

Thank you for the opportunity to make a submission to the Productivity Commission study into the health workforce. I have read the Issues Paper with interest and wish to make a number of comments relating to workforce issues in rural and remote regions of Australia.

From the outset, let me say that I do not wish to reiterate at length the information about workforce recruitment and retention relating to rural and remote areas – there exists an extensive published literature that is well-known and readily available elsewhere. Moreover, I have no doubt that many professional organisations, peak bodies and individual practitioners will respond in relation to these issues. Rather I wish to comment on a number of broader issues relevant to the health workforce and which I think are not emphasised sufficiently in current documentation.

First, I would endorse wholeheartedly the need to address systemic issues relating to the rural and remote medical workforce if we are to address the current shortcomings in the health care system. Setting the recent national health workforce strategic framework aside, for too long now, the government has shied away from a proactive approach to addressing outstanding issues that impact on medical workforce shortages in rural and remote areas, and the problem of recruitment and retention. Several major studies have provided ample evidence of the need for a systemic response to the problem and recommendations of ways of addressing these issues.<sup>i</sup>

Secondly, in regard to the specific needs of rural and remote communities, I would strongly urge that the response to outstanding workforce and service provision issues does not fall back into to old way of trying to meet them only through mainstream programs. The Auditor General's Report in 1998 highlighted the failure of mainstream approaches to address rural health needs and the need for specific rural measures.

For more than twenty years I have been undertaking research into the issues and problems associated with how to ensure an adequate medical workforce for residents of small rural and remote communities<sup>ii</sup>, and how best to ensure sustainable models of rural practice<sup>iii</sup>. The problems with medical workforce recruitment and retention in rural and remote areas are not just supply issues (university medical education, articulated medical training, International Medical Graduate supply and so on), but also the range of important factors that impact upon recruitment and retention. These comprise both 'pull' and 'push' factors - the 'pull' being the attraction of procedural activity (diminishing in significance as today's graduates feel inadequately prepared and less supported in this role), cradle to grave care, lifestyle etc, and the 'push' being the changes that increasingly drive GPs back to cities – excessive on-call and after-hours care, lack of locums, inadequate remuneration, fear of limiting one's career path, spouse and family considerations, loss of opportunity for procedural activity, indemnity issues, opportunity costs, lack of professional support etc<sup>iv</sup>. A number of initiatives have been introduced over recent years in an attempt to address these issues – albeit belatedly as reaction to crisis rather than proactively based on forward planning and understanding of how change impacts upon rural practice. These initiatives include devolved training through rural clinical schools, More Allied Health Scheme, PIP scheme, Rural Workforce Agencies and support from Divisions.

However, the significance of several big issues (recognized in your issue paper) have not been fully appreciated or addressed by the Commonwealth Government to date. Professional satisfaction is only one component of a bigger decision-making environment. For medical and health professionals, the decision to take up and remain in rural and remote practice is a complex one predicated on several things<sup>v</sup>. Increasingly important among these considerations for all health professionals (doctors, nurses, and allied health professionals) are several non-professional factors (that may impact indirectly on the professional decision). Included among these are practitioners' perceptions of rural and remote places, their knowledge and pre-conceptions of how well they can meet their professional aspirations by taking up practice in these locations, and the congruence between their skills, lifestyle aspirations and cultural considerations<sup>vi</sup>. In order to fulfill increasingly important lifestyle aspirational considerations, health professionals make their decisions on their perceptions of the ability of locations to fulfill their needs – for commercial, educational, social and cultural, recreational satisfaction etc. Those places seen as 'amenity poor' or 'least well-resourced' are invariably viewed as unattractive locations for practice – invariably these are the small, inland, economically stagnant places whose hinterlands are the homes to some 2.5 million Australians.

'Innovative' professional initiatives and service models alone will not solve this problem unless they are accompanied by a range of other incentives – including good community infrastructure, relief measures, adequate remuneration, spouse support measures, educational support for children etc. This positive discrimination in terms of remuneration and support is required to address the fact that employment opportunities do not occur on a 'level playing field', and if we are serious about access and equity (especially for servicing populations with the poorest health outcomes) we need to fill in the existing 'potholes'. This does not mean propping up all those communities considered to be economically at risk – rather it requires a collective response from all government departments whose mandate impacts directly or indirectly on the health and wellbeing of the community, rather than persistence of the current dominant silo mentality<sup>vii</sup>. This includes departments such as DOHA, DEST, DOTARS, social security and others responsible for health related issues. Moreover, it requires an approach that emphasizes regional development to tackle many of the broad social determinants of health.

The issue of funding the changes required should not be seen only within the current 'blinkered' cost-benefit perspective adopted by Treasury. The costs to society of not addressing major health care issues or responding only when they manifest at the acute stage (as has been happening with the explosion of mental health problems) are huge, and many are preventable through ensuring an adequate primary and secondary health system that is responsive to human needs at the appropriate time in ways relevant to geographical and social circumstances. The perceived additional costs of subsidizing the health workforce will be recouped down the track in terms of better health outcomes resulting in less demand for expensive acute care and better management of chronic diseases.

In short, the response to workforce undersupply and maldistribution in rural and remote communities requires a package of measures that address the need to increase the attractiveness of taking up and remaining in practice in these places, for both

practitioner and families, together with adequate infrastructure and resourcing of all members of the health care team in order meet the health needs of the population.

The danger of continuing to focus on so-called ‘innovative’ solutions is a tired and clichéd admission by governments that they are unwilling to respond to what is already known by developing an appropriate implementation strategy. There exist many innovative and successful models set up with pilot funding but never sustained – one only has to look at the many examples funded under the Rural Health Support Education and Training program. Moreover, innovation by itself has not been successful in overcoming the one hallmark issue of rural and remote namely access.<sup>viii</sup> While telemedicine has made significant differences in how health care can be delivered to rural and remote areas (as did the role of the Royal Flying Doctor Service many decades ago), it requires significant investment in developing adequate infrastructure, support and training. Telemedicine will only ever be a means to an end, and should not be seen as the panacea. While examples of telemedicine abound to show how it helps deliver information, specialist care, education etc, there is no substitute for the importance of face-to-face interaction between provider and patient at all stages of the preventive, primary care treatment, management and rehabilitation – and preferably at the local level.<sup>ix</sup>

A particular concern that should also be noted is the danger of workforce ‘substitutionism’ and the ‘dumbing-down’ of training of health professionals. Among the so-called ‘innovative’ solutions being put forward today are suggestions (led largely by health economists or disaffected academic nurses) for ‘enhanced’ role changes and new, abbreviated training programs. Evidence abounds to highlight the need and preference for fully trained rural medical practitioners<sup>x</sup>. Moreover, it should be recognized that the issues that currently create and maintain disincentives and barriers to the adequate recruitment and retention of an appropriately trained medical workforce in rural and remote workforce are just as important for all professionals, whether the field be health, education or whatever – something recognized by many private sector companies that provide a range of incentives and flexible career paths for persons taking up employment in remote areas.

The importance of providing appropriate, sustainable, high quality health care to all Australians, regardless of their socio-economic circumstances or geographical location, is paramount. The quest to get the right health professional to take up rural and remote practice should not be compromised – as has happened in some instances as a result of the inappropriate roll-out of Australian Government policies relating to International Medical Graduates (IMGs). ‘Generic’ primary health workers can only provide limited health care services, and consumers are still required to travel long distances increasingly at their own expense. Moreover, by the time many of these ‘substitute’ health workers are up-to-speed with their training and expertise, most move on – invariably back to major cities.<sup>xi</sup> The result is that many rural and remote communities, at best, only ever see the rotation of often relatively inexperienced or inadequately prepared IMG doctors who need considerable supervision and support. Clearly there are significant limits to the roles that nurse practitioners, physician assistants and primary care workers can play in delivering the full spectrum of health care required by rural Australians, and it is worth re-iterating the point that the same factors that impact of the recruitment and retention of doctors applies to other health professionals.<sup>xii</sup>

Recent research undertaken by Monash University in conjunction with the Health Services Commissioner has highlighted that the overwhelming concern of rural residents is inadequate access to appropriate health care. In order to redress this situation, significantly more public investment is required to support and sustain rural health professionals, and medical practitioners in particular. The local availability of medical care is pivotal to ensuring effective health care for all, and to realize the social and economic benefits that result from a healthy productive rural population. In the absence of such strategic investment by Government, we shall see the continued hollowing out of Australia, with major consequences for the future.

I would be happy to speak at greater length to this submission or to contribute to any supporting reference groups. I look forward to reading the outcome and recommendations from your enquiry.

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<sup>i</sup> See for example P. Mara, M. Jones & R. Vining, 1998: *Rural and Remote Medical Workforce and training*, Health Connections, Gundagai; Australian Department of Health and Aged Care, 2001: *Relative Value Study Overview* [Overview accessed 2002 Mar 7] Available from: URL:- <http://www.health.gov.au/rvs/overview.htm>; Rural Doctors Association of Australia and Monash University, 2003: *Viable Models of Rural and Remote Practice: Stage 1 and Stage 2 Reports*, RDAA: Kingston, ACT.

<sup>ii</sup> JS Humphreys & F Rolley, 1998: A modified framework for rural general practice: the importance of recruitment and retention, *Social Science & Medicine*, 46: 939-945; JS Humphreys, 1985: A political economy approach to the allocation of health care resources: the case of remote areas in Queensland, *Australian Geographical Studies*, 1985: 222-242; JS Humphreys, 1987: Locational disadvantage and inverse care in Queensland: A rejoinder", *Australian Geographical Studies*, 25: 121-128; JS Humphreys, 1988: Social provision and service delivery: Problems of equity, health, and health care in rural Australia, *Geoforum*, 19: 323-338

<sup>iii</sup> Rural Doctors Association of Australia and Monash University, 2003: *Viable Models of Rural and Remote Practice: Stage 1 and Stage 2 Reports*, RDAA: Kingston, ACT.

<sup>iv</sup> JS Humphreys, M. Jones, J. Jones & P. Mara, 2002: Workforce retention in rural and remote Australia: Determining the factors that influence length of practice, *The Medical Journal of Australia*, 176: 472-476

<sup>v</sup> JS Humphreys, J. Jones, M. Jones, G. Hugo, E. Bamford & D. Taylor, 2001: A critical review of rural medical workforce retention in Australia, *Australian Health Review*, 24: 91-102

<sup>vi</sup> See for example ME Jordan, 2005: *Balanda*, Allen & Unwin, Crows Nest.

<sup>vii</sup> See JS Humphreys, D Hegney, JM Lipscombe, G Gregory & AB Chater, 2002: Whither rural health? - Reviewing a decade of progress in rural health, *Australian Journal of Rural Health*, 10:2-14.

<sup>viii</sup> JS Humphreys & J. Dixon, 2004: Access and equity in Australian rural health services, in J. Healy & M. McKee, *Health Care: Responding to Diversity*, Oxford University Press, 89-107.

<sup>ix</sup> JS Humphreys & S Mathews-Cowey, 1999: *Models of Health Service Delivery for Small Rural and remote Communities*, Bendigo, Latrobe University.

<sup>x</sup> KB Smith, JS Humphreys, Y Lenard, JA Jones, V Prince & GS Han, 2003: Still the doctor – by a country mile! Preferences for health services in two country towns in north-west New South Wales, *The Medical Journal of Australia*, 181(2):91-95.

<sup>xi</sup> GS Han & JS Humphreys, 2005: Overseas trained doctors in Australia: Community integration and their intention to stay in a rural community, *Australian Journal of Rural Health*. 13 236-240.

<sup>xii</sup> Belcher *et al.*, 2005: *The VURHC Allied Health Recruitment and retention Study*, Rowville.