselves. The second is how an agreed amount of health care should be provided and by which professionals.

Answers to these questions will help determine both the numbers required in particular professional groups and the time pressures they are under. For example, if podiatrists undertook some of 'the foot work' currently undertaken by GPs, there would be the need for a greater number of the former and doctors would be spared some of the pressure they are under. Such potential redistributions of health care activity will affect required competencies of the professions and, therefore, their training and required skill sets. The shortages of health professionals are so serious that scopes of practice, professional boundary issues, potential 'hybrid professionals'[9] and multi-skilling are matters that are now firmly on the agenda.

Australia should not solve its own health workforce challenges by making the situation worse in poorer nations. As a rich nation Australia has a moral responsibility to make a net contribution to the world supply of health professionals – particularly in the South West Pacific of which Australia is a part. This means at least two things: not actively recruiting health professionals from poorer nations; and training more than enough health professionals for its own needs.

The Australian Government is a signatory to a Commonwealth Code of Practice, described by the Commonwealth Secretariat in the following terms:

> "Over the last three decades there has been a steady flow of trained health personnel from developing member countries to more developed countries within and outside

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[9] These were the topic of a Media Release from a meeting at Murwillumbah held on Friday 22 July and reported in the Weekend Australian, 23-24 July 2005. See also "Call for 'super nurses' goes out to all governments" – Health Business Daily News, Tuesday July 26 2005.

> the Commonwealth. This has had an adverse effect on the ability of the source countries to meet the health needs of their people.
>
> In 2001, Ministers requested the Secretariat to develop Commonwealth Codes of Practice for the International Recruitment of Health Workers. This was done through the activities of an electronic working group of senior officials from several countries. In 2002 they accepted the Code and agreed that work on a Companion Document continue. The Companion Document was tabled at their meeting in May 2003." (Accessed on-line, 20 July 2005, on the website at thecommonwealth.org/templates)

This is an international protocol with a low profile. In its work on the topic, however, the Australia Government's OTD Task Force does determine the countries from which its commissioned agencies may enlist doctors and the list excludes developing nations.

An ethical approach to recruitment of health professionals is outlined in *The Melbourne Manifesto*[10] which is a useful framework for action by professional associations.

Australia: home alone

Whereas Australia's health workforce is closely affected by some international global forces, there are other ways in which our circumstance is quite difference from what pertains overseas. Countries that in other respects are similar, such as the United States and Canada, have a substantial supply of health professionals such as physicians' assistants and nurse practitioners. Given their number in those countries, it is a curiosity[11] that these professions are so poorly developed in Australia. There are a number of reasons. Medicare dominates the payments system and plays a major part in determining the structure and shape of the health workforce. Fee-for-service is the dominant commercial culture in medicine and parts of allied health and specialist practice. Individual craft groups work to protect the interests of their existing members.

All of this means that it takes significant political will and organisational acceptance for new professions to become well established, especially where it involves some redefinition of scopes of practice. In recent years there has been wider acceptance of the value of nurse practitioners although there are still relatively few of them in rural and remote areas.

A more recent and contrasting phenomenon is the way that the profession of practice nursing has been significantly expanded, partly as a result of supportive changes to Medicare. What this illustrates is that changes to the funding system in health, coupled with support from existing professions, can result in major improvements in the supply of health workers. The case of practice nurses, who can effectively extend the reach of GPs, is another illustration of how the number and scope of practice of one group of health professionals impact on the effective supply and the scope of practice of another.

Wherever there are health workforce shortages they are worst in rural and remote areas. This means that such areas are already seeing adapted work practices and that they are likely to

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[10] *The Melbourne Manifesto,* A Code of Practice for the International Recruitment of Health Care Professionals; Adopted at 5th Wonca World Rural Health Conference Melbourne, Australia, May 2002.

[11] But a curiosity that is welcomed by some people, who regard (for example) ambulance officers who can amputate as "a terrible prospect".

benefit differentially from the existence of practice nurses, physicians' assistants and nurse practitioners. In their preparation, training and support, however, and as for that of other professionals, it will always be necessary to accommodate the special practice and lifestyle facets of rural and remote health work. As Australia moves towards a stronger safety and quality framework in health, there needs to be allowance for the particular challenges of rural and remote areas, where safety and quality are no less important but can be even more elusive.

The workforce is in poor health

As described above, the structure of our health care system dictates to a large extent the workforce we need and its numbers. Its funding and policy characteristics make the Australian health care system doctor-intensive, notwithstanding the fact that nurses are the most numerous professionals within it. Across the board there are strong professional demarcations and considerable inflexibility in the health workforce[12], as elsewhere on the industrial front. Medicare is demand-driven rather than being strategically planned. Also, Australia has a uniform system ("one size fits all") so that, for example, the rural health sector is essentially designed to operate like the urban health sector, except that it does not have as many parts.

It is widely expected that the workforce situation will get worse before it gets better. There is therefore the need for some major reform.

Supply

It takes at least ten years for planned workforce changes to impact. Health training, particularly in medicine, currently takes a long time. Australia cannot meet its present and future health workforce challenges simply through attempts to train more doctors, nurses and allied health professionals. There will simply not be enough new workers. Our demographics mean that there will be fewer people leaving school and fewer entering university. They will have more choices and they are unlikely to opt for the same things as young people have done over the past decade.

The supply problems we are likely to experience are illustrated by reference to the numbers of new entrants to Australia's workforce as a whole. In the year 2004 there were about 170,000 new entrants to the workforce. Due to the ageing of the population, Australia's workforce will grow more slowly in future. For example it has been estimated that the number of workers will grow by a total of only one million in the seven years between 2003-04 and 2010-11. The same growth is predicted for the entire twenty-one years 2023-24 and 2044-45.[13] These estimates of the declining annual recruitment to the workforce have been highlighted in a Parliamentary statement to the effect that the total number of new entrants to Australia's workforce in the whole of the decade 2020 to 2030 will be 200,000.[14]

Some health employers feel that universities are not turning out job-ready professionals; reviews of nursing have confirmed this view and medical training is not exempt from such

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[12] The impacts of this inflexibility are described in papers by John Menadue and Stephen Duckett, among others.
[13] Productivity Commission, Economic Implications of an Ageing Australia, Research Report, Canberra, 2005.
[14] Hansard record of questions in the Northern Territory Parliament, 15 February 2005; Mr Bonson to the Minister for Education. Both estimates deal only with recruits to the workforce; its total number is also affected by the rate of withdrawal.

assertions. Whatever the truth of these views, there clearly needs to be close (and possibly closer) partnerships between Universities and health care services and employers on this.

Young graduates in some health professions are increasingly disillusioned over the work context in which they are expected to operate, so a greater number of them choose part-time work or leave the health sector altogether. Given the changes in fees and charges for tertiary education, more graduates from university will have significant debts, meaning that more of them may choose to 'follow the dollar'.[15] Both of these issues have an adverse effect on the supply of health professionals to rural and remote areas.

Medical specialists are also under represented in rural and remote Australia. Their work is important both in its own right and as a means of adding value to the efforts of others. Medical specialists are also key members of the multi-disciplinary team. The same goes for allied health professionals, managers, dentists and pharmacists.

Demand

The demand for health professionals will be influenced by changing demography (ageing and migration), increased chronic disease, escalating costs, fiscal constraints, increased use of technology in the form of diagnostic and invasive procedures, de-institutionalisation in favour of home and community care, and increased consumer expectations as people become better informed about health and health care. There are serious - often life and death - allocation and rationing issues around procedures like transplants, joint replacement and cardiac surgery, which are not only expensive but which also help to determine the demand for health professionals.

All of these developing trends influence demand in one direction – upwards.

Despite all of these issues, and as mentioned above, Australia should not seek to solve its workforce supply problems chiefly through deliberately importing international medical graduates and other overseas trained health professionals. (It should, however, provide substantial support and recognition for those international health graduates who choose to work here.)

Rather than focusing only on training more in the current 'mainline' health professions, health care needs to be broken up into different parcels - and the parcels allocated to a wider range of health professionals, each with their own scope of practice. This will result in some elements of health care being undertaken by sub-specialists or 'mid-level practitioners' who can be trained more quickly and at less cost than medical or allied health specialists and can also operate at lower cost. In July 2005 a planning meeting on the health workforce was held under the auspices of one of the NSW University Departments of Rural Health. Among other things the meeting suggested the need for hybrid health professionals or mid-level practitioners. These issues are likely to become the focus of more attention in the near future. As ever, in any such developments as occur there will be the need to protect safety and quality in the particular circumstances that apply in rural and remote areas. Rural areas will continue to need higher levels of generalist skills and special staff support.

[15] HECS-HELP assists with the costs of education and is repaid once earnings reach a given level. The HECS reimbursement scheme reduces the debt for those willing to work in designated rural and remote areas. Students who undertake full-fee-paying courses will have stronger financial considerations but will presumably have taken account of their financial situation prior to enrolling.

Assuming that the health workforce changes in these ways there will be greater need for interprofessional education, joint professional placements, and greater use of professional substitution.

General practice will remain at the centre of primary care and the GP will usually be the key member of the multidisciplinary health care team. Australia has had success with many of its policy responses in rural general practice and work should continue both to evaluate and promote them within general practice, and to continue to adapt and adopt them as program models for use in nursing, allied health and other disciplines.

Evaluation of programs in rural general practice will give attention to anomalies that arise as a result of unintended friction between the initiatives of various government agencies. For example, the NSW medical cadetships scheme will have greater difficulty in increasing the supply of doctors to the State's Base Hospitals because of the Australian Government's HECS reimbursement scheme, which provides an alternative means by which young doctors can defray the cost of their education.

Some short-term responses for rural and remote areas

There is overall a health deficit situation in rural and remote Australia compared with its major cities. Health status is poorer, risk factors are more common (including generic and fundamental ones like low income), and the costs of delivering a unit of health care are higher, particularly in remote areas. Governments at all levels have accepted this deficit and have put in place specific rural and remote programs as compensation and for remedial purposes. This was done at the behest of leaders of the rural and remote health sector, with doctors often 'front and centre' in the effort. Where there has been no constitutional or related political uncertainty, the funding has flowed in generous proportion. For example, the Australian Government has a clear responsibility for general practice and a sequence of general practice strategies has delivered resources to enhance and support the profession.

For other professions, the political situation has been and remains much less clear, with the result that interventions have been much more contested and so less generous. Contestation between governments over rights and responsibilities leads to gaps and duplication. The Australian Government has filled some of the gaps in support for nursing and allied health, but the levels of support remain low. As well as these less categorical situations there are also some outright oddities, such as the patient's mouth and the diabetic's foot. Although poor oral and dental health is entirely preventable, and affects general health, it remains the Australian Government's view that responsibility for the mouth lies with the State. As far as the diabetic foot is concerned, it may be amputated *in extremis* under Medicare, but cannot be prophylactically treated by a podiatrist.

Some observers believe the rural and remote health workforce to be in crisis. There is undersupply, a distribution which does not fit with the distribution of health service need, poor morale, major losses of health graduates from the health sector, high expectations and poor professional support which lead to alienation and burnout. Whether or not there is a health workforce crisis, it is important for a balance to be retained between the good news and the bad in rural and remote areas. To focus only on the challenges would add to the difficulty of recruiting people to country areas. As a nation it is always likely to be useful to celebrate the benefits and opportunities of health professional practice in rural and remote

areas. In addition to the lifestyle benefits, many of the best practice opportunities lie outside the major cities.

The impressive rural health education infrastructure, based on University Departments of Rural Health and Rural Clinical Schools, needs to be expanded, both geographically and professionally.

As a nation we might investigate measures to ensure that, upon graduation, all health professionals directly experience practice in rural or remote communities. The aim would be to encourage people to undertake rural practice rather than draft them to cover workforce shortages. This will require good systems for the support and mentoring of students, and new as well as re-entering practitioners.

Consideration should be given to increasing the number of salaried staff working in rural and remote communities, with packages that might include guaranteed infrastructure, support and relief. This should be achievable within existing funding parameters, eg through MBS 'cash-out' arrangements. The evidence suggests that a greater number of young heath professionals would prefer to operate this way than used to be the case, partly because they are uninterested in commercial business practice and because their indemnity risks can be borne or financed by the employer.

In areas where the traditional responses have not worked, there have already been moves towards support for a greater number of salaried health professionals. The New South Wales Rural Doctors' Resource Network, for example, has a successful program in north-west New South Wales in areas that are particularly challenging for fee-for-service medicine. Salaried medical officers work for a consortium which includes the local and state governments. It remains to be seen if this is a sustainable approach. The Australian Government is certainly backing it: in the 2005 Federal Budget, a new program was announced which will help local authorities to provide physical infrastructure and financial support for GPs.

Such programs are welcome, but the fact remains that they emphasise the existing culture and structure of our health and workforce systems. The complete resolution of the problem will require innovation and work on a broad canvas.

Broader answers

One of the general goals of national rural recruitment and retention initiatives should be to have a greater number of people as enthusiastic about work in rural and regional centres as a small number currently are for the most remote locations.

Parts of the infrastructure that supports business and community life in Australia are in need of major investment. Notwithstanding current integrative activity by the Australian Government, an 'infrastructure report card' approach suggests that there is insufficient national investment, particularly in rail, irrigation, local roads and stormwater systems.[16,17] To these can be added information technology, public housing, public transport and new energy systems. Governments should see investment in infrastructure, especially in rural and

[16] see the 2001 Australian Infrastructure Report Card, at http://www.infrastructurereportcard.org.au/

[17] The latest is for Victoria. It asserts that "As of 2005, some sections of Victoria's infrastructure have become deficient. Those of particular concern have been identified as roads, rail, ports, irrigation, stormwater, electricity and gas." See www.InfrastructureReportCard.org.au

remote areas, as determinants of the (health and other) workforce situation; the availability of high quality infrastructure is related to the distribution of workers in all sectors.

The best medium-term program for the recruitment and retention of workers to country areas would be successful rural development. Investment in a comprehensive and high quality road network and IT communications system is a pre-requisite for rural, regional and remote development. They are also priorities for enabling people in rural and remote areas to access the full range of health services so important to ensuring equitable life-chances.

There will not be the political will for major investments in rural and regional development unless and until there is a shared vision about what rural and remote parts of Australia should look like in twenty-five years' time. Such a vision would be supported by national policies on population, settlement and access to services. Humphreys has put it in the following terms:

> The current lack of a national vision for rural communities and rural development has undoubtedly impeded sustainable economic and social development in non-metropolitan Australia. In the absence of any national vision and without an integrated national settlement strategy and regional development policy for small rural and remote communities, initiatives confined to the health sector, no matter how innovative, seem destined only ever to achieve limited success in meeting the health needs of rural and remote Australians, whether Indigenous or European.[18]

Particular challenges

There are three particular challenges that need to be faced.

First, there is the particular problem created in rural areas because of the split of Commonwealth and state responsibilities and funding streams in health. Where resources are scarce and major health facilities are not as readily accessible as in most urban settings, it makes sense to have as much integration of funding and services as possible. Consideration might be given to having one level of government responsible for all rural health services, be it State or Commonwealth. Suitable funding transfers between the jurisdictions and acceptable accountability measures would be part of the arrangement. With one point of accountability and resource management, rural communities should be better placed to access available services than is the case now.

Effective management is a crucial first step in the successful recruitment and retention of all rural and remote health staff. It is sometimes lacking because of the division of responsibility between agencies and governments. Any new arrangement would have to emphasise the real control of rural and remote staff and resources being held in the area and region, not in the capital city.

Second, there are the problems of workforce attraction and retention, which are exacerbated by the current jurisdictional split of responsibilities. A nationally co-ordinated approach to health workforce training, recruitment and skills assessment of overseas professionals should bring about greater flexibility, certainty for those entering the Australian workforce from

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[18] Humphreys, John, "*Revisiting the wellbeing of remote communities twenty years on - a time for celebration and reflection*", Keynote Paper to 8th National Rural Heath Conference, Alice Springs, March 2005.

overseas and more consistent orientation and support for them as part of their settling into the health system. There is a strong case for the Commonwealth to have the overall responsibility, again with appropriate funding transfers and accountability measures.

Finally, Australia's approach to professional training, especially medical specialist training, does not suit the needs of the 21st century health system, particularly for rural Australia. The College-based training, despite recent changes in some specialties, remains hospital-centred and follows a timeserving apprenticeship model. Apart from general practice, specialist training is predominantly confined to urban settings and rural training is generally an add-on or elective. Australia now has excellent networks of Rural Clinical Schools and University Departments of Rural Health and Regional Training Providers for general practice. However there are insufficient formal links with other specialist training. Clearly few, if any, specialist medical colleges have structures adequate to support rural streams of training or even to incorporate significant rural components into their programs. It is therefore timely for the current specialist training arrangements to be opened up to bring in other potential providers, including the universities. This could be done either through a semi-competitive model (as in General Practice) or a co-operative model between the Colleges, universities and other potential providers.

A good example is the initiative of the RACP to have a compulsory rural term of six months for general paediatrics trainees.

Impact of models of care on the health workforce

For over a decade in Australia there have been trials, funding innovation, pilots and projects including (for rural and remote areas) through schemes like the Rural Health Support Education and Training Scheme, the Regional Health Service Scheme and Co-ordinated Care Trials. By now these have produced a wealth of information about how the system can be improved, and such system changes as envisaged will impact on supply and demand in the health workforce.

However, because of our Federal system, arbitrary jurisdictional borders and professional rivalry, this wealth of information has not been drawn together and rigorously analysed against particular criteria, to see what works and what directions we should take – or what further work we might need to do.

The research agenda should get to that task immediately, to synthesise the work that has been done and analyse it against policy parameters. The purpose of this research must be to change things - to make things better, to make things work that do not currently work. The research outcomes need to be able to be explained in ways that are relevant to policy makers, particularly those in central agencies like Departments of Treasury, Finance and of the Premier, who are becoming increasingly influential in health and who are seeking workable solutions.

Australia should investigate new options for delivering both services to people and people to services. Against a backdrop of the loss of hospitals, of procedural activity and obstetric care in many small communities, the scope for initiatives such as small-scale birthing units (staffed by midwives with obstetric back-up) should be investigated. For residents without local health care services, travel costs associated with accessing health care services could be

reimbursed. Adequate telehealth infrastructure could be made available to selected remote sites as a means of increasing access to distant services for remote families.

Such proposals should remind us that in some instances there are better options for providing access and service than ‘workforce programs’ in the narrow sense.

New models of care are developing which will help to transform health practice roles and definitions. In the case of the University Departments of Rural Health and the Rural Clinical Schools, the new models of care are building infrastructure in rural and remote areas. The goal must be to encourage a major proportion of health professionals to spend some of their working life in rural and remote areas, rather than hoping for a sufficient number who will serve their whole working life there.

The current funding and remuneration models in health are sub-optimal. There is a focus on acute care in a medical model - which is relatively expensive - and insufficient emphasis on prevention and early intervention. With new models of care we will need new models of funding. It is to be hoped that the work currently being led by the Council of Australian Governments will expedite new financing arrangements and collaborative models.

The fee-for-service model for doctor remuneration has a number of disadvantages for rural communities. Fee-for-service is not well suited to meeting the needs of those with chronic and complex care needs - which is an increasing proportion of the population. Fee-for-service sets medical care in primary and ambulatory settings as a funding silo and provides little opportunity for strategic planning of services. A uniform and singular focus on fee-for-service results in the phenomenon ‘No Doctor: No Medicare’ for some people.

Increasingly, young doctors are showing themselves to be risk-averse, indicating that they would prefer salaried positions or a mix of salary and fee-for-service, particularly if it means they can avoid setting up their own practice and managing the associated risks and costs of their own business. The fee-for-service model, on the other hand, leaves the financial and business risks with the practitioner.

These are some of the opportunities and likelihoods that will inexorably change the demand and supply situation for the Australian health workforce.

Appendix 1:
Some mainstream health workforce issues

The mainstream health professionals in Australia include general practitioners, specialists, Aboriginal and Torres Strait Islander Health Workers, nurses, allied health professionals[19], health service managers, pharmacists and dentists.

Health workforce shortages in rural and remote Australia need to be seen within the context of the **global situation** and dealt with in that context. There is a global shortage of health professionals, and non-metropolitan Australia is well-off compared with poorer nations. Australia should make a net contribution to the world supply of health professionals. This will mean *not* actively recruiting health professionals from poorer nations, and training more than enough health professionals for Australia's needs.

International Medical Graduates (IMGs) are of particular importance to people in rural and remote Australia. IMGs should be sought for Australia only from developed countries, carefully assessed for clinical and cultural competence so that there is no reduction in the quality of service provided, and should be well supported and highly-valued.

The successful recruitment of IMGs requires high level and ongoing collaboration between the health and immigration agencies of the Australian Government, the States and Territories, the Health Insurance Commission, the Australian Medical Council, the State Medical Registration Boards, Medical Colleges and other professional bodies.

Australia is an attractive country in which to work and, given supportive legal and administrative structures, there will always be IMGs here, both as temporary visitors and as new settlers. The shortages of supply and unique opportunities of rural and remote practice will mean that many of them are likely to be working in non-metropolitan areas.

Significant developments in **rural and remote medical education** in recent years have included the regionalisation of medical education. This should help improve the distribution of doctors between city and country areas in the medium term. The health sector has arguably set a new standard for useful regionalisation of resources through the Rural Clinical Schools, the University Departments of Rural Health and the work of General Practice Education and Training Ltd (GPET). These have made health the envy of sectors in which so many key resources and decisions are still tied to the capital cities.

The **nursing workforce** is the largest single part of the health workforce, including in rural and remote areas. The shortage of nurses in rural and remote Australia is already very serious. At any given moment, a significant proportion of those trained as nurses within Australia are not in the nursing workforce. This attests to relatively poor rates of pay in nursing, the difficulties and conditions of the work, and probably the perceived low status of the profession.

The United States is among those to have initiated action to obtain up to one million extra nurses from overseas and the UK government has also embarked on a large recruiting

[19] In this submission the term 'allied health' refers to health professions other than nursing and midwifery, medicine, dentistry and community pharmacy. The largest numbers are physiotherapists and psychologists, followed by speech pathologists, podiatrists, dieticians and occupational therapists.

exercise. The pressure on supply in Australia is becoming stronger. Initiatives that would help ease the situation in rural and remote areas include:

- assured access for nurses to information technology;
- nursing employers (Area Health Services, hospitals, nursing homes) providing special incentives in recognition of the special circumstances and costs associated with work in those areas;
- better undergraduate preparation for rural and remote practice; and
- promotion of rural and remote nursing as a rewarding and safe profession.

There is also a national shortage and mal-distribution of **allied health professionals,** with the worst shortages being in rural and remote areas. Despite increased activity at national, state and territory level, rural and remote Australia is losing allied health positions and clinicians. Area Health Services and public hospitals in non-metropolitan areas should increase the priority they give to allied health positions.

Allied health professionals provide a diverse range of services in a variety of settings in the health sector, including acute hospital care, rehabilitation, children, women and men's health and aged care, community health, Indigenous health, veterans' affairs, health promotion and participation in research. They also provide a range of services in other sectors, including education, aged care, public health, industry, disability, and welfare. They work in both the public and private sectors.

ABS data indicate critical shortages across all allied health professions[20]. Many of the issues impacting on the recruitment and retention of GPs and nurses impact similarly on allied health professionals.

Evidence shows that having a safe and rewarding **rural placement** while training or retraining increases the likelihood of a health professional working in rural or remote areas. Rural placements of longer duration further increases this likelihood.[21] Such placements must be well-supported, planned and safe, and this makes demands on existing rural practitioners who are the mentors of those on placement. There are currently insufficient practitioners with the time and skills to support the placements of all health undergraduates in training. It would be very valuable to have a quality rural health placement system that gives priority to those who indicate an intention to practise in country areas.[22]

There is a successful workforce program funded by the Australian Government for **rural pharmacists**. It was initially established in 1999 and now includes an emergency locum service, undergraduate scholarship schemes, including one for Indigenous students, assistance for placements, funding to allow a pharmacist academic to be located in each of the existing University Departments of Rural Health, continuing professional education support, and an infrastructure and support scheme to help link rural and remote pharmacists with each other and with other health practitioners and clients.

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[20] *Australian Allied Health Workforce - National Population and Allied Health Profiles*, SARRAH, Canberra, June 2004. (available on SARRAH's website.)

[21] Denz-Penhey H, Shannon S, Murdoch JC, Newbury JW (2005), *Do benefits accrue from longer rotations for students in Rural Clinical Schools?* Rural and Remote Health; 5: 414.

[22] *A Quality Rural Placement System for Health Students*, NRHA Position Paper, March 2004; available at www.ruralhealth.org.au/

The training and retention of **Aboriginal and Torres Strait Islander Health Workers** is also a matter of great importance to health outcomes, particularly in more remote areas and for Aboriginal and Torres Strait Islander people. There is a National Strategic Framework for the training of Aboriginal and Torres Strait Islander Health Workers, and Community Services and Health Training Australia Ltd (CSHTA) is leading work to produce a revised set of competency standards for such workers, to replace the set agreed in 1996[23].

The NRHA is among those bodies have argued for national leadership and funding, with the States and Territories, of additional **public oral and dental health** services[24, 25]. This will be of most value to people on low income and to school children and elderly people. Currently there is poor oral and dental health and oral and dental problems are largely preventable. Proponents of the view do not see this as a time-limited intervention by the Australian Government in order to reduce waiting times at existing public services, but as an area where there should be joint Commonwealth/State action on an ongoing basis.

Health service managers make important contributions to health outcomes. No matter what the health service is, where it is or which professions it includes, it needs to be well managed.

For some years there has been significant interest in the role of **nurse practitioners** (or **advanced practice nursing**). In recent years there have been significant developments across the country with nurse practitioners. Currently the ANC is working with its New Zealand counterpart on educational standards and competencies for nurse practitioners. Nurse practitioners have a great deal to offer to people in more remote areas where fee-for-service general practice is difficult to sustain.

For some time, people in small country towns and more remote areas have been very concerned about diminishing local **birthing services**. There has been a gradual loss in country areas of general practitioner proceduralists delivering babies. The recent difficulties with indemnity (still not solved to everyone's satisfaction) have exacerbated the service losses. As far as birthing services and the workforce are concerned, there are unresolved issues relating to access to GPs and/or midwives.

Practice nurses are trained nurses who work for a GP, often in the general practice but sometimes in the community. They have a mix of nursing and administrative duties. They are part of the general practice team and MedicarePlus allows certain services provided by a practice nurse - eg immunisations and wound dressing - to be charged to Medicare even if a doctor is not present. There are calls for this system to be extended to other services like Pap smears, home visits and aspects of geriatric, antenatal and infant care to allow doctors to spend more time providing services at the level for which they are appropriately qualified and so reduce patient waiting times. In some places, it would also give consumers a much appreciated choice of male or female service provider.[26]

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[23] *Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project,* Community Services and Health Training Australia Ltd; accessed from www.cshta.com.au

[24] Position Papers 2000-2001, NRHA, Canberra; available at www.ruralhealth.org.au

[25] See for example the second report from the Senate Select Committee into Medicare (chapter 5): http://www.aph.gov.au/senate/committee/medicare_ctte/medicareplus/report/index.htm

[26] *Good Health to Rural Communities – A Collaborative Policy Document,* ALGA, RDAA, CWAA, NFF and HCRRA, March 2004.

Attachment 4

NATIONAL RURAL HEALTH ALLIANCE INC.

Base level / optimal health services for rural and remote populations

- a paper prepared for the Department of Health and Ageing

Background

The topic on which the Department has sought an Alliance view seems to be very similar to what the Alliance and others term ‘benchmarking of health services’.

There have been discussions about this and related issues within the Alliance for a considerable time. The fact that the Alliance does not have an agreed position on it is perhaps an illustration of the complexity of the notion.

Much of the Alliance’s discussion has been in terms of benchmarks for services in places of particular size and with particular economic, geographic and social characteristics; and using a benchmarking approach to identify shortages of health professionals.

It is vital for people in rural and remote areas that ‘benchmarking’ - however conceived - is not used to legitimise a two-tier health service.

Some theoretical considerations

The idea of benchmarks for levels of health services is attractive for a number of reasons. From the point of view of service providers, benchmarks can give certainty and accountability about levels of services being made available. The obverse of this, and something of a Holy Grail for health advocates, would be the situation in which quantitative certainty could be given to statements about shortages of health professionals, lack of access to services and concerns with health outcomes. Quantitative measurements of these deficits would enable proponents of improved rural and remote health to establish more clearly the absence of ‘equity of access’ and the failings of a health system purporting to be universal.

So, for example, health service providers may be able to assert that they are meeting expectations by reference to the benchmarks they are achieving. For their part, health advocates could make a clearer case for change in policies and programs if quantitative targets existed for base level and/or optimal level health services which were not being met.

There seems little certainty about what notions of ‘base level’ or ‘optimal’ services might mean. A base level health service is presumably one which provides some minimal level of service. This implies the existence of universally accepted minimum standards for health and related services: perhaps clean air, sufficient and fresh food, potable water, the freedom to work and keep fit, and access to illness prevention (eg immunisation) and acute emergency care in ‘reasonable time’ (with regard to the location) when required. This approach to the definition comes from a primary health care view of health.

The definition of ‘optimal’ health services might seem to be simpler. It might be defined as “the best standard of health care for a person of particular characteristics, in which cost is no object and in which the most advanced technology, pharmacology and human resources are applied to any particular intervention designed for illness prevention, diagnosis, management and/or treatment”.

However there is clearly a potential difference between what is optimal in health treatment terms and what is optimal for the patient. Optimal health care for an individual must accommodate the distinct possibility that the patient may prefer a point in the hierarchy of potential treatments which is not clinically optimal. For instance, the patient may prefer to have less invasive rather than more invasive treatments, or to stay at home or in their local area rather than go to or stay in a tertiary facility, or to trade off longevity against quality of life.

Six theoretical categories

There seem to be at least six theoretical types of ‘benchmarking’ where health services are concerned.

1 Setting benchmarks for minimal services for individuals and for populations of particular sizes and characteristics. Such benchmarks focus on inputs rather than outputs or outcomes. The approach accommodates such targets as:
   - “No group of 1200 people shall be without a doctor.”[27]
   - Every family on reticulated public water systems shall have access to fluoridated water.
   - All schoolchildren shall have a dental check-up at least once every three years.
   - Towns of 1,000-5,000 population shall have the following services provided by the public sector: [list them]; towns of 5,000-7,000 population shall have following additional services [list them]; etc etc.

2 Setting benchmarks for access to health professionals in terms of simple population to professional ratios. This approach accommodates such targets as the following.
   - The ratio of population to doctors shall not exceed 1000 to one.
   - The ratio of population to physiotherapists shall not exceed 1500 to one.
   - The ratio of population to psychiatrists shall not exceed 2000 to one.[28]

[27] All of the numbers in the examples in this paper are arbitrary and hypothetical.
[28] A paper offered to the 9th National Rural Health Conference included, “A good example is the Western Australian Country Health Service Allied Health Assistant project, a partnership between a number of state and federal disability, health, and education and training agencies. Its purpose was to develop generic standards and benchmarks for allied health assistant work in the rural and remote context.”

Two of the recommendations from the 9th National Rural Health Conference in Albury (March 2007) related to these kinds of benchmarks and read as follows:

- *"The Australian Institute of Health and Welfare should be funded to collect and analyse national workforce and workload data for the allied health professional workforce in rural and remote Australia. This would enable better benchmarking, strategic planning and funding of allied health."*

- *"There needs to be benchmarking of demand and supply of the primary health care workforce in rural and remote Australia to establish the numbers required for effective delivery of service. Given the seriousness of the maldistribution of health professionals, the new health workforce committee of the Australian Health Ministers' Advisory Council should give a high priority to health workforce planning for rural and remote areas."*

3 Setting benchmarks for health professionals according to the population health groups they are expected to service. For example:
   - No psychologist should have more than 65 patients.
   - Integrated mental health teams shall not have a caseload greater than 85 patients.
   - The State/National ratio of people with diabetes to diabetes nurse educators shall not be greater than 400 to one.

4 Focusing the benchmarks on the development of desirable health workforce systems and structures:[29] [30]
   - 50 per cent of the nation's dentists should work in the public sector.
   - General practices should have one practice nurse for each 2.5 doctors.
   - One third of medical undergraduates shall spend one third of their undergraduate training in a rural area.
   - All health undergraduates should have a minimum of 50 hours a year on Indigenous cultural orientation.
   - The proportion of health undergraduates in interprofessional educational settings should increase by 10% a year.

5 Using selected standards of health outcomes as targets or benchmarks against which the outcomes of particular jurisdictions or services (hospitals, clinics, practitioners) can be compared, or to facilitate comparison between more than one service. For example:
   - Hospital P met the specified standard for the proportion of births by caesarean, whereas hospital Y did not.

[29] Both Kate Lundy, then Shadow Minister for Health Promotion, and Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner, included a benchmarking approach in their comments at the 9th Conference on governmental programs. Kate Lundy, on health promotion and illness prevention, observed that "This government has dragged its feet in this area and continues to do so. There are no benchmarks for health investment, no taskforces or reviews driving change or searching for prevention solutions that work." Tom Calma, commenting on the way forward for improved Indigenous health, said that the required actions from government included "benchmarks and targets".

[30] A paper offered to the 9th National Rural Health Conference in 2007 included: "If proper benchmarks of allied health workforce through Improving Medicare were met there would be less need for excessive transdisciplinary management of communities and rural populations."

- Drs Q and R reported a significantly higher rate of death among their patients than the average.
- The clinic at S reports a higher rate of false positives for screening than the average [or than the clinic at T].

Such benchmarking as this has been standard practice for many years for women's and children's hospitals, for example.

6 Benchmarks as targets to be met in education, training and support of health professionals:
- All health professionals working with Indigenous people shall have a minimum of three months' cultural awareness and cultural safety training.
- Certificate 4 competencies shall be the minimum requirement for [national registration of] Aboriginal Health Workers.
- All international medical graduates working as general practitioners shall have met [specified standards].

The practical difficulties

Political: State and Commonwealth Health Ministers and the public servants who work for them may be reluctant to establish public targets against which they could be held accountable. Health professionals will also be reluctant to agree to targets for service which inhibit their practice and/or stress them and/or impact negatively on their remuneration.

Data: the setting and monitoring of such benchmarks requires undisputed and up-to-date data. Currently there is relatively good data in some areas (eg hospital admissions and separations, and general practice) but poor data in numerous other areas (eg the incidence and distribution of disease states, the allied health workforce[31], out-of-pocket costs incurred by patients, the preferences of citizens where health services are concerned, and the willingness of individuals to trade off various aspects of their own care for perceived alternative benefits).

Definitions and boundaries: there will always be questions about what is 'optimal' for individual patients; the population parameters established (eg with a break at 5000 people) do not match the size of real communities; in most places there are unclear boundaries between communities; there are cross-jurisdictional border issues; and inter-professional issues in circumstances where some work can be safely and effectively undertaken by more than one profession.

Disparate communities: it will always be difficult to categorise communities as being 'like' or 'same'. For example, two towns of 5000 people may be the same in terms of occupational mix and incomes, but only one of them may have access to high-speed broadband or one of them may have a higher proportion with diabetes than the other. Mining communities of 5000 are quite unlike inland pastoral communities of the same population size.

[31] We understand that SARRAH is seeking funds for research "to identify and collate unpublished data relating to benchmarking/establishing minimum service standards for allied health services in rural and remote Australia".

Further commentary

The Alliance has discussed these matters 'in house' with no resolution or clear direction as yet. Some in the Alliance have suggested that the Australian Primary Health Care Research Institute (APHCRI) could be funded to do further exploration of benchmarking work.

The Alliance has a strong interest in some very pragmatic 'benchmarks', such as the successful placement of a mental health academic with each University Department of Rural Health (UDRH). Given its strong multidisciplinary focus, the Alliance hopes it will soon be possible for each UDRH to have a specialised allied health academic as well. Health service managers, paramedics, dentists and pharmacists are other professions with which the Alliance is particularly concerned.

The collection of better data on the distribution of illness, health expenditures, and workforce numbers is something in which the Alliance has an ongoing interest.

A greater emphasis on illness prevention and health promotion will require more evidence on individuals' self-care regimes and how they can be influenced for the better. New benchmarks on which the health sector should focus include the number of people undertaking self-care, and engaging in health risk behaviours - these to be used as bases for the development of further effective programs (including in rural and remote areas) related to these phenomena.

The Alliance is committed to its vision of securing equivalent health services and equal health for people in rural and remote areas by the year 2020. Benchmarking must not be used as a means of legitimising lower levels of services or health outcomes in rural and remote areas, or to legitimise a two tier health service.

A practical benchmarking-type exercise is underway in relation to maternity services, involving the RDAA, the College of Midwives and others. We understand it shows that some studies "reported rural and remote perinatal outcomes comparable with national benchmarks". A recent article has provided ideas about how to work out the size and scope of maternity services in British Columbia.[32]

We understand that benchmarking has also been applied in a small way in some Indigenous communities in Australia - and perhaps this year's intervention in the Northern Territory provides some evidence of what is desirable and practicable in that respect.

We also understand that, in 2006, the Primary Health Care Research and Information Service (PHCRIS) produced a benchmarking tool which enables users to identify groups of general practice divisions with the same demographic characteristics. The tool can filter the data by state, population size, RRMA and Indigenous population and is available online at www.phcris.org.au/products/asd/benchmarking_tool.php

Currently, the Alliance has a strong interest in having some benchmarks for health service inputs and outcomes included, by mutual consent of the Australian and State Territory

[32] "The evolution of rural maternity care in British Columbia, Canada: a model for evaluating and planning level of services", Grzybowski, S. Kornelsen, J and Schuurman, N., - through http://www.ruralmatresearch.net/aboutus.htm

Governments, in the new Australian Health Care Agreements. The Alliance has publicly asserted its support for the AHCAs to include, in particular, agreements on mental health, maternity services, patients' accommodation and travel systems, school dental services, and other national health priority areas.

On school dental services, for example, negotiation of the AHCAs provides an opportunity for the States/Territories to agree with the Commonwealth to meet certain targets in relation to service provision and outcomes.

In summary: it would be a great step forward for rural health if a standard could be agreed for the provision of health services – a standard that is objective, approximate and appropriate for the context and region in which it is to be applied; and, following this, analysis of the evidence be undertaken. This would soon show the practicality or otherwise of the notion, and the gaps in data and evidence that certainly exist.

16 December 2007

Attachment 5

NATIONAL RURAL HEALTH ALLIANCE INC.

Improving the rural and remote health workforce

A submission to the
Department of Health and Ageing
related to the audit of the
rural and remote health workforce

February 2008

National Rural Health Alliance
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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.

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Executive Summary

Despite its affluence, Australia is not exempt from the shortages of health professionals that are experienced worldwide. The mismatch in this country between the demand for health care and the supply of health care professionals is likely to become worse over the next 20 years.

Within Australia, the shortages and the effects of maldistribution are worst in rural and remote areas. This exacerbates the situation in which people in rural and remote areas already have worse health than their metropolitan cousins. Solving the under-supply of health professionals and attaining a better distribution of those in practice are therefore critical challenges for rural and remote people. It is also something that will contribute to workforce participation and national economic productivity.

On one side of the equation, the demand for health care is increasing with population ageing, technological advances, greater understanding and increased capacity to pay. On the other, the supply of health care through health professionals is constrained by the number of people available to enter the workforce and the competition from other sectors and employers. The shortage of health care will therefore only be met through a combination of moderating demand and increasing supply.

Australia will not be able to meet the demand for care merely by increasing the supply of health care *personnel*. However, with a creative approach to demand and supply, it should be possible to meet the demand for health *care* through a range of actions. For a balanced outcome, increased self-care will have to become part of the equation.

Although there will not be enough of them to meet burgeoning demand, there are currently significant numbers of additional health professionals in training. For people in rural and remote areas, the important thing will be to ensure that sufficient of these new professionals are skilled for and committed to practice in rural and remote areas so that, at any given time in the future, rural and remote areas have their fair share of the nation's health professionals.

Although only 30 per cent of Australians live in rural and remote areas, a 'fair share' of health resources for non-metropolitan areas needs to be slightly greater than 30 per cent given the already poorer health of people in those areas, the greater distances to be covered, the greater complexity of practice and the larger proportion of Indigenous people.

The health of Indigenous people should be the signal indicator for both national and rural health outcomes, given the tragic discrepancy in life expectancy that currently exists. There are particular problems in dealing with Indigenous health care and the measures at paragraphs 51 to 57 would provide a basis for additional support.

The submission begins (paragraphs 1-14) by asserting the continued need for government involvement in 'the market' for health professionals. People in rural and remote areas will be among the greatest losers if demand and supply of health professionals are left entirely to the free market.

The demand for and supply of health care are complex and dynamic phenomena (paragraphs 15-37) and are influenced by factors ranging from individual human attitudes to macro policy issues such as the nature of national health funding.

A more strategic approach to health workforce planning, involving consultation with consumers and professionals and all levels of government, will result in significant national savings. There are very substantial productivity gains to be made in the health sector from better utilisation of personnel, and these gains will to some extent moderate the demand for new entrants to the health professional workforce.

The submission distinguishes the demand for health professionals from the demand for health care. Planning in the health sector should focus on the latter, and should adopt a creative and open approach to how such health care may best be provided. If, as a nation, we focus only on workforce, and do not systematically address other health system factors, we will continue to struggle with health care shortages.

Where the focus is more narrow – ie on the supply of health professionals - there needs to be separate consideration of incentives for recruitment as distinct from retention. Rural and remote areas also need special programs, as has for some time been acknowledged, and the raft of incentive programs in existence, particularly for rural general practice, need to be thoroughly reviewed and evaluated. There are currently insufficient benchmarks that can be used to inform policy makers if and when targets have been met.

Political support for the current health workforce audit should stimulate further debate about scopes of practice, multidisciplinary teams, the relationship between health professionals, and the increasing importance of self-care.

International health professionals continue to be particularly important in country areas (paragraphs 38-43). More needs to be done at a national level to assess, train and support international health professionals. Related to this, Australia should give further consideration to the means by which mutual benefits could be obtained if Australia contributes to the health, education and training of people in the Pacific region.

In the medium term, rural development is the best strategy for both recruitment and retention of professionals to non-metropolitan areas, including health professionals (paragraphs 51-56). One of the general goals of national recruitment and retention initiatives should be to have a greater number of people as enthusiastic about work in rural and regional centres as a small number currently are for the most remote locations.[33] Rural and remote health care jobs need to be enriching and sought-after by people as a desirable career move.

The current shortage of doctors is particularly serious in circumstances where it means people are unable to access a GP. Consideration also needs to be given to the supply of nurses, allied health professionals, dentists and oral therapists, ambulance officers and paramedics, Indigenous Health Workers, pharmacists and health service managers.

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[33] A correspondent writes: "It must be recognised that remote workers, being a small group, may be self-selecting along personality lines. To get a continual stream of people entering the rural workforce, the work environments need to be acceptable to 90% of the health workforce – at present many rural working environments are archaic."

In such a large and complex area as health workforce planning, it will not be possible to advance on all fronts simultaneously. In rural and remote areas the priorities for consideration should be the workforce aspects of:

- Indigenous primary health care,
- oral and dental health,
- mental health,
- maternal and child health, and
- care in the aged care sector.

The training and retraining systems for health professionals should be subject to expert scrutiny with a view to some potential redesign.

Chief recommendations

1. The Australian Government must continue to be involved in planning and managing the supply of and demand for health care and health professionals.

2. Public expenditure on health promotion and illness prevention should be seen as an investment in workforce participation and economic productivity, as well as in better health outcomes.

3. Where access to Medicare and the PBS is limited, the Australian Government should continue to provide funding for alternative first-point-of-contact health treatment, and should also work with the States to improve the assistance provided to patients for unavoidable travel to more specialised services.

4. The review of *Healthy Horizons* should be seen as a key step in the development and agreement of a new national rural health plan.

5. Over time, the Australian Government's health workforce programs should lead to greater equivalence of incentives across all health professions.

6. Recent evaluations of the existing rural and remote general practice incentive programs should be made public and augmented by further evaluations as necessary.

7. The Australian Government should work with the States and Territories, the universities and the public and private health sectors to establish a comprehensive and well-supported national undergraduate rural placement system for students in all health disciplines.

8. The Australian Government should use both direct programs for recruitment and retention, as well as changes in the design features of the health system and its funding, to ensure that people in rural and remote areas have access to the range of health care they require.

9. Governments should continue to provide support and incentives to newer models of health care in which clinicians may be salaried and which are characterised by multidisciplinary teamwork.

10. The Australian Government should give its support to further consideration of altered scopes of professional practice in the health workforce, and the ways in which this can be achieved without compromising quality of service or outcomes.

11. The Australian Government should include returns from improved health in its evaluations of the cost-effectiveness of expenditures on infrastructure and regional development.

12. The Australian Government should continue to lead work to improve the systems in place for assessing, supporting and upskilling overseas-trained health professionals working in Australia.

13. The Australian Government should increase the priority it gives to various means by which improvements in Indigenous school retention rates and Indigenous health training can be obtained.

14. The Australian Government needs to give greater attention to the means by which the increased numbers of medical students soon to graduate will be trained for general practice and the specialties, and means by which a greater proportion of their training can include exposure to rural and remote areas and issues.

15. The Australian Government should establish a special support scheme for the staff of rural and remote aged care services.

16. The Australian Government should give early consideration to the means by which sufficient numbers of new dental and oral hygiene graduates can be encouraged to work in rural, regional and remote areas (the NRHA has a detailed proposal on this).

17. The Australian Government should increase the number of scholarships available for rural people to study allied health.

18. The Australian Government should consider various options for increasing both the annual number of nursing graduates and their rate of retention in the health workforce.

19. The Australian Government's planned investment in maternity services will require consideration of the obstetric, procedural and midwifery workforces.

20. The Australian Government should consider the introduction of a HECS reimbursement scheme for health professions whose members are currently in serious undersupply and who choose to work in rural or remote areas.

The need for government involvement

12. Providing adequate workforce in any situation involves two sides of an equation: demand and supply. Where the health professional workforce is concerned, limitations and opportunities apply to both elements. To ensure sufficient health professionals for rural and remote areas, the Australian Government must continue to be involved in planning and managing both supply and demand to achieve a balanced and sustainable outcome that will serve rural people into the future. The alternative - a heavy reliance on the free market system - would result in a serious under-supply in rural and remote areas that would have major health, social and economic consequences for people in those areas and for the nation.

13. This involvement of governments in health workforce planning and management can also be justified by the fact that the health of people in rural and remote areas is a key determinant of national workforce supply and productivity. Health workforce investment is therefore in the national interest as well as in the interest of individuals and communities.

14. Despite the ageing of Australia's population, public expenditure on health promotion and illness prevention will help reduce demand for the services of health professionals. In particular, investing in certain health professionals and certain interventions (for instance those concerned with healthy pregnancies and early childhood) can lessen the demand for health professionals at other stages of the life cycle, and reduce the overall call on public funds for health.

15. There are major savings to be made from increases in workforce efficiency in the health sector. These savings have been estimated to be as high as $3 billion a year.[34] This submission suggests a number of ways in which this increased efficiency can be obtained.

16. Health workforce shortages become worse as one moves from metropolitan to remote areas. This trend is evident for all health professions, although nurse to population ratios, while reflecting national shortages, are comparable to non-metropolitan ratios. The significant number of nurses makes national recruitment, retention and re-entry programs for nurses particularly important to rural areas.

17. The key principle of Medicare and the PBS is universality, which underpins their ability to deliver on access, equity, efficiency and simplicity. However, universal access is not a reality for many people in rural and remote areas, given the unavailability of doctors and pharmacists in some places. Where this is the case it is critical that the Australian Government continues to provide funding for alternative first-point-of-contact assessment and treatment services.

18. The explicit national health policy to be developed through the Health and Hospitals Reform Commission should address the workforce challenge and include a national

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[34] "The Productivity Commission in its 'Potential Benefits of the National Reform Agenda', February 2007, estimates that a 5% improvement in the productivity of health services would deliver resource savings of around $3B each year. I think this estimate is extremely conservative." - John Menadue, speaking to AHCRA Summit, 31 July 2007. Workforce efficiency is a major contributor to the sector's productivity.

rural health plan. The rural health plan would in part be based on the outcome of the review of the current rural health framework - *Healthy Horizons.*

19. As a general principle, government health workforce programs should be targeted at greater equivalence of recruitment, retention and re-entry incentives across all health professions.

20. The current multiplicity of rural health programs can be confusing, particularly for young professionals considering their career options, and runs the risk of duplication and program shopping, leading to reduced overall effectiveness. There is little published information on the costs and benefits of the programs. Analyses of the programs carried out since 2000 by or for the Government should be made available for consideration by stakeholders and to form the basis of future policy and program development.

21. The Alliance believes that immediate priority should go to workforce aspects of Indigenous health, oral and dental health, mental health, maternal and child health, and care in the aged sector.

22. Rural students are under-represented in health studies programs apart from medicine (which is supported by a range of scholarship schemes), and there is unmet demand for the scholarships that exist for rural nursing and allied health students. Rural scholarships will increase rural students' representation in health studies programs and help improve workforce supply to rural and remote areas.

23. There is a pressing need for a new national undergraduate rural placement system. It would be heavily reliant on both the university and the clinical service sectors. At present there is much buck-passing between the two, mainly because of concerns about who should pay the students' and mentoring agencies' costs. An injection of additional funds is required.

24. Australia cannot meet its present and future health workforce challenges simply through attempts to train more doctors, nurses and allied health professionals: there will simply not be enough people available to be trained and to fill the positions required. Workforce supply problems are likely to become much worse before they get better. Whereas in 2004 there were about 180,000 new entrants to the workforce, trends already in place will see the working age population grow by just 190,000 for the entire decade of the 2020s – a tenth of the current annual in-take.[35]

25. This means that there needs to be a clear understanding of the factors determining the demand for and supply of health professionals and their services. Work then needs to aim at both sides of the equation: at reducing demand and increasing supply.

Moderating the demand for health care and health professionals

26. The demand for health professionals is determined largely by the demand for health care. The demand for health care is a complex and dynamic phenomenon. Key

35 ACCESS Economics, 2005

determinants include the consumer's educational and employment status, access to information and understanding (ie their expectations), income and assets (ie the ability to buy health care), attitudes and age, as well as by actual (objective) health status.

27. On average, people in rural and remote areas face more health risk factors and have poorer health than people in metropolitan areas. This means that there is more real demand (or 'need') for health care per head of population in rural and remote areas. Therefore people in such areas should have proportionally greater access to health care professionals than people in the major cities, and arguably have an even greater need for investment in infrastructure and staff relating to such things as physical fitness, fresh fruit and vegetables, and occupational health and safety.

28. The demand for health care is also influenced by the structure of the health care system and the role played by specific health professionals in it. If professional scopes of practice change, the demand for GPs, dentists or physiotherapists, for example, will also be affected.[36] For some people this raises the possibility of duplication of service, which raises concerns about exactly how multi-disciplinary teams operate.

29. The very structure of healthcare funding significantly influences the demand for health professionals and health professionals of particular types. The demand for particular interventions by particular professionals is stimulated by their listing on the Medicare Benefits Schedule (MBS). The corollary is that recorded (or 'actual') demand for a particular piece of health care is low (and often under-stated) if it is not listed on the MBS.

30. The demand for health professionals in a particular area is influenced by demography (ageing and migration), the incidence of chronic disease, and the availability of technology and institutional care. It should also be influenced by an increasing emphasis on illness prevention, and there will need to be a shift in workforce to that area. In this context, more allied health workers may lead to less demand on GPs.

31. The need for health professionals can be moderated by a greater emphasis on 'managed self-care', including through a range of structured programs. In the likely event that it continues to prove impossible to provide a sufficient health workforce to meet the demand for services, such personal and community investments will become even more vital.

32. There are also some outright anomalies that affect the availability of heath care and thus the number of health professionals required, such as the patient's mouth and the diabetic's foot.[37]

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[36] A discussion of the reasons why physicians' assistants and nurse practitioners, for example, are still rare in Australia is included in the Alliance's submission to the Productivity Commission (attached).

[37] Although poor oral and dental health is mostly preventable, and affects general health, it was the view of the previous Australian Government that responsibility for the mouth lay with the States and Territories. As far as the diabetic foot is concerned, it may be amputated *in extremis* under Medicare, but can only be treated under Medicare by a podiatrist in a team arrangement under the supervision of a GP and with a strict limit on the number of podiatrist consultations. These oddities could be considered in the context of the review of the MBS.

Increasing the supply of health care

33. To equalise the demand for and supply of healthcare professionals, governments will also need to work on the supply side of the equation. The supply of health care is determined by the number and distribution of formal and informal care givers.

34. The Alliance prepared a submission (March 2006) for the Council of Australian Governments in which it included best estimates at that time of the additional number of student places and health professionals required in each discipline. That submission is attached.

35. The Australian Government needs to lead work to ensure that the health sector attracts an appropriate proportion of the available supply of new entrants to Australia's workforce. This is made more important by the fact, as argued above, that it will not be possible in the foreseeable future to meet all demands simply through increasing the number of people trained in health professions.

36. To help increase the proportion of new graduates willing and able to work in rural and remote areas, Federal and State Ministers for Health and for Higher Education should encourage higher education institutions to affirm special entry requirements for rural students, and include more inter-professional education, rural placements and joint professional placements in undergraduate health curricula. A structured and ongoing professional support/mentoring program would be of particular benefit to professionals practising in isolation (eg the one physiotherapist in a town).

37. There need to be close partnerships between Universities and health care services and employers to ensure that the universities train job-ready professionals.

38. Consideration should be given to increasing the number of salaried health professionals working in rural and remote communities, auspiced by local authorities or other agencies, and with packages that might include guaranteed infrastructure, support and relief. This should be achievable within existing funding parameters, eg through MBS ‘cash-out’ arrangements. Evidence suggests that a greater number of young health professionals would prefer to operate this way than used to be the case, partly because they are uninterested in commercial business practice and because their indemnity risks can be borne by the employer.[38]

39. In some areas where the traditional labour force models have not worked, there have already been moves towards support for a greater number of salaried health professionals. In many areas, health professionals are employed by government (including local government) or non-government agencies, with the auspice taking some of the responsibility for maintaining the business assets and guaranteeing the clinicians’ ability to leave when the time comes.

40. These models include Walk In/Walk Out or Easy Entrance/Gracious Exit schemes. Such initiatives can now be augmented by support from the Rural Medical Infrastructure Fund, whose guidelines are due to be revised. Joint appointments

[38] Indemnity is a particular issue in more remote areas where there are low patient numbers and therefore minimal opportunities to earn enough to cover costs.

involving the public and/or private health system and the university sector are also increasing in importance and should be further encouraged.

41. Retention in the health workforce would be improved if terms and conditions were better. The Catch 22 situation is that as pressure on existing individuals in the health workforce increases, more are likely to leave. Because of the increased cost of tertiary education for individuals, more and more of them are likely to 'follow the dollar'. This can have an adverse effect on the supply of health professionals to rural and remote areas where numbers of patients and their ability to pay are both limited.

42. Retention strategies will be different from recruitment ones and will include access to affordable and appropriate continuing professional development, housing and locum support, travel allowances, peer support, and attractive working arrangements.

43. The supply of health care will be increased through greater flexibility of scopes of professional practice and changes to the relationships between particular health professionals.

44. The current health workforce audit, and the political support it has, should stimulate further research and debate about the scope of practice of various health professionals and the relationship between those professionals. Some of the services of professionals can (and should) be supplemented by the self-managing activities of individual patients; and some by the services of other professionals. Patient self-care can be encouraged through incentives for managed self-care programs, for instance in chronic disease.

45. In any developments relating to scope of practice there will be the need to protect the safety and quality of services in rural and remote areas. Rural areas will continue to need higher levels of generalist skills and special staff support.

46. Changes to the health funding system, coupled with support from existing professions, can result in major improvements in the supply of health workers. The case of practice nurses, who can effectively extend the reach of GPs, is an illustration of how the number and scope of practice of one group of health professionals impact on the effective supply and the scope of practice of another.

47. As already discussed, health workforce shortages are worst in rural and remote areas. This means that such areas are already seeing adapted work practices and are likely to benefit disproportionately from increased numbers of such professionals as practice nurses, physicians' assistants and nurse practitioners. In their preparation, training and support, as for other professionals, it will always be necessary to accommodate the special practice and lifestyle facets of rural and remote health work.

48. Rural infrastructure is crucial to an increased supply of health care. A procedural service cannot exist and an operating theatre nurse cannot work to their scope of practice unless there is recurrent funding and infrastructure is constantly updated to provide safe and appropriate facilities.

International health professionals

49. International graduates in many professions are now important contributors to the Australian health workforce.

50. There should be a national approach to the training, recruitment and skills assessment of all overseas-trained health professionals, with the Australian Government having overall responsibility. Such an approach would bring about greater flexibility and certainty for those entering the Australian workforce from overseas, and more consistent orientation and support for them as part of their settling into the health system.[39]

51. International medical graduates (IMGs) account for over 25 per cent of the rural GP workforce, and over 50 per cent of rural GPs under 45 years old. There is a fear that the *Strengthening Medicare* program will result in losing rural IMGs to urban Districts of Workforce Shortage. IMGs are an essential part of the rural health workforce but concerns have been expressed about assessment processes, cultural adaptation, the amount of support and assistance provided by governments and the level of training, mentoring and supervision available from experienced rural GPs.

52. Specifically, the government should:
    - introduce a more intensive case-management approach to supporting international medical graduates and their families to help ensure that they are successfully placed in fully equivalent medical practice; and
    - provide support for international medical graduates to collaborate with other members of inter-disciplinary health teams, such as allied health workers, clinical nurses, dentists and practice managers.

53. The Australian Government should either re-commit[40] to not actively recruiting health professionals from poorer nations (and require the private sector to adhere to the same

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[39] One of the Alliance's correspondents writes: "All International Medical Graduates (including GPs) should be required to do 2-3 months in the teaching hospitals, and associated clinics, on arrival. This would quickly help them get to know the local culture in a secure environment, with other young doctors to provide support and advice. They could then work in the country, with a network of people they already know to contact for help. This would require a bank of registrars who have almost finished training, who are, from the Colleges' perspectives, equivalent to the IMG. They would cover the 2-3 month gap at the sponsoring rural hospital until the IMG was ready to come to the rural town. If no IMGs need a teaching hospital placement, they would stay home and work at the parent hospital. This would have the desirable effect of exposing more senior Australian trained registrars to rural practice and rural lifestyles. It would be cost neutral because no net increase in numbers of doctors is involved. It would also ensure that there was pay parity between IMG and local trainees."

[40] The Australian Government is a signatory to a Commonwealth Code of Practice, described by the Commonwealth Secretariat in the following terms: "Over the last three decades there has been a steady flow of trained health personnel from developing member countries to more developed countries within and outside the Commonwealth. This has had an adverse effect on the ability of the source countries to meet the health needs of their people. In 2001, Ministers requested the Secretariat to develop Commonwealth Codes of Practice for the International Recruitment of Health Workers. This was done through the activities of an electronic working group of senior officials from several countries. In 2002 they accepted the Code and agreed that work on a Companion Document continue. The Companion Document was tabled at their meeting in May 2003." (Accessed on-line, 20 July 2005, on the website at thecommonwealth.org/templates) An ethical approach to recruitment of health professionals is outlined in *The Melbourne Manifesto.*

principle) or build up the system in such a way as will support developing countries, particularly those in its own region.

54. Around half the population of the Pacific Islands is under 20 years of age. Australia could extend and subsidise its programs in Australia to train students from the Pacific and then employ them for a limited period in the Australian public health sector. They would contribute to health care in this country while gaining education, qualifications, professional experience and a first-hand understanding of the functioning of a prosperous democracy. Many of them would send money home to their families which would help improve lifestyle in their home country. There would be a new cohort to the scheme each year and after a certain time in the Australian workforce, each cohort would return to their own countries. They would all take with them qualifications and experience, and the capability of making significant improvements in their own region.

Enhancing the Indigenous health workforce

55. There will be a substantial interrelationship between the Government's Indigenous education agenda and the Indigenous health workforce challenge. For example, it will be difficult to improve school retention rates and educational outcomes for Indigenous people without significant investment in infrastructure, housing, sanitation, food and health.

56. There is a national workforce crisis and yet the capacity and potential of Indigenous young people are still overlooked. They are an untapped resource. Indigenous students should be given some focus on health sciences at the beginning of their high school years to encourage them to consider health subjects. The universities should promote themselves to students in Grade 8 and above.

57. Indigenous representation in the health workforce can be increased, through:
    - improving the quality of early childhood and primary education;
    - incentives for secondary completion and tertiary entrance;
    - encouragement for pursuit of health sciences;
    - scholarships for Indigenous students;
    - reserved health science places for Indigenous students;
    - specific support for them to enhance their prospects of completing; and
    - transparency of outcomes so that universities can be accountable for rates of course completion by Indigenous students.

58. Aboriginal Health Workers play a key role in the provision of health services to Aboriginal and Torres Strait Islanders and additional support is needed to develop and support the profession. There needs to be implementation of standardised competencies, and attention given to workforce shortages, retention strategies and support for members of the profession (eg for registration and professional association issues).[41]

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[41] The profession is currently regulated only in the Northern Territory.

59. There is often a lack of incentives and support for housing for Aboriginal Health Workers, with the result that recruitment to positions is very difficult and retention rates extremely low.

60. Indigenous Health Workers also continue to encounter stigma in workplaces dominated by non-Indigenous staff. This impacts on levels of satisfaction and retention rates for Indigenous workers. This is another argument for increased cultural awareness training for non-Indigenous health workers, perhaps as a core requirement of service industry orientation programs.

61. There needs to be an established career path for Aboriginal Health Workers from VET to higher education, and it should give recognition of prior learning. There should also be a horizontal path that will provide supports and update training (and affirmation) for people who want to continue at the level of career for which they are qualified.

Rural development: a strategic approach to both demand and supply

62. Because it makes rural areas more attractive places in which to live, rural development is the best medium-term program for recruiting and retaining health professionals in country areas. Attractive rural communities and lifestyles will lead to a greater number of spontaneous decisions by individuals (including health professionals) to go to and stay in such areas.

63. Investment in a comprehensive and high quality IT communications system is a pre-requisite for both rural development and providing equitable access to certain health services, such as digital imaging and virtual medical procedures.

64. Given that indirect (or 'distal') determinants of poor health have significant impact in rural areas, improving both educational and health-related infrastructure has the added advantage of generally improving the health of local residents, thereby reducing the demand for health professionals. The Australian Government should therefore see rural and regional development as an investment in improved health and economic productivity.

65. Parts of the infrastructure that supports business and community life in Australia are in need of major investment. An 'infrastructure report card' approach suggests that there is insufficient national investment, particularly in rail, water management, local roads and stormwater systems.[42,43] To these can be added information technology, public housing, public transport and new energy systems. The availability of high quality infrastructure improves the distribution and productivity of workers in all sectors, and governments should see expenditure on such infrastructure as an investment, not a cost.

66. The political will for major investments in rural and regional development depends in part on there being a shared vision about what rural and remote parts of Australia

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[42] See the 2001 Australian Infrastructure Report Card, at http://www.infrastructurereportcard.org.au/

[43] One for Victoria asserts that "As of 2005, some sections of Victoria's infrastructure have become deficient. Those of particular concern have been identified as roads, rail, ports, irrigation, stormwater, electricity and gas." See www.InfrastructureReportCard.org.au

should look like in twenty-five years' time. The Australian Government should work collaboratively with the public towards such a shared vision. The vision would then need to be supported by national policies on population, settlement and access to services.

67. For these reasons a 'whole of governments' approach is necessary for effective rural development, which is of vital interest to people in the health sector, as well as to country people themselves.

Issues for specific sectors and professions

Rural general practice

68. In Australia the GP is at the heart of primary care and will normally be the key member of the multidisciplinary health care team. There should be further work to evaluate and, as appropriate, consolidate the various rural and remote general practice incentive programs. Following this there needs to be further work to adapt and adopt the effective ones as models for use in nursing, allied health, paramedicine, dentistry and other professions.

69. The further evaluation of programs for rural general practice will give attention to anomalies that arise as a result of unintended friction between the initiatives of various government agencies. For example, the NSW medical cadetships scheme is likely to have greater difficulty in increasing the supply of doctors to the State's Base Hospitals because of the Australian Government's HECS reimbursement scheme, which provides an alternative means by which young doctors can defray the cost of their education.

70. It has been predicted that the number of domestic graduates from Australian medical schools will increase by 81 per cent by 2012. Medical workforce planning will need to manage the flow-on effects of this significant increase in medical student numbers. Initially, this will involve balancing undergraduate student numbers with adequate training places. It will also involve strategies to ensure that there are sufficient numbers of clinical teachers, that allocation of teaching time and access to patients is adequate, and that necessary infrastructure to accommodate increased numbers of trainees and doctors is in place.

71. Medical workforce planning will also need to involve strategies to influence the career choices of doctors so that population health requirements are reflected in the composition of the future medical workforce.

Aged care

72. There is an acute shortage of staff in the aged care sector, particularly in rural and remote areas, and governments do not allow for the higher costs of providing aged care services in rural and remote areas. The Viability Supplement has been extended to community (cf institutional) aged care services in rural and regional areas, but many facilities in more remote areas still find it very difficult to be economically sustainable and to attract staff.

73. The government should establish a staff support scheme for rural and remote aged care services, to include support for e-learning and other forms of distance education and give access to training for staff, support the recruitment and induction of skilled staff, and provide staff and family benefits. Many registered and enrolled nurses have been replaced by unlicensed health care workers.

74. Governments should also consider how to overcome the impact of the pay differential for nurses between the aged care and acute care sectors, which has a significant impact on the number of nurses willing to work in aged care. Nurses in aged care in some jurisdictions currently earn around 30 per cent less (which equates to $20,000 per annum or $250 per week) than their colleagues in the acute sector.[44]

Mental health services

75. Poor mental health continues to be a serious challenge in Australia and, where mental health services are concerned, rural and remote people have special needs. A substantial part of the Australian Government's new allocation to mental health is being provided through new Medicare item numbers for GPs and psychologists. There is the worrying possibility that the new item numbers may attract mental health professionals from the public to the private sector, and (potentially) from rural and remote centres to regional and metropolitan centres where the market for their services is more aggregated.

76. The workforce audit should analyse the data on the distribution of current Medicare expenditure and recommend specific measures for rural and remote areas as appropriate.

77. Promoting direct entry mental health nursing programs (similar to direct entry training for midwives) would be one way to increase the mental health workforce.

The oral and dental health workforce

78. People in rural areas suffer poor oral and dental health, yet there is a very serious shortage of dentists in rural areas. There are 55 dentists per 100 000 people in the major cities compared with 17 per 100 000 in western New South Wales and even less in remote Queensland. In parts of Victoria people have to wait up to four years for public dental treatment.

79. The commitments of the government to making public dental health services available to eligible patients will be of major importance.

80. The distribution of dentists and allied oral health professionals in rural and regional areas should be assisted in the medium term through the new dental schools at Charles Sturt and James Cook Universities and by the growth in undergraduate places elsewhere. Nonetheless, a system of incentives or managed practice rights will be essential to ensure that sufficient numbers of the new graduates practise in rural, regional and remote areas.

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[44] Australian Nursing Federation, Nurses Paycheck, December 2007-February 2008, Volume 7, Number one.

81. There is a multitude of challenges to be overcome to have some of the private dental/oral health workforce move from the wealthier parts of major cities into regional private practices, let alone rural and remote public dental services. More rural students in dental and oral health courses, excellent rural/remote undergraduate placement experiences, significant rural incentives for new and experienced graduates, vital rural communities and well-resourced health services are all essential elements of what needs to be in place.

82. The Alliance reiterates its call for undergraduate scholarships for students from rural and remote areas to study dentistry, oral therapy and oral hygiene; for professional and infrastructural resources in rural and remote areas to enable all dental schools to promote and support undergraduate training opportunities and new graduate placements; and for relocation incentives for city dentists and allied oral health professionals to live and work in rural areas.

Allied health

83. There are still major gaps in data relating to allied health professions and the need for their services. A benchmarking approach (ie checking on ratios of numbers of staff to patients) would help highlight the shortages, especially when account is taken of the great distances and number of communities single allied health professionals often have to serve. In these circumstances it is seen as grossly inequitable that the incentives available to nursing and medical staff – as well as to teachers – are not available to allied health professionals.

84. Despite data issues, it is clear that there is a serious continuing shortage of allied health services in country areas. The Australian Government should make further efforts to encourage rural people to study allied health disciplines, and State and Territory governments should increase the priority given to allied health positions in non-metropolitan areas.

85. Specifically, there is the need for an increase in the number of scholarships for rural people to study allied health.

Rural specialists

86. Although specialists are thin on the ground in rural areas, they play a critical role both in making it possible for rural people to avoid going to capital cities for treatment, and in teaching the next generation of students (eg through the University Departments of Rural Health).

87. The limited amount of data available indicates that the distribution of health specialists is becoming worse. In Victoria, 50 per cent of paediatricians in rural areas will have retired in five years.

The role of hospitals in workforce supply and distribution

88. Hospitals are key players in the health workforce system. They are not only places for the delivery of health care. They provide both the practice and industrial location for many people in the health workforce and the bulk of the training for a number of health professions.

89. Hospitals should be encouraged, including through the new Australian Health Care Agreements, to play a leading role in the development of multidisciplinary teams and pioneering new scopes of practice.

Nursing

90. The nursing workforce is the largest single part of the health workforce, including in rural and remote areas. The shortage of nurses in rural and remote Australia is very serious. At any given moment, a significant proportion of those trained as nurses within Australia are not in the nursing workforce. This attests to relatively poor rates of pay in nursing, the difficulties and conditions of the work, and perhaps a perceived low esteem of the profession.

91. There are still too few nurses to meet the future health needs of the Australian community. It has been estimated that an extra 3000 nursing undergraduate places need to be funded initially to address this shortfall, and the ANF is now calling for an additional 1000 places a year.

92. In addition to increasing the actual numbers of trained nurses, strategies need to be implemented to make nursing a more attractive career by removing some of the disincentives and improving pay and working conditions.

93. Work should be done with the States and Northern Territory to provide nurses in rural and remote areas with access to reliable information technology, and training and support for its use.

Health service managers

94. Some rural and remote health services have very limited management capacity and there need to be enhanced opportunities for management training. There are reports that many rural health clinicians move into management positions without any preparation and have to ‘muddle through’ – even though a manager's incompetence can be more dangerous than a clinician's. One of the other consequences is that the clinician workforce - often nurses - is depleted.

95. Improving the preparation of and support for health service managers is particularly important in relation to Aboriginal health staff. The joint ACHSE/Aboriginal Health and Medical Research Council of NSW management training program has been discontinued due to lack of ongoing funds, and at a national level it has been difficult to get agreement from the States to fund a national initiative in this important area.

96. The position of health service manager in rural and remote areas should be recognised as a specialist area of management and should be an attractive position with good career opportunities. Employers of health service managers, including governments, should resource the positions appropriately, and managers in rural areas should be remunerated on a competitive basis with those in metropolitan health services.

97. Opportunities should be provided for career health managers to experience rural aspects of health management and a general rural orientation. Health systems should recognise the importance of providing career progression opportunities and good access to professional development for managers in country areas.

Ambulance officers and paramedics

98. The ambulance paramedical sector - particularly in rural, regional and remote areas - has been playing a leading role in the safe and supported expansion of scopes of practice.

99. The sector has had long-term recruitment and retention problems but, despite this, new flexible workforce roles have emerged to meet the needs of communities in rural and remote areas. With hospital emergency department resources becoming stretched and with the limited number of medical practitioners who can attend to patients outside their surgeries, paramedics are becoming first line primary health care providers, particularly in small rural communities.

100. This integration of publicly-funded clinical care by ambulance services and other local professionals has further potential to enhance services in rural and remote areas.

Maternal and child health professionals

101. Workforce planning should, as a matter of priority, seek to better meet the needs of mothers and babies in rural and remote areas. This is not only a social justice issue but one of the best possible investments in the future health of Australia. The challenge is for Australia to develop world's best-practice programs for supporting pregnant women and their babies in the first few years of life.

102. There is a shortage of appropriately qualified health professionals in rural and remote areas for maternity services. The loss of local maternity services shifts significant risk away from health services and onto families. There is an increased chance of birth occurring outside the appropriate care setting, a higher risk of associated complications, and greater costs in time and money to be borne by mother and family. These immediate costs are incurred through increased travel and accommodation away from home, with concomitant family dislocation.

The workforce and the evidence base

103. As discussed above, many parts of the rural and remote health workforce puzzle are not yet informed by a good evidence base. A small additional investment in targeted rural and remote health research would yield substantial benefits through greater certainty about health service program effectiveness, labour force gaps and duplication, and specific workforce incentives.

104. Improved research infrastructure and quarantined funding for rural and remote health research would not only help improve the evidence base and the research effort, but would also help support the recruitment and retention of clinicians to rural and remote Australia. It would allow clinicians to maintain and develop their research skills and interests while working in rural and remote areas.

Redesigning training systems

105. The best future for rural and remote health services will see a greater emphasis on multi-disciplinary teams, with individuals from a variety of health disciplines working together. This has important implications for how health professionals are educated and trained, and for the infrastructure that needs to be provided for their work. The variety

of successful service arrangements already in place in rural and remote areas provides some evidence of how workforce reform should proceed in Australia and should encourage further developments in interprofessional education and professional development.

106. Any program designed to increase the exposure of health students to rural and/or remote areas will impact on communities, mentors, teachers in the field, as well as on students themselves. When added to the significantly increased numbers of medical students already required to have rural exposure, this will mean a substantial challenge for the existing clinicians and institutions who will undertake the mentoring and support. This challenge must be provided for and supported as part of the rural health workforce plan.

107. Governments should work with the universities and health professions to establish a national system of quality rural placements for health science students. Part of this would be enhancement of the network of University Departments of Rural Health (UDRHs), through the establishment of new and the augmentation of some existing UDRHs, to service regions that currently have no connection with a UDRH.

108. New and existing UDRHs should all have a strong multi-professional focus across their education and training programs, including where possible the promotion of joint placements of medical, nursing, dental and allied health students.

109. There should be an increase in the number of joint academic/clinical health positions in rural and remote areas, providing support to health science students, new graduates and local practitioners.

110. Consideration should be given to the introduction of a HECS reimbursement scheme for nurses, dentists, oral therapists and hygienists, allied health professionals and others who choose to practise in rural and remote areas.

111. The current system for training medical specialists should be scrutinised to determine what improvements are possible. The apprenticeship model tends to favour urban settings, where the majority of staff and institutions are located.

Attachment 6

NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to
the Department of Health and Ageing

related to its Review of
Rural and Remote Health Service Programs

February 2008

National Rural Health Alliance
PO Box 280
DEAKIN WEST ACT 2600

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

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Executive summary

The need for special health services in rural and remote areas can be justified by poorer health status, the lower density of population, poorer access to the financial pillars of the health system (MBS and PBS) and relatively poor access to health professionals.

Over the years, governments at all levels have responded to this particular need by instituting special programs. Although a number of the more important and better-funded services are bundled in the Rural Health Service program, there has been a piecemeal or incrementalist approach overall to the development of new policies and programs. This has resulted in a large number of rural health programs - so many, in fact, that it is commonly assumed (in the absence of clear evidence on the matter) that there must be generally poor interrelationships between the various programs and, in all probability, gaps and overlaps in their operation and coverage.

This historical incrementalist approach might be attributed in part to the proliferation of separate interest groups based on particular professions, disease conditions and locations. The NRHA works to synthesise the views from particular professions and locations into a service approach that can be rolled out - with due allowance for local conditions - in all rural and remote areas.

The systematic review undertaken through the Australian Primary Health Care Research Institute (APHCRI) has described how models of primary health care for rural and remote areas may be classified, and also identified some of the key characteristics of success for such services. A two-page summary of that APHCRI report is attached to this submission. The Alliance has also made available to the Rural Health Branch a copy of its submission to the health workforce audit and that piece of work includes a number of issues relating to the efficiency and effectiveness of rural and remote health services.

As the current review of *Healthy Horizons* is demonstrating, that national framework provides considerable clarity about the most important goals and principles which should direct health services in rural, regional and remote areas. *Healthy Horizons* also lists many of the principles to which appropriate and effective rural health services should adhere.

The Alliance has undertaken a 'straw poll' of its Member Bodies' opinions about the programs included in the Branch's current review. A summary of those opinions, in note form, appears in an attachment to this submission. (In the absence of comprehensive and up-to-date evidence, a straw poll may be likened to the one eyed man in the country of the blind. To improve the situation, the Alliance has compiled a list of research priorities in rural and remote health, which it first produced in August 2006 and which it has from time to time updated.)[45]

Finally, this submission briefly comments on selected issues which pertain to the operation or evaluation of health services in rural, regional and remote areas.

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[45] This health services review may also benefit from revisiting the recommendations to Health Ministers from the 'Improving Rural Health' Reference Group for the Australian Health Care Agreements in 2002.

The National Rural Health Alliance (NRHA) welcomes this review. It would welcome some rationalisation of programs without an overall loss of funding, always assuming that increased effectiveness would be the result. The Alliance's general position is for increased funding but with a broader, equitable national perspective, and thus a greater consistency across the nation. We should be aiming for a systematic approach to sustainable systemic change. The logical sequence would be:

(1) have the National Health and Hospitals Reform Commission develop, in consultation with health service providers and consumers, a national health plan and a rural health plan;
(2) rationalise the multiplicity of rural health programs through identifying gaps and overlaps consistent with the plan, while ensuring no net loss of funding; and
(3) design and implement a monitoring and evaluation strategy that is built into these programs.

Recommendations

The Alliance recommends that the Australian Government:

1. re-commits to its policy of providing special health services in rural and remote areas to compensate in some measure for the poorer health status, the lower density of population, poorer access to the MBS and PBS, and the relatively poor access to health professionals;

2. should put in place the means to systematically evaluate rural health services on an ongoing basis, the relationships between them, and any gaps or duplication that might exist in their operation and coverage;

3. develops a planned and strategic (ie longer term) approach to the provision of rural and remote health services, based on the flexible application of consistent outcome targets and input benchmarks;

4. should re-commit to achievement of the goals of *Healthy Horizons* and to the principles specified in it;

5. continue to fund the Rural Health Strategy at a level at least maintained in real terms; and

6. augment the evidence base on the need for and effectiveness of rural and remote health services by supporting additional research activity, including through the NHMRC and AIHW.

Specific issues

Rural Health Strategy
A number of the programs being reviewed are part of the $830 million Rural Health Strategy. That Strategy is the centrepiece of current Australian Government rural and remote health initiatives.

In the absence of any clear evidence about more effective approaches, the Alliance hopes and assumes that the Rural Health Strategy will be rolled over for another four years with at least equivalent real funding.

Patients' assisted travel schemes
Almost wherever one turns in consideration of rural and remote health services, transport is an issue of concern. The Alliance has made improved patients' travel and accommodation one of its top priorities.

Improving access to specialist and tertiary care for people living in rural and remote areas will help narrow the gap in access to health services and in health outcomes. Where this cannot be achieved by providing local services, the only reasonable alternative is subsidised travel and accommodation to enable these patients to access care in major centres. Because much diagnostic testing, complex treatment and follow-up care will only be available at tertiary hospitals, patients' travel and accommodation schemes should be seen as a key part of the core services for health in more remote areas.

Healthy babies
The Government's increased emphasis on health promotion and illness prevention is clearly the best approach in rural and remote areas - as elsewhere.

Aboriginal and Torres Strait Islander children should be the highest priority for government programs relating to maternal and child health, and the Alliance welcomes the recent announcement relating to Indigenous babies and pre-schoolers. For many families in quite remote areas, much of the maternal and child service, as well as pre-school and early educational support, is provided by Frontier Services of the Uniting Church in Australia (a Member Body of the Alliance). Frontier Services and other organisations with networks like it will need to be heavily involved if the aspirations for the health and early education of Indigenous children in remote areas are to be met.

Significant health improvements are already being made through programs such as Healthy Mothers: Healthy Babies and there should be increased investment in these.

Building capacity in small towns to deliver integrated health care
There are many small towns in which it is not economically or clinically sensible to sustain a number of stand-alone facilities. A range of programs funded by the Australian Government and the States provide services to smaller towns, such as the Regional Health Services program and the Rural Medical Infrastructure Fund. Despite these, the shortage of 'multipurpose infrastructure' (eg clinic buildings, staff accommodation, IT services) in such small towns is still a barrier to the provision of primary health care delivered by integrated teams.

People in rural and remote areas value the Australian Government's collaboration with the States and the Northern Territory in localised 'funds pooling' that occurs through the Multi-Purpose Services program. It may be possible to formalise this collaboration, and to further improve health services, through the new Australian Health Care Agreements - particularly given the significant improvement in Commonwealth-State relationships (or 'collaborative federalism').

Regional cancer care

An estimated 106,000 new cases of cancer were diagnosed in Australia in 2006 and the Australian Institute of Health and Welfare expects this number to increase by 31 per cent over the next five to ten years as the population ages.

A New South Wales study has shown that survival rates from cancer are lower in rural and remote areas, reflecting later diagnosis due to poorer access to services, including specialist cancer services, and difficulty in accessing treatment. The relative difficulty in accessing specialist cancer services also means that the interventions chosen tend to be more radical, in order to reduce the need for regular repeat trips away from home for treatment.

The NRHA is among those to have called on the Australian Government to establish a regional cancer care reform program built around cancer centres of excellence in larger rural centres. Currently just eight sites service almost half the Australian population. The existence of specialist cancer services in regional areas would reduce the need for people from more isolated areas to travel to the capital cities.

New models of care

For over a decade in Australia there have been health service trials, funding innovation, pilots and projects including (for rural and remote areas) through schemes like the Rural Health Support, Education and Training Scheme, the Regional Health Service Scheme and Co-ordinated Care Trials. These have produced a wealth of information about how health service systems can be improved.

The APHCRI study mentioned above has made a start in drawing together and analysing the evidence against particular criteria, to see what works and what directions should be taken.

However further work needs to be done and the research agenda should get to that task immediately, to synthesise the work that has been done and analyse it against policy parameters. The research outcomes need to be able to be explained in ways that are relevant to policy makers, particularly those in central agencies like Departments of Treasury, Finance and of the Premier.

Such detailed evaluations may well lead to the development of some new options for delivering services to people, and people to services. Against a backdrop of the loss of hospitals, of procedural activity and obstetric care in many small communities, the scope for initiatives such as small-scale birthing units (staffed by midwives with obstetric back-up) should be investigated. Adequate telehealth infrastructure should be made available to selected remote sites as a means of increasing access to distant services for remote families.

The neglect of primary health care has led to an over-reliance on specialised medical care to deal with readily preventable chronic diseases. There needs to be greater public investment in community health care, especially through direct Government funding of new multidisciplinary health centres.

As indicated by the Government, there needs to be less focus on acute care in a medical model - which is relatively expensive - and more on prevention and early intervention. New models of care are likely to require some new funding models. The fee-for-service model has a number of disadvantages for rural communities. Fee-for-service is not well suited to meeting the needs of those with chronic and complex care needs - which is an increasing proportion of the population. Fee-for-service sets medical care in primary and ambulatory settings as a funding silo and provides little opportunity for strategic planning of services. A uniform focus on fee-for-service results in the phenomenon 'No Doctor: No Medicare' for some people.

Increasingly, young doctors (and, it might be assumed, new graduates in other disciplines) are showing themselves to be risk-averse, indicating that they would prefer salaried positions or a mix of salary and fee-for-service, particularly if it means they can avoid setting up their own practice and managing the associated risks and costs of their own business.

The classification of 'rurality'

Apart from its inherent attraction to students of geography, the challenge of classifying Australian places by size and density, remoteness, or 'liveability' was of little importance until it became the basis of policies that allocated benefit – usually money. Governments need the means of targeting programs to particular spatial areas, and currently there are three systems used: RRMA, ARIA and the ever more popular ASGC.

The Alliance made a submission to the review of RRMA and some of the views expressed there are relevant to the current review of rural health services. The Alliance's experience as manager of RAMUS has given it insights into the pros and cons of the RRMA classification.

In an ideal world, the distribution of health resources should be on the basis of five elements: geography, workforce supply, health and wellbeing, population size and access to other health services (not just access to health professionals).

This would require five indices:

1. a measure of remoteness as currently conceptualised in RRMA and ARIA;
2. a measure of town size;
3. measures of the ratio of particular health professionals to the need for their service;
4. a measure of the community's access to health care (the Rural Workforce Agency Victoria undertook some work on a proposed National Index of Access to Health Care; paper attached); and
5. a measure of health status or the need for health care (SEIFA is a reasonably proxy for this).

The existence of these five would enable programs related to particular issues to be better targeted. For example, distribution of resources in an allied health program would be assisted by the measure of allied health professionals to allied health need. A public health program relating to low income or attitudes to diet would be assisted by consideration of the SEIFA

scores for particular areas. Programs related to outreach services or new health infrastructure could be guided by a new National Index of Access to Health Care.

Existence of the five indices would also permit useful analyses, for example on the health impact of particular levels of access to health professionals; the health impact of distance on places with equivalent access to health services; or the relationship between town size and health service or health status. Analyses like these are not possible with just a single indicator of remoteness.

There might also be a composite index. All places, city and country, could be scored on the combined place/access/status index and it would provide a useful tool for policy makers concerned with overall health need.

This situation would be much preferable to the one that currently exists and it is an ambitious undertaking. However, as the Department's Discussion Paper on RRMA put it: "An enormous increase in computing power and functionality of geographic information systems and the continuing increase in the availability of spatial data has allowed the development of more sophisticated geographic classifications than was possible ten years ago".

If RRMA is still to be used, it should be updated, using ABS data from 2001 and with an updated list of place names. The Alliance's experience with RAMUS suggests that information about the structure of RRMA and its scores should be freely and publicly available, including through simple on-line access to the RRMA score for each place.

An objective measure of health service need would show that some outer-metropolitan areas are more deprived than the inner city. However it is a matter of concern to country people that an increased focus on outer metropolitan areas might be at the expense of resources or efforts directed to rural and remote areas.

Service access standards

In a paper produced for the Department in 2004, focused on the specialist health workforce, the Alliance proposed that governments should develop and endorse 'service access standards'. These would provide benchmarks to assist regions and others in planning health services and to define for Australians the publicly-funded health services to which they can reasonably expect access.

This notion has remained under discussion in the Alliance since that time but without clear resolution. The Alliance is aware that the States and the Northern Territory have service standards or benchmarks for individual services, as well as some more generalised or high level targets for their jurisdiction as a whole.

Services and access have to be measured at the local level.

The care provided by a particular profession should be considered in the context of broader considerations of access to health services, particularly in rural and remote Australia where there is a greater need for generalists and health care teams.

Health service access standards would be a useful tool to guide future health service planning and to educate Australians about the publicly-funded health services to which they can

reasonably expect access. Further, they would be useful to guide the rebalancing of health funding to more closely link funding to health needs.

As described in the Alliance's submission to the workforce audit, an effective approach is to consider the population's needs in broad areas of care, for example birthing services or child health (not obstetricians or paediatricians) and how best to provide these services to local communities. This requires the determination of sustainable service models and their associated workforce requirements. Such a level of comprehensive health service planning would be beneficial across the board.

Flexibility for communities in the development of health plans is essential. It will enable local communities to integrate programs to suit their unique health requirements and fully utilise their limited resources. At any time there may be funding sources across a range of services from local, state and commonwealth programs, as well as private providers. Additionally workforce availability and health status within the community may change during the life of a program.

A national plan to improve health in rural and remote areas

The Alliance supports a more focussed and co-ordinated approach to addressing health workforce and healthcare access problems in rural and remote areas. A new national plan or framework should be agreed within which locally-relevant models of care can be developed.

Local communities should be assisted to devise local solutions for their health care needs, informed by evidence about their own health needs, available resources and health priorities, the experience of other communities and the findings of research and evaluation of alternative approaches.

To assist in this process it would be useful for the Australian Department of Health and Ageing to publish and regularly update a compendium of good practice models which have been successful in increasing access to care in sustainable ways in rural, regional and remote areas with previously poor access.

The evidence would show that effective and sustainable rural and remote health services are those which:

- involve the local community;
- have sufficient and secure levels of funding;
- build upon local resources and themselves contribute to local capacity building and infrastructure;
- have effective leadership/management, governance and administrative support structures;
- have sufficient staff; and
- provide for the professional and personal needs of their staff.

Outreach services

In the short-term, whilst a critical mass is being established in an area, outreach services from metropolitan centres can be funded to provide specialist medical services to outlying areas of the region. This role should always include a substantial element of transfer of skills and expertise to the local health workforce and be in line with an agreed service development plan for the region.

As with outreach service provided from local centres there must be agreed protocols about roles and responsibilities, eg who is responsible for follow-up care (routine or in an emergency), what must be provided by the outreach team and what locally (eg personnel, equipment, supplies, complementary services), and who is responsible for organising and funding the program and its detailed implementation.

Special funding should not be provided to support metropolitan clinicians providing outreach services in regional areas unless the service is an agreed part of a health service plan for the region. In such cases there must be co-ordination with other health services and agreed protocols defining the roles and responsibilities of the outreach staff and local professionals.

Medicare: the central pillar – but not immutable

Medicare is the centrepiece of the health system, including in rural areas. It includes access to medical services at affordable prices, funding for public hospitals and the Pharmaceutical Benefits Scheme. The system has to be protected and enhanced.

Notwithstanding its centrality, however, the Alliance welcomes the Government's intention to review aspects of Medicare.

Medicare's achievements in rural and remote areas have been limited by the under-supply of GPs, long distances to hospitals, higher costs of health care, and the relatively small proportion of Indigenous people with Medicare cards. With the lower level of bulk-billing in rural areas, average out-of-pocket costs of medical attention are higher in the country. There is also a decline in access of rural residents to their local hospital, partly because of the decline in numbers of practising procedural GPs.

A number of professions contribute to health outcomes in rural and remote areas and the Australian Government needs to consider how coordinated primary health care can be enhanced, especially in more remote areas.

The Alliance strongly supports Medicare's fundamental principle of universal access. This provides ease of access, avoids the stigma and poverty traps of a purely welfare system, and makes access to health services a common right – not a 'safety net'.

The Government should enhance the capacity of the existing Medicare system to cover the costs of other forms of primary health care, as it has done for practice nurses. There needs to be further consideration of the role of psych. nurses for mental illness and physios for musculoskeletal illness, in order to expand primary health care and provide a more cost-effective system overall.

Attachments to this report

Attachment 1 is a summary of the Australian Primary Health Care Research Institute (APHCRI) report on models of primary health care – how they may be classified and the key characteristics of success.

Attachment 2 contains a listing of the programs included in the current internal review and some brief comments provided by members of the Alliance Council who are familiar with the operation of these programs.

Documents attached to this submission are the RWAV paper on a national index of primary health care access, the Final Report from the 'Improving Rural Health' Reference Group (September 2002), the NRHA's Models of Specialist Outreach Services paper (February 2004) and its recent submission to the Workforce Audit.

Attachment 1

Sustainable Models of Primary Health Care in Rural and Remote Australia –

What the Evidence Says

Rural health policies over the past decade have been driven by the need to reduce health inequalities between metropolitan, and rural and remote Australia. These policies have concentrated on addressing workforce issues, targeting the medical workforce in particular. Less policy attention has focused specifically on the systematic development of sustainable comprehensive Primary Health Care (PHC) service models appropriate to rural and remote Australia. There is a need to know what model works best where, and why.

The following are key messages from a series of studies focusing on rural and remote PHC services carried out by an Australian Primary Health Care Research Institute rural and remote research 'spoke'.

- There has been a significant amount of 'innovation' over the past 15 years, but with an overall relative lack of rigorous health services evaluation.
- Given the geographical and demographic diversity of rural and remote Australia, there is no ‘one size fits all’ health service model.
- Evidence suggests a number of PHC models that can be classified as *discrete*, *integrated*, *comprehensive* and *visiting* model types.
- There exist well evaluated exemplars of each of these model types which are amenable to generalisation and evaluation in other regions.
- The nature of population distribution is a critical factor in designing PHC services: successful models address diseconomies of scale by aggregating a critical population mass, whether it is a discrete population in a country town or a dispersed population across a region. Based on current experience, it would appear that a minimum population base of about 5000 for rural and 2000 to 3000 people for remote communities supports an appropriate, sustainable range of PHC activities.
- Successful implementation is linked to systematically addressing *environmental enablers* (appropriate policy, compatible Commonwealth/state relations & community readiness) and a number of *essential service requirements (*funding, workforce, governance/management/leadership, infrastructure & linkages)
- This framework forms the basis of guidelines & principles for PHC service development (see reference 2 below).
- Policy is critical to sustaining services.
    - Funds pooling is effective in enabling services to meet community needs.
    - Agreed Commonwealth-state relations & accountabilities facilitate appropriate service development.
    - Australia needs a national rural & remote health policy & plan.
- Community involvement is essential.
    - Different forms of community participation must be recognised.
    - Community involvement in service development & governance training needs to be funded.

- Effective governance, management & strong leadership are priorities in the implementation and sustainability of PHC service, although existing community capacity is often limited
- Workforce is important, but may be significantly de-emphasised when other linked ‘essentials’ are addressed, especially human resource (HR) practice. Effective HR practice requires recognition of and training for managers.
- Workforce recruitment and retention are different.
- Effective recruitment contributes significantly to good retention.
- A workforce retention ‘package’ is the best retention strategy, underpinned by good management and governance. This ‘package’ includes:
  - Adequate staffing with reasonable workload;
  - Adequate infrastructure, including housing, vehicles, appropriate IT;
  - Realistic remuneration that includes retention bonuses;
  - A workplace culture that values workers with adequate CPD, support & mentoring;
  - An attractive workplace environment, including orientation & career pathways.

Research evidence highlights that health service planning for small rural and remote communities will only be effective within a constantly changing demographic and economic environment when it takes account of the need for comprehensive, sustainable and systems-based solutions that address all components in an integrated way.

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Attachment 2

Summary of responses from Council

Program	Comments
1. Improving Access to Primary Care Services in Rural and Remote Areas (COAG)	Not widely known. “Is it in all jurisdictions?” “Some Divisions don't have the infrastructure or local networks to support the coordination of quality services in areas outside regional centres. The service focus, eg drug and alcohol, needs to be driven by the community and based on local needs and partnerships. There needs to be a local program not a generic one.”
2. Helping Public Patients in Hospitals Waiting for Nursing Home Places (COAG)	Not widely known yet (just starting?) – “some States have negotiated to use some of this money for education and training - it needs to be done in a consultative way”. (The focus in this area is mostly on the need for more nursing home places for towns with small populations, with criteria for application that are distinct for rural areas.)
3. Multipurpose Services (MPS)	Widely known and strongly supported. “Has much value.” “Underpins the very existence - the viability - of aged care facilities in many small communities.” “An excellent initiative but some state health services do not understand the value of the program and its potential - the program is crying out for evaluation and for benchmarks or other standards.”
4. Regional Health Services	Well known and highly valued. “most valuable in creating multidisciplinary teams and recruiting allied health professionals in remote areas. Its experience provides strong modelling for permanent Commonwealth funding of remote primary health care” “Enables some fund pooling and so innovative and locally responsive services.” However “funds have not grown or kept pace (for 7 years?)”. “Great things are sometimes accomplished but resources tend to get sucked into acute care.” “the RFDS has used the RHS funding to deliver mental health services to remote areas from Cairns and around Longreach”
5. Royal Flying Doctor Service	Very well known and very highly regarded. “has much value – including for transfers to higher levels of care” “Couldn’t survive without them” “It remains not only the safety net but also the de facto primary care service to the people of remote stations. Blending primary or even hospital duties into RFDS positions is difficult because of staff shortages and the difficulties of maintaining emergency responsiveness”
6. Rural Women's GP Service	Managed by the RFDS. Not widely known but regarded as valuable, increasing the choice for women in smaller towns.

Program	Comments
7. Medical Specialist Outreach Assistance Program	Widely known. "It depends on the availability of specialists at the regional or tertiary centre, so continuity of service is not guaranteed. It is not always well coordinated with local services and too little use is made of e-health strategies. It is essential that it reaches out to 'difficult' areas - not just to sea-change towns". "has much value – including for oncology, orthopaedic, ENT services to rural and regional hubs." Seems to vary between jurisdictions. Very useful in Qld. which is more decentralised and has longer distances. "Lack of capacity for this program to support allied health staff linked to medical (eg audiologist and ENT)."
8. Rural Private Access Program	Not well known. "has much value - enables upgrade of capital stock to attract and retain health professionals and expand range of service." "limited private services in country WA. Need a different approach to facilitating private services." "underpins Wheatbelt Podiatry in WA" "it does not seem to have the capacity for increasing primary health care services to any great extent. Need money for infrastructure grants"
9. Visiting Optometrist Scheme	Not widely known. "The service is under-promoted and underutilised in remote areas" "Calls monthly – is highly valued"
10. More Allied Health Services	Widely known and highly valued. "Need to integrate MAHS service planning with other service providers (so services are complimentary)." "Funded since 2001 for counselling (psychology); has much value; held as best practice; high uptake by community" "an ad hoc program that seems to have had its best results in bringing practice nurses into GP rooms rather than allied health into underserviced rural communities. The expansion of the EPC program would be more effective in encouraging allied health services to become established in the private sector" " the finite resource of allied health professionals would have greater community benefit if it had a broader role incorporating clinical practice with prevention and promotion" "maybe MAHS could be funded under Regional Health Services so that new services can be developed?"
11. Multipurpose Centres	"a one-stop shop - great for the community and good for teamwork" "some confusion with MPSs"
12. Better Management of Rural Health Programs (COAG)	Not widely known.
13. Mental Health Services in Rural and Remote Areas (COAG)	"has much value" "monthly service here is much needed" " RFDS has provided services under stage 1 and applications are are in under stage 2 for Queensland, NSW and NT"

Program	Comments
	"all UDRHs now have mental health academics funded to June 2008 and these positions need to be funded through to 2012."
14. Mental Health Support for Drought Affected Communities Initiative	"This is an area where there is duplication with other Commonwealth and State efforts - GP networks do not always have links on the ground in agricultural communities, especially where the GPs are locums or short-term OTDs" "much value; helps local service network development" "much needed; needs to be counselling services available locally and a good referral system"
15. Rural Palliative Care Project	"worked very well with local hospital" "has much value"
16. Supporting Women in Rural Areas Diagnosed with Breast Cancer	"much needed; currently left to locals to organise; has much value"
17. Building Healthy Communities and National Rural Primary Health Projects	"RFDS Queensland section has run two BHC projects from Cairns - healthy towns project, and increasing capacity through health leadership in remote Indigenous communities" "BHC projects usually do good work -- in low capacity communities there are real problems of sustainability but that doesn't mean the efforts should stop"
18. Rural and Regional Building Fund	Not widely known.
19. Aged Care Adjustment Grants for Small Rural Facilities	Well known and highly valued. "Conditional Adjustment Payments support training services. The training program not sustainable without this funding." "CAP assists in ensuring our IT meets requirements for training"
20. Rural Pharmacy Maintenance Allowance/Start-up and Succession Allowance	Not widely known.
21. Rural Pharmacy Pre-Registration Allowance	Not widely known.

Note: Those programs tagged 'not widely known' and those programs for which only little information is provided should not be deemed to be inferior on that basis. These comments from our members are provided for the Department's assistance, to give a sense of how the programs (with which our members are familiar) are received 'on the ground'. A nil response or minor response should not be taken to mean a negative response.

Attachment 7

NATIONAL RURAL HEALTH ALLIANCE INC.

A new geographic classification for a new health system

A submission to the
Department of Health and Ageing
related to its review of remoteness classifications

22 December 2008

National Rural Health Alliance
PO Box 280
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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

A new geographic classification for a new health system

This paper outlines the thoughts of the National Rural Health Alliance regarding geographic classifications used by government to allocate rural health incentives (scholarships, retention payments, etc). It proposes a layered system of geographic classifications that we believe could better target assistance in rural and remote areas and could therefore potentially be used to guide allocations in many rural health programs.

The National Rural Health Alliance is the peak non-government body concerned with rural and remote health issues in Australia. It comprises 28 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers, educators and researchers. The vision of the National Rural Health Alliance is equal health for all Australians by 2020. A list of Alliance Member Bodies is at Appendix 1.

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INTRODUCTION

In 2005, the Australian Government Department of Health and Ageing (DoHA) reviewed the geographic classification system used to describe broad levels of geography related to rurality or remoteness. This was called the 'Review of the RRMA Classification', although it was clear that what was being reviewed was geographic classification generally, rather than the RRMA classification specifically.

That work, developed with what appeared to be some good and wide consultation, was never released publically.

The Alliance is pleased that DoHA is currently in the process of reviewing geographic classifications along with its rural health programs generally. This represents a good opportunity to install a strong, flexible and long lasting tool.

BACKGROUND TO GEOGRAPHIC CLASSIFICATIONS

Previously, the Rural, Remote and Metropolitan Areas classification (RRMA), Accessibility/Remoteness Index of Australia (ARIA) and the ABS Australian Standard Geographic Classification Remoteness Structure (ASGC Remoteness, sometimes known as ARIA+) have each been used by government to allocate funding, with all three currently being used by different programs within DoHA and/or for statistical reporting purposes.

Each of the classifications has its own strengths and weaknesses.

The RRMA classification is based on population data from 1991 and allocates a category to each Statistical Local Area (SLA). Since 1991, populations have changed (in some cases substantially), and many of the original SLAs have been broken up or amalgamated. One of the important things about RRMA was that it classified areas in what appeared to be a clunky but sensible way (eg large rural towns versus small rural towns), and both remoteness and town size were taken into consideration so that, for example, larger centres in remote areas like Broken Hill and Mount Isa are distinguished from centres of the same size in rural areas.

ARIA was developed by the Department of Health and Ageing in 1997. Under ARIA, 81% of the population lived in Highly Accessible areas (for example Tamworth and Inner Sydney). This left 19% of the population to be distributed among what were called Accessible, Moderately Accessible and Remote areas (the use of the term ‘accessible’ may have trivialised the remoteness issue and risked losing the concepts of rural and regional from the mix). On another note, places like Urana, Dubbo and Darwin were allocated similar levels of remoteness. From the perspective of the Alliance, and probably from the perspective of the residents of those places, this makes little sense. Additionally, the ARIA system formed the basis for classifying geography for other specific purposes, for instance, when it became useful to look specifically at the distribution of GPs, the ARIA methodology was used as the basis of GP ARIA.

ASGC Remoteness Structure – a recent addition to the ABS Australian Standard Geographic Classification (ASGC) - is what ABS call ‘purely geographic’. It is based on the continuous ARIA+ classification – is like ARIA but with better definition at the remote end, and on a continuous scale of 0 (central Sydney or Melbourne) to 15 (somewhere very remote - deep space perhaps or Central Australia). ABS have allocated a remoteness category by inserting 4 cut-points on the ARIA+ scale of 0-15 (e.g. if ARIA+ score is less than 0.2, then the Remoteness category is ‘major cities’) to form the five categories Major Cities, Inner Regional, Outer Regional, Remote and Very Remote.

The ASGC Remoteness structure makes reasonable sense on the ground, as do the names of the categories. It also benefits from having been developed and maintained by ABS, who want a stable classification that will last for many years. SLA structural changes are taken into account by ABS each time SLAs are broken up or amalgamated, and all (or almost all) ABS (and AIHW) data is available for these categories (i.e. it is possible to statistically describe many of the characteristics of these areas).

One of the fundamental differences between RRMA and both ARIA and ASGC Remoteness is that RRMA combines a measure of remoteness (cities, rural and remote) with settlement size (e.g. large rural, small rural, ‘other’ rural area), whereas the others relate only to remoteness from major population centres. None of them refer to remoteness from actual services: services are assumed to be related to the size of population centres. Also, RRMA uses remoteness based on straight-line distance and relates only to Statistical Local Areas, while the other two relate to remoteness based on road distance and can relate to any area that can be built from census collector districts (eg Statistical Local Area, Statistical Divisions, postcodes, Electorates, states etc).

NRHA struggles to define rural

The Alliance itself defines ‘rural and remote’ in a manner that does not neatly fit with any of the known geographic systems.

In its Constitution ‘rural and remote’ is defined as RRMA 3, 4, 5, 6 and 7, but not including Townsville. Which rural and remote cities should be ‘in’ and which should be ‘out’ continues to nourish debate within the Alliance. Some would advocate that (for example) Albury and Toowoomba (Inner Regional with populations~100,000) be included within the Alliance’s sphere of interest, but that ‘remote’ Darwin (Outer Regional with population~100,000) should not.

Necessarily when Government programs use new classifications, or a range of classifications, organisations such as the Alliance need to translate their understanding of the old classification so that it fits the new classification – this can be rather messy, it is certainly contentious and not at all satisfactory. For example, the Alliance may ask itself whether Inner Regional areas are pretty much the same as Large Rural Centres (RRMA3), and if not, how would RRMA3 be defined using ARIA+?

This new nested system we are proposing would go a considerable way to allowing the Alliance to review and better define its jurisdiction.

The Alliance recognises that along with needy areas outside Metropolitan boundaries, there exist many needy areas within metropolitan boundaries. The new system we propose may also be of use in providing a more uniform tool for allocating resources to populations of need, irrespective of their location. The new system we propose combines elements of place (rural, remote, urban) with elements of need (health and social status etc) – but in a manner which allows them to be dealt with separately when necessary.

What the Alliance would like to see is a well devised, powerful, flexible classification system, capable of being maintained and appropriately adjusted to reflect changes on the ground over a long working life. These characteristics are further discussed below.

FACTORS IN DESIGNING A NEW CLASSIFICATION SYSTEM

In this section we will discuss:

- potential uses for a new classification system;
- desirable characteristics of a new system; and
- important parameters to include in a new system.

Uses for a new classification system

A new classification system could have a number of uses. It could be used to:

- allocate cash incentives, rewards and benefits to rural workers;
- allocate scholarships to students from rural areas;
- allocate and target community development programs, aimed at benefiting health and wellbeing in rural and remote areas;
- differentially stagger Medicare payments;
- differentially stagger health service budgets in rural and remote areas;
- differentially stagger patient assisted travel scheme (PATs) payments depending on circumstances;
- provide a single robust system to underpin the administration of many rural health programs;

- report health statistics in rural/remote areas (so as to monitor performance of and steer policy and programs); and, potentially
- for other purposes.

These are discussed in greater detail on page **Error! Bookmark not defined.**.

Desirable characteristics of the new system

The Federal Health Minister has expressed "concern" that the current system is based on population data from 1991. DoHA previously commenced a process of review with the intention of producing a 'draft review of RRMA', although this has not yet been released.

To the Minister's concerns we add our own. Not only is RRMA based on 1991 population data, but some programs relating to rural health and wellbeing also rely on ARIA and ASGC Remoteness. Confusion and dated systems walk hand-in-hand. To this we would add that these geographic classifications by themselves are very blunt tools – they lump what we see as very different populations together in the same categories.

A new classification system would benefit from a number of qualities, which are discussed below.

The system must be compatible with other standard tools across professions and Departments. There is not much point having a great system if it is used only by Health (to the exclusion of other portfolios).

If the classification is useful only for allocating subsidies to health workers and students, then we will have a very limited system. For example, one would imagine that it would be useful to be able to refer to demographic, economic, health, workforce, etc data using one single set of classifications e.g. those used by ABS. Allocation of subsidies frequently relates to disadvantage on at least one of a number of fronts – and most of these would be available using standard ABS classifications.

The system must be widely adopted in Australia. We currently have at least three classifications in use, which is confusing and not very convenient. Also, current Health programs appear to rely on RRMA and ARIA while available data describing demography, health status, risk factors and access to services in rural and remote areas employ ASGC Remoteness. Whichever system is adopted by Health, it would be extremely handy if this was also widely used elsewhere (ie in other portfolios and/or by statistical agencies).

The system must be meaningful for delivery of rural and remote health services and the overall management of people's health. Clearly the system must make sense on the ground for rural people, for service providers and for administrators.

The system must be long-lived. For example, will the system continue to be used for the next 20 years? The system needs an 'owner' and must be stable over time with regular updates (for example, reflecting population changes). RRMA had been developed by DPI, and was then adopted by DoHA. But no agency took responsibility for keeping it alive - refreshing and updating it so it could continue to be current and clearly justifiable. ASGC is 'owned' by ABS who aim to keep it operational and up-to-date for as long as possible and/or appropriate. Remoteness updates and tools are available from ABS, as is support expertise.

The system must be flexible and powerful. In other words it should provide the capacity for useful information to be both built up and disaggregated (i.e. a multilayered system), providing fine detail when necessary. By itself, ASGC Remoteness will not satisfy this criterion, however, as part of a larger system it may be very useful. If, for example, the new

system utilised not only ASGC Remoteness but also SEIFA, local town size, percentage of population who were Indigenous, local health statistics (e.g. death rates) together, then a powerful and flexible classification could be developed.

Of course, potential downsides include the fact that not all components of the 'classification' could be used on every occasion when reporting statistics. For example, the reporter would start running out of people in very specific categories: eg Indigenous people aged 55-59 in outer-regional areas who are in the lowest SEIFA quintile. However, any of the components could be aggregated in reporting, and not all parts of the system would necessarily need to be reported simultaneously. However, for allocating subsidies, inducements or other benefits, such a system would appear to have real strengths.

The system must be capable of being used for multiple purposes. These might include allocating subsidies to individuals on the basis of their characteristics or those of their community, or allocating benefits to health districts on the basis of the characteristics of the people living there; and it might also be used to report health statistics. This is further discussed below.

The system must be easy to use. The components of the system need to be readily available, easy to use, and with access to expert advice. For example, all components could be available on the DoHA (or ABS) website, along with definitions, concordances, and lists of communities within each category.

Important parameters in an integrated classification system

In our opinion, the following parameters have a bearing on the health and wellbeing of people in rural and remote areas, and so should be included in the new system.

Remoteness

This tells us about the average distance of a particular location from a range of population centres. For example, a location classified as 'inner regional' could be a small town (eg Tumut) moderately close to larger centres, or a large relatively isolated town (eg Dubbo). Remoteness does not necessarily tell us about the size of the population of the urban centre, and it can sometimes be a proxy for other issues, for example, socioeconomic status, or the percentage of the population who are Indigenous.

Living in a rural or remote area may not influence access to some things (eg a doctor, a nurse or to open space), but it likely reduces access to other things such as specialists, schools, universities, public transport, broadband, television, lower prices, teaching hospitals and the ballet.

So remoteness can mean different things in different situations. For example, while a person living in a rural town of 8,000 people may be remote from an oncologist, they may be less remote from a GP (if they have one) than a person living in a major city. Use of remoteness alone and uniformly in each situation to describe rural disadvantage is likely to be inappropriate.

Size of the urban centre

The size of the urban centre is an important concept which is not the same as remoteness. For example, both Darwin NT (population about 100,000, ARIA score 3.0) and Urana NSW (population about 1,200, ARIA score 2.8) are classified as Outer Regional areas. Clearly opportunities for a range of benefits in each urban centre are different, employment and

education opportunity will be different, access to a GP, cancer treatment, aged care and trauma care are likely to be very different in each centre, and while one centre may be attractive to health workers, the other may not.

The size of the local urban centre tells us something about the range of services likely to be available locally and the setting in which health workers and others in the population work and live their lives. It is an important parameter, and one that RRMA (but neither of the ARIAs) recognised.

Prevalence of Indigenous people

The presence of Indigenous people in the population is important because a substantial Indigenous population in an area may require additional and an especial focus on culturally appropriate care. It may also be desirable to increase funding in areas with proportionally large Indigenous populations so as to better address poor health and infrastructure issues.

Recognising the prevalence of Indigenous people in the population is important because closing the gap between the health of Indigenous and other Australians is a national priority.

Socioeconomic status

Socioeconomic status (SES) is important because populations with low SES will tend to have poorer health outcomes and will tend to be less able to access services. Populations with low SES also tend to have lower health literacy, and are more likely to smoke and exhibit other poor health behaviours.

Socioeconomic status can also influence the sustainability of rural and remote communities; for example, industry is more strongly attracted to areas with a well educated workforce. Populations with higher SES are also more likely to be able to take advantage of opportunities and may be more capable of attracting and retaining health workers. Populations with low SES are also less likely to be able to pay for their health care and may have difficulty accessing interventions or diagnostic tests.

Health outcomes

Heath outcomes could arguably be regarded as a consequence of all of the other parameters mentioned here. However, it is also arguably a useful parameter to be included in a classification suite.

Some measure of health deficit is important because it informs where and on what additional effort is required, and where there may be special need for additional health workers.

It is possible that health outcomes (perhaps as measured by mortality) may be correlated with SES, and may be a redundant factor; perhaps SES tells us all we need to know? The degree of correlation may need to be tested.

Law and order/social cohesion

Such a factor is important because safety, fear (and its converse, community social cohesion) are critical for a healthy environment, the development of health itself, and the recruitment and retention of health workers.

Communities with poor social cohesion or law and order problems are unlikely to be attractive places to live, and are less likely to be sustainable communities.

Communities with high levels of social cohesion tend to be more likely to take care of one another in adversity.

We are unsure which measures would adequately and conveniently describe this concept. One option would be a measure, for each area, of the per-capita reported crime rate (eg assault rate). There may also be other, less negative measures.

Amenity

Amenity is an important parameter. In the context of this paper it relates to the physical attractiveness of a location, climate, trees along streets, things to do (eg surfing at beach or skiing on the dam), butterflies, mosquitoes, quality of urban planning etc; that is, those parts of the built and natural environment that allow or encourage residents to enjoy life.

Amenity is the first aspect of a community to strike someone newly arrived (including a health worker), and it is frequently what attracts people to an area in the first place, but for some reason it has tended to be ignored as an important factor affecting rural health.

Good amenity affects health because it attracts health workers, helps to attract industry (eg tourism) and impacts directly on the health of individuals by providing residents with a sense of joy, encourages people to spend time outside and be engaged with life, with each other, with activity and with the environment.

Amenity may explain some of the difficulty in attracting health workers to inland compared with coastal regions.

While some rural and remote towns are outstanding on this criterion, others have poor amenity.

We are unsure what to suggest as a measure of, or proxy for, amenity. It is possible that no single measure currently exists. Bearing in mind the importance of the concept, we believe that it is important (and not only from a health perspective) for a measure to be identified and/or developed.

Existing health workforce

Information about the existing workforce is important – why encourage health workers to move to areas where there are already enough? Why improve access for a population for whom it is already outstanding?

If done cautiously, we suspect that reducing focus on areas with adequate health workforce while increasing the focus on areas with an inadequate health workforce could reduce expenditure overall, and provide greater power to address workforce shortages in those areas truly experiencing them.

Development and use of this parameter, in conjunction with use of the other parameters mentioned above, has the opportunity to feed research identifying those factors that make communities healthy and/or adequately populated by health workers.

Identification of, and action on, the key factors for enhancing the health of people in rural and remote communities, for attracting and retaining health workers, and for bolstering the sustainability of rural and remote communities would reduce the need for the Department of Health and Ageing to inject funds into other rural health programs.

Two measures of the existing health workforce in an area may be necessary:

- a measure of health workforce in the community in question; and
- a measure of the health workforce in the broader 'region' or catchment.

Currently, information about the presence of health workers on the ground is poor because there is still no single national register and no effective compilation of national health workforce data. Both Medicare data and AIHW survey data can only describe some parts of the workforce, or suggest what it might look like nationally.

The anticipated establishment of a new single registration board for all registrable health professions, if linked to an appropriately confidential dataset, would provide better data for populating this parameter.

POTENTIAL DIFFICULTIES IN INTRODUCING A NEW SYSTEM

Introduction of a set of new classification systems could be disruptive. Everyone (except the unimaginative) would go through a period of some confusion. Not only would administrators need to become familiar with the new system, but the new system could disadvantage some 'clients' while benefiting others. It might take some time for a new system to become bedded down and accepted. The Government will be concerned that some people and communities will be classified differently under a new system.

Some people have made financial or business decisions based on the understanding that they are eligible for benefits under the current system, and the new system might threaten that eligibility.

Clearly, classifications have been changed in the past, and will be changed in the future. We believe that the plethora of wrecked classifications littering the landscape, and which are still hobbling along trying to fulfil their purpose, is evidence of this assertion. We also believe that this soup of multiple classifications of varying levels of utility signals the need to 'tidy-up' and to move on to a single well-devised system.

The timing to move to a new system would appear to be good. The Government's focus on overall reform of the health system and its review of rural health programs, in conjunction with the availability of improved data, classification systems and tools (for example Meshblocks – see box) makes this an auspicious time to move to a single and better system.

ABS is very soon to commence the use of Meshblocks. These are discrete geographic areas of a small number of households (nominally 50); that is, they are smaller than a Census Collector District. These Meshblock areas will be geocoded by street address (including RMB address). This will allow a finer detail of mapping, and more accurate and easier allocation of remoteness than is currently possible using postcode. Meshblocks can be aggregated-up to any other ABS geographic area (e.g. SLAs, Remoteness category, postcode, etc). Also, usefully, Meshblocks are designed to 'never' change (unlike SLAs) - making the application of geography substantially less troublesome that it has been in the past.

A potential solution to address the concern about disadvantaging some beneficiaries of the current classification system is to employ time-limited grandfathering, giving people time to adjust before they become subject to the new system. For example, while fresh applicants would need to be assessed under the new system, people who have been eligible under the old system could continue to be classified as eligible for the duration of their tenure (eg if

students), or for a specified amount of time (eg 3 years). People who had previously been classified as ineligible, would need to reapply.

Levels of eligibility would also likely change – so not only would some people become ineligible and others eligible, but the degree of eligibility could change - for example, benefits for some may increase by (say) 20%, while for others they may decline by 30%. Again, negative (and possibly positive) changes could be buffered by time-limited grandfathering.

Of consolation is the fact that if the older systems were ‘about right’, and if therefore resources are being allocated appropriately, the number of losers will be small, as will be their loss.

Additionally, the influence of each of the components of the classification suite could be adjusted so that the initial net change (as experienced by incentive recipients) is small. Over time, the influence of each of the components could slowly be adjusted so as to fine-tune the system and deliver optimal benefit to the right people in the right areas.

The Government has been at pains to stress that net expenditure on the programs involved should not increase. This might well limit the pace at which a new classification system is rolled out. At present, it appears very likely that people in rural and remote areas not only have lower access to public medicine, but also to a wide range of publically-provided services - even though they pay the same level of tax. For example, apart from lower levels of access to health services, people in rural and especially remote areas also appear to have lower levels of access to education, public facilities (eg Opera House), public transport, roads, libraries and so on.

People in rural and remote areas provide many of the basic and essential raw materials upon which the rest of us rely, while at the same time earning less, dying younger, paying as much tax and individually consuming fewer taxpayer dollars than people in Major Cities. As might be expected, the Alliance is attracted by the argument that if people in rural and remote are to continue to pay taxes at the same rate as those in the major cities (the very small remote zone allowance notwithstanding), they deserve and need access to more services than they are currently receiving.

HOW AN INTEGRATED CLASSIFICATION SYSTEM MIGHT WORK

This draft method suggests:

- adoption of ASGC Remoteness (ARIA+) as a remoteness classification;
- adoption of a multilayered classification system to take account also of other issues (where important), such as town size, Indigenous status etc;
- a mechanism for using this multilayered system for allocating funding using easily derived and pertinent parameters, which can be easily applied by the funding body, and which arguably distributes funding more effectively;
- that the multilayered classification should reduce the reliance on and/or become the new basis of a range of specific rural health programs, many of these would no longer be required in their present form;
- that the multilayered classification would be the framework for monitoring health status, determinants, access to services and health workforce in rural and remote areas; and

- that the multilayered classification would be the framework for better targeting and funding Indigenous population health.

As discussed previously, a multilayered classification system could draw on:

- remoteness of the SLA or postcode (R);
- town size (using GISCA or ABS data to classify the area based on the population size of the closest urban centre. It may be best to use ARIA+ settlement cut-offs of 1000, 5000, 18,000, 48,000 and 250,000 population)
- an Indigenous component (either percentage population that is Indigenous or whether applicant is Indigenous or not);
- socioeconomic status (SEIFA);
- mortality index for the area;
- social cohesion/crime index;
- amenity index;
- index relating to the existing health/welfare workforce.

No longer would remoteness alone dictate funding.

These parameters would feed individual funding formulae for a range of purposes discussed below. Each formula would be used to calculate the incentive/reward/etc applicable in each situation.

For example, the formula used to determine the scholarship received by a student would be different from the formula used to determine the practice incentive received by a GP, because in each case a different set of issues is important.

The formulaic approach should not be an issue for those allocating funding because all they need to know is the nature of the application, the applicant's postcode and perhaps some personal details (for example, Indigeneity). These details are then entered into a 'black box' (eg secure excel worksheet) to calculate the size of the benefit.

We believe that the ABS ASGC Remoteness Structure (sometimes known as ARIA+) is the most appropriate current geographic classification on the basis that it actually makes sense on the ground, is a truly geographic measure of remoteness, and is regularly serviced and updated by ABS (unlike RRMA and ARIA which are not serviced and not updated). It is also a classification for which much ABS and other data is or could easily become available, and it lends itself to the use of meshblocks (which could be particularly useful in this context in the future).

We have substantial concerns about ARIA+ being used in isolation. At the very least, remoteness should be coupled with a measure of local town size but overall our strong preference is for the development and application of the multilayered index proposed in this paper.

Under the current system, an applicant either receives funding or doesn't; under the proposed system, funding could better reflect the particular circumstances (not just the remoteness) of the applicant (i.e. funding is in shades of grey rather than black and white).

Characteristics (for example, the remoteness, mortality, SEIFA, etc) of the postcode or SLA could easily and reliably be available through ABS at relatively small cost.

Allocating incentives, rewards and benefits to rural health workers

There is currently an undersupply of GPs, specialists and allied health workers in rural and remote areas.

Doctors and other health workers are less likely to want to work in rural and remote areas than in Major Cities for a number of reasons.

- The opportunities for a spouse's career are poorer outside major cities; this can result in lower household incomes and/or feed spouse discontent.
- Net incomes for health workers are thought to be lower outside major cities. In the case of GPs this is partly due to the existence of two markets: one for those who, like IMGs, are required to practise in specific areas, while others are free to go where they will. The market for health workers is also affected by the absence of economies of scale in small hospitals and solo practices.
- Most training centres for the health workforce are in major cities, young people from major cities are more likely to study medicine than young people from the country, and social networks and responsibilities (including marriage and aging parents) developed while studying and in early career can make it difficult for health workers to move away from major cities.
- Access to formal recreation of particular kinds (eg theatre) is poorer outside major cities.
- The perceptions of living and working in rural and remote areas can be negatively stereotyped.
- The opportunities to take time off work (eg for holidays, a day or a weekend) and for a decent roster are lower outside major cities, largely because of the limited availability of colleagues and of locums to cover the workload.
- Smaller population centres and smaller aggregations of health workers reduce the opportunity for professional interaction, contributing to feelings of professional isolation.
- Lower levels of choice regarding schooling for children, especially in secondary school, reduce the attractiveness of many of the smaller rural and remote towns for parents at a particular stage of their life.
- There may be a fear of becoming 'locked-in' because of personal financial investment in the practice, with little opportunity to escape without losing a substantial investment, and/or leaving patients without care.
- Some rural and remote areas, like some major cities areas, are dangerous or unpleasant places in which to live. For example, some areas have higher crime rates than others, which would tend to reduce the level of attractiveness, or they may simply be very hot and very humid.
- There may be limited availability of good housing at affordable prices.
- There may be a limited range and quantity of supportive infrastructure and equipment, and the scope of practice may limit people's ability to self-actualise and control their own destiny.

The plethora of government programs to encourage health workers, especially doctors, to work in rural and remote areas attests to the established belief that the supply of health workers needs to be improved.

Clearly there are a range of potential actions to address each of the concerns listed above, with many of these having been addressed by the Alliance in previous submissions and position papers.

We believe that an effective resource allocation tool, such as an improved and well devised geographic classification or classifications, driving a formulaic approach to providing incentives, is key to addressing some of the rural health and welfare divide.

One possible action to address or compensate for this long list of issues is the payment of incentives which may overcome some of these concerns and encourage doctors and other health workers to actively seek work in areas outside major cities.

Relevant variables to be built into a formula which would be used to calculate size of the incentive would include the following:

- the remoteness of the town;
- the population of town and town catchment (hinterland);
- the Indigenous population in town;
- a law and order/social cohesion index;
- health outcomes (eg death rates) or SES as a proxy for health generally;
- an amenity index;
- the state of the existing workforce in or servicing town, relative to the population; and
- the existing workforce in the region or catchment, relative to the population.

It may also be useful to include an index of the ‘economy of scale’ likely to be achieved by a health worker. For example, such a measure could be used to encourage the development of group or regional practices, or affiliations of solo practices which aim to mutually support and share resources.

A demonstration of how these parameters might be used to allocate incentives is included as Appendix 2.

Allocating scholarships to students from rural areas

Rural/remote students are less able to study a range of health-related courses for a number of reasons (access to quality education, aspirations, poverty, costs of living away from home, etc), but are more likely to work, when qualified, in rural and remote areas than those who have grown up in metropolitan areas.

We believe that the rural and remote health workforce would be bolstered if more students from rural and remote areas chose to study medicine and other health disciplines.

Financial incentives based on an appropriate funding formula could encourage students who grew up in rural and remote areas and perhaps those who are Indigenous to study target health courses. Additional bonuses may be appropriate for students from poorer areas, or for other desirable characteristics, using a simple formula backed by high quality and consistent data.

Such funding formulae may rely on variables such as:

- the remoteness of the area in which the student grew up;
- the population of the town associated with the area in which the student grew up; and
- Indigenous status.

Remoteness of the area and size of the town where students grew up is important because it influences the sort of 'place' where students prefer to work after they qualify.

Indigenous status may be an important variable if it is considered important to give Indigenous students a 'leg up' so as to overcome disadvantage, encourage the development of Indigenous role models and increase the size of the Indigenous health workforce.

Incentives (eg scholarships) would be calculated using formulae in a similar way to that used to calculate incentives for health workers (see Appendix 2).

For example, a formula designed to seek students who grew up in small rural towns would weight outer regional and remote areas with small population centres higher than areas of similar remoteness but with large centres.

The number of 'scholarships' available would be determined in consultation with the single health professions registration (board) apparatus, training bodies, and workforce planning organisations within Australia.

Specific intake of students from suitable rural and remote areas should be mandatory for all health faculties responsible for training professionals for which workforce shortages exist in rural areas. And there should be further investigation of (and consequent action on) the reasons why so many in some health professions do not practise long in their chosen field. (What is the point of training astronauts if they choose to stay on Terra Firma?)

Differentially stagger Medicare payments

While enjoying many benefits (and suffering a few disadvantages), people living in rural and remote areas experience the related evils of lesser ability to afford to pay for health services, lower rates of bulk billing, and lower access to medical practitioners.

Differentially staggered Medicare rebates could potentially address all of these problems.

For example, if GPs in small rural towns were entitled to a higher Medicare rebate than their metropolitan colleagues, they may be more inclined to bulk bill, or to charge the patient a smaller co-payment. Rural practice would then potentially be more attractive, rural GPs better rewarded for providing a more complex service than their metropolitan colleagues, and hopefully residents would have greater access to Medical services, especially to primary care.

Additionally if, under national reform, Medicare were to be modified and broadened so as to bolster medical practitioner, nurse practitioner and allied health efforts to prevent or delay the onset of chronic disease and other costly health conditions, it is plausible that there would be an overall benefit to economic productivity (and that frequently discounted intangible 'health and wellbeing') if not also a reduction in expenditure on health care in Australia.

Potentially a model that might successfully enhance Medicare along these lines could include parameters such as:

- remoteness of the area in which the worker operates;
- town size in which the worker operates;
- SES of the area in which the patient lives;

- possibly health outcomes (although this might be covered by SES?); and
- Indigenous status.

Under such a model, Medicare rebates would be higher than is currently the case for health workers in small rural towns, populated by people who, on average, have lower incomes, higher death rates and who are more likely to be Indigenous.

Differentially stagger health service budgets

Should the Australian health system undergo radical improvement over the next few years, it could potentially be feasible for a region's whole health budget to be allocated on the basis of need, rather than on the basis of supply as is currently, at least partially, the case. For example, this could be the case if management of all health services were managed by regional health authorities under the 'supervision' of a single national health authority. Under such a radically improved scenario, it may be possible to use a formulaic approach to allocate budgets to regions on the basis of:

- remoteness;
- town sizes;
- SES;
- health outcomes;
- Indigenous proportion;
- and possibly other factors.

Regions would then deploy resources locally so as to best address the specified aims of their charters.

Differentially stagger patient assisted travel scheme (PATs)

If health services are not available for taxpayers close to where they live, they must either pay to travel to the service, be assisted to travel to the service, or choose not to access the service.

As well as being unpalatable to an egalitarian society, the choice not to access the service reduces or prevents their ongoing contribution to the nation's productivity. However, we believe that this choice is made too frequently because people, especially in the smaller towns and more remote areas, too frequently cannot afford to pay to travel and for accommodation, even with the contribution made by PATs payments.

In some instances relatively poor (and not so poor) people from rural communities need to rely on the generosity of the community to raise funds to attend essential medical care. In communities where social capital is poor, community support may not be an option. Assistance may be especially difficult in some Indigenous communities where the supply of money may be limited, and when travel away from their own community may be especially traumatic for cultural reasons.

In our opinion, there is a case for PATS to be enhanced so that payments reflect a number of factors:

- remoteness;
- town size;
- SES of town;

- Indigenous status of the patient; and
- social capital.

We believe that social capital should be drawn upon - but not to the point that it drains and exhausts the community. People should be given the opportunity to give since it makes them feel good and bolsters social capital. However, assistance could be in-kind, should not be critical to the decision to seek care or not, and should not be habitually relied upon nor be a drain on the community.

Allocate and target community development programs

The Alliance believes that many of the problems associated with rural health (eg health outcomes and supply of workforce) would dissipate or reduce if rural centres were more sustainable in economic, social and ecological terms.

The sort of economic decline that comes from drought-reduced farm incomes, lower expenditures in the local town, closure of the local supermarket, redundancy of staff and their migration to another area is likely to lead to further decline in the community. Such decline could take the form of the loss of the town's doctor or downgrading or closure of the local hospital, despondency, greater reliance on social security, reduced opportunities for youth, reduced opportunities for care of the elderly locally, and so on.

Local development has a number of effects. It can shield or bolster a community from damage to its sustainability, improve efficiencies of scale, and/or increase income diversity. These things in turn will enhance sustainability and boost prosperity. They will also improve local 'amenity' or attractiveness of the area as a place to live (including for health professionals), and help improve people's health directly.

Potentially, the multilayered classification system proposed here (or a relative of it) could be used to differentially stagger income-tax liabilities for people living in rural and remote areas. This would be justified by the fact that they have lower levels of access to public funded benefits such as health care, secondary and tertiary education, public transport, public facilities, broadband etc, as well as lower levels of job mobility.

A model that, as part of a broader Australian Government policy, aims to enhance rural and remote area sustainability, could make use of the following parameters:

- town size;
- remoteness;
- health outcomes;
- Indigenous proportion; and
- SES.

A potential danger of targeting rural development is that it may be like joining in guerilla warfare: once committed, it is difficult to withdraw, even when it becomes obvious that you ain't going to win. Government commitment at any one time may be taken to mean commitment for all time. Political expectations are raised. Certainly recent experience shows that all governments have been unwilling to 'pick winners', whether communities, regions or industries.

Nevertheless, there will always be government intervention in many of the policy areas that impact on regional and local growth and decline: taxation, schools, telecommunications, housing, transport and other infrastructure – as well as hospitals and other health services.

We believe that the classification system and process outlined in this paper would have the capacity to throw light onto these important policy areas and, potentially, be used to guide intervention justified on the basis of a collection of indicators.

Report health statistics in rural/remote areas (so as to monitor performance of and steer policy and programs)

Monitoring and evaluation of the effectiveness of policy and programs is critical.

Without adequate evaluation, government is unaware whether expenditure of public funds is having an adequate impact or whether it could be better deployed elsewhere.

Administering without evaluation is like driving with your eyes closed: you can hear the ‘suggestions’ and abuse of the onlookers, but you can only guess where you are going and when you are going to get there, and may miss the destination by miles (and hours). This should not be a model for the administration of publicly-funded programs.

Previously, reporting for rural and remote areas has employed a single ‘remoteness’ classification (eg RRMA, ARIA or ASGC Remoteness (ARIA+)). While this has provided adequate detail to identify poorer health in rural and remote areas generally, it could be greatly improved upon to closely steer rural health policy.

Use of a multilayered classification system to describe health determinants and status, and to assess the effectiveness of rural and remote health policies and programs, has the capacity to be tremendously useful.

If the classifications are chosen carefully, it should be possible to ‘easily’ and readily report for several selected variables at once (although it may not be possible to report for all variables simultaneously - at least because we would likely ‘run out of numbers’ if we stack too many variables on top of one another simultaneously). Such an ability should allow greater power to ‘see’ where we are going than is possible under the current system.

Potentially useful variables and their suggested classification systems

Variable	Classification
Remoteness	ARIA+
Town size	Size of urban population (employing ‘Section of State’ boundaries)
SES	SEIFA index of disadvantage
Indigenous	Percentage Indigenous
Workforce	Based on registrations with the proposed National health workforce registration entity
Amenity	To be developed
Industry	ABS industry classification (broad ASIC)?
Health outcome	Standardised Mortality Ratio

APPENDIX 2

This Appendix provides a hypothetical demonstration of how modelling could be used to allocate financial loading incentives for health workers (in this case GPs) in rural and remote areas.

Adjustment to the Medicare rebate, or flat rate payment, or other form of incentive may be based on a formula such as:

Financial Loading=WRIPSED (ie W*R*I*P*S*E*D).

Where W,R,I,P,S,E and D are defined below.

For simplicity's sake, both the social cohesion index and the amenity index have been omitted from this demonstration.

Clearly there are many options for the design of the specific formula, and indeed, the design of the formula would likely be subject to manipulation over the years as it becomes clearer how to wield it for good, justice and the ~~American~~ Australian way! The formula provided here is an example only.

Using this simple formula, and inserting dummy values, a GP electing to work in Wilcannia would be eligible for a loading of 2.1, a GP in Dubbo for a loading of 1.35, and a GP in Wellington for a loading of 1.75.

Now, it is quite possible that the calculated loading in Dubbo is too high, while that in Wilcannia (relative to Wellington) too low. Others may feel differently. However, the working formula would need to be modelled so as to adjust the outcomes to what appears to be 'reasonable'. It should then be tested on the ground and finally adjusted based on the reaction of health workers – its actual effect. If incentives based on this formula above appeared to yield optimal numbers of health workers in Dubbo, Wellington and Wilcannia, one would assume that it is 'about right' and needs no further adjustment.

With the Australian health system under reform, we are unsure by which vehicle financial loadings should be delivered to the recipient; but options include Medicare (ie a Medicare loading), an annual payment, tax relief and so on.

Parameter definitions

Workforce (W)

It is undesirable for a rural community to have no locally based health workers or insufficient workers, and it is undesirable for health workers if the town is crawling with them, and that they have to engage in arm wrestling to apportion work.

Using medical practitioners as an example.

We are assuming for the purposes of this demonstration that the population/GP ratio be as close as possible to (say) 1,000 people per GP:

- if health district Population/GPFTE ratio is more than 1200 then W_1=1.05;
- if town Population/GPFTE ratio is more than 1200 then W_2=1.1;
- if GP is only GP and town population is less than 2,000 people, then W_3=1.1;
- $W=W_1*W_2*W_3$.

The modelling for this parameter could be quite tricky. On the one hand it should reward GPs for working in difficult circumstances, on the other, it would be sensible not to organise the financial incentives in such a way as to perversely discourage a GP from welcoming others to town. Allowances would also need to be made for the on-call duties (in hospital and/or practice) of the GPs.

Regional population/GP ratios (W1) should be included because regional GP loads would take some of the pressure off sole practitioners in small towns and could potentially be a source of collaboration, locums, filling rosters, outreach or efficiencies of scale.

Remoteness (R)

The more remote the location, the less likely health workers are to be attracted to it and be retained.

- if Remoteness=MC then R=1;
- else if Remoteness=IR then R=1.05;
- else if Remoteness =OR then R=1.1;
- else if Remoteness=R then R=1.15;
- else if Remoteness =VR then R=1.2.

Indigenous population (I)

The greater the proportion of Indigenous people in the population, the greater the likely need for health services.

- If indigenous pop>50% then I=1.2;
- Else if indigenous pop>20% then I=1.15;
- Else if indigenous pop>10% then I=1.1;
- Else if indigenous pop>5% then I=1.05.
- Else I=1.0

Town and catchment population (P)

The smaller the town, the greater the need to attract and retain health workers.

- If the population>25,000 then P=1.0;
- If the population>10,000 and <=25,000 then P=1.01;
- If the population>5,000 and <=10,000 then P=1.02;
- If the population>2,000 and <=5,000 then P=1.03.
- If the population>1,000 and <=2,000 then P=1.04
- If the population<=1,000 then P=1.05

Socioeconomic index of disadvantage (S);

Low SES is linked with poorer health determinants and poorer health outcomes. While these areas may be less competitive at attracting a health worker, the people living in them will likely have greater need of health services.

If SEIFA quintile='lowest (5)', then S=1.04;

Else if SEIFA quintile='4', then S=1.03;

Else if SEIFA quintile='3', then S=1.02;

Else if SEIFA quintile='2', then S=1.01;

Else if SEIFA quintile='highest (1)', then S=1.0;

Economy of scale (E)

An economy of scale index could reward efficient group or regional practices, amalgamations and partnerships. For the purposes of this demonstration practices are either classified as efficient (E=1.15) or not efficient (E=1.0).

Health outcomes (eg death rates) (D)

Areas with poorer health outcomes may well benefit from greater prevalence of health workers. Compared with other health outcomes measures, death rates in small areas are easily and accurately measured.

It is unlikely that death rates and need for health workers are directly correlated (eg death rates are affected by many issues, only one of which is access to health care). However, for the purposes of this work, it is assumed that death rates could be lowered to some extent by greater presence of health workers.

If SMR>1 but <= 1.1, then D=1.05;

Else if SMR>1.1 but <= 1.2, then D=1.1;

Else if SMR>1.2 but <= 1.3, then D=1.15;

Else if SMR>1.3 but <= 1.4, then D=1.2;

Else if SMR>1.4, then D=1.25;

Results

Calculation of Financial Loading, using dummy values for each parameter, and the trial formula FL=WRIPSED

	Wilcannia	Dubbo	Wellington
Index	**Estimated Index value**		
Workforce	1.05	1.00	1.10
Remoteness	1.20	1.05	1.10
Indigenous	1.20	1.05	1.05
Population	1.05	1.00	1.02
SES	1.05	1.01	1.03
Efficiency	1.00	1.15	1.15
Death rates	1.25	1.05	1.15
Calculated Financial Loading	**2.08**	**1.34**	**1.77**

Attachment 8

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Rural and Remote Health Workforce Innovation and Reform Strategy

Submission to Health Workforce Australia

28 October 2011

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.

Rural and Remote Health Workforce Innovation and Reform Strategy
Submission to Health Workforce Australia

Introduction

The National Rural Health Alliance is comprised of 32 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health organisations (see Attachment).

The vision of the Alliance is good health and wellbeing in rural and remote Australia, and it has the particular goal of equal health for all Australians by 2020. The Alliance believes that access to health care as close to home as possible is integral to achieving this goal.

On health workforce, the Alliance's general position is that a sufficient, well-trained, well-supported multi-disciplinary health workforce should be distributed throughout Australia so that access to relevant healthcare is available according to the health needs of the population.

As is well-known, health outcomes for the more than seven million people who live in rural and remote Australia are significantly worse than for those in major cities. The serious maldistribution of health professionals must be addressed so that people in rural and remote areas have access to levels of health services comparable to those in other parts of the nation.

The parlous state of Indigenous health remains the most important social challenge for Australia – and 70 per cent of the nation's Indigenous people live outside the capital cities. To help to remedy this situation, action must be taken to increase the numbers of Aboriginal and Torres Strait Islander health workers in all professions.

At the same time, action is required to ensure that all health professionals have the understanding necessary for them to provide service in a culturally-aware fashion. And health service providers must recognise and manage power differentials to ensure that health services are culturally safe for Aboriginal and Torres Strait Islander people.

Recognition and support must also be given to members of the unpaid and voluntary health workforce such as carers, support workers and consumers themselves.

The free market and the fee-for-service system alone will not deliver a fair amount of health care or a fair distribution of the health workforce, especially where populations are small and distances vast. An effective and equitable health service system will require planning and management by all levels of government – including 'positive discrimination' and intervention where needs are greatest; moderating the demand for care through health promotion and other upstream activity; as well as increasing the supply and managing the distribution of the health workforce and of other elements of health care.

It must be recognised that, in remote areas, health service delivery is largely dependent on remote area nurses, Aboriginal Health Workers and visiting or emergency staff, including the RFDS. Funding and support for these essential services must be guaranteed and flexible.

The priority for addressing health workforce issues must be 'worst first', making Aboriginal health and issues affecting the allied health workforce and oral health the places to start.

In recent years, a number of programs have been implemented to encourage medical students and young doctors to take up rural practice. These include a 25 per cent target for intake of rural students to medical schools; scholarships; and HECS reimbursement in return for

practising in rural or remote areas. To improve the health of people in rural areas, patients need access to multi-professional teams. Therefore strategies similar to those in place for doctors should be implemented for other health professions, especially in light of the greater number of nursing, dental and allied health students now in training.

Health service managers are critical to the provision of effective services and to the recruitment and retention of health professionals. The Australian Government should undertake substantial new investment in the education, training and support of rural and remote health service managers to assist in the implementation of the health reform agenda and to underpin safety and service excellence. These activities would ideally be undertaken in an interprofessional framework.

The Alliance recognises the value of outreach and visiting services to communities without a full range of health services. Similarly, e-health initiatives have a great contribution to make to such communities. However, these should always be seen as complementing and enhancing the capacity of local health services, with ongoing relationships built through face to face services as the model of first choice.

Support should be provided for rural communities to 'grown their own' workforce. A community could identify and mentor potential health workers from the community and its schools or from within the current workforce. Provision of funding to enable a community to support a local person to complete education and training, perhaps with an obligation to return and work in local health services during holidays and on graduation, would empower small communities to build their workforce from within the community.

DOMAIN 1

Health Workforce reform for more effective, efficient and accessible service delivery

Reform health workforce roles to improve productivity and support more effective, efficient and accessible service delivery models that better address population health needs.

Key lessons from the literature:

- Promote, value and support generalist practice across all professions
- Expand existing roles
- Develop new roles, such as support and assistant roles
- Sustain what has worked in the past, such as GP proceduralists
- Address attraction and retention of health professionals through a range of initiatives

Questions:

1.1 In what ways (if any) would health workforce roles and responsibilities need to change to improve the accessibility of health services or to support appropriate models of care in rural and remote settings?

The Alliance supports the increased focus on generalist practice across all professions, with broader scopes of practice and less rigid professional boundaries. The role of multi-professional teams in primary care is well recognised and current and future health professionals should be encouraged to go through a process of education and change management to optimise the functioning of these teams. Inter-professional learning as students and through continuing professional education will help health workers to adapt to the required changes in roles and responsibilities.

At the same time, the Alliance is concerned at the lack of specialists in rural and remote areas and advocates for greater numbers of specialist training places in rural and remote areas. The Medical Specialist Outreach Program and telehealth initiatives are assisting in increasing access to specialist care. However, these programs should not substitute for increasing numbers of specialists living in rural areas, so that people in rural and remote areas can develop long term relationships with their specialist and be able to have face-to-face consultations in the same way as city dwellers.

A strong shift to patient-centred care will improve health outcomes. To enable this to happen, practitioners and health systems need to be more flexible, less ‘siloed’ and to recognise the roles and contributions of the patient themselves and the people in the patient’s life: family, carers and community supports. There need to be enhancements of health literacy and competencies within the community and for general workers within the health system, such as receptionists and ward clerks.

The roles of case coordinator and care coordinator are an essential part of a multi-professional team. All health staff need to learn and take on the new role of ‘health system

navigator' to assist consumers and their families to work their way through the complexities of our health system. This will improve the provision of holistic care and the patient journey.

1.2 What are the major issues facing health workers that impact on productivity and their capacity to deliver services in ways that best meet community need?

Many health professionals cannot operate at their highest level of efficiency because of excessive red tape, or lack of coordination, support or appropriate supervision. Such problems frequently lead to long hours of work and the potential for errors or burnout. In many rural and remote health services, the provision of adequate support, both within and outside the workplace (and for the health professional as well as their family), would make a significant difference to retention of the workforce. The up-and-coming workforce from Generation Y seeks a work-life balance and its members are unlikely to want to work the same number of hours and overtime as rural and remote health professionals in the past, making it even more important to address these issues.Young health professionals who move into rural communities need a package of support to ease their transition into a fulfilling work life.

A national system to support the provision of local orientation and induction to both the workplace and the community; social and professional support; and capacity to take leave for continuing education and holidays would make rural practice more inviting and more sustainable for the longer term.

The design of care delivery in some rural services needs to be flexible enough to accommodate models which better serve small populations, for example caseload models of midwifery care.

1.3 What strategies have already been successful in reforming workforce roles and responsibilities to better address need?

While the notion of increasing mental health literacy is not universally applauded and is certainly not a sufficient response to challenges in the mental health sector, the way in which the Mental Health First Aid training initiative has been rolled out provides a good example of how to increase health literacy within the community and for a wide range of health workers at all levels. This approach could be used across a range of health issues such as diabetes management and heart health.

The use of technology for e-health and telehealth initiatives, for professional education and training, mentoring and professional support can be successful and should continue to be expanded. Similarly, provision of outreach and visiting services (such as the Medical Specialist Outreach Program and the Visiting Optometrists Scheme) has been very successful but access is limited in many areas.

The wider use of caseload service systems would help.

Increased positions and support for Nurse Practitioners and therapy assistants would also be useful. The nurse practitioner role was introduced as an expansion of registered nurse practice ten years ago and the promotion and support of the role of nurse practitioners and eligible midwives in rural and remote practice should be encouraged.

1.4 What strategies show enough promise that they could be considered for broader implementation?

There is potential for physician assistants to enhance the capacity of existing medical practices and health services through the provision of medical care under medical practitioner supervision. It is also important to promote the role of highly qualified, regulated registered nurses, midwives and nurse practitioners working to their full scope of practice in rural and remote areas.

Medicare Locals (MLs) have the potential to improve the coordination and delivery of primary care. But for this potential to be met, program allocations as well as overhead support will need to reflect that additional costs that rural MLs will face. Some State/Territory Departments accommodate such higher costs and the same must be true for the funding of MLs.

If they are appropriately funded and work collaboratively with Local Hospital Networks, Integrated Regional Training Networks, University Departments of Rural Health (UDRHS), Rural Clinical Schools (RCSs) and other local stakeholders, MLs in rural areas will be able to lead effective activity to address local workforce issues.

1.5 What new or novel strategies could be considered in relation to reforming workforce roles to increase access?

The National Rural Health Students' Network, made up of 29 Rural Health Clubs and 9,000 members, reports that some teaching staff at Universities display a negative attitude towards rural practice. This is clearly inappropriate and dysfunctional. At all levels and in all possible ways, universities need to encourage students to consider a career path in rural and remote settings.

Students should be aware of the many different life circumstances that may impact on a person's health care choices and be informed of various care options that can be offered to the patient. This will ensure a flexible and culturally variable approach and the capacity for patients to make informed choices about their health care. This should result in greater willingness to access care on the part of people who are inhibited by a range of barriers.

A patient-centred and health promoting culture should also be encouraged within health educational settings, including in high schools, at undergraduate and postgraduate level, and in the registration and CPD processes of the professions.

Reducing the rigidity of registration requirements for practitioners in the later stages of their career could enable them to contribute to the development of the health workforce in a number of ways and delay the loss of their expertise. These very experienced practitioners could act as supervisors and mentors for the up-and-coming workforce.

Establishing a greater number of salaried health professional positions would make a significant difference in rural and remote areas and would meet the preferences of a significant number of new and future graduates in all professions. Comprehensive primary care services with salaried staff, similar to the Aboriginal Medical Service model, can provide rural communities with access to a range of disciplines under one roof. Involvement

of local government and the local community in the establishment and governance of such services can enhance the attractiveness of positions and the rural lifestyle, and help encourage practitioners to stay.

As well as failing in remote and sparsely populated areas, the current MBS fee structure does not adequately support the provision of preventive health service or health promotion. MBS items and rebates for such services could change the emphasis of service delivery (e.g. for getting people into group sessions, such as for diabetes education). Management of chronic diseases requires input from health professionals who do not have access to the MBS, with the result that many patients cannot access these services because of the out of pocket expense. Extending the capacity of GPs to refer patients to other professionals under the MBS would improve health service delivery and outcomes. Where access to doctors is limited, these multidisciplinary services can be block-funded.

1.6 Are there potential barriers (e.g. organisational, industrial, professional) to achieving change in this domain? What are they? How could they be overcome?

At an organisational level, poor leadership can act as a barrier to innovation, adapting to new models of service delivery, and the ready acceptance of other health professions. Professional boundaries and competition can also inhibit change and innovation. Leadership development involving all disciplines and working through professional associations is required to help overcome such issues.

Registration requirements can limit flexibility. Agencies with responsibility for setting and applying such requirements should be aware of the particular need in rural and remote areas to strike an appropriate balance between safety/competence and enabling innovation and adaptability.

1.7 Are there things in rural and remote communities that could be built on to seed or speed innovation and change in models of care and the workforce reform needed to support them?

Regional Development Australia committees have great potential to have a positive impact on health systems and infrastructure. Each regional committee should be required to have a health sub-committee to work with agencies in the region to improve health infrastructure, workforce and service availability.

DOMAIN 2

Health workforce capacity and skills development

Develop an adaptable health workforce equipped with the requisite competencies and support that provide team-based, interprofessional and collaborative models of care.

Key lessons from the literature:

- Increase initiatives to attract more Aboriginal and Torres Strait Islander people and more people of rural origin to the health workforce
- Sustain the benefits of exposure to rural practice during training programs
- Provide culturally appropriate training and continuing professional development for the whole health workforce
- Adequately prepare students and staff for working in regional, rural and remote areas
- Develop curricula, teaching approaches and articulated programs throughout the continuum of education that build and develop generalist skills in all disciplines yes with qualification e.g child health Northern Territory
- Implement interprofessional learning throughout the continuum of education
- Retain and support workplace supervisors and mentors
- Improve access to continuing professional development for all health roles
- Use technologies, such as simulation and distance technologies, for training and up-skilling
- Build capacity for rural health research this must be applied, tied to health service improvement and build local capacity

Questions:

2.1 What could be done at the undergraduate level to encourage people to take up health careers in rural and remote settings?

Increasing the number of rural and remote area placements for students and young graduates in all health professions will undoubtedly expose Aboriginal and Torres Strait Islander people to career options in the health sector.

This exposure could encourage Aboriginal and Torres Strait Islander persons who have chosen to undertake the Aboriginal and Torres Strait Islander Primary Health Care Certificate II and III to further their study and access pathways to a range of health careers.

Building the capacity of the community controlled sector with additional placements of young graduates will have a positive effect on the Aboriginal and Torres Strait Islander Health Worker (ATSIHW) workforce. These placements will promote peer supervision; formal and informal continuing professional developments (CPD) of the students and young graduates, and hopefully provide learning opportunities for the ATSIHWs. Informal learning activities such as self-study of reference material, clinical case discussion with other health professionals and internet research could indirectly assist ATSIHWs.

From July 2012 people who register under the grandfather clause or who may be working towards achieving the Aboriginal and Torres Strait Islander Primary Health Care CERT IV – Practice (in order to become registered under the National Registration and Accreditation Scheme as Aboriginal and/or Torres Strait Islander Health Practitioners) could also have the opportunity of having onsite access to supervision and CPD.

All applicants for Aboriginal and/or Torres Strait Islander health practitioner registration must be able to demonstrate they have an adequate command of the English language to the satisfaction of the Board. Given that in some of the remote services English is often a second or third language, the opportunity to practise English language skills is fragmented. Having an increased workforce and placements undertaking frequent visits to very remote communities would assist in English language proficiency.

It is well documented that rural background, rural education and training experiences, and rural scholarships are predictors for rural work location[1 2]. Establishment of a clear, well defined pathway to a health career in a rural or remote location, with appropriate support and mentoring through the years of education and during transition to work in a rural or remote area, would assist in attracting people to rural health careers. It would be essential to develop and implement a strong marketing campaign targeted at high schools; university schools of health; students and their families; and rural health professionals.

A rural pathway is relatively well developed for medicine. University medical schools are expected to meet a target of having 25 per cent of their intake from rural areas. A number of generous scholarships are available for medical students and they are supported to undertake rural placements which include the provision of travel and accommodation assistance. HECS reimbursement following a period of rural practice obviously makes that option more attractive for junior doctors.

However, this pathway could be streamlined and made more successful. Compulsory rural placements for students who are not interested in rural health are not helpful and students and young graduates who have demonstrated a commitment to rural practice or who have a strong rural connection may miss out on their choice of a rural placement. Students who have demonstrated a commitment to rural practice should be given preferential entry to rural training posts or placements. For example, The Australian General Practice Training (AGPT) program and the Prevocational General Practice Placements Program (PGPPP) are effective in increasing exposure of general practice trainees to rural experience. However, there is no explicit policy within these programs to ensure that an adequate proportion have a strong rural connection. Regional Training Providers (RTPs) who deliver these programs should be able to select on the basis of individual applicants' 'connection to rural'.

The Rural Clinical Training and Support (RCTS) Program managed by the Australian Government Department of Health and Ageing provides funding and resources to medical schools to meet certain targets (such as the 25 per cent intake for rural students) and undertake rural-focused programs aimed at increasing the likelihood that medical graduates take up rural practice. Universities should be held accountable for meeting these targets and should be encouraged to share successful strategies for encouraging students to choose rural/remote practice.

A rural pathway similar to that available to medical students should be developed and marketed for other health professions including dentistry, allied health and nursing. Rural

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[1] *Choosing general practice as a career – the influences of education and training,* Bunker and Shadbolt, Australian Family Physician 38:5, May 2009

[2] *Nature of association between rural background and practice location: A comparison of general practitioners and specialists,* Matthew R McGrail, John S Humphreys, and Catherine m Joyce, BMS Health Services Research 2011 http://www.biomedicacentral.com/a472-6963/11/63

entry schemes and selection criteria that take into account applicant openness to pursue future rural practice are likely to ensure that a greater proportion of health graduates choose rural and remote careers. Most rural entry schemes currently apply only to medical courses and should be expanded to include all health disciplines. Nursing, dentistry and allied health students continue to lack access to quality and well-supported rural placement opportunities both as part of their degree and also extra-curricular opportunities. Extension of the RCTS Program to include all health disciplines would assist in addressing this issue. Only when appropriate pathways and supports are available will sufficient of these graduates take up rural practice.

University Departments of Rural Health (UDRHs) have had a significant impact on providing positive rural experiences for students, especially in nursing and allied health, in the regions that they cover. They also provide significant support for clinical supervisors. Rural Clinical Schools (RCSs) have had a similar impact for medical students. If both UDRHs and RCSs catered for all health professions, the impact would be much greater with the likely outcome that more graduates would take up rural practice.

2.2 What are the major issues in educating and training and supporting the workforce in rural and remote settings?

Cultural awareness and provision of culturally safe health services for Aboriginal and Torres Strait Islander people is particularly important for health professionals in rural and remote Australia because of the significant proportion of Indigenous people who live there. There should be cultural awareness education and training for all health professionals.

Shortage of accredited training positions and a limited numbers of clinical supervisors are major issues. The following comments relate to junior doctors but the principles apply in the areas of dentistry, allied health and nursing and similar strategies need to be put in place for these professions.

For junior doctors, reduced working hours, shorter rotations and job sharing[3] have been proposed as potential ways of adding to the stock of accredited intern and junior doctor training places. Limiting the hours that individuals are allowed to work would also reduce the occupational health and safety and clinical risks associated with long working hours.

Increasing the number of innovative training places should be a high priority. State/Territory jurisdictions have already introduced a range of non-traditional placements for junior doctors, such as in rural general practice, Aboriginal Medical Services (AMSs), palliative care and paediatrics. The number of such positions should be increased, and expanded to include other settings such as the Royal Flying Doctor Service (RFDS), radiology, and pathology.

In any such expansion of intern and junior doctor training positions, a number of challenges need to be addressed in order to ensure that patient safety and community needs are taken care of, and that junior doctors receive positive clinical experiences.

- Postgraduate Medical Education Councils (PMECs) and the Medical Board of Australia will need to act cooperatively and quickly to accredit the new positions.

[3] *An urgent challenge: new training opportunities for junior medical officers,* Brendan J Crotty and Terry Brown, Medical Journal of Australia 2007: 186: S25–S27

- More clinical and community infrastructure needs to be provided to accommodate greater numbers of junior doctors, including in settings which have not had a history of having them.

Increasing the number of clinical supervisors in rural and remote areas is essential. In all professions, expert clinicians need to commit time, energy and infrastructure to undertake this role, reducing their capacity to carry a full clinical load. In rural hospitals and private practices, this can have a significant impact on the clinician's ability to meet the needs of the community and on their earning capacity. In city teaching hospitals, systems have been funded and established to cater for students and junior clinicians. Governments need to commit similar resources to enabling rural hospitals and private practitioners to provide clinical supervision.

Indirect and distance supervision are already accepted practice in rural and remote parts of Australia and represent perhaps the area of greatest potential for increasing supervision in rural and remote areas. The Australian College of Rural and Remote Medicine (ACRRM) Independent Pathway[4] and the Remote Vocational Training Scheme (RVTS)[5] both provide successful models of distance supervision. Expansion of these schemes and applying similar strategies for other professions should be explored.

Another potential source of clinical supervisors is clinicians who are approaching the end of their career, semi-retired and newly retired. A project to identify existing barriers which discourage senior clinicians from clinical supervision, and finding ways to overcome them, would be beneficial.

Establishment of integrated regional and local training networks should be a high priority. These networks will coordinate and develop training programs and placements in rural areas; facilitate the accreditation of new training positions; and provide support for clinical supervisors. These networks should build on existing programs and resources and make best use of the scarce human and physical resources available in rural areas.[6] These regionalised networks would need to include Regional Training Providers, Medicare Locals, Local Hospital Networks, University Departments of Rural Health (UDRHs) and Rural Clinical Schools (RCSs). The system being developed in Western Australia to enhance rural and remote opportunities for junior doctors could provide a model. It includes:

- regional and local education structures to provide teaching and administration support to both junior doctors and supervisors;
- training positions so that the junior doctors are employed;
- simulated training environments; and
- financial support for travel and accommodation for junior doctors.

2.3 What are the major issues facing health workers in rural and remote settings in relation to continuing professional development, access to mentoring and support and clinical supervision?

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[4] http://www.acrrm.org.au/files/uploads/How%20to%20Apply%202011%20Guide_0.pdf

[5] http://www.rvts.org.au/

[6] Lyle, D. and Perkins, D. (2010), Health Workforce Australia: For all?. Australian Journal of Rural Health, 18: 179–180. doi: 10.1111/j.1440-1584.2010.01158.x

The difficulty in accessing continuing professional development (CPD) locally is a major issue. Rural and remote health workers face significant travel and accommodation costs as well as the problem of leaving a gap in service provision for the time they are away. Similar issues make leave for other purposes problematic as well, which can lead to burnout, disillusionment and departure from rural practice.

Limited funding is available for scholarships to assist with CPD travel and accommodation costs but funding and the number of scholarships available does not meet the need. The Nursing and Allied Health Scholarship and Support Scheme is available for nurses and at least 14 allied health professions in a range of streams to cover undergraduate, postgraduate, CPD and clinical placements. The chances of an individual being successful in gaining a scholarship are slim.

Complementing these CPD scholarships is the Nursing and Allied Health Rural Locum Scheme (NAHRLS) which provides locums so that health professionals in rural and remote Australia can get away to do CPD. The NAHRLS arranges and pays the locum's travel, accommodation, meals and incentives payments whilst on placement, but not the base locum wage for the period during which the locum is required. Feedback received by the Alliance indicates that some health service providers, including some State and Territory health departments, are unwilling to cover the salary of the incumbent as well as the locum, with the result that the health professional is unable to attend the CPD. Ways and means of addressing this problem need to be explored.

The use of technology to provide access to CPD, mentoring, support and clinical supervision needs to be increased. For many rural and remote health service providers, financial support will need to be made available to set up the required infrastructure and to train local health personnel in its use.

2.4 What strategies have already been successful in addressing these issues?

Technological solutions offer great potential to address issues of professional isolation, mentoring and CPD. Health workers in rural and remote areas will be among those seeking further assurances that the NBN reaches all areas of Australia (including remote and very remote) with sufficient speed and at an equitable cost. Additional support is needed for the development of educational products and programs to be delivered with the technology.

Based on their success in addressing these issues, the number of UDRHs and RCSs should be expanded so that all regions have access to their services.

The establishment of the Mental Health Professionals Network provides a model for reducing professional isolation and providing mentoring and support, especially for young professionals new to rural and remote practice.

Medicare Locals (MLs) and Local Hospital Networks (LHNs) will also have a significant role which has yet to be developed. Funding and contracts need to specify expectations in relation to addressing these issues and MLs and LHNs must be held accountable for meeting these expectations.

2.5 What strategies show enough promise to be expanded?

The success of the Queensland Rural Generalist Pathway in attracting junior doctors to rural practice and meeting some of the requirements of Queensland Health should be used as a model for development of rural pathways in all professions. The clarity of the career outcome for those undertaking the training pathway is one of its main attractions.

Mentoring for students during rural placements and for new graduates starting a rural career can make a huge contribution to the development of their confidence and competence. The Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS) provides and supports rural mentors for RAMUS scholars throughout their training. Feedback indicates that this is one of the factors contributing to positive rural experiences and to the scholars' intentions to take up rural practice. The RAMUS scheme gives clear expectations for the mentoring and provides support to both mentors and mentees. If this became part of all rural scholarship schemes, for all health professions, the uptake of rural careers may be significantly increased.

2.6 What new or novel strategies could be considered?

On-line mentoring and supervision should be funded and supported. In NSW, a 'virtual' mentorship program is provided via Skype with both participants receiving a fee.

The National Rural Health Students' Network reports that the up and coming workforce will expect access to broadband and social networking for both professional and personal support. The roll out of the NBN to all parts of Australia has potential to assist with this but attitudes of the current health workforce may inhibit acceptance.

2.7 Are there potential barriers to achieving change in this domain? What are they? How could they be overcome?

Change management strategies, education and programs to develop leadership at all levels of the health system will be necessary for successful transition to new ways of doing things. Health service managers are particularly important in this context.

The rural and remote health sector in particular needs to be more aware of the potential benefits of change management and leadership programs and needs to support the attendance of staff at such courses and the development of new courses tailored to the needs of their sector.

There needs to be a better understanding of the reasons why some health professional organisations choose to slow down health workforce reform or redesign and some of the things that contribute to it, such as Inter-Professional learning, changing scopes of practice and work to build multidisciplinary teamwork. Armed with better understanding it will be easier for the change managers and leaders to overcome organisational and institutional barriers.

DOMAIN 3

Leadership for the sustainability of the health system

Develop leadership capacity at all organisational levels to support and lead health workforce innovation and reform.

Key lessons from the literature:

- Strengthen and support leadership capacity throughout the system
- Prepare the rural health workforce for their leadership role in smaller communities
- Enable front line clinical leaders to implement reforms
- Develop leadership programs that are relevant to the non-urban context. CEC Clinical leadership program is exemplary.
- Acknowledge and support Aboriginal and Torres Strait islander leadership within the health system
- Enhance social capital in rural communities through cross-sectoral leadership

Questions:

3.1 What are the major challenges facing health leaders and health service managers in rural and remote settings?

Keeping abreast of changes in policy and practice is always a major challenge. The health reforms currently being implemented are not well understood on the ground and the way that new structures (such as Medicare Locals) relate to health workforce reform will develop over time. Strong two-way communication strategies to keep people informed about changes and to monitor the impact of these changes on the ground will need to be put in place.

Health service managers will have a critical leadership role to play in keeping health workers informed, leading and managing change and in recruiting and retaining staff. The Australian Government should undertake substantial new investment in the education, training and support of rural and remote health service managers to assist in the implementation of the health reform agenda and to underpin ongoing excellence. These activities would best be undertaken in an interdisciplinary framework.

The Australian Safety and Quality Framework for Health Care specifies three core principles for safe and high-quality care. These are that care is consumer centred, driven by information and organised for safety. The professional and service culture changes demanded by these principles will require passion, courage and persistence, and managers will have a crucial role in driving this change.

There is often great resistance from professionals to the concept and practice of patient-centred care, firstly, because of the disorienting change required in the power dynamic between professionals and their patients; and secondly because it is seen as demanding more resources to deliver an outcome whose quality may be difficult to assess. This in turn requires more resources to gather the information to provide the evidence base.

3.2 What strategies have already been successful in addressing these?

Developing leaders and health service managers from within the community and from within the existing health workforce may be a successful strategy. Education, CPD, networking, mentoring and support as well as the ability to take recreation leave are as essential for these workers as for clinicians, and strategies need to be implemented to ensure they are accessible.

3.3 What strategies show enough promise to be expanded?

On-line mentoring, networking, supervision and support have great potential. Fast broadband at equal prices should be guaranteed to health professionals as well as others in remote areas.

Governments should build and maintain strong working relationships with peak bodies in Indigenous health such as NACCHO, AIDA, CATSIN and IAHA.

The leadership and mentoring capacities of older health professionals should be better utilised. Leadership should be expected and supported from the full range of health professionals. Collaborative leadership across sectors (education, housing, transport economic development, health), which reflects the reality of life in rural communities, should be supported through rural leadership programs.

Existing regional entities such as local authorities, Regional Development Australia committees, Medicare Locals and Local Health/Hospital networks should be encouraged and resource for cross-sectoral leadership and regional sustainability activity.

The key place of rural social capital should be reflected in national programs relating to infrastructure, natural disaster planning and relief, and rural development and income maintenance.

Regional universities should be encouraged to provide leadership, research expertise and advice to regional agencies.

Greater equivalence of support from the public purse would be both fairer and useful in underpinning the establishment and operation of multidisciplinary teams.

3.5 How could the system better support and empower Aboriginal and Torres Strait Islander people to be leaders at all levels within the health system?

Governments should continue to build and maintain strong working relationships with peak bodies such as NACCHO whose members are in the best position to provide the opportunities for young health professionals to service their own people. It is well documented and widely researched that the best gains in health improvements for Aboriginal and Torres Strait Islander people occur when provided with good quality comprehensive primary health care through community controlled services.

The education system from early childhood through to tertiary education needs to be strengthened to meet the needs of Aboriginal and Torres Strait Islander people. A broad range of supports, mentoring, and supportive articulated professional education are required throughout the educational pathway.

Identifying potential leaders or potential health professionals at an early age and supporting them throughout their education and career development would assist. Leadership development programs and mentoring are very important because of the numerous demands placed on Aboriginal and Torres Strait Islander leaders who need to advocate for their people in multiple forums, to meet family obligations as well as community obligations (both Indigenous and non-Indigenous).

3.6 Are there potential barriers to achieving change in this domain? What are they? How could they be overcome?

Rigidity among and between health professional bodies can be a barrier to innovation and reform and needs to be better understood. Lessons may be learned from overseas research into institutions and change management in the health sector.

Health service managers need to navigate between the ‘business’ side of their position and the clinical aspects of running a health service. Lack of understanding or resistance from clinicians to having a non-clinician being involved in some decisions can make their job particularly difficult. Education of health professionals about the roles and responsibilities of health service managers may assist. Health service managers need to develop excellent negotiation and mediation skills.

3.7 How would you strengthen and support leadership capacity throughout the health system?

Establishing leadership and change management support networks across the health system, between large and small hospitals, private and public services, and regional centres and more remote services would be helpful in terms of problem solving and support.

Leadership in the health sector needs to embrace a health promoting and patient-centred service culture. The development and prosecution of such a culture requires support networks founded on common values, beliefs, goals and practices involving all parts of the health system and all professions.

DOMAIN 4

Health workforce planning

Enhance workforce planning capacity, taking account of current and emerging health needs and changes to health workforce configuration, technology and competencies.

Key lessons from the literature:

- Plan for a health workforce that is based on local need and context
- Move beyond simply planning for existing professional groups
- Collect and use appropriate data that reflects regional, rural and remote contexts

Questions:

4.1 What are the major issues that need to be taken into consideration in planning the health workforce for rural and remote settings?

A fundamental issue is the lack of adequate data about the existing health workforce (particularly allied health), community needs and appropriate levels of workforce for the population.

Recent and current planning has primarily focused on the medical workforce despite the government's recognition of the importance of multi-professional teams in primary care and in reducing avoidable hospital admissions. It has also focused on increasing the number of graduates in a range of professions without addressing the maldistribution of the health workforce.

Strategies suggested in this submission will have a fiscal cost but this is justified by the fact that, to date, workforce programs have failed to meet rural and remote area needs. Funding streams and workforce programs need to ameliorate and then end the inequitable situation, and meet the needs of rural and remote communities. For years there has been a primary care funding deficit in rural and remote areas, which currently amounts to at least $2.1 billion a year. This equates to a shortage of 25 million services a year, and includes a rural Medicare deficit which has now reached $1 billion a year[7].

A re-distribution of funding and tailoring of workforce programs would reduce this rural primary care deficit by increasing access to general practitioners, medical specialists and other providers of primary care. This redistribution of funding will be the basis for the establishment of additional public and private sector places for health professionals in rural and remote areas.

There is a need to consider the career preferences and expectations of Generation Y. It is important that health systems in rural and remote settings are responsive to these so that they can be best placed to attract a health workforce into the future. Today's health students expect:

- to know what communities can offer in terms of work and lifestyle opportunities for them and their families when deciding on where to train and work;

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[7] *Fact Sheet 27 The extent of the rural health deficit*, National Rural Health Alliance, March 2011

- a good work-life balance; (so it may not be sufficient to aim to recruit one new Generation Y health professional for every baby boomer health professional who retires);
- to work in multidisciplinary teams - they do not want to work in silos;
- to work in multi-professional practice and be supported by appropriate staffing;
- alternative employment models; and
- adequate accommodation, educational resources and technology while on rural placements so they are not educationally disadvantaged.

4.2 What strategies have already been successful in addressing these?

Some rural communities have developed innovative strategies to attract workers. These often focus on increasing the attractiveness of the location to the worker and their family. These strategies should be analysed and developed and promoted widely. Regional Development Australia committees and the Department of Regional Australia should be engaged in this activity.

4.3 What strategies show enough promise to be expanded?

Many rural health services have developed local solutions that make the best use of scarce human resources and the particular skills available locally, thereby improving the efficiency and quality of local services. These solutions should be publicised and promoted widely so that other communities can build on these ideas.

There should be greater equivalence of support across all health professions.

On-line services and other e-health applications show great promise but need to be available uniformly in all areas and at uniform prices to consumers and other users.

The competence of newer health professionals can be supported by leadership and mentoring from older health professionals.

Planning and management of workforce demand and supply would be simpler and more effective with better data on workforce issues. To this end, non-traditional data sources such as commercial survey systems should be considered as adjuncts to public data systems and the capacity of those public systems to obtain and analyse for rurality should be enhanced. Regional universities and other such entities should be involved in such work.

Medicare Locals should work together and with Local Health/Hospital networks should be encouraged and resourced to undertake local workforce planning for local needs.

4.4 What new or novel planning strategies could be considered?

Additional research to examine issues that impact on health workforce and health care delivery in rural and remote areas should be undertaken so that appropriate strategies can be developed. The best strategy would be to assess the health profile of rural communities and then calculate the workforce required to address the identified challenges of the region or community. This would establish a workforce benchmark that all parties could then try to

meet over time. Once bedded down and adequately funded, Medicare Locals could be the key drivers in such a process.

A planned approach such as this has the capacity to build and sustain systems of patient-centred comprehensive primary health care. It would also be valuable to understand more about the reasons why people leave rural practice as well as why they stay; about peaks and troughs of demand for locums or fly-in, fly-out workers; how to modify demand on health services by more effectively delivering preventive health measures and health promotion; social marketing strategies that are appropriate for rural and remote areas; and appropriate media for the effective delivery of health messages in rural areas.

Among other things, a patient-centred system might need to provide longer appointment times and specific information to patients on their condition before deciding treatment options. It would be necessary to solicit information from the patient about any cultural aspects of the condition being treated and the treatment options. The treatment and management schedule would take account of the patent's needs, not just those of the hospital or the clinician. And the patients and their families would be treated at all times with respect and dignity. All of these characteristics of care have implications for the education and training, enculturation, continuing professional development and indeed numbers of health professionals.

4.5 How would you suggest that current data collections and data collection methods about workforce be improved to better capture an accurate picture of the rural and remote workforce?

All funding allocation, health service and health workforce data should be identified by rurality (using the ASGC-RA categories) so that all reporting can be analysed by rurality. Only then will an accurate picture of health service delivery and health outcomes in rural and remote Australia be available. This will permit ongoing evaluation of outcomes and monitoring of health service development in many areas that are currently being served inequitably.

4.7 Who could or should be working together to improve local planning capacity?

MLs and LHNs will have a strong role in analysing population health, identifying gaps in service provision and addressing workforce shortages. It will be crucial for these organisations to work together and to collaborate with UDRHs and RCSs which have the capacity to act as research and evaluation partners and have experience in education of health professionals.

DOMAIN 5

Health workforce policy, funding and regulation

Develop policy, regulation, funding and employment arrangements that support health workforce reform.

Key lessons from the literature:

- Support rural and remote workforce flexibility with appropriate health and education policy, funding mechanisms and regulations
- Develop registration requirements that accommodate isolated practitioners and maximise the supervisor workforce outside urban areas
- Use policy and funding levers to support, value and encourage generalist practice and increase flexibility in course and training site accreditation

Questions:

As previously mentioned, the following strategies are advocated by the National Rural Health Alliance to address a range of barriers.

- Existing funding mechanisms and allocations for workforce initiatives have had limited success in addressing the maldistribution of health workforce. Funds to address rural workforce shortages need to be increased, specifically targeted and closely monitored.
- Monitoring will only be effective if data are available to give a complete picture of health workforce and health service delivery. Immediate action needs to be taken to ensure that data are available for all health professions and that all data can be analysed by rurality.
- A number of initiatives have been funded to encourage medical students and doctors to take up rural practice. A similar level of funding and activity needs to be applied to dental, nursing and allied health initiatives to make sure that multi-disciplinary teams are available to people living in rural and remote areas.
- Existing funding arrangements for health service delivery have been developed based on service delivery models which are effective in cities and large regional centres. Flexible funding models must be developed which are appropriate for innovative and flexible models of care which are utilised in rural communities. These may include comprehensive primary care centres where positions are salaried rather than fee for service and mixed funding models.
- The flexibility of the MBS could be increased so that services delivered by a greater variety of health professionals could be charged against the MBS and preventive and health promotion services appropriately remunerated.
- Registration standards and requirements are necessary to protect the public. However, greater flexibility in application of those standards to enable experienced practitioners to act as clinical supervisors and mentors to students and young professionals would help meet the shortages that will worsen as members of the ageing workforce in rural areas retire.

- **ADDITIONAL INFORMATION:**
  - *What are some of the most innovative and successful health workforce reforms that you have been a part of?*

    1. Gradual integration of nursing and allied health into national health workforce planning and management. (But still have a long way to go!)
    2. Engaging researchers with clinicians and policy makers in setting and working towards shared goals and endeavours.
    3. Encouraging discussions of health workforce re-design – sometimes necessarily 'in camera' – and bringing combined rural/remote voice to the national table.
    4. Provision of scholarships for undergraduate medical students from rural areas and scholarships for continuing professional education for a wide range of health professionals.
    5. Providing a biennial national opportunity for the exchange of reports on health service and workforce success as well as failure, and producing a range of regular and ongoing communications tools in which debates on these matters can be held.

  - *Do you give permission for HWA to follow up with your organisation to obtain further information about these reforms?*

Yes

Attachment 9

Extracts from
Presentations to Parliamentarians by Alliance delegations: 2009, 2010, 2011

2009

Oral and dental health: improving the workforce first

The NRHA supports the principles inherent in the proposed Denticare but believes the first priority is to improve the supply and distribution of the oral health workforce.

In rural and remote areas, dentists are, respectively, half and a third as prevalent as in major cities (a distribution much worse than doctors). Without an increase in the number of dentists and other oral health workers in rural and remote areas, Denticare could perversely result in a widening of the gap between the health of people in rural and remote areas and major cities.

The fact that in remote areas a very small proportion of visits to a dentist are for routine or preventive work is an indictment of a wealthy developed country in the 21st century.

Poor oral health also has implications for cardiovascular health, with rates in rural and remote areas measurably higher than in major cities.

Addressing the lower prevalence of dentists in rural and remote areas will take time, perhaps as long as five to ten years. Measures to be immediately adopted should include:

- one-year internships for dentists, oral health therapists and hygienists in rural and remote areas. Such internships could be hosted through some of the proposed five new dental teaching hospitals (Hubs) and 50 oral health centres (Spokes). There is good argument to have some dental teaching hospitals in regional centres and oral health centres in rural areas. The established and multidisciplinary University Departments of Rural Health would be ideal host organisations.
- dental service outreach from the Hubs and Spokes to other towns and communities beyond the centre in which they are located should extend to the 180 towns with a population of between 5,000 and 48,000, integrated within a network of comprehensive primary care centres and services (which would include MPSs).
- until numbers of rural dentists increase, outreach services such as visiting dentists, therapists and eligibility for PATS should be extended to allow rural and remote Australians similar access to dental services envisaged under Denticare, compared with city dwellers.
- the full package of measures applicable to medicine (rural undergraduate scholarship scheme, HECS relief, rural and remote incentives for attraction and retention, and locum relief services) is well justified for dentists and oral health therapists.

Specific workforce initiatives

Compared to urban Australia, regional rural and remote areas of Australia suffer from significant shortages of all health professions.

The attachment shows the figures for doctors, dentists and mental health professions.

Without better distribution of the workforce, the notion of universal access to health equity will remain a pious hope. This situation must be rectified.

A crucial step is to substantially increase the rural share of clinical training and placements for all health professions. Governments are funding large increases in the overall number of clinical training places over the next four years, but there is currently no evidence that rural Australia is getting its share, let alone the increase in numbers that will be required to attract more health professions to rural and remote areas.

A second major policy direction must be to expand the range of incentives available to GPs to other designated health professions in most need. (Oral and mental health professions are a clear case in point.)

These should include funding incentives for health professions for relocation and retention, substantial investment in health-related infrastructure, remuneration for health professionals that is competitive with that available in the major cities through a mix of fee-for-service, salary and blended payments, and greater emphasis on attracting rural and Indigenous students to a role in health sciences.

Distribution of Health Professionals

The AIHW survey of Medical Labour Force changes from 2002 to 2006 indicates that the investment in national medical workforce training and distribution initiatives is serving to reduce inequalities in access to GPs, as shown in the following table. In overall terms, however, there is an increasingly geographically skewed distribution of employed medical practitioners.

AREA	Total Medical Workforce per 100,000 2002 2006	Growth Rate in Employed Medical Practitioners	Employed Primary Care Clinicians FTE per 100,000 2002 2006	Employed Hospital non-specialists FTE per 100,000 2002 2006	Specialists/ in training FTE per 100,000 2002 2006
Metro	312 332	18.5%	105 98	29 39	154 170
Inner Regional	176 184	8.3%	90 87	14 18	65 71
Outer Regional	146 154	4.9%	80 86	15 15	43 45
Remote, Very Remote	140 191	31.2%	89 108	22 34	21 35
Overall Clinicians	271 290 252 272		101 97		

Note: AIHW urges care in interpreting 2006 data for Remote/Very Remote because of few numbers responding to survey.

The AIHW survey also found that hours of work by primary care clinicians were 2.6 hours more in inner regional, 6.1 hours more in outer regional and 10.3 hours more in remote/very remote, compared to their metropolitan counterparts. Thus it is clear that primary care practitioners in rural Australia already work longer hours and have a broader range of demands for their services and will be significantly less well placed than their metropolitan colleagues to devote additional time to health promotion and prevention measures.

Oral Health

Despite the greater need for care, a 2005 AIHW study of the dental health workforce (see Table) showed that rural and remote Australians enjoy less than half the access to dental health services of their urban counterparts.

Per 100,000 pop	Major cities	Inner regional	Outer regional	Remote
Dentists	58.6	34.6	28.5	19.8
Hygienists	5.0	3.1	2.5	2.6
Therapists	6.6	8.5	10.9	8.1

The study also shows that the 2005 dental therapist workforce was significantly better distributed than dentists. This reflects an ageing cohort trained and recruited in the 1970s and 1980s in an era of vibrant growth of government-driven School Dental Services. Looking ahead to the next 10 years, the opportunity presents for another transformation, this time in adult and rural oral health, if there can be another government-sponsored surge and dispersal of dentists and suitably trained oral health therapists. Oral health therapists, like clinical nurse practitioners, potentially have a far greater role to play.

Mental Health

In terms of psychologists working in the health field, 20.5 per cent of psychologists were reported in the National Allied Health Workforce Report as working in rural and remote regions. This equates to between 0.83 psychologists per 10,000 head of population in very remote areas to 3.44 in inner regional centres, compared to 5.92 psychologists per 10,000 head of population in major capital cities. The rural sector tended to attract the youngest and hence least experienced health professionals. Although data are scarce, there would appear to be few Indigenous people working as psychologists, regardless of whether or not they are located in rural and remote regions.

The *2nd Report on the Mental Health and the New Medicare Services* for the two years to August 2008 by the Mental Health Council of Australia (MHCA) revealed that people living in rural and remote Australia had less access to the new MBS Items for mental health services, indicating a lack of appropriate health professionals and mental health specialists in rural Australia. Access ratios per 1000 population compared to urban areas were:

- GP mental health plans: 0.91 for rural, 0.34 for remote;
- for psychological assessment and therapy by a clinical psychologist: 0.76 for rural and 0.17 for remote; and
- treatment by a registered psychologist: 0.43 in rural and 0.12 in remote.

2010

Build the rural and remote health workforce.

A package of measures to further build and redistribute a health workforce to rural, regional and remote areas, resulting in greater equivalence of support across all health professional groups. The package would include:

- support (as outlined in the election campaign) for practice nurses, nurse practitioners and dental scholarships;
- a specific focus on the oral health service workforce, with the establishment of a foundation (training) year for new dental graduates; HECS reimbursement for rural service by dentists and oral therapists and hygienists; [see above re a new public dental health program];
- new Medicare items for telehealth consultations with more specialised clinicians, to be accessed by GPs, practice nurses or nurse practitioners in towns where there is no doctor (see a above).

Reporting requirement: A public annual report each year on progress with these measures, with analysis by region (major city through to very remote).

Inequity in health workforce

There are shortages of health professionals of all types across rural, regional and remote areas. In general, the more remote the area, the more serious the shortages.

Table 2: Persons employed in health occupations, per 100,000 population, by Remoteness Areas, 2006

Occupation	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Medical practitioners	324	184	148	136	70	275
Medical imaging workers	58	40	28	15	5	51
Dental workers	159	119	100	60	21	143
Nursing workers	1,058	1,177	1,016	857	665	1,073
Registered nurses	978	1,056	886	748	589	979
Enrolled nurses	80	121	129	109	76	94
Pharmacists	84	57	49	33	15	74
Allied health workers	354	256	201	161	64	315
Complementary therapists	82	82	62	40	11	79
Aboriginal and Torres Strait Islander health workers	1	4	10	50	190	5
Other health workers	624	584	524	447	320	602
Other health services managers	32	33	28	28	18	31
Total health workers	2,777	2,536	2,166	1,827	1,379	2,649

Source: ABS, Census of Population and Housing, 2006.

Although there are now greater numbers of students in medicine and nursing than ever before, the policy settings are still not in place to ensure that a fair proportion of them will choose to work in non-metropolitan areas after graduation. And despite the inventiveness and resilience of rural

health workers, many of the service types that work well in rural areas cannot be established without the necessary workforce.

2011

Improving rural educational outcomes

Attempts to avoid the looming workforce shortage identified by the Productivity Commission must embrace the one third of Australian school students who either live in rural/remote Australia, or are Indigenous.

A concerted national effort is urgently needed to widen the curriculums of rural high schools and improve high school completion rates for rural, remote and Indigenous students as well as access to tertiary and vocational training. High school completion alone will improve health outcomes for these young people. It will also reduce the difficulty they have in accessing higher education. Developing a specially-designed pathway for rural students to and through tertiary education will help to add value and efficiency to our future workforce and reduce the need to import labour – and contribute in a major way to the rural health workforce.

The Alliance asks that:

1. as part of their funding agreements with the Commonwealth Government, tertiary educational institutions and the VET sector be required to meet and report on targets set (in conjunction with the Department of Education) relating to the number and proportion of their students who are of Indigenous origin and rural/remote origin, including in nursing and allied health disciplines;

2. additional programs of support for Indigenous and rural/remote students should be provided during secondary school and tertiary studies, in order to optimise tertiary enrolment and completion rates, including:
   - improvement of the quality and breadth of the educational experience though grasping the educational opportunities offered by high speed internet and better valuing quality teachers for these students in both primary and secondary school; and
   - providing financial support to enable Indigenous and rural/remote youth to live away from home so that they can attend school and access tertiary education.

The Education Revolution should not only be available for youth from major cities and in those regional centres where university campuses exist.

Educational aspiration does not develop in a vacuum. Students' aspirations develop through contacts with role-models and are also shaped by perceived opportunities in the workforce. Their educational aspirations will be enhanced through the development of sustainable rural, remote and Indigenous communities, with economies that need a diverse workforce – including those with technical and professional skills. These aspirations will develop further when young people live in an environment presided over by accountable and local governance, in which high speed internet is available, and as part of a decentralised economy which is taking advantage of renewable energy and 21st century green technology.

Rural placements for health professionals

Positive experiences in rural practice for students and new graduates strongly influence health professionals to choose to work in rural areas. A strong rural pathway which allows students with an interest in rural careers to have an opportunity and, once graduated, to stay rural is essential to maximising every opportunity to attract and retain members of the future rural health workforce.

Graduates from UDRHs and Rural Clinical Schools are starting to constitute the intern intake in large regional hospitals.

There are two major issues: to ensure equity of opportunity for students in all health professions when it comes to rural placements; and to ensure an integrated scheme of rural placements for all health graduates.

The first requires the establishment of a collaborative system engaging universities, TAFEs, clinical practices and clinicians, and health and related sector organisations in rural areas to provide undergraduate rural placements on an equitable basis across the professions and between universities. Such a scheme should include:

- identification and funding to address infrastructure deficits, eg teaching facilities and accommodation;
- extension to allied health and nursing of short-term scholarships for familiarising students with rural areas with appropriate funding for travel, accommodation and living expenses; and
- support (including remuneration) for the preceptors and mentors supervising students.

The second proposal - for integrated graduate rural placements - requires a rapid expansion of Health Workforce Australia's program and particularly its Integrated Regional Training Networks. The Alliance stands ready to work with Health Workforce Australia and other interested parties to develop systems for collaborative vocational placements for health graduates in rural areas that recognise and build on the work of agencies already demonstrating success in the area.

In both of these schemes, students and graduates who have demonstrated a commitment to rural practice or who are of rural origin should be given preferential entry and more opportunities for pursuing a rural training pathway.

This will help bridge the current gap in the rural pathway from university graduation to future work where potential rural health workers may be lost to the city if rural areas do not have the capacity and resources to support them.