



NATIONAL RURAL  
HEALTH  
ALLIANCE INC.

## **Position Paper**

# **Current issues for Australia's rural and remote health workforce**

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*This Position Paper represents the agreed views of the National Rural Health Alliance but not necessarily the full or particular views of all Member Bodies.*



# Current issues for Australia's rural and remote health workforce

This paper outlines some of the key health workforce issues currently of concern to the National Rural Health Alliance. For the purposes of this paper the term 'health professionals' includes doctors (general practitioners and specialists), Aboriginal and Torres Strait Islander Health Workers, nurses, allied health professionals<sup>1</sup>, health service managers, pharmacists and dentists.

The Alliance advocates for people in rural and remote Australia and is therefore primarily concerned with the supply of health professionals and their distribution in those areas. However its work is based on principles of social justice and the right to have affordable access to high quality health services, so it recognises that there are also serious shortages of health professionals in some outer metropolitan areas. In aggregate, however, the health of people in rural and remote areas is worse and their income lower than in the capital cities, so that the Alliance does not apologise for asserting that the most serious workforce shortages are those in country areas.

The shortages in rural and remote Australia need to be seen within the context of the **global situation**. They also have to be dealt with in that context. There is a global shortage of health professionals, and non-metropolitan Australia is well-off compared with poorer nations. The Alliance therefore advocates strongly for Australia not to solve its own problems by making the situation worse in poorer countries. More than this, the Alliance believes firmly that Australia has an ethical responsibility to make a net contribution to the world supply of health professionals. This means at least two things for Australia: not actively recruiting health professionals from poorer nations; and training more than enough health professionals for its own needs.

The Alliance and its Member Bodies support the ethical approach to recruitment of health professionals outlined in *The Melbourne Manifesto*<sup>2</sup> and will continue to promote the document as a valuable framework for international action.

Global considerations of supply and demand for health professionals raise two important issues not canvassed in this paper. The first is just how much health care is warranted for any particular individual, given competing demands for resource allocation. The second is how an agreed amount of health care should be provided and by which professionals. These questions are important and answers to them will help determine the numbers required in any professional group (doctor, nurse, podiatrist). If podiatrists were to do 'all the foot work' there would be the need for a greater number of them, and less doctors, than if the foot work were to be shared between podiatrists and doctors. Answers to the second question (who does the work) will also determine the boundary issues relating to individual professions. These in turn will impact on multi-skilling, the nature of multi-disciplinary teams, and the work of professionals whose work might in the old days have been seen as 'crossing boundaries', such as advanced practice nurses.

Given the importance of **overseas-trained doctors** (OTDs) to rural and remote Australia, the Alliance has an ongoing interest in matters related to OTDs. Some of the Alliance's concerns have been expressed in the Policy Portion recently published<sup>3</sup> and by Media Release<sup>4</sup>. The Alliance's overall view is that overseas-trained doctors should be sought for Australia only from developed countries, should be 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 Alliance welcomes the activity under way at national level as part of the MedicarePlus package, and expects continued adherence to the principles relating to assessment and support for OTDs.

The matter is so complex that, in order for sustainable solutions to be found, there will need to be a high level of 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.

There will always be overseas-trained doctors working in a country like Australia, and the unique opportunities and challenges of rural and remote practice will mean that many of them will be in those areas. The Alliance's long-term hope is that, as a nation, we will soon be able to make a net contribution to the world supply of doctors. This means that at any given time there would be more Australian-trained doctors working overseas than overseas-trained doctors working in Australia.

There have been a number of significant developments in **rural and remote medical education** in recent years and the Alliance is on the record as welcoming these. The regionalisation of medical education has been a great boon to the health sector currently and will underpin a better 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 other sectors in which so many of the key resources and decisions are still tied to the capital cities.

The Alliance has had a long-term interest in measures to provide a larger, better-trained and safer **nursing workforce** for rural and remote areas. It is co-ordinating a rural and remote nursing project led by the three nursing organisations within the Alliance and involving a further five national nursing bodies.

The shortage of nurses in rural and remote Australia is already very serious. At any given moment, a significant proportion of those trained within Australia as nurses 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.

At the time of writing, the United States has initiated action to obtain up to one million extra nurses and the UK government has also embarked on a large recruiting exercise. The pressure on supply in Australia is going to become even worse.

The most important recommendations being promoted in the rural and remote nursing project are:

- to develop access for rural and remote nurses to information technology;
- to encourage nursing employers in rural and remote areas (Area Health Services, hospitals, nursing homes) to make available special incentives, in recognition of the special circumstances and costs associated with work in those areas;
- to find ways to help potential employees prepare for rural and remote practice;
- to support the rural and remote aspects of the follow-up work from the National Review of Nursing and Nursing Education;
- to seek the means for promoting rural and remote nursing as a rewarding and safe profession; and
- to encourage curriculum changes that will lead to better preparation of nursing students for clinical and cultural practice in rural and remote areas.

There is a maldistribution of **allied health professionals** and shortages 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. This has adverse consequences for patients and the remaining workforce. The Alliance has called for Area Health Services (or their equivalent) and public hospitals in non-metropolitan areas to increase the priority they give to allied health positions.

Allied health professional 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, and provide services to people in rural and remote communities.

Australian Bureau of Statistics data indicate critical shortages across all allied health professions<sup>5</sup>. Many of the issues impacting on the recruitment and retention of GPs and nurses impact similarly on allied health professionals.

Health practice in rural and remote areas provides great rewards as well as some well-known challenges. The Alliance works hard to present a balanced picture of the circumstances faced by practitioners in country areas. Evidence shows that having a **rural placement** while training or retraining increases the likelihood of a health professional working in rural or remote areas. However 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. The Alliance has therefore called for a quality rural health placement system that gives priority to those who indicate an intention to practise in country areas.<sup>6</sup>

There is a special 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.

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 peoples. 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 1996<sup>7</sup>. The Alliance has to date had a low-level of activity in relation to Aboriginal and Torres Strait Islander Health Workers — through recommendations at its biennial Conferences, for instance. In consultation with NACCHO and ATSIC, which are Member Bodies, and others, the Alliance will increase the priority it gives to this matter.

There is as yet no rural **dental** organisation in the Alliance. This is arguably a serious deficiency. Nevertheless, the Alliance has an agreed Position Paper on Oral and Dental Health<sup>8</sup>. The Alliance has continually pushed for national leadership and funding, with the States and Territories, of additional public oral and dental health services<sup>9</sup>. This will be of most value to people on low income and, potentially, to school children and elderly people. This is a serious issue because of the current poor state of oral and dental health and because oral and dental problems are largely preventable. The Alliance does not see this merely as a time-limited intervention by the Australian Government in order to reduce waiting times at existing public services. Rather it sees this as an area where there should be joint Commonwealth/State action on an ongoing basis.

The Alliance, in collaboration with the National Aboriginal Community Controlled Health Organisation (NACCHO) is pushing for a substantial proportion of the effort on dental services through MedicarePlus to be for Indigenous patients. Oral and dental health is getting even worse among Indigenous peoples, including for pre-schoolers, who have a rate of dental caries three times as bad as for Australian pre-schoolers overall.

Like Aboriginal and Torres Strait Islander Health Workers, **health service managers** are sometimes forgotten in discussions about the health workforce. This is a serious oversight because no matter what the health service is, or where it is, or which professions it includes, it needs to be well managed. The Alliance intends in future to focus more of its effort on measures that will improve recruitment, retention and support of health service managers. It will be led in this endeavour by the rural sub-group of the Australian College of Health Service Executives, a Member Body of the Alliance.

For some years the Alliance has been interested 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 Australian Nursing Council is working with its New Zealand counterpart on educational standards and competencies for nurse practitioners. Nurse practitioners obviously have a great deal to offer to people in more remote areas where fee-for-service general practice is difficult to sustain. Issues related to nurse practitioners raise some of the puzzles referred to above about boundaries between health professions.

For many years people in small country towns and more remote areas have been concerned about their continuing ability to have 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. The Alliance has been approached by national bodies involved with **midwifery** to develop a position on the matter.

**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. *Good Health to Rural Communities — A Collaborative Policy Document*<sup>10</sup> 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.”

## Notes

- 1 The Alliance uses the term ‘allied health’ to refer to health professions other than nursing and midwifery, medicine, dentistry and pharmacy. The larger groupings of allied health professionals, according to this definition, are in physiotherapy, psychology, social work, medical imaging, occupational therapy, speech pathology, optometry, dietetics, podiatry, and audiology.
- 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 Policy Portion 2003/3, November 2003, available at [www.ruralhealth.org.au/nrhpublic/PublicDocs](http://www.ruralhealth.org.au/nrhpublic/PublicDocs)
- 4 See the Media Releases of 5 November 2003 and 27 February 2004.

- 5 National, State and Northern Territory Allied Health Workforce Reports, Ann O’Kane and Shelagh Lowe, Services for Australian Rural and Remote Allied Health, March 2004.
- 6 *A Quality Rural Placement System for Health Students*, NRHA Position Paper, March 2004; available at [www.ruralhealth.org.au](http://www.ruralhealth.org.au)
- 7 *Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project*, Community Services and Health Training Australia Ltd; accessed from [www.cshsa.com.au](http://www.cshsa.com.au)
- 8 Position Papers 2000–2001, NRHA, Canberra; available at [www.ruralhealth.org.au](http://www.ruralhealth.org.au)
- 9 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](http://www.aph.gov.au/senate/committee/medicare_ctte/medicareplus/report/index.htm)
- 10 *Good Health to Rural Communities — A Collaborative Policy Document*, ALGA, RDAA, CWAA, NFF and HCRRA, March 2004.