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## Senate Standing Committee on Community Affairs References Committee

**Factors affecting the supply of health services and medical professionals in rural areas**

# Supplementary submission

**11 May 2012**

The topic of this Inquiry is core business for the Alliance. In fact the first part of the terms of reference could pass as a synopsis of the Alliance's very purpose:

> "the factors limiting the supply of health services and medical, nursing and allied health professionals to small regional communities as compared with major regional and metropolitan centres."

We want therefore to thank the Committee for initiating this piece of work and for the energy it continues to display, including at the public hearings already held in Alice Springs, Darwin and Townsville. At those public hearings, members of the Committee heard directly from organisations and researchers with detailed knowledge of the challenges of providing health services in rural and remote areas.

The Alliance synthesises the views of its 33 Member Bodies. Many of them are peak organisations in their own right, representing health professionals, health service providers, researchers and consumers with an interest in improving access to health care for the people who live in rural and remote communities. From this base, the Alliance seeks to develop high level policy recommendations and strategic approaches to overcome the challenges of providing health services in rural and remote communities. These challenges and the policy recommendations we develop are identified and tested through consultations with our members and networks. Specific and particular advice to the Committee best from the providers of these services and the organisations that represent them directly.

In this Supplementary Submission the Alliance outlines six points:

1. the need to recognise the full range of health professionals providing front line services in rural and remote communities;

2. the importance of establishing and maintaining the data sets necessary for evidence-based policies to address the factors limiting supply of health services and the availability of health professionals in rural and remote communities;

3. improving on the ASGC-RA as a means of simplifying the targeting of strategies to attract, sustain and retain an appropriate mix of health professionals in rural and remote communities;

4. the pros and (mainly) cons of a Universal Health Service Obligation;

5. the role of rural and remote health and medical research in informing and implementing health policy reforms effectively in rural and remote communities; and

6. the relationship of the Inquiry with other Parliamentary and governmental activity.

**Recognising all front line health professionals in rural and remote communities**

Among the distinctive features of health service delivery in rural areas are the team-based approach to care; the involvement of a range of professions in the team; the nature and extent of the team members' interdependence; and, where there are shortages of any profession, the reliance of the community on having many of the necessary services provided by a member of a profession which might not normally provide that service in a metropolitan area.

GPs and other health professionals do not want to work alone in rural areas; they would prefer to have peers with whom responsibilities can be shared, and a range of other health professionals with whom they can work.

In many metropolitan and other areas, general practitioners are the coordinators of care for an individual patient and frequently the leaders and coordinators of action related to the health of the local community. However, the rural and remote health workforce relies heavily on nurses in the front line, including where doctors are scarce. While members of the rural health team may not all work in the same location every day given the distances involved and the distributed populations, multi-disciplinary or, better still, interdisciplinary teams, often brought together by phone or video, or by driving in, become more and more important for health service provision as the population becomes more sparse.

The terms of reference for this Inquiry speak properly of the supply of health services and medical, nursing and allied health professionals. To these could be added Aboriginal Health Workers, pharmacists, dentists, paramedics, midwives, chiropractors and health and aged care service managers.

The Alliance is constantly working on improved access for people in remote areas to all such health professionals - whether on-site, using eHealth technology, or by one party in the patient/clinician partnership travelling to the other.

These four options explain the Alliance's continued interest in education and training of health professionals in all disciplines; in programs to recruit and retain them in rural areas; in eHealth applications and the IT infrastructure to support them; and in good, all-weather roads, public transport and patient assisted travel schemes.

Notwithstanding the importance of the numbers and distribution of general practitioners and medical specialists, we are confident that, in its final report, the Committee will include whatever recommendations are necessary to ensure that this Inquiry makes a significant contribution to health service and health professional availability across the board in rural and remote areas.

**Establishing, maintaining and using the necessary data sets for evidence-based policy decisions**

If there are two facts it might be assumed would be clearly and certainly known in the Australian health sector, it would be the number and distribution of general practitioners. And if there was one

organisation that you might expect to know the situation relating to the distribution of GPs and other health professionals in rural and remote areas, it would be the National Rural Health Alliance.

However, for many years there has been uncertainty about the actual full time equivalent supply of doctors to rural areas and (given the quite different scope of practice and travel requirements of GPs in rural areas) the number of doctors in practice compared with the number needed for fair access, and a variety of understandings of 'rural and remote'. Thanks to our friends at the Australian Institute of Health and Welfare and Health Workforce Australia, and the work of the Australian Health Professionals Registration Authority, we believe we are closer to being able to report accurate figures relating to supply and distribution of doctors.

Thanks to those three agencies we may soon have better information for nurses and allied health professionals as well. But the historic data is not clear-cut for nurses and has been highly deficient for allied health.

Given the close relationship between the numbers of professionals and the supply of health services in any particular area, it will be critical for the report from this Inquiry to make recommendations on what might be called 'the health data system' in which those three agencies and a number of others are involved (such as the COAG Reform Council and the National Health Performance Authority).

The Alliance would like Health Workforce Australia to fund the AIHW for some particular projects that relate closely to the Committee's terms of reference. These projects might include better and more regular reporting for allied health, and joint projects between Medicare, PBS and AIHW to compare rates of utilisation of MBS and PBS services across remoteness. Such data would help the COAG Reform Council to report on access to primary care. The results of these projects would also assist the annual reporting against progress for Medicare Locals and Local Hospital Networks.

There is still the need for more detailed analysis and reporting on the number and distribution of 'full time equivalent' doctors and other health professionals by geographic location. This might include better collection of data about primary, secondary and other locations of practice, such as when a particular GP practices in Dubbo, Wellington and Bourke.

It is important to monitor the actual hours worked by doctors, as the number of registered doctors alone includes many who are no longer practising or who are working more limited hours. For example, the effect of long working hours on classification as a District of Workforce Shortage is poorly understood. Unrefined data may not take into account the time practitioners spend on the road to conduct clinics in outlying towns, nor the additional administrative burden they carry to ensure these services as close to home as possible for their patients.

**Improving on ASGC-RA as a means of simplifying the targeting of strategies to attract, retain and sustain an appropriate mix of health professionals**

The Australian Standard Geographical Classification – Remoteness Areas scheme should not be used on its own for the identification of 'rurality', for the distribution of financial incentives or for the return of service to rural or remote areas under various student bonding arrangements. Nor should there be multiple and competing ways of targeting a confusing array of such strategies.

The Alliance has been working for several months on a composite measure of the balance between the supply of and demand for doctors. The measure would include three elements or criteria for each place: its ASGC RA classification; its population size; and an index reflecting its success in the past in recruiting and retaining health professionals. This last is a proxy for the range of variables which results in a particular place being one to which it is easy or difficult to attract and retain staff.

Many of the Alliance's member bodies have approved this approach, while some others (with particular interests in the matter) have sought further conceptual work and modelling, and more time, prior to any public promotion by the Alliance of the final measurement system.

**Universal Health Service Obligation**

We note from Hansard's record of the Committee's earlier public hearings that there is some enthusiasm for the notion of universal health service obligations - described more colloquially as an agreed basket of services appropriate for different communities. We want to place on record the reasons why the Alliance believes this to be an impractical approach to health service planning for rural and remote areas.

The main problem, as recognised by previous witnesses, is that there is great diversity in the types of rural community. Just as advocates for rural and remote areas use the reminder that one size does not fit all for not having a metro centric approach to service delivery in those areas, so one might apply the same dictum to different rural communities.

A similar concept for hospital services was flagged in a discussion paper on South Australia's Country Health Care Plan in 2008. A 'Service delineation framework for country health services' was proposed as a planning tool. It outlined the fundamental level of services at country hospitals of different sizes, working together to provide health services as close to the patient's home as possible whilst maintaining the highest level of safety and quality and reducing duplication of infrequently used and complex services. (It is not clear to us whether the planning tool is being used in that State.)

The Alliance favours health service planning and delivery that is based on local population needs, and is developed in consultation with the local community to make the best use of the health services and health professionals available locally, while identifying the gaps that need to be filled. This approach helps to foster innovative and flexible ways of providing the range of necessary services.

We recognise the important role a small hospital and/or a primary or community health care centre and/or aged care plays in the viability and attractiveness of small towns and as a centre where people know that they can get health care advice and assistance, as well as providing a location for outreach services and visiting medical, allied health and nursing specialists. But such services or centres can take many shapes.

While we recognise that more highly specialised services may be more appropriately provided in regional centres and that certain services will need to occur in tertiary teaching hospitals, we seek an appropriate balance of local core services, supported by outreach services, telehealth etc, that minimize the need for patients to travel away from home for basic primary care.

We understand that the new Medicare Locals are finalizing the first draft of their health service needs reports and look forward to this process being developed and refined over time. We will be monitoring Medicare Locals to make sure that their focus is on necessary health care as close to home as possible.

We have also strongly advocated for the importance of block funding for small rural hospitals rather than Activity Based Funding to ensure they can be sustained to fulfill their community service obligations, despite a potentially smaller population base and fluctuations in need, for example, with tourism or seasonal workers, or changes in health and aged care needs of the local people.

We are particularly keen to see flexible funding models that allow for the pooling of acute, aged care, primary care and community services funding to better meet the needs of local communities.

The existing Multi-Purpose Services, where they have been developed in consultation with the local community, are good examples.

**Recognising the role of rural and remote health and medical research in informing and implementing health policy reforms in rural and remote communities**

Members of the Committee are aware that there is currently in train a strategic review of health and medical research (McKeon). We have made the point above that there are data problems relating to the Inquiry's terms of reference and it is also the case that there is insufficient information and evidence relating to other specific elements of the Inquiry. For instance, little is currently certain about the impact of the introduction of Medicare Locals on the provision of health (including medical) services. The Budget announcement about incentives for dentists to relocate to rural and remote areas is very welcome but it is the case that little, if anything, is known about the specific issues which might affect the mobility of dentists, let alone retaining their services in rural and remote locations.

The McKeon Review will hopefully conclude, among other things, that there needs to be greater research effort on rural and remote aspects of the national health system, and it should include more of the research 'on either side' of biomedical health and medical research. Upstream this means understanding the social determinants of health and wellbeing. Downstream from biomedical endeavours, it means greater emphasis on health services research. As a nation we need to apply an evidence base to choices made between policy options, just as we have and need an evidence base on illness and disease.

Researchers who are close to the health services, have relationships with the local health professionals and community members, not least through their role in training rural health professionals locally, will better understand the challenges to local health service improvement. These researchers are important contributors to the design and formative evaluation of health service improvements that are effective in rural and remote locations. Too often the authorities are satisfied with major city approaches which may have little impact on the poor health outcomes of the seven million Australians who live beyond.

**Relationship of Inquiry with other Parliamentary and governmental activity**

Finally, the Alliance wants to make the point that the subject matter of this Inquiry overlaps with a number of other pieces of work recently completed or currently in train. In particular, the recommendations from the House of Representatives Inquiry on overseas trained doctors should be integrated with the considerations of this Inquiry.

The Department of Health and Ageing is beginning another review of its workforce programs. Health Workforce Australia is engaged on a number of very relevant fronts with the business of this Inquiry. And the Alliance has a considerable number of relevant documents about these matters on its website.

## TWENTY STEPS TO EQUAL HEALTH BY 2020

### The NRHA's 20-Point Plan for improving health services and health workforce in rural and remote areas

Inspired by the terms of reference and work of the Senate Committee's Inquiry, the Alliance has produced this 20-Point Plan. The Plan is consistent with the views of the Alliance's 33 member bodies and each element of the Plan is specific enough to be adopted by governments as a new policy proposal. The total cost of the Plan would be modest, with some of the elements having no budgetary cost at all.

The elements of the Plan are listed in the chronological order in which they relate to the lifetime path of an individual who might work in the rural and remote health sector.

**1. Getting more rural students into health professions**

This first goal should be the subject of a coordinated series of campaigns to encourage high school students from rural and remote areas to enter health professional training. This work would be underpinned by the government mandating increased targets of rural student intake for all health professional faculties to 30 per cent, and requiring health science faculties to report publicly on the target. Other specific activities would include those to encourage rural students to apply for places in health science faculties. These programs would include modest additional funding for the health student clubs in the National Rural Health Students' Network to undertake their high school visits program, and micro-grants to organisations capable of producing good news stories about rural students in health professional training. These stories would be produced in various media forms: social media, television, radio and print. Among the results of this work would be more students in regional campuses with strong ties to rural and remote areas.

**2. Getting more health students to undertake rural placements while in training**

There is a desperate need to rationalise the system for rural placements in all health disciplines. The current situation is one in which individual universities compete for scarce places, and there is insufficient support for students when they take up ruralplacements (with the possible exception of medical students). The need for student accommodation is critical. These deficiencies of the current arrangements mitigate against undergraduates having the sort of supported, safe and successful placement which will lead them to further interest in rural and remote practice. Consideration should be given to increasing the mandatory requirement for undergraduate students to have at least some time in a regional placement. Curriculum development to support rural and remote practice is also an issue.

**3. Getting more Aboriginal and Torres Strait Islander people into the health workforce**

Some great strides are being made on this front already but efforts need to be redoubled, with the Federal Government showing leadership and providing necessary financial and institutional support. The benefits of having Aboriginal and Torres Strait Islander health staff to work with Indigenous patients are well-known. Successful developments on this front should be augmented by activity to ensure that people in the so-called 'mainstream' health system are equipped with the training and tools to work in ways that are culturally safe with Aboriginal and Torres Strait Islander people. (Canada has some good approaches to this.)

4. **Ensuring positive modelling and leadership on rural practice for tertiary students**

It is very dispiriting to hear anecdotes of the way health students are exposed by their teachers and mentors to views and myths about rural practice. Universities and professional associations should take the lead to ensure that both through the protocols and practices of their profession, and through the words and modelling of individual teachers and leaders, health professional practice in remote areas is promoted for what it is: challenging but rewarding, broad in scope, more frequently multidisciplinary and interdisciplinary, and undertaken in parts of Australia with strong social and community benefits.

5. **Promoting knowledge of the various rural incentives available, and of the positive elements of rural practice, to late-year undergraduates and new graduates**

It is clear that, even in their later years, many students and even their teachers are unaware of the range of incentives available for rural practice and the special programs designed to encourage and support clinicians in rural and remote areas. The Alliance has heard anecdotes of health faculty Heads who are not aware of the HECS reimbursement scheme for medical students.

6. **Creating a greater proportion of supported placements for new health graduates that can be undertaken in rural and remote areas**

Health Workforce Australia will be the key agency to increase the proportion of 'practice ready training' that is undertaken in rural and remote areas. This is the training that junior doctors and new graduates from nursing, dentistry and allied health courses need to undertake to further develop their skills and competencies in professional rural practice.

7. **Increasing the proportion of vocational training for health professionals that is undertaken in rural and remote areas**

Among other things, this will require the collaboration of professional colleges and registration bodies to ensure that the accreditation of training posts is flexible enough to permit a greater proportion of training to occur in rural areas without any loss of quality and safety. The Alliance has completed work on this issue where junior doctors are concerned and it is clear that, with the goodwill and support of the range of regulatory bodies and organisations engaged, the settings in which vocational training is undertaken could be varied with great advantage for potential rural practitioners. Rural and regional communities would be better able to grow their own health professional and the vocational training system could in some circumstances be turned on its head. Rather than having training rotations based only in capital cities and major regional centres, with occasional placements in rural areas, the home base for vocational training could be in regional centres with rotations in the cities as necessary for more specialised content.

8. **Enhancing the capacity of existing practitioners in rural areas to accommodate, mentor and supervise new graduates and vocational trainees**

This will require continued budgetary allocations to the upgrade of rural practices to enable them to provide space and infrastructure for vocational trainees. There also needs to be proper remuneration and support for the mentors and preceptors involved, including academic support and capacity building.

9. **Extending the coverage of University Departments of Rural Health**

The number and capacity of UDRHs should be expanded to ensure that all rural and remote regions are served by a UDRH and that they have enhanced capacity to support the training and placement in rural and regional areas of health professionals across the board.

**10. High-level work to balance the incentives for health professionals to train for generalist rather than specialist practice**

It is widely acknowledged that specialisation and sub-specialisation - and not just in medicine - can undermine efforts to recruit and retain health professionals in rural and remote areas. There needs to be a rebalancing within the professions so that broad, general qualifications and competencies are encouraged, enabled and competitive in terms of remuneration with specialties.

**11. Targeted infrastructure and human resources programs to maximise the opportunities for use of information technology in health, including as back-up to training and mentoring of health professionals in rural areas**

Flexibility of training posts and supervision can obviously be enhanced through greater use of information technology. This requires both the IT infrastructure and the human skills. The rollout of the NBN should further emphasise its benefits for rural and remote health. Improved IT infrastructure will also speed the adoption of telehealth and its further adaptation across other settings and applications, as well as supporting the uptake of eHealth records. IT innovations have great and ever increasing capacity to help the safety of patient pathways for people in rural and remote areas who of necessity will receive more specialized care from cities and regional centres.

**12. Enhanced support for the role and capacity of Rural Workforce Agencies**

The Rural Health Workforce Agencies play a leading role in the recruitment and retention of health staff, and provision of support for professionals relocating or taking up their careers in rural and remote settings.

**13. National leadership on work to ensure health practitioners are able to work collaboratively and maximize their individual contributions within their full scope of practice**

With ever-increasing demand for health care, due to demographic ageing and greater volumes of chronic disease, and the shift to collaborative multidisciplinary health care as best practice, it is essential to make the best use of every health practitioner available. In the context of team care which is already characteristic of rural and remote areas, this means that all health professionals should be working within their competencies to their full scope of practice and only doing what others available cannot safely and competently achieve. Australia needs to work confidently through its fears about 'workforce substitution' to the situation in which there is optimal use of each member of the health professional workforce team.

**14. Refurbishment of the recruitment and retention programs for health professionals to ensure their effectiveness for places in particular need and for the new generation of practitioners**

This refurbishment should include the development and application of an improved and consistent measure of health workforce shortage, that extends beyond the geographic remoteness measures such as ASGC-RA and RRMA alone. Consideration should be given to extending the use of HECS reimbursement schemes to dentists, nurses and allied health professionals willing and able to practice in rural and remote areas.

**15. Ensuring that the funding and governance of Medicare Locals equips them for their role in the identification of service gaps and provides them the wherewithal to fill those gaps**

A great deal is expected of Medicare Locals, including with respect to service gap analysis and workforce development. Given the logistical challenges of greater distance and sparse

populations, Medicare Locals that cover rural and remote areas will need particular support and funding to meet these expectations.

**16. Greater involvement of Commonwealth, State and Territory governments in special cost sharing arrangements for salaried staff in areas of very particular need**

It is inherently difficult to recruit health or other professionals to some areas and communities in various parts of Australia. Equal health for people in these 'hard to recruit' places will continue to depend on special arrangements between jurisdictions for such things as salaried health and medical positions.

**17. Working with professional Colleges to ensure that mature-age clinicians willing to work part-time as mentors and preceptors are able to do so**

Mature age health practitioners who want to relinquish full-time practice constitute a significant resource which should be better utilised. There will need to be agreement about registration and competence matters, so that creative and collaborative approaches can be developed in which their skills as mentors, supervisors and supporters can be used to best effect.

**18. Improvement of national data collection and analyses to provide the means by which health outcomes can be measured for individual Medicare Locals and by rurality**

Data on health professionals in practice and access to appropriate healthcare professionals and services is still deficient. The work of the Australian Health Practitioners Regulatory Authority promises much, as does the forthcoming activity of the National Health Performance Authority. But there will need to be a measured and conscious effort to maximise the use of data available, including for the healthy communities reports to be produced by a Medicare locals. In terms of making progress towards equal health by 2020, much could be gained from having analyses of existing datasets by rurality.

**19. An increased emphasis in Australia's health research effort on health service system research for rural and remote areas**

Australia's health and medical research effort is currently focused to too great an extent on biomedical research. There needs to be greater emphasis on the social determinants of health, and on health service system research. The considerable capacity of Australia's rural and remote health research sector needs to be recognised and better supported.

**20. Continued national commitment to building universal schemes for dental care and disability**

The starts made in this year's Budget on improved dental health services and the national disability insurance scheme must be continued in the next few years. With uniform national schemes in place for these two key need areas, some of the inequity and disadvantage faced by people in these population groups will be ameliorated.

**Attachment**

## Member Bodies of the National Rural Health Alliance

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|---|---|
| **ACHSM** | Australasian College of Health Service Management |
| **ACRRM** | Australian College of Rural and Remote Medicine |
| **AGPN** | Australian General Practice Network |
| **AHHA** | Australian Healthcare & Hospitals Association |
| **AHPARR** | Allied Health Professions Australia Rural and Remote |
| **AIDA** | Australian Indigenous Doctors' Association |
| **ANF** | Australian Nursing Federation (rural members) |
| **APA (RMN)** | Australian Physiotherapy Association Rural Member Network |
| **APS** | Australian Paediatric Society |
| **APS (RRIG)** | Australian Psychological Society (Rural and Remote Interest Group) |
| **ARHEN** | Australian Rural Health Education Network Limited |
| **CAA (RRG)** | Council of Ambulance Authorities (Rural and Remote Group) |
| **CHA** | Catholic Health Australia (rural members) |
| **CRANAplus** | CRANAplus – the professional body for all remote health |
| **CWAA** | Country Women's Association of Australia |
| **FS** | Frontier Services of the Uniting Church in Australia |
| **HCRRA** | Health Consumers of Rural and Remote Australia |
| **ICPA** | Isolated Children's Parents' Association |
| **NACCHO** | National Aboriginal Community Controlled Health Organisation |
| **NRHSN** | National Rural Health Students' Network |
| **PA (RRSIG)** | Paramedics Australasia (Rural and Remote Special Interest Group |
| **PSA (RSIG)** | Rural Special Interest Group of the Pharmaceutical Society of Australia |
| **RACGP (NRF)** | National Rural Faculty of the Royal Australian College of General Practitioners |
| **RDAA** | Rural Doctors Association of Australia |
| **RDN of ADA** | Rural Dentists' Network of the Australian Dental Association |
| **RHW** | Rural Health Workforce |
| **RFDS** | Royal Flying Doctor Service |
| **RHEF** | Rural Health Education Foundation |
| **RIHG of CAA** | Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia |
| **RNMF of RCNA** | Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia |
| **ROG of OAA** | Rural Optometry Group of the Australian Optometrists Association |
| **RPA** | Rural Pharmacists Australia |
| **SARRAH** | Services for Australian Rural and Remote Allied Health |