

Position Paper

Wanted: A uniform system for assessing health workforce shortages and targeting programs to attract health professionals

June 2012

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

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WANTED: A UNIFORM SYSTEM FOR ASSESSING HEALTH WORKFORCE SHORTAGES AND TARGETING PROGRAMS TO ATTRACT HEALTH PROFESSIONALS

Background and purpose

The purpose of this NRHA Position Paper is to propose a single system to rationalise the analysis and presentation of health workforce shortages, and to simplify the application and administration of related Commonwealth initiatives.

A single uniform national system is proposed which would define any given place according to the level of its need for greater numbers of health professionals.

It is proposed that there be a composite measure which would include, for any location, a geographic indicator of its remoteness, its population size and, potentially, a third indicator picking up its other social and economic characteristics.

The single system would be simple to understand, and transparent. It would balance the need for stability (so that health professionals and health services can plan ahead with confidence) and dynamism (so that it can be adjusted from time to time as necessary to secure a fair distribution of health professionals). It would be rules-based but with flexibility to accommodate particular circumstances either by administrative discretion or through an appeals system.

The genesis of this Position Paper was the obvious sense in rationalising the different systems that currently exist for measuring and defining *doctor* shortages. However, it is worth noting that, given the availability of the required data, the proposed system could apply to shortages of health staff of any profession.

This paper is not concerned with the various spatial bases or geographic scales of different health services or service systems. That is a different question to measuring remoteness.

The current situation

At present, various workforce initiatives use different ‘maps’ to determine a doctor’s eligibility to work in a particular area or to receive incentives. The four main maps are:

1. **Districts of Workforce Shortage:** “DWS is determined by the Department of Health and Ageing (the Department) using both Australian Bureau of Statistics population data and Medicare Australia billing data. In general, a location is deemed to be a DWS if it falls below the national average for the provision of medical services. Population needs for health care are deemed to be unmet if a district has less access to medical services than the national average.”¹ This map determines where GPs are likely to be granted an exemption from Section 19AB² of the Health Act and thus have the ability to provide services funded by Medicare.

¹ Accessed at www.doctorconnect.gov.au on 2 April 2012.

² Section 19AB of the Health Act applies to overseas trained doctors (OTDs) and foreign graduates of an accredited medical school who gained their first medical registration on or after 1 January 1997. It restricts such persons’ access to Medicare benefits and requires them

2. **ASGC-RA:** Based on ABS data and derived by GISCA at Adelaide University, the ASGC-RA map determines distance from population centres of various sizes. It is used to determine eligibility for:
 - General Practice Rural Incentives Program (GPRIP);
 - return of service under the Medical Rural Bonded Scholarship (MRBS) Scheme;
 - service under the ten-year moratorium; and
 - service under the HECS reimbursement scheme for medical graduates.³
3. **Outer Metro areas:** This is developed and managed by the Department of Health and Ageing and used for the allocation of incentives under the More Doctors for Outer Metropolitan Areas Relocation Incentive Grant. The basis of the classification is unclear to outsiders.
4. **Area of Need classification:** This is determined by each State/Territory Health Department using distinct systems, and is applied differently in each jurisdiction. Generally, Area of Need:
 - is applied to individual workplace positions rather than geographic areas;
 - can be granted to positions in metropolitan and non-metropolitan areas;
 - is granted on a 'case by case' basis to a specific hospital or health service; and
 - is not always open about the criteria and processes used in its determinations.

Some GPs and hospital doctors are required to work in a location that is classified as both AoN and DWS.

Concerns with the current system

Anomalies leading to unfair comparisons

The anomalies with the RA system can be demonstrated in the following groupings of places categorised in the same ASGC-RA group.

RA 2 - Hobart, Dubbo, Coffs Harbour, Gundagai, Ulladulla, Tumut, Cobram, Tallangatta, Kingaroy, Rockhampton, Bunbury and York.

RA 3 - Darwin, Cairns, Townsville, Moree, Urana, Wellington (NSW), Narrogin, Roma, Albany, Narromine, Ballimore, Mount Beauty, Swan Hill, Broken Hill, Geraldton, Burnie, Longreach and Balranald.

Compare those groups with the following sets of places in RA4 and RA5, which are clearly much more alike within the sets:

RA 4 - Alice Springs, Mt Isa, Kakadu, Broome, Port Lincoln, Mallacoota, Bourke, South Hedland, and Walgett.

to work in a 'district of workforce shortage' (DWS) for a period of up to ten years from the date of their first medical registration in Australia.

³ It is understood that return of service in the Bonded Medical Places scheme (BMP) is still subject to the Rural, Remote and Metropolitan Areas classification scheme (RRMA).

RA 5 - Wilcannia, King Island, Maralinga, Lord Howe Island, Weipa and Horne Island.

Both Townsville and Urana are RA3. Under the previous system (Rural, Remote and Metropolitan Areas classification - RRMA), Townsville was RRMA 2, Urana RRMA 5. Townsville has a population of 170,000, is on the coast in north Queensland, has an annual mean rainfall of 45 inches and a broad economic base which includes service to the resources, fishing and pastoral industries, tourism and the public service (including a major army base and a university). Urana is in central-southern NSW, has a population of some 1500 people and is 375km from Melbourne and 566km from Sydney. Urana's population has been falling slowly for some years and it is small enough for most of its inhabitants to have a sense of place.

Critiques of ASGC-RA and alternatives proposed

NSW Divisions of General Practice

In 2009 a consortium of three rural Divisions of General practice in NSW made a submission to the Federal Government about the impact of the switch from RRMA to ASGC, focusing on the potential effect on places like Hay and Deniliquin.

“Under the new system, it is clear that numerous already-disadvantaged, small rural towns that were previously classified as *Other Rural Areas* (RRMA 5) through to *Other Remote Areas* (RRMA 7) fail by only slim margins to classify into more remote ASGC-RA categories.”

The submission referred to the fact that moving to the ASGC-RA system would have implications for the rurality loadings in Practice and Service Incentive Payments (PIP/SIP) and bulk-billing incentives, as well as for the GP Rural Incentive Program (GPRIP).

On the plus side, the submission emphasised the relative robustness of the data on which ASGC-RA is based, but continues:

“- it is paradoxical that the ASGC-RA system then takes the robust ARIA+ scores and reverts them back to an ordinal ranking system which once more categorises non-metropolitan Australia into a few, large and apparently homogenous, areas. Even more counter-intuitive, the ASGC-RA only provides five classifications and so arguably then becomes a less sensitive differentiation tool than the RRMA system it replaces.”

It argued that a limitation to the ASGC-RA system is its inability to adjust for a town's relative capacity to provide adequate services, employment, education and other social capital - contrasting coastal with inland towns of a similar size. Remoteness, the submission argued, is only one of the three well-recognised independent variables for predicting social vulnerability, the other two being the relative proportion of Indigenous residents and low socioeconomic status. The point was made that the ABS itself cautions against using remoteness classifications as a stand-alone tool for determining the distribution of funding, particularly in non-metropolitan regions.

The submission from the consortium of NSW Divisions referred to the ‘buffer zone’ process applied to Exceptional Circumstances (EC) funding for drought-affected areas. Already-disadvantaged communities that are put on the cusp by reclassifications are compensated for inadvertently being made worse off by the change.

The submission proposed that the ARIA+ score for each location be weighted by a ‘Disadvantage Adjustment’ which would take into consideration the proportion of Indigenous residents and the Socioeconomic Index for Areas (SEIFA) index of relative socioeconomic disadvantage.

Humphreys et al

The February 2012 issue of the Australian Journal of Rural Health (20(1)) includes an article entitled *Who should receive recruitment and retention incentives? Improved targeting of rural doctors using medical workforce data* by John S Humphreys, Matthew McGrail, Catherine Joyce, Anthony Scott and Guyonne Kalb.

The study used geo-coded data for 3,636 GPs to establish that town size (population) is associated with four of six factors known to relate to recruitment and retention (total hours worked, public hospital work, on call after-hours, difficulty taking time off, partner employment, and schooling opportunities). The article reports four distinct population size groups to minimise ‘within group’ and maximise ‘between-group’ variation: 0–5000, 5001–15,000, 15,001–50,000 and >50,000. The study goes on to develop a new six level classification based on town size first, then remoteness (ASGC-RA):

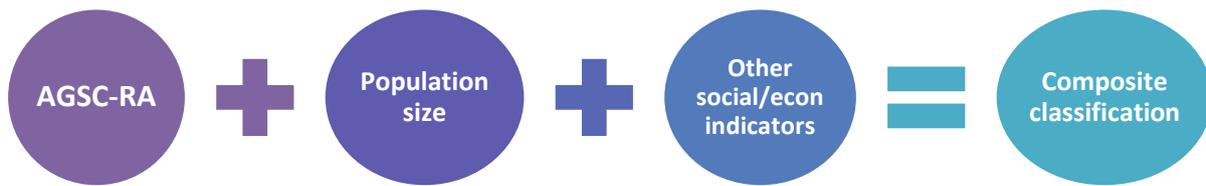
“Although geographical remoteness (measured using the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA)) was statistically associated with all six indicators ($P < 0.001$), population size provided a more sensitive measure in directing where recruitment and retention incentives should be provided. A new six-level rurality classification is proposed, based on a combination of four population size groups and the five ASGC-RA levels. A significant increase in statistical association is measured in four of six indicators (and a slight increase in one indicator) using the new six-level classification versus the existing ASGC-RA classification.

This new six-level geographical classification provides a better basis for equitable resource allocation of recruitment and retention incentives to doctors based on the attractiveness of non-metropolitan communities, both professionally and non-professionally, as places to work and live.”

This Alliance Position Paper proposes that both of those pieces of work be considered by the Commonwealth Government in building and modelling the proposed composite classification system. For instance, the weighting by population size could be done on the basis of the four population size groups identified by Humphreys et al.

The Alliance proposal for a composite classification system

The proposed new classification would be comprised of the following elements:



1. ASGC-RA

The ASGC-RA system is currently used for many of the incentives provided by the Department of Health and Ageing and is represented on a map on the ‘Doctor Connect’ website. Its classification is based on average road distance to a range of different sized urban centres. It is a hotly-contested system, mainly because of its anomalies, most specifically because it does not include a factor for town size. For example, because of their distances from Melbourne and Brisbane respectively, ASGC-RA allocates the same category (RA3) to Urana (population 1,500) and Townsville (population 170,000).

The reason the system is so discredited is that it is used for the allocation of financial incentives. Currently a doctor moving to Gundagai (Shire population 4,000) in ASGC-RA2 is entitled to the same relocation grant (\$15,000) as one re-locating to Yass (12,000 people, one hour from Canberra), Coffs Harbour (70,000), Albury (55,000 or 90,000 with Wodonga), Toowoomba (90,000) or Hobart (205,000).

Nevertheless, as reported in the Humphreys et al study, ASGC-RA is associated in a statistically significant way with four of six factors affecting a GP’s decision to go to and stay in rural areas. It is also based on good data (from the ABS) and its incorporation in the new composite index will provide some continuity from the current schemes. Increasingly health system performance and health outcome data are analysed and monitored by remoteness, using the ASGC-RA scheme, and it is important to be able to analyse and track the impact of funding to health workforce programs on health system performance and health outcomes.

2. Town size

Town size and distance to a capital city are two of the most significant factors affecting the decision of a doctor’s family about living in a rural area. Town size determines or affects the amenity and services available as well as the opportunity for the spouse to work, educational opportunities for children, professional interaction and support, access to a range of more specialised entertainment opportunities, the quality of housing, and access to specialist professions.

The proposed new classification system would include a loading for places of a particular size. The four groups identified in Humphreys et al could be used, but ultimately the weightings used for this and the other two variables will be set following modelling to see the effect of particular combinations of weightings on particular places. This modelling would be done in consultation with interested parties.

Proposed 'look-up' table

A look-up table would be constructed, using the agreed weightings for each of the agreed criteria. The table would be the basis of publicly available information for every locality, as is now the case through DoctorConnect.

Use of the weightings

The classifications or loadings would be applied to both cash-based and time-based incentives.

The cost of moving to the new system would depend on the unit value of the incentive to which the cumulative loading was applied. The differential between small and large places, and remote and regional places, should increase. The absolute amount of incentive may well have to increase in order to succeed in recruiting and retaining staff to difficult or remote areas.

Conclusion

There are currently three federal systems for assessing doctor shortages and allocating incentives of various kinds, when a single transparent system would be preferable. The ASGC-RA system has been roundly criticised by interest groups, academics and health service managers, and several of these parties have indicated support for alternative models which would be simpler, more transparent and provide fairer incentives for doctors working in and moving to towns of various sizes.

A range of values on the variables proposed should be modelled, in consultation with industry groups and other interests, to ensure that the revised system is widely accepted. Selecting the units of financial incentives and time-based programs to which the composite weighting is to be applied is a political decision. Where the unit value is set will determine the extent to which there may be losers as well as winners from adoption of the new system.

If nothing else, the new system would provide much greater fairness between towns of various sizes and would increase the proportional weighting given to towns to which it is difficult to recruit doctors.

A similar scheme could be applied to measurement of workforce shortages and the pattern of incentives for other health professions, always assuming that the required data are available. We commend the alternative proposal to the Government and other interested parties.

Attachment: Member Bodies of the National Rural Health Alliance

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| ACHSM | Australasian College of Health Service Management |
| ACRRM | Australian College of Rural and Remote Medicine |
| AGPN | Australian General Practice Network |
| AHHA | Australian Healthcare & Hospitals Association |
| AHPARR | Allied Health Professions Australia Rural and Remote |
| AIDA | Australian Indigenous Doctors' Association |
| ANF | Australian Nursing Federation (rural members) |
| APA (RMN) | Australian Physiotherapy Association Rural Member Network |
| APS | Australian Paediatric Society |
| APS (RRIG) | Australian Psychological Society (Rural and Remote Interest Group) |
| ARHEN | Australian Rural Health Education Network Limited |
| CAA (RRG) | Council of Ambulance Authorities (Rural and Remote Group) |
| CHA | Catholic Health Australia (rural members) |
| CRANApplus | CRANApplus – the professional body for all remote health |
| CWAA | Country Women's Association of Australia |
| FS | Frontier Services of the Uniting Church in Australia |
| HCRRRA | Health Consumers of Rural and Remote Australia |
| ICPA | Isolated Children's Parents' Association |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NRHSN | National Rural Health Students' Network |
| PA (RRSIG) | Paramedics Australasia (Rural and Remote Special Interest Group) |
| PSA (RSIG) | Rural Special Interest Group of the Pharmaceutical Society of Australia |
| RACGP (NRF) | National Rural Faculty of the Royal Australian College of General Practitioners |
| RDAA | Rural Doctors Association of Australia |
| RDN of ADA | Rural Dentists' Network of the Australian Dental Association |
| RHW | Rural Health Workforce |
| RFDS | Royal Flying Doctor Service |
| RHEF | Rural Health Education Foundation |
| RIHG of CAA | Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia |
| RNMF of RCNA | Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia |
| ROG of OAA | Rural Optometry Group of the Australian Optometrists Association |
| RPA | Rural Pharmacists Australia |
| SARRAH | Services for Australian Rural and Remote Allied Health |