

The Health Workforce

Submission to the Productivity Commission

National Rural Health Alliance

and

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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'¹ 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 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

¹ 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.

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*² 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 different 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 curiosity³ 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 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.

² *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.

³ But a curiosity that is welcomed by some people, who regard (for example) ambulance officers who can amputate as “a terrible prospect”.

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 workforce⁴, 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 2044-45.⁵ 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 200,000.⁶

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 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

⁴ The impacts of this inflexibility are described in papers by John Menadue and Stephen Duckett, among others.

⁵ Productivity Commission, *Economic Implications of an Ageing Australia*, Research Report, Canberra, 2005.

⁶ 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.

more of them may choose to ‘follow the dollar’.⁷ 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.

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

⁷ 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.

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 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 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.^{8,9} 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 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

⁸ see the 2001 Australian Infrastructure Report Card, at <http://www.infrastructurereportcard.org.au/>

⁹ 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

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.¹⁰

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 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.

¹⁰ Humphreys, John, "Revisiting the wellbeing of remote communities twenty years on - a time for celebration and reflection", Keynote Paper to 8th National Rural Health Conference, Alice Springs, March 2005.

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 professionals¹¹, 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

¹¹ 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 professions¹². 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.¹³ 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.¹⁴

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.

¹² *Australian Allied Health Workforce - National Population and Allied Health Profiles*, SARRAH, Canberra, June 2004. (available on SARRAH's website.)

¹³ 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.

¹⁴ *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 1996¹⁵.

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**^{16, 17}. 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.¹⁸

¹⁵ *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

¹⁶ Position Papers 2000-2001, NRHA, Canberra; available at www.ruralhealth.org.au

¹⁷ 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

¹⁸ *Good Health to Rural Communities – A Collaborative Policy Document*, ALGA, RDAA, CWAA, NFF and HCRRRA, March 2004.