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

Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine

The Rural Doctors Association of Australia (RDAA) and the Australian College of Rural and Remote Medicine (ACRRM) welcome the opportunity to provide a response to the Productivity Commission's Position Paper: *Australia's Health Workforce*.

The RDAA was formed in 1991 to give rural doctors a national voice. RDAA comprises the Rural Doctors Association (RDA) of each State and the Northern Territory, representing rural doctors from right around the country. RDAA's vision is for excellent medical care in Australia's rural and remote communities. RDAA advocates for highly skilled and motivated medical practitioners who are adequately trained, remunerated and supported, both professionally and socially. By working closely with its members and key stakeholders such as the Commonwealth Government, RDAA provides support, policy development, research, submissions and strategic advice on relevant issues.

ACRRM was founded in 1997 as the peak professional body for the provision of rural medical education and training. The College represents more than 1800 rural doctors across Australia. Central to ACRRM's activities, and to many of the issues raised in this submission, is the understanding that rural and remote medical practice is a specialty area of generalist medical practice, requiring specific training, support and ongoing professional development. ACRRM's core function is to determine and uphold the standards that define and govern competent, unsupervised rural and remote medical practice.

General comment

It is critical that the development of any proposals outlined in the position paper be done in close and transparent consultation with the major stakeholders, especially rural communities and their healthcare professionals.

Such proposals should all be subject to rural proofing, or differential analysis to assess their impact on rural and remote communities, and the medical workforce which serves them. Where this impact is likely to differ from that in metropolitan and interregional areas, the proposals and their practical implementation must be adjusted to see that adjustments are made to address current inequities and ensure rural and remote communities achieve equivalent health outcomes to the broad Australian population.

ACRRM and RDAA are keen to continue meaningful consultation with the Productivity Commission and the Government on rural and remote health workforce issues.

Draft Proposal 3.1

In its upcoming assessment of ways to improve the level of integration within the health care system, the Council of Australian Governments (CoAG) should consider endorsing the National Health Workforce Strategic Framework (NHWSF), subject to broadening of the self sufficiency principle, in order to enhance cohesion between the various areas and levels of government involved in health workforce policy.

Response

There is general agreement with this issue, with the proviso that this should enhance a more timely response to the current workforce crisis Just to be clear, the NHWSF does talk about workforce redesign. Perhaps should reiterate that workforce redesign needs to be with the agreement of professional groups, quality and safety must be maintained or improved and is not to be as a cost reduction measure primarily

Draft Proposal 3.2

CoAG, through its Senior Officials, should commission regular reviews of progress in implementing the NHWSF. Such reviews should be independent, transparent and their results made publicly available.

Response

Both organisations strongly support this issue. The need for independence and transparency is vital. Such reporting should include the impacts on the rural and remote health workforce.

Draft Proposal 4.1

The Australian Health Ministers' Conference should establish an advisory health workforce improvement agency to evaluate and facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.

- Membership of the board should consist of an appropriate balance of people with the necessary health, education and finance knowledge and experience.

Response

Agreed, however the membership must include those with specific current experience of these matters in a rural and remote context. If this is to occur then it should have input from ACRRM with regard to standards and from RDAA with regard to industrial matters.

Draft Proposal 5.1

The Australian Government should consider transferring primary responsibility for allocating the quantum of funding available for university-based education and training of health workers from the Department of Education, Science and Training to the Department of Health and Ageing. That allocation function would encompass the mix of places across individual health care courses, and the distribution of those places across universities. In undertaking the allocation function, the Department of Health and Ageing would be formally required to:

- consider the needs of all university-based health workforce areas; and
- consult with Vice Chancellors, the Department of Education, Science and Training, other relevant Australian Government agencies, the States and Territories and key non-government stakeholders.

Response

This proposal may present some advantages in terms of greater alignment between workforce needs and the general workforce agenda. However, it needs very careful consideration to ensure balance and due regard to the diversity of the healthcare workforce, the environments in which it works and the paramount need for flexibility in education and training to prepare for future needs and evolving models. In addition, the issue of access to appropriate and sufficient funding should be considered to ensure high quality teaching of undergraduates.

Draft Proposal 5.2

The Australian Health Ministers' Conference should establish an advisory health workforce education and training council to provide independent and transparent assessments of:

- opportunities to improve health workforce education and training approaches (including for vocational and clinical training); and
- their implications for courses and curricula, accreditation requirements and the like.

Response

This is a proposal in which ACRRM should play a significant role. In addition, RDAA strongly supports the view that the Colleges must remain the arbiter of standards. It is essential that we have independent arbiters of standards external to employers and government.

Draft Proposal 5.3

To help ensure that clinical training for the future health workforce is sustainable over the longer term, the Australian Health Ministers' Conference should focus policy effort on enhancing the transparency and contestability of institutional and funding frameworks, including through:

- improving information in relation to the demand for clinical training, where it is being provided, how much it costs to provide, and how it is being funded;

- examining the role of greater use of explicit payments to those providing infrastructure support or training services, within the context of a system that will continue to rely on considerable pro bono provision of those services;
- better linking training subsidies to the wider public benefits of having a well trained health workforce; and
- addressing any regulatory impediments to competition in the delivery of clinical training services.

Response

There is a strong need for infrastructure support for the rural training environment – not just the "teaching" hospitals. RDAA also notes that the moral hazard, of employing bodies being involved further in setting standards, remains a major determinant of role in this matter. The recent events in Bundaberg provide a case in point. It is essential to ensure sufficient resources to provide for adequate infrastructure for training

Draft Proposal 6.1

The Australian Health Ministers' Conference should establish a single national accreditation agency for university-based and postgraduate health workforce education and training.

- It would develop uniform national standards upon which professional registration would be based.
- Its implementation should be in a considered and staged manner.

A possible extension to VET should be assessed at a later time in the light of experience with the national agency.

Response

RDAA and ACRRM support ACRRM's taking the lead in responding to this proposal generally; however, national registration is strongly supported. However, given the complexity and diversity of the various components of the healthcare workforce, this body should be utilizing the standards of professional colleges in recognizing vocationally trained doctors.

There are some dangers in the creation of a single accrediting body in the health education arena. This may lead to an unworkable monopoly and create uncertainty as to where the responsibility lies for setting the standards against which this body would operate. However, there is a need for a well coordinated, responsive and transparent system that is capable of managing both current and future national accreditation needs.

To this end, the current system of accreditation which is managed via the Australian Medical Council (AMC) has many weaknesses. In particular, the AMC has not been able to efficiently or effectively manage a process to consider the recognition and standards needs for "generalist" disciplines/specialties.

RDAA would support a single national registration accreditation body for medical practitioners.

Both ACRRM and RDAA believe it is vital that any changes to the current arrangements are dealt with in a consultative and incremental manner.

Draft Proposal 6.2

The new national accreditation agency should develop a national approach to the assessment of overseas trained health professionals. This should cover assessment processes, recognition of overseas training courses, and the criteria for practise in different work settings.

Response

This is supported; however consideration should be given to the need for a structured and funded program for overseas-trained medical practitioners to achieve the standards set by ACRRM for rural and remote practice.

Draft Proposal 7.1

Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters.

Response

Strongly agreed. In Bundaberg the problems were related to not independently testing evidence presented to them in relation to registration of overseas trained specialists.

Draft Proposal 7.2

States and Territories should collectively take steps to improve the operation of mutual recognition in relation to the health workforce. In particular, they should implement fee waivers for mobile practitioners and streamline processes for short term provision of services across jurisdictional borders.

Response

Agreed. This is an important issue. The recognition and legal coverage for cross-jurisdictional phone advisory services should also be addressed.

Draft Proposal 7.3

Under the auspices of the Australian Health Ministers' Conference, jurisdictions should enact changes to registration acts in order to provide a formal regulatory framework for task delegation, under which the delegating practitioner retains responsibility for clinical outcomes and the health and safety of the patient.

Response

Indemnity and clinical governance issues around this matter require clarification. These demand a lot of work in consultation with the relevant professional bodies. There has been external discussion around whether or not this proposal means to include referred

as well as delegated services. RDAA believes that the position with regard to referred services is perfectly clear within current paradigms.

Draft Proposal 8.1

The Australian Government should establish an independent standing review body to advise the Minister for Health and Ageing on the coverage of the Medicare Benefits Schedule (MBS) and some related matters. It should subsume the functions of the Medical Services Advisory Committee, the Medicare Benefits Consultative Committee and related committees. Specifically, the review body should evaluate the benefits and costs, including the budgetary implications for government, of proposals for changes to:

- the range of services (type and by provider) covered under the MBS;
- referral arrangements for diagnostic and specialist services already subsidized under the MBS; and
- prescribing rights under the Pharmaceutical Benefits Scheme.

It should report publicly on its recommendations to the Minister and the reasoning behind them.

Response

RDAA is in principle against changes in these areas because it is removing the direct involvement of the profession in the process. The current MBS funds general practice. The process as outlined appears to be facilitating the funding of a broader range of health professionals without indication of additional financing.

As a principle there must be adequate recognition of the costs and complexity of delivering services particularly in a rural and remote environment with regular and adequate indexation. Rural proofing is particularly important here as models of care and service delivery which may be appropriate in metropolitan or inner regional areas may not be so in rural and remote settings. Quality and whole patient care must remain the paramount principles in any consideration of changes.

RDAA does not support the extension of prescribing rights under the PBS to other health professionals.

Draft Proposal 8.2

For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:

- the service would be billed in the name of the delegating practitioner; and
- rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances.

This change should be introduced progressively and its impacts reviewed after three years.

Response

RDAA supports proposals which have the potential for the expansion of delegated health worker item numbers in the general practice setting. However, the difference between clinical service items and fixed cost items must be taken into account in setting the level of rebates. The system of an independent and transparent mechanism to set fees should be continued.

Draft Proposal 9.1

Current institutional structures for numerical workforce planning should be rationalised, in particular through the abolition of the Australian Medical Workforce Advisory Committee and the Australian Health Workforce Advisory Committee. A single secretariat should undertake this function and report to the Australian Health Ministers' Advisory Council.

Response

It is important that AMWAC's specific focus on the rural medical workforce be maintained. Advice given to government also needs to be independent and transparently available.

Draft Proposal 9.2

Numerical workforce projections undertaken by the secretariat should be directed at advising governments of the implications for education and training of meeting differing levels of health services demand. To that end, those projections should:

- be based on a range of relevant demand and supply scenarios;
- concentrate on undergraduate entry for the major health workforce groups, namely medicine, nursing, dentistry and the larger allied professions, while recognising that projections for smaller groups may be required from time to time; and
- be updated regularly, consistent with education and training planning cycles.

Response

While generally agreed there needs to be a focus on the specific sub groups of the medical workforce including generalist and specialty groups.

Draft Proposal 10.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of rural and remote areas.

Response

Agreed

Draft Proposal 10.2

The brief for the health workforce improvement agency (see draft proposal 4.1) should include a requirement for that agency to:

- assess the implications for health outcomes in rural and remote areas of generally applicable changes to job design; and
- as appropriate, consider major job redesign opportunities specific to rural and remote areas.

Response

Principles here are that quality and safety must be preserved, professions should only give up or take on roles with their agreement. Role redefinition should be to enhance quality and safety and not be a cost reduction measure primarily. Without buy-in by all concerned changes will not work. The current good outcomes in healthcare delivery in rural and remote areas could be undermined by inappropriate or ill-considered models and the tensions they may produce within the healthcare disciplines. Attention is drawn to RDAA's draft policy on the future workforce which was provided as part of the earlier submission.

Draft Proposal 10.3

The Australian Health Ministers' Conference should initiate a cross program evaluation exercise designed to ascertain which approaches, or mix of approaches, are likely to be most cost-effective in improving the sustainability, quality and accessibility of health workforce services in rural and remote Australia, including:

- the provision of financial incentives through the MBS rebate structure versus practice grants; and
- 'incentive-driven' approaches involving financial support for education and training or service delivery versus 'coercive' mechanisms such as requirements for particular health workers to practise in rural and remote areas.

There should also be an assessment of the effectiveness, over the longer term, of regionally-based education and training, relative to other policy initiatives.

Response

Agreed, but with the proviso that evaluation and the development and assessment of incentives to support the rural workforce must be based on input from rural stakeholders. RDAA is a strong advocate of building incentives into major funding mechanisms like the Australian Health Care Agreements (AHCA), for example through quarantined funding for small rural hospitals which would have the effect of supporting the rural procedural workforce.

Attention should be given to difference between total workforce numbers and skill mix of that workforce: for example, recent increases to the overall rural and remote medical workforce are not reflected in the proportion of incoming proceduralists. Urgent consideration must be given to building procedural skills in the rural and remote workforce. Incentives and initiatives must be designed to support the needs and aspirations of the future workforce including the rising proportion of female doctors.

RDAA reiterates its strong emphasis on fee for service payments, complemented by blended payment where appropriate

Draft Proposal 11.1

The Australian Health Ministers' Conference should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular workforce requirements of groups with special needs, including: Indigenous Australians; people with mental health illnesses; people with disabilities; and those requiring aged care.

Response

Agreed. In rural areas this is highly pertinent due to the current lack of access to many of these services. Methods need to be found to address the requirements of groups with special needs in rural and remote settings**.**