



**NATIONAL HEALTH AND HOSPITALS REFORM
COMMISSION**

INTERIM REPORT

A SUBMISSION

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Rural Health Workforce Australia

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1. Background

Having the health workforce where it is needed is crucial to any reform of the health system in Australia. This foundation is not dependent upon any of the models put forward by the NHHRC but, rather, is a pre-condition upon which all or any models should be based.

Research into the medical labour force over the past 40 years has shown that there has been a chronic maldistribution of that workforce – which is unrelated to the various peaks and troughs of workforce supply over the same period. Thus, even when the medical workforce supply has been plentiful, rural and remote Australia has experienced an overall shortage.

As a consequence of the structure of the Medical Benefits Scheme, this has also translated into a shortfall in funding - put simply, people living in rural and remote areas of Australia do not receive an equitable share of the health care budget – let alone a share that is related explicitly to their health care needs.

The proposals outlined in this report do not address the issue of workforce maldistribution and therefore further strategies are needed.

2. Governance and Funding

Rural Health Workforce Australia (RHWA) is strongly supportive of any option that will enhance the capacity for local input into service planning and delivery. The evidence shows that successful rural and remote service delivery models, such as the Aboriginal Community Controlled Health Services and Multi-Purpose Services, have achieved this precisely because of their capacity to design services around local need. Similarly, programs such as MSOAP owe their success to their responsiveness to local service planning. We need planning and delivery structures that build upon these local successes.

The Interim Report discusses the formation of Divisions of Primary Health Care, to be possibly based upon the current Divisions of General Practice, as local planning and service co-ordination structures. However, whilst the governance structures of Divisions have changed over time, there would need to be a major redevelopment of these Boards away from representatives and towards people with the appropriate skills (financial, legal etc) to ensure the appropriate governance of these new service delivery and planning organisations.

We are extremely interested in the concept of Regional Health Authorities, who are also fundholders and service planners. However, if these are to be of a particular size – say populations of 500,000 – there would need to sit beneath these Authorities more localised planning structures. Unless this happens, the needs of the smaller rural and remote communities will be overlooked and marginalised.

Whatever funding framework is adopted will need to be flexible enough to allow for localised planning, decision making and delivery to occur. One

option, as the NHHRC has suggested, would involve the cashing out of MBS, PBS and other health funding into a pool from which can be commissioned locally appropriate services. We support this cashing up for rural and remote communities.

We would stress that cashing out of MBS/PBS etc cannot be done on any national average basis – but must be developed according to a properly devised population weighted factor. Thus, communities with higher rates of chronic illness and disease should receive higher levels of funding than those who have lower rates. Critically, the extra costs of delivering services in rural and remote should also be factored in.

3. Primary Health Care Services

We support the development of Comprehensive Primary Health Care Centres. However, we would stress that there needs to be considerable flexibility around where they are placed. For example, although many smaller communities may not have the population mass to support a centre on its own, the joining of a number of small towns through a hub and spoke model could support a centre. These centres must be relevant for rural areas.

Supplementing primary health care services with outreach models such as MSOAP have a long and successful history of service delivery in rural and remote areas. We suggest the new Centres build upon this success and also provide infrastructure for visiting services.

4. Workforce

The main strategy in the report for addressing the maldistribution of the current workforce is to replace one profession (GPs) with another (Nurse Practitioners). Whilst role substitution already occurs to some extent in rural and remote areas, it is not, in itself, a panacea to workforce distribution problems. Furthermore, it is not possible to directly compare the situation in Australia with that in the USA because in that latter country the rapid increase in nurse practitioners and physicians assistants has also coincided with the growth in managed care.

Any reformed system in Australia must look seriously at the incentives and barriers to living and working in a rural and remote area. Workforce maldistribution is a chronic problem and cannot be easily 'fixed'. Therefore our new system must constantly adapt and change to be focussed on attracting the health workforce to the areas they are needed most.

Whilst increasing clinical training opportunities outside cities is one strategy, it is only a partial solution and will not address workforce maldistribution. People will work where the environment is attractive.

The Primary Health Care Centres could provide an excellent opportunity for the development of first class infrastructure in rural areas in which health professionals can practise without having to buy their way in or having to

worry about running a small business. So implementation of the Centres must be in rural and remote areas first, where the need is greatest.

Complementing the centres, we also need to invest in our existing general practice structure to retain the workforce where they are, particularly in smaller rural and remote communities. Rural Workforce Agencies currently provide business support to some practices as an important measure to retain practitioners and this support could be expanded across the country. Focussing on already-established bricks and mortar and IT and business solutions can significantly ease the difficulties encountered by practitioners.

These centres could also provide significant opportunities for team-based care as well as providing the foundation for vertical integration of training (and teaching) of undergraduate, through to commencing professionals. Through these means more integrated planning between the educational and health care sectors could occur. However, training more graduates in rural areas does not lead to an increased workforce – it is only one step so more comprehensive strategies are needed.

The training of new graduates notwithstanding, Australia will remain dependent upon International Medical Graduates (IMGs) into the foreseeable future. IMGs are now almost half of our rural and remote GPs. They have also cost this country nothing in terms of their basic training but require intensive orientation and support when they arrive. We must therefore develop a primary health care system that invests in them and ensures their successful integration. This investment will need to include opportunities for further training to enable them to pass their AMC or fellowship exams. This will contribute to the quality and safety of the primary health care workforce.