Senate Inquiry

Introduction

The intention of this submission is to be brief and to address the key factors that impact on the supply of services and the supply of the appropriate workforce in the rural sector in our context.

There has been a certain amount of research and articles written on these issues over the years but not a great deal has changed on the ground. The rural sector is in a constant state of watching, responding and trying to plan for changes and initiatives that have been created by the ultimate decision makers who do not fully understand the rural context. But more dangerously feel they do understand the context. The positive aspect of this is many of the agencies "just get on with it" and this has led to an innovative culture in some organizations.
A number of years ago a number of articles were written addressing the need to apply the "rural lens" to decision making. Some of this philosophy found its way into policy. However it is difficult to find demonstrations of this thought and in some cases this ethos is non-existent.

The work in Victoria to define the role of the rural health sector which has assisted in setting the boundaries of role and function of services but even this has had to allow for some flexibility as the health demands across the regions vary and the skill that resides in each of the facilities is also variable due to workforce and infrastructure constraints.

The health service is critical to rural communities. It is often the biggest employer in the town. It may be the reason that some people settle in the area so they become critical to maintaining the population. Also the sustainability of the health service itself is dependent on maintaining the population so there is an interdependence which means the rural health services involve itself in the community planning and economic development of their regions which is not a traditional role for the larger health services. That population factor and the demographic also determines the type of services required and ultimately affects access to workforce.

Rural health services are also a wonderful micro-system that should be looked at closely as they are dotted with excellent examples of properly integrated care and have excellent outcomes for their clients. They clearly understand what services can be delivered close to the community safely, understand what services require partnerships and what service will always be the province of others.

Often it is assumed that "big is best" however it has been my experience that the examples of excellence are found in small rural health services with local committed boards and some flexibility in their funding arrangements.

a)
Workforce
The rural areas are still not producing the number of professionals they need to meet their service needs so their contribution to the greater health workforce pool is not proportionate. Much of this is due to:

- a different aspiration by parents and students and the perception that University education is hard to obtain
- access to skilled teachers in core science subjects in the rural schools
- the additional burden of cost and the emotional factors of leaving home to receive a tertiary education

- some younger people have the aspiration to leave the rural areas and may never return. However there is evidence that some will return to settle and raise families in the rural environment due to a value judgement some make when they settle and want to raise young families. Some will also leave again so their children can access better secondary education. We find that this is a big factor in our recruitment. We have used this information to understand the success factors in recruitment when we are looking for staff that may stay longer in a rural community.

- we have found that being involved with the local high school and having the students exposed to other role models has had some success in changing the aspirations of students. Recently due to some effort in this area we have had one student entering medicine, one in physiotherapy, one in pharmacy and a number of nurses.

Therefore the rural sector relies on migration of skilled workers to the area and not all people are suited to the rural environment. Those best suited are the ones with the ability to work and make decisions in a less traditionally supported environment and are comfortable and confident to do this. They must also enjoy diversity as you do have to "pitch in" on occasions.

On many occasions a worker will be a one man work unit. Many organizations have support structures and paid supervision to assist these individuals but this is not recognized in the workforce funding models.

To ensure ongoing competency in areas of lower volume and skilled activity we have to create arrangements for our staff to gain experience and refresh skills in other organisations which is difficult as we seldom have funding to do this. We need to pay them whilst absent to retain them and do without the service while they undertake these experiences. More consideration needs to be given to the issue of mechanisms for ensuring ongoing competency.

The medical and nursing staff in the rural sector need to be "expert generalists". The significant specialization of these workforces over time has been detrimental to the rural sector.

In the medical area we rely on GP's and GP proceduralists and visiting specialists from time to time. We find that in the GP cohort some individuals are only interested in the GP practice role but others seek out the GP practice attached to a rural hospital. These same GP's are the ones that wish to pursue further procedural training. This is difficult to organize and access as there are no formally described pathways for them to follow. I have assisted three GP's to undertake this process in the last three years and every one has led us down a different process and ad hoc funding streams. Then when they do undertake the training they have to "compete" with the hospital trainees and their prescribed requirements so the GP become a lesser priority which led to fairly unsatisfactory experiences.

We have two medical students per year and we believe this investment in time and effort will ensure that every now and then one may return to our organisation to work. This is a long term strategy that we need to stay optimistic about as the benefits from a workforce perspective are unpredictable. Having the students does have a flow on benefit however as we must all stay current and contemporary in our practice to meet the expectations of the students and the University.

There is a similar experience in the nursing work force area however we have more opportunities to "grow our own". We have found that in rural communities the lack of aspiration for tertiary education often means that as people get older they may regret some of those earlier decisions and wish to enter some professions such as nursing. We have found that they have families and need more flexible approaches to their education and training. We have developed our own documented

pathways for our own community to enter nursing as it is complex and daunting. We find they have more success if they come to us and we provide the support for them to navigate the system.

When we are unable to recruit we may need to close a service or some aspect of that service temporarily. This is difficult to communicate effectively to a community that may have become used to having that service and have built expectations around its availability.

Another aspect of the connection between service delivery and the workforce is that over time the recruitment opportunities (or lack of success) starts to change the profile of the services delivered if you are not vigilant. When you lose a staff member and recruitment is problematic you may be tempted from time to time to recruit someone that has a different skill to fill the gap. They, in turn, start to work to their strengths which may have been different from the previous incumbent and then the service profile starts to change. We have had to ensure that our workforce planning and service plan is rigorous enough not to succumb to this temptation as it is not in our long term interests.

We have been fortunate as we have been fully employed in the last few years but this has been after a huge effort to be the employer of choice in the subregion and we invest in health and wellbeing programs for our workforce and fund education and training as an incentive for staff recruitment and retention and to address issues of ongoing competency.

We would like university's to look at the possibility of running core first and second year applied science subjects (generic to allied health and nursing education) in the rural and regional environment so that rural students do not necessarily need to leave home in the early years of their tertiary education. This would reduce costs for that same group of students.

B) The impact of the introduction of the Medicare Locals is hard to fully understand at this stage. We have been very involved in the process and will take the opportunity to be members in our Medicare Local. I believe at the moment the focus has been on technical aspects of getting them established and winding down the Divisions of General Practice's. Therefore the ability to have a Vision and seize the opportunities that this initiative may provide is in danger of being missed or delayed.
Our GP's did not engage with the Division due to local issues and did not benefit significantly from its existence. So there will be a level of cynicism about the Medicare Locals if they look anything like the Divisions of General Practice. The broader involvement from health services and private practitioners from the primary care industry will occur as they see the benefits and the Medicare Local takes leadership.

But some issues are of concern for small rural health services related to MLO and reforms.
Example: we currently receive Medicare Out of Hours funding and use this to ensure 24 hour cover 365 days of the year in a very large geographical area. No one in living memory can recall a time when we have not delivered on this. However we are about to lose the direct allocation of this money to the Medicare Local. We will have to apply for this money and we assume will be successful if as we are the best mechanism for 24 hour cover in the subregion. We are now dependent on a new and unproven entity to make the correct decisions and this makes us feel vulnerable. The decision should be straight forward but we have seen poor decisions happen around us so we are concerned.

We are already a fully integrated health service so we are unclear how the Medicare Local will support us or be of assistance to us and our community in the short term. We are concerned that the Medicare Locals will become a convenient way to centralize regional funding that should be provided direct to the local health service. This would ensure valuable service hours are not lost to

administrative margins being removed prior to allocation by the Medicare Local or large travel costs as a result of geographical centralization.

C)
1) The incentive programs are too variable across state and federal programs. They feel ad hoc at our end as they are not well communicated and we have to spend a lot of time trying to research their existence or the pathways to apply. As mentioned above a simple schematic describing the pathways would be of assistance.
Some funding initiatives only lends itself to a subregional response which is appropriate to some degree as regional workforce systems do have some success. However we find that when we join these consortia type bids the needs of the bigger organisations once again take priority and we start to become the afterthought or the token gesture no matter how we persevere in trying to educate others about our needs or what we have to offer as a placement option.
11) the delivery models have been addressed to some extent above. However we need to remind people that GP's who commit to further training are often leaving successful practices, feel the pressure of the community left behind and may have to relocate families temporarily as they tend to be more mature people. They also have to deal with the stress of entering an education system after a gap in time and are working beside people that are still in their initial training straight from University. The GP cohort may need more technical support than currently given.
111)
The application of the current Australian Standard Geographical Classification - Remoteness Areas classification scheme has been detrimental to our service. We were a RAMA 7 area, one of only two in Victoria. The reclassification was a shock to us as we were unaware of the process to review the classification as all of the consultation was undertaken at a higher level (peak body level) and there was no mechanism of appeal. We wrote a number of letters about our concerns and made representation to parliamentarians and felt ignored in the process due to the tone of the responses. We do not understand the rationale for our change from Remote to Outer Regional. Nothing had changed for us. We are still an hour ten minutes from the nearest subregional hospital and two hours from the nearest intensive care bed. We are 5 hours from a capital city and have no regional air service. We are surrounded by national park, forest and mountains.
The bulk of the health service delivery area sits within the remote classification but our office/hospital sits just outside of this area in the Outer Regional classification. Some of our clients take two hours to drive to. We are remote and have had to develop all of the skills to be self-sufficient which has made us innovative. However we find that any support in recognition of our distance from anywhere is being eroded steadily.
As a result of this reclassification we have lost some of our grants for the support of relocation and training of our GP's. To compensate the individuals for the loss we have chosen to supplement their incomes as their work environment and circumstances have not changed - they still work in a remote environment. Also a number of grants that are specifically established for the purpose of supporting remote health services we can no longer access. Some still state in their criteria "previous RAMA 7 agencies can apply" however our concern is that this phrase may soon be dropped as history is lost and all of the support opportunities we have had in the past will be gone.