The future health workforce: options we do and do not have

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FACILITATOR: Our first speaker today is Robert Wells. He is the Director of Policy and Planning (Health) at the ANU. Robert probably knows more about the health workforce and health research policy than anyone else. He was a senior officer in the Commonwealth Department of Health responsible for these things for a long period, until quite recently. His job at the Australian National University is to co-ordinate the health policy work of various institutes and research bodies at the university and increase their engagement with the health policy. Robert Wells.

ROBERT WELLS: Thank you, Rachel, and good morning everybody. First of all I'd like to thank the original owners of these lands for their wonderful welcome on Thursday night. It was truly a moving experience. And before I start, by way of clarification, I'm going to use the term "rural" to cover both rural and remote. So where I use the word "rural" and you feel you're remote, please don't feel excluded, I just want to use the one term for simplicity.

I'll start with the big picture and John Humphries gave an excellent big picture overview on Thursday night and I certainly don't want to repeat that and I certainly couldn't do it with the same erudition and depth of analysis that John did. But there are a couple of points that I do want to make, that first of all there is a big picture and things are happening. Most of those things are trending in a direction which suggests that the current rural health or rural communities, they're not good, they're sort of on the negative side of the ledger, if you like. But these things are happening and I think whether or not they can be changed or not is one question, but even if they can, it will take time and things are not going to get better.

One particular change that I draw attention to is the issue of centralisation of policy within governments. Increasingly, all governments I think, both Federal and State, but certainly the Federal which is the one with which I have some experience, policy over recent years has much more centred in what I call the central agencies. They're the Premier's or Prime Minister's departments, the Treasuries, the Finance departments, those sorts of environments.

Now, I think the implication that we need to think about for that is, (a) well, where do you target your approaches to government? But more importantly, those agencies of course are dealing with policies across the whole spectrum of government administration and don't have the capacity to get into the detailed analysis and perhaps understand the issues that you have as fully as they might. So they look for more simplistic approaches and more simplistic solutions. So I think that's an important consideration in thinking about the way forward.

In terms of workforce, again, there are a number of imperatives. And I use the word "imperatives" deliberately because I think there are things that will happen, whether we like it or not. I think the rural health crisis can't be fixed by workforce measures alone. Nevertheless, an adequate and effective workforce is essential to health service delivery, no matter what models we have.

There have been some excellent workforce programs introduced over recent years and governments should be commended for those. But the extra workforce fillip we receive from say the entry of the 100 rural bonded scholars starting in a few years time, I think that will be largely to replace retiring baby boomers and we know the rural health workforce has a higher

proportion, particularly in the medical workforce, of baby boomers, people like myself, than the rest of the workforce. So there'll be a more significant number of retirees.

And also I think they will reduce our reliance on increasingly hard to attract foreign guest workers, particularly in medicine. We rely heavily on temporary resident doctors in medicine and increasingly we're drawing rural nursing workforce from overseas. And those streams will, I think, if not dry up, certainly the competition for those streams is getting much greater with United States, Canada, England and other similar countries to ours trying to attract from the same pool.

Already we're unable to fill all our GP training places. This year the entry into the rural stream, for example, of general practice was about a third under the quota. We are having difficulty retaining nurses. We've had two major reviews of nursing in the last three years I think, three or four years, both of which concluded that retention of nursing is a significant problem and it's largely to do with the way we run our system, (a) the jobs that we give people are not satisfactory and they go elsewhere and they have the skills and the attractiveness in what is increasingly a generally short supply workforce anyway, across all the sectors of the economy. They can do better elsewhere.

And I think in the long run, with the demographic, there are fewer people with population birth rate decline, there'll be fewer people leaving school, entering university and they'll have more choices and they might not make the same sorts of choices that people are making these days. So we can't presume that in the long run we can just continue to pump out workforce to meet our needs.

I think we have to look at health care models because that's — essentially the model of health care that you have dictates to a large extent the sort of workforce that you need and the numbers. Our current model is doctor intensive, there are strong professional demarcations, a lot of inflexibility in our workforce and our funding system is demand driven. Medicare is essentially a demand driven system rather than, if you like, a strategically planned system. And it's basically a one size fits all models so that the rural health sector is essentially designed to operate like the urban health sector, except it doesn't have as many parts. And some of the parts it has are older and that sort of thing. So it's not a particularly, I think, useful paradigm to continue to say that we should have one sort of health system right across the country.

So the upshot of all that is that if we persist with current structures, current funding models and approaches, the future is in fact not very rosy. We can only go downhill. The problems and their causes are complex and so there's no simple solution. So we can't just say, "Well, we'll fix the workforce and terrific, we'll be right. She'll be apples". But one thing is clear, we need to start now because we're talking about — a lot of these negative impacts are occurring now and more will occur over the next — within the next five years and it takes a long time to redress some of these issues. Workforce changes, for example, I think take at least 10 years before you get any impact at all.

So we in fact probably are starting too late. So what do we do? I think we have to, in fact, change the system, particularly the system of care for rural areas. And I think there are four major areas where we can make those changes. To some extent these are interdependent but there are separate steps we can take under each heading right now to get started. And I'll deal with those.

New models of care. We've had a decade or at least a decade here in Australia of funding innovation, trials, pilots, projects or whatever through various funding schemes, the Rural Health Support Education and Training Scheme or RHSET, the Regional Health Service Scheme, Co-ordinated Care Trials, etcetera, etcetera. I mean, there's a multiplicity of schemes

that we've had over the years, a multiplicity of projects and those schemes and those projects contain a wealth of information about how we might improve our system.

But, of course, being Australians we haven't quite got it all together and we haven't undertaken the real task of drawing all that work together, analysing it in a rigorous way against some particular criteria, which I'll come to, and seeing what works and what directions there might be from all of that and where we might go and what further work we might need to do.

So I think a research agenda can start right now and that research agenda is in fact to draw a lot of that together, a work of synthesis of the work that's been done and analysis of the outcomes of that work against policy parameters. I mean, the whole point of this is to change things, to make things better or to make things work that don't work. There's no point just having research outcome which is purely academic. I keep telling my colleagues at the university this, they don't believe me but nevertheless, that's what the real world is about, that's why we do research, whether we like it or not.

So I think this research needs to be undertaken in a way that is actually relevant to policy, the outcomes need to be able to be explained in ways that are relevant to policy makers, particularly those policy makers I referred to earlier who are sitting in central agencies, who don't know much about the health system, have a lot of other worries on their mind and are looking for simple solutions. There's been talk about research at this conference, there's been a concurrent Rural Research Conference but I think whatever we do, that's where we ought to start. And I suggest we start that on Monday.

We need new approaches to workforce. The speakers who follow me, Deborah Humphress* and Ruth McNair will speak on interprofessional and multi-disciplinary issues, so I won't touch on those. But there is increasing discussion in Australia, including at this conference, of the need in a complex health system for other categories of workers, particularly nurse practitioners and physician assistants. These categories provide a multitude of services in other countries and it's difficult to see why we couldn't benefit from their introduction into the health system here. So I'd encourage those discussions to continue but with a focus for something happening.

Workforce, education and training in this country needs major reform. Employers say that universities are not turning out job ready professionals and we've had reviews of nursing which confirm that, over a decade. Young health professionals are increasingly disillusioned over the work context in which they are expected to operate so they are choosing more part time work, they're choosing, in fact, to leave the health sector and go to other sectors of the economy. And training, particularly in medicine, takes far too long, especially as graduates emerge from university with significant debts.

I mean, some of the debts in the future will be in the hundreds of thousands of dollars, as people pay full fees. So these are not trivial issues for the students and for the system. And we know, from New Zealand, for example, where the students have been graduating with more debt, they tend to leave New Zealand and go to countries where they can earn more money more quickly. And there's an increasing sense of professional isolation once people do leave university, particularly in rural areas.

We now have an extremely valuable rural health education infrastructure, developed as part of the University Departments of Rural Health and Rural Clinical Schools Initiatives. I think this needs to be expanded, both geographically, ie, there needs to be more of it in more places; and professionally, in terms of its professional reach, ie, it should be a resource for the whole professions, all of the professions throughout their careers. So not just for students or not just

for trainees, but also for workers in the system who need to continually upgrade their skills and knowledge. So I suggest that we could look at expanding that network fairly rapidly.

I also suggest perhaps that it's time to look at merging those two programs into one and using the resource more flexibly across the gamut of health professions rather than, again, having them demarcated as we do now, between doctors and the rest.

I think we need to look at new funding and remuneration models because clearly the models we have aren't working. And I particularly would like to make a few comments about the fee for service model for doctor remuneration. That's the current dominant model and that's the model that Medicare predominantly recognises, that most of the dollars that go out through Medicare go out through fee for service transactions.

I think it has a number of disadvantages, again, I'm focusing on rural communities. Fee for service is not well suited to meeting the needs of those with chronic and complex care needs which, of course, 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.

Also I'm finding, and this is anecdotal, but increasingly young doctors are saying, they prefer salaried or mix of salary and fee for service rather than just fee for service, and particularly where they'd be expected to make an investment in setting up their own practice and all the associated risks and costs around that. So if it's unattractive to people, even for that reason alone, we ought to think about whether we can vary it.

Another option I think that needs to be looked at is where our health budgets are actually centred. Currently — in fact it's actually difficult to find a locus of control for our health budgets. Sometimes it's in capital cities, in some states some of it's in regional health authorities, some of it's in Canberra and most of that which is in Canberra is, in fact, just demand driven so it runs through a computer.

There isn't actually a lot of strategic thinking about how we spend our health dollars and perhaps it's time we thought about that and perhaps it's time we drew them together a bit and gave them to local communities and said, "Well, here you are, you've got some flexibility, you've got some funding which is based on a formula more related to need than to access" etcetera. So I think that's something that certainly needs serious attention. And, again, I think it's something that can be dealt with.

I mean, the point is, if we're going to have new models of care and I think that is fairly clear, we probably need new models of funding to support them.

Finally, I think we need to look at the levels of government. Now, this is not about the current debate of whether the Commonwealth should take over everything. That's a debate that others are much more competent to talk about than I but I think we can let that debate run and it probably will run, for a fair while I suspect. But what I want to suggest is that whatever the outcome of that debate, we ought to think about whether rural health could in fact be funded by one level of government.

And I'm not suggesting which level of government, it might in fact vary from state to state. But I think the time has come to say, "Well, look, we can't really deliver services in rural areas where we've got a split of funding, where we've got multiple funding buckets within jurisdictions, it's about time we sort of pulled it together, we thought more strategically and the people who are responsible for making the decisions about the services actually have access to the funds they need to deliver those services".

So I think we ought to seriously think about leaving aside the big debate about Commonwealth/State relations and who owns the GST and whether it should have been given to the states in the first place or whether the Commonwealth felt it diddled itself or whatever. Let's forget about that, let's focus on the needs of rural communities.

So, in conclusion, I think the rural health crisis will get worse and then it will get worse still. I don't think it will get worse before it gets better, I think it's in fact the reverse, unless we do something and I think we need to work at several levels. There's no point just saying, "Well, we'll fix the workforce or we'll fix this or we'll fix that". We've actually got to see it as a major problem, tackle it on several fronts at once but get some actions going straight away. Thank you.