Submission from Aboriginal Medical Services Alliance Northern Territory [AMSANT] to Senate Community Affairs Committee:

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

Introduction

AMSANT is the peak body for community controlled health services in the NT. We have 26 members providing comprehensive primary health care to communities right across the NT including in the most remote locations.

ACCHSs aim to provide comprehensive Aboriginal primary health care which is multidisciplinary and based on the principles espoused in the Alma Ata Declaration. AMSANT recognises the need to recruit skilled general practitioners to the team and indeed our services even in very remote locations aim to attract resident general practitioners. However, it is important to look at the supply of all the health professionals required to provide comprehensive Aboriginal health care and therefore AMSANT urges the Inquiry to take a broad view rather than to be too focused on the factors affecting doctor recruitment and retention. In many ways, the shortages of nurses—especially those with specialist training, is at least as acute. The shortage and misdistribution of allied health professionals, dentists and mental health workers mirrors that of GPs.

Of particular concern is the situation of Aboriginal Health Workers, who are at the centre of the multidisciplinary team in Aboriginal primary health care but the issues that are causing the collapse in the growth of this profession have been ignored for too long. We therefore request that you give some focused attention to the issues affecting Aboriginal Health Workers in the workforce.

This knowledge is essential if the Inquiry is to make findings relevant to Aboriginal comprehensive primary health care.

Factors affecting the supply of medical, nursing and allied health professionals to remote areas.

There are currently over 15 vacancies in rural and remote NT, mostly in Aboriginal health, with eight vacant for over 12 months. This situation can only add to the poor outcomes for Aboriginal people *and* increase levels of stress on the existing staff in our sector

Remote Aboriginal primary health care offers a uniquely rewarding career for health professionals. However, there are ongoing struggles to recruit and retain health professionals in these environments and anecdotal evidence indicates that recruitment and retention (particularly of nurses and Aboriginal Health Workers) is at least not improving and likely getting worse. There is a high reliance on short term locum staff in many locations and this is impacting directly on the quality of care provided—both in terms of continuity of care, and in costs of supplying that care. The NTER (with fly in – fly out child health check teams) provided official government support for reliance on short term locum staff which has been further embedded by RAHC and NAHLS (government funded locum agencies which focuses on short term workforce for doctors nurses and allied health who do not necessarily have prior remote experience). However, the recent review of the CHCI and EHSDI

(health components of the NTER) found that the child health checks were exorbitantly expensive and detected very little that more experienced practitioners had not already diagnosed.

There are numerous problems with reliance on short term locum staff including that they are unable to undertake most of the extended roles required in remote Aboriginal primary health care including public health/health promotion work/input into clinical governance and system development, and relationship building with the community amongst others. Even at the level of permanent staff, the Aboriginal comprehensive primary health care sector experiences high staff turnover and consequently is unable to perform many of these extended roles effectively. Clinicians new to remote often reorganise clinical systems and structures without listening to the knowledge of local Aboriginal staff as described in the article "Do not move the furniture and other advice for new remote area nurses" (Lenthall S, Gordon V et al, 2012).There are also significant economic costs in the high staff turnover with the cost of recruitment of a health professional estimated to range from $6,000 to $22,000 (CDU). The challenges of recruitment and retention generally become more difficult with increasing remoteness as does the health gradient that is so severely reflected in the life expectancy gap. Therefore, although there are financial costs to many of the solutions presented here, ignoring the workforce problems is likely to be much more expensive.

Some of the factors that influence recruitment and retention are common across health professionals whilst others vary between professional groups. Some of the common barriers to recruitment include:

1) The highly competitive job market for most clinicians. This competition for the ACCHS sector includes state governments who operate primary health care and small hospitals in remote locations and who offer relatively lucrative conditions, particularly for doctors. ACCHSs in the NT are currently very concerned that their employment conditions are no longer competitive with the NT government. However, the salary support provided by OATSIH is fixed. There is capacity to generate Medicare income to top up salaries, but Medicare income is often the only untied funding that ACCHSs receive—and these funds are already devoted to supplying culturally safe, comprehensive primary health care which is not limited to GP-supplied services. There are many calls for this funding with many ACCHSs funding services such as patient transport to hospitals (because the PATS system is inadequate,) and other essential services through Medicare. Furthermore, doctors and nurses generally have no problem finding work in urban areas where the work is generally less challenging, and at least as lucrative.
2) The challenges of living in remote regions including social isolation, employment for partners (and lack of support to find appropriate employment), education for children, quality of accommodation, and challenging climates and living conditions.
3) Lack of awareness of employment opportunities in remote areas combined with a negative perception of remote Aboriginal communities which has worsened in the last few years.
4) The breadth of skills required to operate safely in this environment. New clinicians commonly recognise that they need to improve their emergency skills whilst core skills in essential areas such as cross cultural competence/public health/ primary health care delivery including chronic disease management are often not prioritised. This leads to

many new clinicians requiring substantial support to operate safely in this environment. Safety in this context refers to safety for the patients and community as well as for the practitioner.

5) Workload and on call work, which in turn is a consequence of and contributor to high staff turnover, reliance on locums and unfilled vacancies (in effect, a vicious cycle for some services that struggle to maintain a competitive workforce).
6) The lack of support and funding for orientation and mentoring for new clinicians. In the NT, doctors are provided with a comprehensive orientation package by GPNNT but nurses, allied health professionals and AHWs receive little, if any, orientation support outside of their workplace nor any skill development around self care in this challenging environment. There is no funding for the mentoring and support that new clinicians need both from experienced clinicians and from Aboriginal leaders who can orientate and support them to adapt to the cultural context and so minimize the shell shock which is common in people who are new to the remote contexts and which contributes to high turnover. This lack of support combined with the high staff turnover is leading to inadequate staff orientation in some services. Indeed it is a vicious cycle as experienced Aboriginal Health Workers and other clinicians becoming exhausted from orientating and supporting too many new practitioners who only stay for short periods. This is a factor in the loss of experienced practitioners in the sector.

7) The lack of incentives for retention for professions other than doctors. Remote area nurses and allied health professionals do not receive any retention bonuses
8) An ageing health workforce (a particular problem for the nursing, allied health and AHW workforce)

9) Lack of funding for staff housing. Many services cannot increase staff numbers because of the lack of funding for new staff housing. This causes services to use very expensive fly in fly out models which do not provide the same type of service as resident health professionals. The lack of clinic space and inadequate health infrastructure is also a critical limiting factor.
10) Conflict within small work teams in remote areas which is often accompanied by severe work stress and a lack of management support to deal with these conflicts. This situation is aggravated by a lack of training for PHC professionals about working within a multidisciplinary team and working in a cross cultural context.
11) Very poor social determinants in remote communities, including housing and education which leaves clinical staff (even if they themselves have excellent housing) being frustrated and demoralised because they are treating the health results of these poor social determinants. Most practitioners recognise that to make substantial improvements in health, social determinants need to change.
12) Size and composition of the clinical team with smaller more isolated clinical teams often (but not always) more difficult to recruit to.
13) Lack of support from managers off and on site
14) Lack of support/adequate training pathways for managers particularly in small and remote services.
15) Difficulty getting time away (remote leave, CPD etc) due to staff shortages and high to extremely high costs of accessing CPD.

16) Tardy government response to shortages in professions including nursing, Aboriginal Health Workers and (until recently medicine).
17) Financial disincentives for staff (particularly doctors) located in regions already classified as remote to move to a more remote location.
18) Selecting staff with the personal attributes that enable them to thrive in a remote cross cultural context.

General workforce

There needs to be attention to the systemic factors affecting recruitment and in particular retention. Orientation and mentoring for new practitioners is a key area. Some initiatives that would assist in improving orientation and ongoing support/mentoring include

1) Funding for health professionals new to remote practice to undertake courses such as the CRH Foundation course which is available to all practitioners.

2) Support for a system of orientation that includes orientation support prior to arriving at the workplace (including orientation to clinical and public health services provided in the nearest regional centre, cultural orientation prior to arrival etc) and funding support for high quality orientation at the workplace.

3) Funded cultural orientation and cultural mentoring by a senior person in the community who would be supported in the mentoring role and paid for this work (and who would not need to be a health professional themselves). AMSANT has previously submitted proposals with NTGPE to develop a remote cultural mentoring program for non-Aboriginal health staff.

4) Project support for services to collaborate and share resources around orientation.

Support to retain health staff needs to include:

1) Additional funding for retention incentives for professionals other than doctors (discussed below) with loading for working in an Aboriginal community

2) Additional quarantined funding and professionals for CPD support for professionals (most of the funded support is currently aimed at doctors).

3) Support for family of health professionals working in remote locations including support around employment, schooling etc.

4) Other innovations such as support to family/friends to visit

5) Funding that allows for realistic and competitive salaries indexed to CPI in remote regions (higher than in urban regions). This would allow the ACCHS sector to compete on equal terms with the government sector.

6) Continuation of bonded scholarships for students (of all disciplines) willing to go remote

Increased hub support around recruitment and retention is another solution with the following as suggested actions.

1) Hub support for HR and management training which is provided regionally and which could assist with recruitment and retention for all health professionals (not just doctors). An expanded role for rural health workforce agencies should be considered.

2) Recruitment which gives a realistic picture of the work including the workload and amenities in remote communities whilst emphasising the personal rewards of working in a cross cultural context and developing relationships with Aboriginal people.

3) HR support for staff having difficulties including because of team conflict. Sometimes this may mean staff who are not suited to remote work are supported (and occasionally forced) to leave as it is usually better to have a vacancy than to continue with a poorly performing clinician.

4) Funding and logistical support for new workforce models for the long term workforce rather than (as is occurring presently through RAHC and NALHS) support for the short term workforce. Innovations such as shared positions (with clinicians working remote month on/month off) have been tried with some success but could be used more broadly with funding support and promotion. This model will be more expensive than a permanent position but will provide better quality of care and be cheaper than reliance on short term locums. Other innovations that have previously been tried have included a nurse or registrar in a regional hospital (such as Alice Springs) being released from the hospital environment one month a year to work remote without losing salary or conditions. This provides hospital staff with a much greater understanding of the remote environment which should improve communication with PHC as well as offering a remote community a locum who could develop relationships and potentially be a link to patients from that community who come to hospital. This model has worked in the past in Central Australia but foundered because the hospital was not willing to release hospital nurses. With additional funding and support, this model could be reinvigorated. Another potential innovation is to fund regional ACCHSs to support and mentor new clinicians for a few months prior to them working in a remote location where there are fewer colleagues to provide advice and more requirements to provide emergency services. Regional Emergency Departments could also be part of this mentoring and support for new practitioners (by funding clinicians to work as supernumerary staff members prior to going remote). Innovative ways of targeting people who may be more likely to understand the work context and have the right attributes could include keeping in touch with practitioners who have worked remotely or lived remotely in the past to increase the chance that they will come back,

Grow your own strategy

1) Increased support for Aboriginal people to train for a variety of health professional roles including scholarships that provide a realistic wage. Many Aboriginal people come to formal study at a later stage when they already have substantial commitments and so they are unable to live on a student stipend.

2) Increased support for Aboriginal people to undertake (supported) foundation courses which would prepare them for health professional training.

3) Continued focus for regional training.

4) Support for the Aboriginal health practitioner workforce as discussed below.

Supporting the community controlled model

1) Ongoing support for sustainable well resourced Aboriginal community controlled health services. This provides the foundation for non Aboriginal health professionals to be able to work effectively and safely in Aboriginal communities with Aboriginal clinician colleagues supported by Aboriginal leadership. There are many practitioners who have spent many decades in this environment and who are very supportive of the principles and practice of community control. However, many practitioners do not understand the history and development of the community controlled sector so this needs to be a formal part of orientation (including to practitioners working in government remote clinics). The sustainability of ACCHSs is slowly being addressed through the regionalization process underway in the NT (with formation of larger regional ACCHSs servicing populations of 2.500 or more people).

2) Improved data on workforce other than doctors in rural and remote regions.

Aboriginal Health Workers

Factors influencing the recruitment and retention of AHWs include:

- Lack of support for housing with many AHW s having to live in extremely overcrowded housing, whilst non Aboriginal health professionals may be provided with staff housing

- Lack of understanding of the AHW role by other health professional staff. This lack of understanding is aggravated by the high staff turnover with many locum/new staff never having worked with AHWs in the past. This can result in a lack of cultural safety for Aboriginal staff in the workplace

- A training model that is not suited to Aboriginal people in remote communities as it requires extensive time away from home This issue includes a lack of on-the ground and day-to-day training and mentoring support for AHW trainees from employing agencies

- Inadequate funding for apprenticeships and traineeships to provide a living wage for AHW students as they undertake their training in the field.

- Inadequate focus on the literacy/numeracy needs of current and prospective AHW students

- Pay and conditions that are not competitive with other roles available to Aboriginal people with reasonable education in remote areas (such as mining).

- Lack of a career structure and professional development opportunities.

- The failure of the education system in the NT which has meant that many adults do not have sufficient numeracy and literacy to access and complete the AHW course.

Actions to improve Aboriginal Health Worker recruitment and retention. A change to the training system to an apprenticeship model with training largely on site

- Quarantined funding for ACCHSs to provide clinical and mentoring/pastoral support to trainee and graduate AHWs
- Provision of an effective and funded apprenticeship scheme for AHW training
- Provision of housing for AHWs even if they are from the community in which they are working. Current NT Government policy is opposed to provision of AHW housing which AMSANT believes is discriminatory.
- Funding of intensive numeracy and literacy support prior to and during AHW training.
- Career structure and better pay.

Medicare Locals

The Northern Territory Medicare Local has yet to be established, and is not due to be set up until 1 July 2012. However—uniquely in the nation—the NT Medicare Local will be a collaborative partnership between AMSANT as representative of the Aboriginal Community Controlled PHC sector, the Department of Health (NT) and GPNNT. In other words, the Aboriginal sector will have a powerful voice in our Medicare Local.

Divisions of General practice have (as the name implies) largely focused on supporting general practitioners and general practice. In the NT, the rural workforce agency is part of the existing Division: this may change once the Medicare Local is established. Medicare Locals aim to support equitable primary health care in its catchment area. They will be less focused on the needs of health professionals (particularly general practitioners) and more focused on the needs of the community. However, recruitment , retention and support of health professionals is still a crucial component of provision of high quality health care and external support to primary health care organisations (particularly in remote environments) is required to improve recruitment and retention. The role of those Medicare Locals vs. Rural workforce agencies and the affiliates needs to be clarified.

AMSANT strongly supports the retention of the Rural Health Workforce Agency within the new Northern Territory Medicare Local.

We believe that the function of the Rural Workforce Agency should expand to support recruitment and retention in nursing and allied health.

3. Financial incentives for doctors and other health professionals

Research has shown that financial incentives are but one of the important factors in influencing a doctor's decision to go to a remote area or to stay there. Other factors such as work satisfaction, professional development opportunities, working within a cohesive team with a good morale and a well defined role are just as or more important than financial incentives. Therefore attention to

other systemic factors such as good orientation and ongoing support are critical to retention and need to be encouraged. Improved recruitment and retention of other members of the multidisciplinary team will lead to improved retention of doctors. In particular, general practitioners in community controlled health services are very concerned about the lack of an Aboriginal health workforce and the future of the Aboriginal health worker (now Aboriginal practitioner) workforce.

However, financial incentives are nevertheless one of the factors influencing a decision and are important. As stated there is significant competition for doctors who are willing and skilled enough to work in remote contexts. ACCHSs in the NT and other jurisdictions are not funded well enough to compete with very generous packages offered by state governments. In the Northern Territory, for example, the EBAs available to government employed GPs are now steadily outstripping that of the capacity of ACCHS's.

We agree with the Rural Workforce Agency that incentives for doctors to practice in rural and remote areas should be based not only on the degree of remoteness but the disease burden. This would ensure that the financial incentive to move to a remote Aboriginal community would be significantly higher compared to a remote mining community or tourist resort with the same remoteness classification. All remote communities where the majority of the population are Aboriginal will be facing a high disease burden and so we believe that a simple way of implementing this approach would be to provide a 50% loading on financial incentives to work in Aboriginal communities above what would normally be paid to a population with a majority non Aboriginal population. Communities where a significant minority of the population is Aboriginal could be paid a proportion of this incentive depending on the number of Aboriginal people in the catchment areas. A greater financial incentive could also be paid to doctors and other professionals working in ACCHSs within a regional centre than to those working in private practice in that centre. There is very strong justification for this action given the life expectancy gap between Aboriginal and non Aboriginal people and the fact that this gap is widest in the NT (17 years in men) where the majority of the Aboriginal people live in remote areas. Also the amenities in a mining town or tourist resort (education/schools/shopping) and the cost of living are likely to be significantly better than those commonly found in Aboriginal communities. Another consideration would be loading incentives for remote areas with more severe workforce shortages so that a doctor or nurse who is filling a vacancy in an otherwise stable team would get less than a doctor or nurse going to a team which is severely depleted.

We also agree that it is not logical to reduce relocation allowances if a doctor has provided locum services to that community or another community with the same ASCG-RA category in the last 12 months. Doctors commonly try out remote work as locums prior to making a longer term commitment and some doctors undertake locum work whilst family or other responsibilities keep them in urban practice and they then relocate to remote regions once they are in a position to do so. It would be logical to assume that doctors who have completed successful remote locum placements are more likely to adapt to a remote location compared to doctor who have never tried remote work.

It is a logical pathway for health professionals to get some experience in a larger centre and then move to a more remote place. They should not be penalised for this transition: indeed it should be encouraged with financial incentives

We also agree with RWA that the rural relocation grants should be made available to IMGs who are *vocationally registered as well as to to doctors undertaking ACCRM and RACGP. The rule requiring a doctor to apply 90 days before relocation should also be relaxed so that doctors and other HPS can apply after they have moved as otherwise doctors are penalised unfairly causing resentment.*

As discussed earlier we believe that financial incentives for staff working in remote areas should be extended to other professional groups including Aboriginal Health Workers. Dentists should also be eligible.

There will be very significant growth in the medical workforce during the next 10-15 years and one might hope that this will lead to an improved capacity to recruit local graduates. However, during the last period of a relative doctor "oversupply", there was still a shortage in rural and remote regions whilst urban areas became progressively more saturated. One of the policy initiatives that has had the most effect has been the restricted provider numbers available to IMGs who are in the training pathway, limiting them to areas of workforce shortage for ten years. Therefore AMSANT believes that the Federal Government should seriously consider capping the number of provider numbers that can be issued in urban locations so as to improve the equitable spread of doctors. AMSANT also supports the continuation of the policy of restricting provider numbers for IMGs to areas of workforce shortage for 10 years with a discount for work in very remote areas. However, the IMGs need to have the right personal attributes for this work and to be very well supported with excellent training opportunities.

References

CDU; Attracting and keeping nursing professionals in an environment of chronic labour shortage.

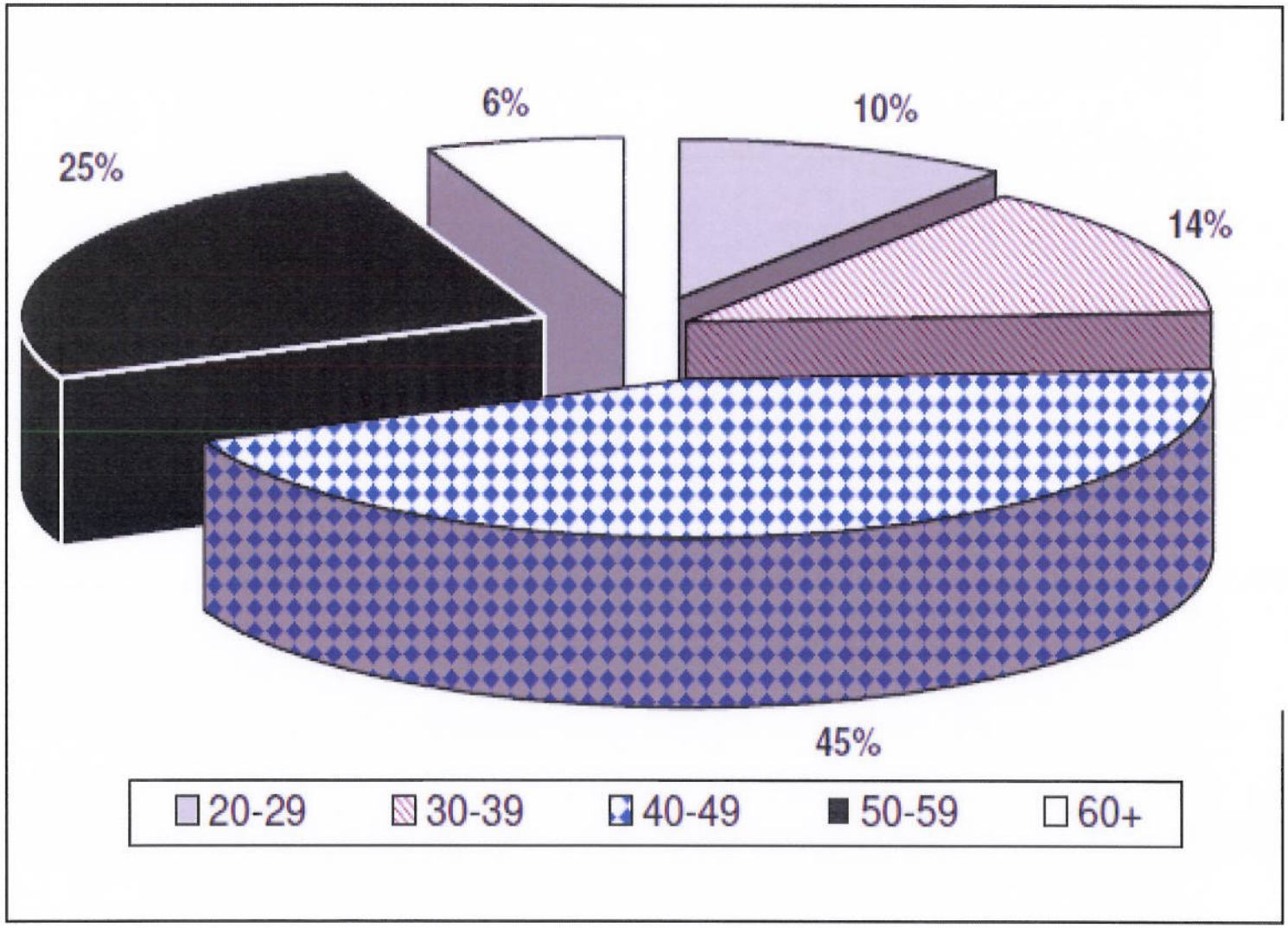
Lenthall S, Gordon V, Knight S, Aitken R, and Ivanhoe T (2012). Do not move the furniture and other advice for new remote area nurses. *Australian Journal of Rural Health*, 20: 44-45.

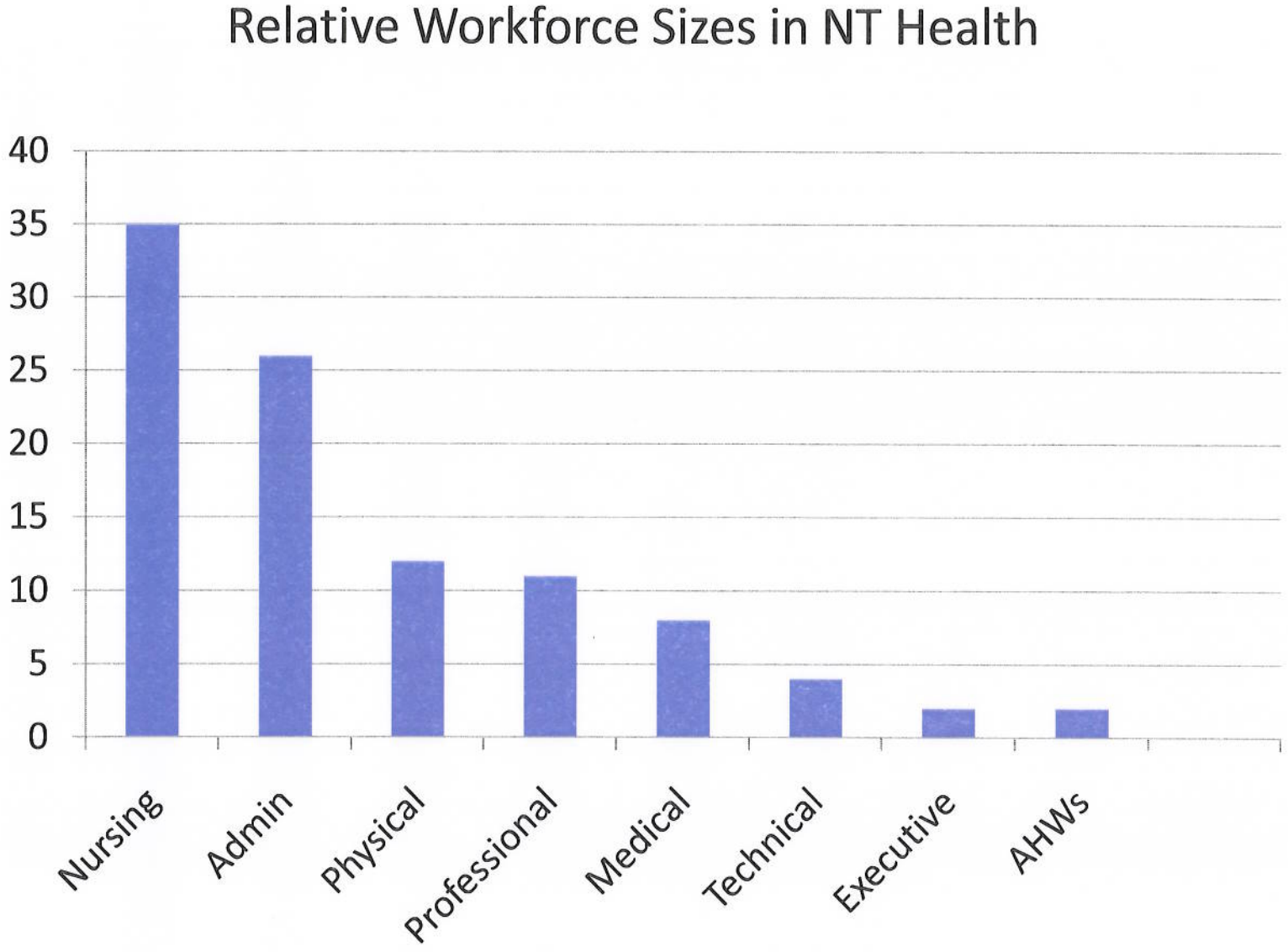
AHW Reform Update

AHW Challenges

- Very few AHWs graduating today
- Many vacant AHW positions
- Ageing AHWs now set to retire
- Confusion over AHW roles in PHC
- Challenge of new workforce types
- Is the AHW profession dying?

Figure 4: Distribution of the current registered AHW workforce by age




Relative Workforce Sizes in NT Health
40
35
30
25
20
15
10
5
0
Nursing
Admin
Physical
Professional
Medical
Technical
Executive
AHWs

Chronology of Events

- Late 1990s: Big drop in AHW numbers
- 2001-2010: Numbers steady around 270
- But ageing workforce, few new grads
- 2007-08: National AHW Competencies
- 2009: NT AHW Professional Review
- 2010: AMSANT's Plan for AHW Training/support
- 2011 (March): Review Report released
- Now: Implementation Steering Committee

AMSANT's AHW Training & Support Plan

1. Regional coordination of AHW training
2. An apprenticeship program for AHW training
3. More training/support for AHW students from employers.
4. All PHC providers responsible for development of AHWs.
5. Effective literacy/numeracy programs
6. Flexible timeframes for AHW training
7. Coordinated marketing of AHW profession
8. Focus on VET in schools for AHW careers.