

# **Health Reform - Note 9**

*October 2009*

## **Development and distribution of the health workforce**

### **What are the characteristics of the rural health workforce?**

The people of rural and remote Australia have had to put up with longstanding shortages of most health professionals. Attachment A shows that specialists, general practitioners, psychologists, dentists and dental hygienists are all substantially less well represented in rural and remote areas, per head of population, than in major urban areas.

Because the problem arises from maldistribution as well as from insufficient professionals, even with projected increases in the levels of graduation in some professions, such as medical practitioners and dentists, the situation is not likely to be easily redressed. Estimates suggest that only five per cent of medical graduates in NSW and Queensland are choosing rural (cf urban) practice, and the reliance of rural and remote communities on international medical graduates has steadily increased.

Overall, workforce shortages in rural and remote Australia, and for Aboriginal and Torres Strait Islander health professionals, constitute a first-order barrier to universality in access and equity in health outcomes and to Closing the Gap in Aboriginal health. The models of care which are known to work, and new approaches to service delivery that should be tested, may be simply impracticable if there is not the local workforce to deliver them.

In addition to addressing current maldistribution, workforce support measures need to allow for changing demand for health services of different types. Various reform proposals before Government covering preventive, primary and system-wide health services have significant implications for the health workforce, requiring increased numbers as well as changes in roles, responsibilities, funding and performance assessment.

### **The current proposals**

The National Health and Hospitals Reform Commission has made a number of recommendations to improve the overall supply of and support for required health professionals, including in rural and remote Australia.

It has proposed “additional investment to build an Aboriginal and Torres Strait Islander workforce across all disciplines”.

To assist in increasing numbers of health professionals in rural areas, the Commission has proposed that a higher proportion of undergraduate and graduate placements be allocated to remote and rural centres, where possible in a multi-disciplinary facility.

It has also proposed that a new Clinical Education and Training Agency be established to advise on the education and training requirements (for health professions) by region and to assist in planning clinical education infrastructure required by region. The new agency would take the lead in developing workforce distribution strategies and extend incentives for rural GPs to other health professions. The Commission notes and supports existing measures such as HECS relief, bonded scholarships and study leave, and suggests preferential access to the training provided by speciality colleges for people with rural or remote experience or commitment.

The Commission proposes that some of the successful measures be extended to all health professions.

To boost the dental health workforce overall and to increase public dental health capacity, the Commission has proposed an internship year for all dental health professions and investment in five new dental teaching hospitals and 50 connected academic oral health service centres.

The Commission has also proposed to improve professional support through referral and advice networks for rural and remote practitioners, and suggests the provision of 24-hour on-call telephone/internet consultations by off-site medical practitioners.

Although there is no indication of the level of funding envisaged, the Commission supports the establishment of a research program to build rural health service, clinical and workforce capability.

More generally, it has proposed improvement in the sustainability of the workforce by making access to Medicare rebates applicable to services provided by a nurse practitioner, midwife, or other competent health professional, acting within scope of practice and in a collaborative team model of care with a general practitioner or specialist.

It supports moves towards a flexible multi-disciplinary approach to education and training, and the availability of clinical training infrastructure across all settings, including in primary care and other community settings.

## **The Alliance position so far**

The Alliance strongly supports the Commission's proposals, and those of other organisations, for increasing the number of Aboriginal and Torres Strait Islanders in the health professions. Currently the Aboriginal and Torres Strait Islander workforce ranges from about 20 per cent of pro rata for registered nurses, to less than 10 per cent of pro rata for all other disciplines. We consider that such actions are a crucial element of addressing the health needs of

Aboriginal and Torres Strait Islander people and increasing culturally appropriate practice and access to services.

The Alliance also strongly supports the range of proposals in the Commission's Final Report for improving the distribution of health professionals across Australia, with the particular view of improving access to all of them for people in rural and remote areas. The overall purpose will be to ensure that the models of health service delivery which work well in rural and remote areas are not constrained by the lack of health workers.

By this means it will be possible to improve health outcomes among people in the rural and remote areas by giving them access to multi-disciplinary team-based care. In some cases such care could be provided under the MBS but the Alliance is wary of instituting a public payment system for services when staff are still in short supply, because of the incentive it may provide for scarce professionals to gravitate to areas of higher population.

A number of the recommendations in the Commission's Final Report have the Alliance's unequivocal support and should be implemented as soon as possible.

For example, substantially increasing the share of clinical education and training places in rural and remote Australia would be an effective measure and Governments currently have a \$1.6 billion program of investment in train for the enhancement of clinical education and training. This represents a singular opportunity to attract more professionals to rural and remote areas, and it will be a major opportunity lost if this is not done now. The existing national health workforce agency should be asked to develop a plan, including targets and actions, to increase the share of clinical education in rural areas. The University Departments of Rural Health offer an ideal multi-disciplinary setting in which to provide such clinical training.

The Alliance also supports the concept of region-by-region assessment and planning of education and training needs and associated infrastructure, and the provision of funding to support that clinical training. This would provide a clear focus on current disparities and set the scene for more equitable approaches. A regional focus would also be more likely to take the needs of all health professions into account, and assist in moving towards distributional incentive measures that apply to all health professions in short supply. This is a key principle for developing the multi-disciplinary workforce required to meet health needs.

Preferential access for remote and rural health practitioners to speciality training would be a valuable incentive and also recognise the value of the experience of the extended range of practice of health professionals working in more remote areas.

The Alliance supports the proposal for an internship year for dental health professionals. It would have a positive impact on the distribution of such professionals provided that the proposed academic oral health centres were developed in regional centres and had the capacity for outreach to smaller towns and to Aboriginal and Torres Strait Islander community controlled services.

The concept of an internship year should also be considered for other disciplines to boost academic, clinical and rural capacities.

## Your input is invited

The Alliance is not convinced of the merits of devolving responsibility for the distribution of the workforce to a Clinical Education and Training Agency and leans towards retention of responsibility within the Commonwealth Department of Health. Having incentives in the hands of a Clinical Education and Training Agency would give a narrow view of required incentives and it would seem in any case to duplicate the responsibilities of the Rural Health Workforce Agencies and governments. At the very least the respective responsibilities of these various bodies need to be carefully defined.

Do you believe that, between them, the various proposals in the NHHRC's Final Report are sufficient to improve the distribution of health professionals and their availability in rural and remote areas?

We acknowledge that measures taken in the 2009-2010 Commonwealth Budget to establish a new geographic classification and to 'scale' incentives according to remoteness, as well as some increases in incentives for GPs, are yet to take effect. The impacts of this program should be closely monitored, especially in relation to the attraction of new GPs.

What are your views on the new Australian Standard Geographic Classification – Remote Areas (ASGC-RA) system?

Further research and consideration is needed of alternative policies and programs for attracting and retaining rural health professionals, including how they impact on remuneration. These could include loadings for specialised skills and for greater on-call obligations.

The Government's actions on health reform, including as they relate to hospitals, subacute and specialist care, should be directed first at population groups with the greatest need for additional or improved healthcare. All new programs should be evaluated for the extent to which they support other initiatives to attract health professionals to rural and remote areas.

If you have a comment, let us know at [nrha@ruralhealth.org.au](mailto:nrha@ruralhealth.org.au) or by mail to NRHA, PO Box 280, Deakin West, ACT 2600.

### *Attachment*

## **Maldistribution of Health Professionals**

### **General Practitioners**

The AIHW survey of Medical Labour Force changes from 2002 to 2006 indicates that the investment in national medical workforce training and distribution initiatives is serving to increase rural access to medical practitioners, as shown in the following table. In overall terms, however, the geographically skewed distribution of employed medical practitioners

continues and is in fact increasing, with greater increases of health professionals per 100,000 population in metropolitan areas than in Inner and Outer Regional areas.

AREA	Total Medical Workforce per 100,000		Growth Rate in Employed Medical Practitioners	Employed Primary Care Clinicians FTE per 100,000		Employed Hospital non-specialists FTE per 100,000		Specialists/ in training FTE per 100,000		
	2002	2006		2002	2006	2002	2006	2002	2006	
Metro	312	332	18.5%	105	98	29	39	154	170	
Inner Regional	176	184	8.3%	90	87	14	18	65	71	
Outer Regional	146	154	4.9%	80	86	15	15	43	45	
Remote, Very Remote	140	191	31.2%	89	108	22	34	21	35	
<b>Overall</b>				271		290		101		97
<b>Clinicians</b>				252		272				

There are similar disparities for allied health professionals, dentists, midwives and nurses, with the last-named profession having the most even distribution across different remoteness classifications.

The AIHW survey of the medical labour force also found that hours of work by primary care clinicians were 2.6 hours more in Inner Regional, 6.1 hours more in Outer Regional and 10.3 hours more in Remote/Very Remote, compared to their metropolitan counterparts. (Rural and remote clinicians are also likely to spend more time on call.) Thus it is clear that primary health care practitioners in rural Australia already work longer hours and have a broader range of demands for their services and will be significantly less well placed than their metropolitan colleagues to devote additional time to health promotion and prevention measures.

### Psychologists

The National Allied Health Workforce Report (2003)<sup>iii</sup> showed that 20.5 per cent of practising psychologists were reported as working in rural and remote regions. This equates to 0.83 psychologists per 10,000 head of population in very remote areas and 3.44 in Inner Regional centres, compared to 5.92 per 10,000 head of population in major capital cities. The rural sector tended to attract the youngest and hence least experienced health professionals. Although data are scarce, there would appear to be few Indigenous people working as psychologists, regardless of whether or not they are located in rural areas.