15th December, 2011

To: Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Submission:

The factors affecting the supply of health services and medical professionals in rural areas

Submitted by : Geri Malone

National Coordinator of Professional Services

On behalf of CRANAplus: *peak body for remote health*

Submission to the Senate Community Affairs Reference Committee

Background:

CRANA*plus* is a member based organization that educates, supports and advocates for all remote health professionals working in Remote Australia and her Territories.

Education

The suite of courses developed by CRANAplus has been in response to needs of remote health workers who provide emergency care to their communities with limited resources and vast distances to specialist services. Whilst principles of emergency care do not vary, these courses realistically address the challenges that present when working with minimal staff and resources, whereby Nurses and AHW's have a very broad scope of practice at an advanced level.

As well as contextualizing to remote practice CRANAplus provides these courses in remote areas, limiting the huge travel and cost impediments for remote health workers to access CPD

We provide postgraduate courses in:

- Remote Emergency Care (mandated for Nurses in remote NT)
- Advanced Remote Emergency Care – aimed at Remote Area Nurses, and Medical Officers/GP's.
- Maternity Emergency Care for non midwives
- MIDUS – Maternity Emergency Care for Midwives
- e- Remote
- Aboriginal Health Worker – REC

Bush Support Service (BSS)

We provide a 24/7 psychologist staffed, phone line for remote health professionals and their families, to provide a confidential service for individuals who may be feeling overwhelmed and in need of a safe avenue to talk. Providing health services and living in remote and isolated communities, away from usual support mechanisms, is a stressful process and the BSS also offers education on self-care and prevention to offer practical coping strategies to prevent burnout and crisis.

It has to be stated at this point in our comments, that both of the above programs are under threat as we have been reliably informed that the Government does not intend to refund any of the education programs and reduce funding to the support program following the expiration of our current funding agreement in 2013. This would mean that the remote sector would lose the only access it has to remote post graduate, professional development delivered in remote locations or on going support - and the most marginalised people in Australia would have inadequately trained and unsupported remote health professionals trying to **close the gap.**

Both of these programs are internationally recognized with all of our courses oversubscribed well in advance, by all health professions. It would appear that such a decision is not based on the value of the programs but budget cuts. Once again it is the remote sector and Aboriginal Australians that get ignored and further marginalised.

We are the only organization in the health sector that has remote as its sole focus and as such are an organization with a great deal of expertise and history in this difficult sector. We are it – in remote there is no one else that does what we do for all remote health professionals.

We are aware that the Committees has as its terms of reference the rural sector as its major focus, but it is incumbent on us to ensure that the remote health sector is considered in any deliberations of this nature.

It must be pointed out however that even though there is some overlap from rural to remote and the two sectors are often considered in tandem, the remote sector is unique in its challenges and the difference between rural and remote is not dissimilar to that of rural to urban.

We will therefore comment on the terms of reference set down by the committee from the ‘remote’ perspective only, as this is our area of expertise.

TERMS Of Reference

a) Factors limiting the supply of health services and medical, nursing and allied health professionals to the remote health sector.

To frame the answer to this question we need to make few points about the remote health workforce.

Health services in remote areas are variable in nature, determined by the unique needs of the communities they service.

Generally these communities are either Aboriginal & Torres Strait Island (ATSI) communities, small 'towns" that were established by pastoral, mining or railway industries and tourist facilities.

Remoteness is determined not just in terms of distance but also geographically through terrain, bodies of water and access limited through weather.

The workforce in remote health as previously stated is predominantly Remote Area Nurses and in the ATSI communities, alongside Aboriginal & Torre Strait Island Health Workers. Other health professionals specifically Medical Officers, may be present in small centres, but more likely are on a visiting basis as outreach from regional centers or as provided by Royal Flying Doctor Service. Likewise Allied Health Workers, Specialists are also most likely, if at all, to be on a visiting basis. Thus it is Nurses and Midwives (though dwindling more significantly in numbers) alongside ATSI health workers who are the dominant workforce.

Due to the lack of access to a multidisciplinary health workforce these health staff have a very broad scope of practice, practice at an advanced level and by virtue of being there are placed under very high demand by their communities and endeavour to provide a safe, quality service with only support through telephone access to Doctors and other support networks.

Hence access to Continuous Professional Development, opportunities to get out of the remote location with access to relief staff and provision for support in the workplace professionally, clinically and managerially is absolutely essential.

The supply of health professionals to remote areas is limited by a number of factors.

Firstly there is limited access to Medicare dollars and the medical model is not necessarily the best model for small Aboriginal Communities that largely make up the client base in remote. There is a need for a team approach with many excellent models of care found in difficult locations.

Remote Area Nurses (RAN's) along with Aboriginal Health Workers (AHW's), make up around 85% of health service professionals in the sector and it must be noted that the incentives offered to GP's to attract them to the sector, are not available to nurses or most other health professionals.

Some other factors limiting supply are:

- Housing for staff
- Fear of the skill base needed for the sector – thus our training courses
- Professional Isolation
- Extremes in climate
- Remoteness and personal isolation
- Oft times inability to take leave or access Professional Development
- Lack of transport in and out for breaks
- Less than optimum cultural training, community orientation (something we are trialing to try and address), and mentoring
- Insufficient funds for Allied Health support who also suffer from those issues mentioned above
- Lack of information and data – something CRANA*plus* will seek to access funding to address in 2012

It must also be noted that the difficulty recruiting staff for the remote sector is exacerbated by the lack of Government recognition and a lesser funding focus on retention programs.

b) The effect of Medicare Locals on the provision of health services in remote.

It is really too early to tell but in the remote sector much will depend on any given Medicare Local's ability to recognize that there is more in Primary Health Care than the medical model and that flexibility and a team approach is the key to success.

What could be an issue however, is the further effect of siloed data and population health. With each ML focusing on Population Health Planning it is quite likely that each region will once again have differing quality data with no real effort to look at the whole picture especially in the remote sector. CRANA*plus* is seeking funding for a project to develop a data warehouse for the whole remote sector. We need workforce data, health planning data, to look at trends and clusters in heath and so on. This will be vital as the Government looks at future health funding in this area of work and more so if we are to ensure that money is spent in such a way that health outcomes can be achieved whilst cutting out duplication and achieving value for a limited resource.

(c) current incentive programs for recruitment and retention of doctors and dentists, particularly in remote communities, including:

(i) their role, structure and effectiveness,

The current incentive programs are having a very limited effect on attracting those health professionals into the remote sector. As we have pointed out there many other factors at play and it is a point of contention that the health professionals that do deliver remote health such as RAN's and AHW's are not offered any additional incentives to either enter the field or remain. Whilst we acknowledge that professional salaries are not on parity there must be some parity in regard to the support available across the whole healthcare team. One of the great features of remote health services is the multidisciplinary approach to health service delivery, where there are teams either in context of permanent or a mix of permanent and visiting. There is respect across the team and acknowledgment of the equal role each member plays in contributing to the health service needs of the community. This inequity between professional groups in regard to incentives creates unnecessary disquiet, and acknowledgment through providing the same types of incentives that apply for relocation, access to CPD, undergraduate support for clinical placements would go a long way towards recruiting and retaining Nurses, Midwives and Allied health professionals to remote practice.

ii The current Australian Standard Geographical Classification – Remoteness

Areas classification scheme for health in particular is an extremely unfair way of looking at funding and workforce issues. There are certainly anomalies in the region/rural classification itself, however to use geography alone as a gauge to remoteness is farcical. CRANA*plus* uses the term geographic and isolated practice and include professional isolation in that descriptor.

A case in point is Bruny Island off the coast of Tasmania. This Island is not considered remote as it is in reasonable proximity to Hobart geographically. However it has no permanent GP and the Ferry stops running at 7pm each evening. To us this is a remote location. The health service is staffed by some very experienced RAN's, who are only able to work under the classification of a community nurse, which does not ascribe to the expanded scope of practice of a Remote Area Nurse in 'remote' locations. This means that users of the health service on this Island are exposed to a more limited level of care than they would if the exponents of the remote classifiers understood that Bruny might well be reasonably close to Hobart but there is a large body of water in the way.

There has to be some understanding that there are areas in this country that suffer the same problems as Bruny and that a more sensible classification should include more factors than distance when determining remoteness.

There are many jurisdictional inconsistencies around legislation related to remote area classifications, significantly Drugs & Poisons Acts that impact on the ability of health professionals, specifically Nurses, to work to a broad scope of practice, in areas where access to other health professionals is limited and transient.

Changing the classification in itself may not prevent issues in the view of the States as this is also an issue of remuneration rather than classification, but to be clear about what we consider remote in health would be a good first step. We understand that the matter of remoteness also has taxation ramifications but there are not that many people working in remote that would make a significant difference and this issue should be resolved.

In closing, we appreciate the opportunity to have input in to this inquiry and would welcome the opportunity to expand further on any of these points. If you have any questions regarding remote health please do not hesitate to contact us as we have the experience and expertise on this topic and are committed to facilitating access to safe, quality health services for people living, working and visiting remote areas, and supporting those health professionals that provide these services.

Geri Malone

National Coordinator of Professional Services

Corporate Services Centre
Ph 08 8959 1111
crana@crana.org.au

Bush Support Services
Ph 08 8959 1110
bss@crana.org.au

Members Services
Ph 08 8408 8200
membership@crana.org.au

First Line Emergency Care
Ph 08 8408 8200
admin6@crana.org.au

Fax 08 8959 1199
PMB 203, Alice Springs, NT 0872

ABN 31 601 433 502

Fax 08 8408 8222
PO Box 2148, Hilton Plaza SA 5033