



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Improving the rural and remote health workforce

A submission to the
Department of Health and Ageing
related to the audit of the
rural and remote health workforce

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This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies

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Executive Summary

Despite its affluence, Australia is not exempt from the shortages of health professionals that are experienced worldwide. The mismatch in this country between the demand for health care and the supply of health care professionals is likely to become worse over the next 20 years.

Within Australia, the shortages and the effects of maldistribution are worst in rural and remote areas. This exacerbates the situation in which people in rural and remote areas already have worse health than their metropolitan cousins. Solving the under-supply of health professionals and attaining a better distribution of those in practice are therefore critical challenges for rural and remote people. It is also something that will contribute to workforce participation and national economic productivity.

On one side of the equation, the demand for health care is increasing with population ageing, technological advances, greater understanding and increased capacity to pay. On the other, the supply of health care through health professionals is constrained by the number of people available to enter the workforce and the competition from other sectors and employers. The shortage of health care will therefore only be met through a combination of moderating demand and increasing supply.

Australia will not be able to meet the demand for care merely by increasing the supply of health care *personnel*. However, with a creative approach to demand and supply, it should be possible to meet the demand for health *care* through a range of actions. For a balanced outcome, increased self-care will have to become part of the equation.

Although there will not be enough of them to meet burgeoning demand, there are currently significant numbers of additional health professionals in training. For people in rural and remote areas, the important thing will be to ensure that sufficient of these new professionals are skilled for and committed to practice in rural and remote areas so that, at any given time in the future, rural and remote areas have their fair share of the nation's health professionals.

Although only 30 per cent of Australians live in rural and remote areas, a 'fair share' of health resources for non-metropolitan areas needs to be slightly greater than 30 per cent given the already poorer health of people in those areas, the greater distances to be covered, the greater complexity of practice and the larger proportion of Indigenous people.

The health of Indigenous people should be the signal indicator for both national and rural health outcomes, given the tragic discrepancy in life expectancy that currently exists. There are particular problems in dealing with Indigenous health care and the measures at paragraphs 51 to 57 would provide a basis for additional support.

The submission begins (paragraphs 1-14) by asserting the continued need for government involvement in 'the market' for health professionals. People in rural and remote areas will be among the greatest losers if demand and supply of health professionals are left entirely to the free market.

The demand for and supply of health care are complex and dynamic phenomena (paragraphs 15-37) and are influenced by factors ranging from individual human attitudes to macro policy issues such as the nature of national health funding.

A more strategic approach to health workforce planning, involving consultation with consumers and professionals and all levels of government, will result in significant national savings. There are very substantial productivity gains to be made in the health sector from better utilisation of personnel, and these gains will to some extent moderate the demand for new entrants to the health professional workforce.

The submission distinguishes the demand for health professionals from the demand for health care. Planning in the health sector should focus on the latter, and should adopt a creative and open approach to how such health care may best be provided. If, as a nation, we focus only on workforce, and do not systematically address other health system factors, we will continue to struggle with health care shortages.

Where the focus is more narrow – ie on the supply of health professionals - there needs to be separate consideration of incentives for recruitment as distinct from retention. Rural and remote areas also need special programs, as has for some time been acknowledged, and the raft of incentive programs in existence, particularly for rural general practice, need to be thoroughly reviewed and evaluated. There are currently insufficient benchmarks that can be used to inform policy makers if and when targets have been met.

Political support for the current health workforce audit should stimulate further debate about scopes of practice, multidisciplinary teams, the relationship between health professionals, and the increasing importance of self-care.

International health professionals continue to be particularly important in country areas (paragraphs 38-43). More needs to be done at a national level to assess, train and support international health professionals. Related to this, Australia should give further consideration to the means by which mutual benefits could be obtained if Australia contributes to the health, education and training of people in the Pacific region.

In the medium term, rural development is the best strategy for both recruitment and retention of professionals to non-metropolitan areas, including health professionals (paragraphs 51-56). One of the general goals of national recruitment and retention initiatives should be to have a greater number of people as enthusiastic about work in rural and regional centres as a small number currently are for the most remote locations.¹ Rural and remote health care jobs need to be enriching and sought-after by people as a desirable career move.

The current shortage of doctors is particularly serious in circumstances where it means people are unable to access a GP. Consideration also needs to be given to the supply of nurses, allied health professionals, dentists and oral therapists, ambulance officers and paramedics, Indigenous Health Workers, pharmacists and health service managers.

In such a large and complex area as health workforce planning, it will not be possible to advance on all fronts simultaneously. In rural and remote areas the priorities for consideration should be the workforce aspects of:

¹ A correspondent writes: "It must be recognised that remote workers, being a small group, may be self-selecting along personality lines. To get a continual stream of people entering the rural workforce, the work environments need to be acceptable to 90% of the health workforce – at present many rural working environments are archaic."

- Indigenous primary health care,
- oral and dental health,
- mental health,
- maternal and child health, and
- care in the aged care sector.

The training and retraining systems for health professionals should be subject to expert scrutiny with a view to some potential redesign.

Chief recommendations

1. The Australian Government must continue to be involved in planning and managing the supply of and demand for health care and health professionals.
2. Public expenditure on health promotion and illness prevention should be seen as an investment in workforce participation and economic productivity, as well as in better health outcomes.
3. Where access to Medicare and the PBS is limited, the Australian Government should continue to provide funding for alternative first-point-of-contact health treatment, and should also work with the States to improve the assistance provided to patients for unavoidable travel to more specialised services.
4. The review of *Healthy Horizons* should be seen as a key step in the development and agreement of a new national rural health plan.
5. Over time, the Australian Government's health workforce programs should lead to greater equivalence of incentives across all health professions.
6. Recent evaluations of the existing rural and remote general practice incentive programs should be made public and augmented by further evaluations as necessary.
7. The Australian Government should work with the States and Territories, the universities and the public and private health sectors to establish a comprehensive and well-supported national undergraduate rural placement system for students in all health disciplines.
8. The Australian Government should use both direct programs for recruitment and retention, as well as changes in the design features of the health system and its funding, to ensure that people in rural and remote areas have access to the range of health care they require.
9. Governments should continue to provide support and incentives to newer models of health care in which clinicians may be salaried and which are characterised by multidisciplinary teamwork.
10. The Australian Government should give its support to further consideration of altered scopes of professional practice in the health workforce, and the ways in which this can be achieved without compromising quality of service or outcomes.

11. The Australian Government should include returns from improved health in its evaluations of the cost-effectiveness of expenditures on infrastructure and regional development.
12. The Australian Government should continue to lead work to improve the systems in place for assessing, supporting and upskilling overseas-trained health professionals working in Australia.
13. The Australian Government should increase the priority it gives to various means by which improvements in Indigenous school retention rates and Indigenous health training can be obtained.
14. The Australian Government needs to give greater attention to the means by which the increased numbers of medical students soon to graduate will be trained for general practice and the specialties, and means by which a greater proportion of their training can include exposure to rural and remote areas and issues.
15. The Australian Government should establish a special support scheme for the staff of rural and remote aged care services.
16. The Australian Government should give early consideration to the means by which sufficient numbers of new dental and oral hygiene graduates can be encouraged to work in rural, regional and remote areas (the NRHA has a detailed proposal on this).
17. The Australian Government should increase the number of scholarships available for rural people to study allied health.
18. The Australian Government should consider various options for increasing both the annual number of nursing graduates and their rate of retention in the health workforce.
19. The Australian Government's planned investment in maternity services will require consideration of the obstetric, procedural and midwifery workforces.
20. The Australian Government should consider the introduction of a HECS reimbursement scheme for health professions whose members are currently in serious undersupply and who choose to work in rural or remote areas.

The need for government involvement

1. Providing adequate workforce in any situation involves two sides of an equation: demand and supply. Where the health professional workforce is concerned, limitations and opportunities apply to both elements. To ensure sufficient health professionals for rural and remote areas, the Australian Government must continue to be involved in planning and managing both supply and demand to achieve a balanced and sustainable outcome that will serve rural people into the future. The alternative - a heavy reliance on the free market system - would result in a serious under-supply in rural and remote areas that would have major health, social and economic consequences for people in those areas and for the nation.

2. This involvement of governments in health workforce planning and management can also be justified by the fact that the health of people in rural and remote areas is a key determinant of national workforce supply and productivity. Health workforce investment is therefore in the national interest as well as in the interest of individuals and communities.
3. Despite the ageing of Australia's population, public expenditure on health promotion and illness prevention will help reduce demand for the services of health professionals. In particular, investing in certain health professionals and certain interventions (for instance those concerned with healthy pregnancies and early childhood) can lessen the demand for health professionals at other stages of the life cycle, and reduce the overall call on public funds for health.
4. There are major savings to be made from increases in workforce efficiency in the health sector. These savings have been estimated to be as high as \$3 billion a year.² This submission suggests a number of ways in which this increased efficiency can be obtained.
5. Health workforce shortages become worse as one moves from metropolitan to remote areas. This trend is evident for all health professions, although nurse to population ratios, while reflecting national shortages, are comparable to non-metropolitan ratios. The significant number of nurses makes national recruitment, retention and re-entry programs for nurses particularly important to rural areas.
6. The key principle of Medicare and the PBS is universality, which underpins their ability to deliver on access, equity, efficiency and simplicity. However, universal access is not a reality for many people in rural and remote areas, given the unavailability of doctors and pharmacists in some places. Where this is the case it is critical that the Australian Government continues to provide funding for alternative first-point-of-contact assessment and treatment services.
7. The explicit national health policy to be developed through the Health and Hospitals Reform Commission should address the workforce challenge and include a national rural health plan. The rural health plan would in part be based on the outcome of the review of the current rural health framework - *Healthy Horizons*.
8. As a general principle, government health workforce programs should be targeted at greater equivalence of recruitment, retention and re-entry incentives across all health professions.
9. The current multiplicity of rural health programs can be confusing, particularly for young professionals considering their career options, and runs the risk of duplication and program shopping, leading to reduced overall effectiveness. There is little published information on the costs and benefits of the programs. Analyses of the programs carried out since 2000 by or for the Government should be made available for consideration by stakeholders and to form the basis of future policy and program development.

² "The Productivity Commission in its 'Potential Benefits of the National Reform Agenda', February 2007, estimates that a 5% improvement in the productivity of health services would deliver resource savings of around \$3B each year. I think this estimate is extremely conservative." - John Menadue, speaking to AHCRA Summit, 31 July 2007. Workforce efficiency is a major contributor to the sector's productivity.

10. The Alliance believes that immediate priority should go to workforce aspects of Indigenous health, oral and dental health, mental health, maternal and child health, and care in the aged sector.
11. Rural students are under-represented in health studies programs apart from medicine (which is supported by a range of scholarship schemes), and there is unmet demand for the scholarships that exist for rural nursing and allied health students. Rural scholarships will increase rural students' representation in health studies programs and help improve workforce supply to rural and remote areas.
12. There is a pressing need for a new national undergraduate rural placement system. It would be heavily reliant on both the university and the clinical service sectors. At present there is much buck-passing between the two, mainly because of concerns about who should pay the students' and mentoring agencies' costs. An injection of additional funds is required.
13. Australia cannot meet its present and future health workforce challenges simply through attempts to train more doctors, nurses and allied health professionals: there will simply not be enough people available to be trained and to fill the positions required. Workforce supply problems are likely to become much worse before they get better. Whereas in 2004 there were about 180,000 new entrants to the workforce, trends already in place will see the working age population grow by just 190,000 for the entire decade of the 2020s – a tenth of the current annual in-take.³
14. This means that there needs to be a clear understanding of the factors determining the demand for and supply of health professionals and their services. Work then needs to aim at both sides of the equation: at reducing demand and increasing supply.

Moderating the demand for health care and health professionals

15. The demand for health professionals is determined largely by the demand for health care. The demand for health care is a complex and dynamic phenomenon. Key determinants include the consumer's educational and employment status, access to information and understanding (ie their expectations), income and assets (ie the ability to buy health care), attitudes and age, as well as by actual (objective) health status.
16. On average, people in rural and remote areas face more health risk factors and have poorer health than people in metropolitan areas. This means that there is more real demand (or 'need') for health care per head of population in rural and remote areas. Therefore people in such areas should have proportionally greater access to health care professionals than people in the major cities, and arguably have an even greater need for investment in infrastructure and staff relating to such things as physical fitness, fresh fruit and vegetables, and occupational health and safety.
17. The demand for health care is also influenced by the structure of the health care system and the role played by specific health professionals in it. If professional scopes of practice change, the demand for GPs, dentists or physiotherapists, for example, will also be

³ ACCESS Economics, 2005

affected.⁴ For some people this raises the possibility of duplication of service, which raises concerns about exactly how multi-disciplinary teams operate.

18. The very structure of healthcare funding significantly influences the demand for health professionals and health professionals of particular types. The demand for particular interventions by particular professionals is stimulated by their listing on the Medicare Benefits Schedule (MBS). The corollary is that recorded (or 'actual') demand for a particular piece of health care is low (and often under-stated) if it is not listed on the MBS.
19. The demand for health professionals in a particular area is influenced by demography (ageing and migration), the incidence of chronic disease, and the availability of technology and institutional care. It should also be influenced by an increasing emphasis on illness prevention, and there will need to be a shift in workforce to that area. In this context, more allied health workers may lead to less demand on GPs.
20. The need for health professionals can be moderated by a greater emphasis on 'managed self-care', including through a range of structured programs. In the likely event that it continues to prove impossible to provide a sufficient health workforce to meet the demand for services, such personal and community investments will become even more vital.
21. There are also some outright anomalies that affect the availability of health care and thus the number of health professionals required, such as the patient's mouth and the diabetic's foot.⁵

Increasing the supply of health care

22. To equalise the demand for and supply of healthcare professionals, governments will also need to work on the supply side of the equation. The supply of health care is determined by the number and distribution of formal and informal care givers.
23. The Alliance prepared a submission (March 2006) for the Council of Australian Governments in which it included best estimates at that time of the additional number of student places and health professionals required in each discipline. That submission is attached.
24. The Australian Government needs to lead work to ensure that the health sector attracts an appropriate proportion of the available supply of new entrants to Australia's workforce. This is made more important by the fact, as argued above, that it will not be possible in the foreseeable future to meet all demands simply through increasing the number of people trained in health professions.
25. To help increase the proportion of new graduates willing and able to work in rural and remote areas, Federal and State Ministers for Health and for Higher Education should

⁴ A discussion of the reasons why physicians' assistants and nurse practitioners, for example, are still rare in Australia is included in the Alliance's submission to the Productivity Commission (attached).

⁵ Although poor oral and dental health is mostly preventable, and affects general health, it was the view of the previous Australian Government that responsibility for the mouth lay with the States and Territories. As far as the diabetic foot is concerned, it may be amputated *in extremis* under Medicare, but can only be treated under Medicare by a podiatrist in a team arrangement under the supervision of a GP and with a strict limit on the number of podiatrist consultations. These oddities could be considered in the context of the review of the MBS.

encourage higher education institutions to affirm special entry requirements for rural students, and include more inter-professional education, rural placements and joint professional placements in undergraduate health curricula. A structured and ongoing professional support/mentoring program would be of particular benefit to professionals practising in isolation (eg the one physiotherapist in a town).

26. There need to be close partnerships between Universities and health care services and employers to ensure that the universities train job-ready professionals.
27. Consideration should be given to increasing the number of salaried health professionals working in rural and remote communities, auspiced by local authorities or other agencies, and with packages that might include guaranteed infrastructure, support and relief. This should be achievable within existing funding parameters, eg through MBS 'cash-out' arrangements. Evidence suggests that a greater number of young health professionals would prefer to operate this way than used to be the case, partly because they are uninterested in commercial business practice and because their indemnity risks can be borne by the employer.⁶
28. In some areas where the traditional labour force models have not worked, there have already been moves towards support for a greater number of salaried health professionals. In many areas, health professionals are employed by government (including local government) or non-government agencies, with the auspice taking some of the responsibility for maintaining the business assets and guaranteeing the clinicians' ability to leave when the time comes.
29. These models include Walk In/Walk Out or Easy Entrance/Gracious Exit schemes. Such initiatives can now be augmented by support from the Rural Medical Infrastructure Fund, whose guidelines are due to be revised. Joint appointments involving the public and/or private health system and the university sector are also increasing in importance and should be further encouraged.
30. Retention in the health workforce would be improved if terms and conditions were better. The Catch 22 situation is that as pressure on existing individuals in the health workforce increases, more are likely to leave. Because of the increased cost of tertiary education for individuals, more and more of them are likely to 'follow the dollar'. This can have an adverse effect on the supply of health professionals to rural and remote areas where numbers of patients and their ability to pay are both limited.
31. Retention strategies will be different from recruitment ones and will include access to affordable and appropriate continuing professional development, housing and locum support, travel allowances, peer support, and attractive working arrangements.
32. The supply of health care will be increased through greater flexibility of scopes of professional practice and changes to the relationships between particular health professionals.
33. The current health workforce audit, and the political support it has, should stimulate further research and debate about the scope of practice of various health professionals and

⁶ Indemnity is a particular issue in more remote areas where there are low patient numbers and therefore minimal opportunities to earn enough to cover costs.

the relationship between those professionals. Some of the services of professionals can (and should) be supplemented by the self-managing activities of individual patients; and some by the services of other professionals. Patient self-care can be encouraged through incentives for managed self-care programs, for instance in chronic disease.

34. In any developments relating to scope of practice there will be the need to protect the safety and quality of services in rural and remote areas. Rural areas will continue to need higher levels of generalist skills and special staff support.
35. Changes to the health funding system, coupled with support from existing professions, can result in major improvements in the supply of health workers. The case of practice nurses, who can effectively extend the reach of GPs, is an illustration of how the number and scope of practice of one group of health professionals impact on the effective supply and the scope of practice of another.
36. As already discussed, health workforce shortages are worst in rural and remote areas. This means that such areas are already seeing adapted work practices and are likely to benefit disproportionately from increased numbers of such professionals as practice nurses, physicians' assistants and nurse practitioners. In their preparation, training and support, as for other professionals, it will always be necessary to accommodate the special practice and lifestyle facets of rural and remote health work.
37. Rural infrastructure is crucial to an increased supply of health care. A procedural service cannot exist and an operating theatre nurse cannot work to their scope of practice unless there is recurrent funding and infrastructure is constantly updated to provide safe and appropriate facilities.

International health professionals

38. International graduates in many professions are now important contributors to the Australian health workforce.
39. There should be a national approach to the training, recruitment and skills assessment of all overseas-trained health professionals, with the Australian Government having overall responsibility. Such an approach would bring about greater flexibility and certainty for those entering the Australian workforce from overseas, and more consistent orientation and support for them as part of their settling into the health system.⁷
40. International medical graduates (IMGs) account for over 25 per cent of the rural GP workforce, and over 50 per cent of rural GPs under 45 years old. There is a fear that the

⁷ One of the Alliance's correspondents writes: "All International Medical Graduates (including GPs) should be required to do 2-3 months in the teaching hospitals, and associated clinics, on arrival. This would quickly help them get to know the local culture in a secure environment, with other young doctors to provide support and advice. They could then work in the country, with a network of people they already know to contact for help. This would require a bank of registrars who have almost finished training, who are, from the Colleges' perspectives, equivalent to the IMG. They would cover the 2-3 month gap at the sponsoring rural hospital until the IMG was ready to come to the rural town. If no IMGs need a teaching hospital placement, they would stay home and work at the parent hospital. This would have the desirable effect of exposing more senior Australian trained registrars to rural practice and rural lifestyles. It would be cost neutral because no net increase in numbers of doctors is involved. It would also ensure that there was pay parity between IMG and local trainees."

Strengthening Medicare program will result in losing rural IMGs to urban Districts of Workforce Shortage. IMGs are an essential part of the rural health workforce but concerns have been expressed about assessment processes, cultural adaptation, the amount of support and assistance provided by governments and the level of training, mentoring and supervision available from experienced rural GPs.

41. Specifically, the government should:
 - introduce a more intensive case-management approach to supporting international medical graduates and their families to help ensure that they are successfully placed in fully equivalent medical practice; and
 - provide support for international medical graduates to collaborate with other members of inter-disciplinary health teams, such as allied health workers, clinical nurses, dentists and practice managers.
42. The Australian Government should either re-commit⁸ to not actively recruiting health professionals from poorer nations (and require the private sector to adhere to the same principle) or build up the system in such a way as will support developing countries, particularly those in its own region.
43. Around half the population of the Pacific Islands is under 20 years of age. Australia could extend and subsidise its programs in Australia to train students from the Pacific and then employ them for a limited period in the Australian public health sector. They would contribute to health care in this country while gaining education, qualifications, professional experience and a first-hand understanding of the functioning of a prosperous democracy. Many of them would send money home to their families which would help improve lifestyle in their home country. There would be a new cohort to the scheme each year and after a certain time in the Australian workforce, each cohort would return to their own countries. They would all take with them qualifications and experience, and the capability of making significant improvements in their own region.

Enhancing the Indigenous health workforce

44. There will be a substantial interrelationship between the Government's Indigenous education agenda and the Indigenous health workforce challenge. For example, it will be difficult to improve school retention rates and educational outcomes for Indigenous people without significant investment in infrastructure, housing, sanitation, food and health.
45. There is a national workforce crisis and yet the capacity and potential of Indigenous young people are still overlooked. They are an untapped resource. Indigenous students should be given some focus on health sciences at the beginning of their high school years

⁸ The Australian Government is a signatory to a Commonwealth Code of Practice, described by the Commonwealth Secretariat in the following terms: "Over the last three decades there has been a steady flow of trained health personnel from developing member countries to more developed countries within and outside the Commonwealth. This has had an adverse effect on the ability of the source countries to meet the health needs of their people. In 2001, Ministers requested the Secretariat to develop Commonwealth Codes of Practice for the International Recruitment of Health Workers. This was done through the activities of an electronic working group of senior officials from several countries. In 2002 they accepted the Code and agreed that work on a Companion Document continue. The Companion Document was tabled at their meeting in May 2003." (Accessed on-line, 20 July 2005, on the website at thecommonwealth.org/templates) An ethical approach to recruitment of health professionals is outlined in *The Melbourne Manifesto*.

to encourage them to consider health subjects. The universities should promote themselves to students in Grade 8 and above.

46. Indigenous representation in the health workforce can be increased, through:
 - improving the quality of early childhood and primary education;
 - incentives for secondary completion and tertiary entrance;
 - encouragement for pursuit of health sciences;
 - scholarships for Indigenous students;
 - reserved health science places for Indigenous students;
 - specific support for them to enhance their prospects of completing; and
 - transparency of outcomes so that universities can be accountable for rates of course completion by Indigenous students.
47. Aboriginal Health Workers play a key role in the provision of health services to Aboriginal and Torres Strait Islanders and additional support is needed to develop and support the profession. There needs to be implementation of standardised competencies, and attention given to workforce shortages, retention strategies and support for members of the profession (eg for registration and professional association issues).⁹
48. There is often a lack of incentives and support for housing for Aboriginal Health Workers, with the result that recruitment to positions is very difficult and retention rates extremely low.
49. Indigenous Health Workers also continue to encounter stigma in workplaces dominated by non-Indigenous staff. This impacts on levels of satisfaction and retention rates for Indigenous workers. This is another argument for increased cultural awareness training for non-Indigenous health workers, perhaps as a core requirement of service industry orientation programs.
50. There needs to be an established career path for Aboriginal Health Workers from VET to higher education, and it should give recognition of prior learning. There should also be a horizontal path that will provide supports and update training (and affirmation) for people who want to continue at the level of career for which they are qualified.

Rural development: a strategic approach to both demand and supply

51. Because it makes rural areas more attractive places in which to live, rural development is the best medium-term program for recruiting and retaining health professionals in country areas. Attractive rural communities and lifestyles will lead to a greater number of spontaneous decisions by individuals (including health professionals) to go to and stay in such areas.
52. Investment in a comprehensive and high quality IT communications system is a pre-requisite for both rural development and providing equitable access to certain health services, such as digital imaging and virtual medical procedures.
53. Given that indirect (or 'distal') determinants of poor health have significant impact in rural areas, improving both educational and health-related infrastructure has the added

⁹ The profession is currently regulated only in the Northern Territory.

advantage of generally improving the health of local residents, thereby reducing the demand for health professionals. The Australian Government should therefore see rural and regional development as an investment in improved health and economic productivity.

54. Parts of the infrastructure that supports business and community life in Australia are in need of major investment. An ‘infrastructure report card’ approach suggests that there is insufficient national investment, particularly in rail, water management, local roads and stormwater systems.^{10,11} To these can be added information technology, public housing, public transport and new energy systems. The availability of high quality infrastructure improves the distribution and productivity of workers in all sectors, and governments should see expenditure on such infrastructure as an investment, not a cost.
55. The political will for major investments in rural and regional development depends in part on there being a shared vision about what rural and remote parts of Australia should look like in twenty-five years’ time. The Australian Government should work collaboratively with the public towards such a shared vision. The vision would then need to be supported by national policies on population, settlement and access to services.
56. For these reasons a ‘whole of governments’ approach is necessary for effective rural development, which is of vital interest to people in the health sector, as well as to country people themselves.

Issues for specific sectors and professions

Rural general practice

57. In Australia the GP is at the heart of primary care and will normally be the key member of the multidisciplinary health care team. There should be further work to evaluate and, as appropriate, consolidate the various rural and remote general practice incentive programs. Following this there needs to be further work to adapt and adopt the effective ones as models for use in nursing, allied health, paramedicine, dentistry and other professions.
58. The further evaluation of programs for rural general practice will give attention to anomalies that arise as a result of unintended friction between the initiatives of various government agencies. For example, the NSW medical cadetships scheme is likely to have greater difficulty in increasing the supply of doctors to the State’s Base Hospitals because of the Australian Government’s HECS reimbursement scheme, which provides an alternative means by which young doctors can defray the cost of their education.
59. It has been predicted that the number of domestic graduates from Australian medical schools will increase by 81 per cent by 2012. Medical workforce planning will need to manage the flow-on effects of this significant increase in medical student numbers. Initially, this will involve balancing undergraduate student numbers with adequate training places. It will also involve strategies to ensure that there are sufficient numbers of clinical teachers, that allocation of teaching time and access to patients is adequate, and that

¹⁰ See the 2001 Australian Infrastructure Report Card, at <http://www.infrastructurereportcard.org.au/>

¹¹ One for Victoria asserts that “As of 2005, some sections of Victoria’s infrastructure have become deficient. Those of particular concern have been identified as roads, rail, ports, irrigation, stormwater, electricity and gas.” See www.InfrastructureReportCard.org.au

necessary infrastructure to accommodate increased numbers of trainees and doctors is in place.

60. Medical workforce planning will also need to involve strategies to influence the career choices of doctors so that population health requirements are reflected in the composition of the future medical workforce.

Aged care

61. There is an acute shortage of staff in the aged care sector, particularly in rural and remote areas, and governments do not allow for the higher costs of providing aged care services in rural and remote areas. The Viability Supplement has been extended to community (cf institutional) aged care services in rural and regional areas, but many facilities in more remote areas still find it very difficult to be economically sustainable and to attract staff.
62. The government should establish a staff support scheme for rural and remote aged care services, to include support for e-learning and other forms of distance education and give access to training for staff, support the recruitment and induction of skilled staff, and provide staff and family benefits. Many registered and enrolled nurses have been replaced by unlicensed health care workers.
63. Governments should also consider how to overcome the impact of the pay differential for nurses between the aged care and acute care sectors, which has a significant impact on the number of nurses willing to work in aged care. Nurses in aged care in some jurisdictions currently earn around 30 per cent less (which equates to \$20,000 per annum or \$250 per week) than their colleagues in the acute sector.¹²

Mental health services

64. Poor mental health continues to be a serious challenge in Australia and, where mental health services are concerned, rural and remote people have special needs. A substantial part of the Australian Government's new allocation to mental health is being provided through new Medicare item numbers for GPs and psychologists. There is the worrying possibility that the new item numbers may attract mental health professionals from the public to the private sector, and (potentially) from rural and remote centres to regional and metropolitan centres where the market for their services is more aggregated.
65. The workforce audit should analyse the data on the distribution of current Medicare expenditure and recommend specific measures for rural and remote areas as appropriate.
66. Promoting direct entry mental health nursing programs (similar to direct entry training for midwives) would be one way to increase the mental health workforce.

The oral and dental health workforce

67. People in rural areas suffer poor oral and dental health, yet there is a very serious shortage of dentists in rural areas. There are 55 dentists per 100 000 people in the major cities compared with 17 per 100 000 in western New South Wales and even less in remote Queensland. In parts of Victoria people have to wait up to four years for public dental treatment.

¹² Australian Nursing Federation, Nurses Paycheck, December 2007-February 2008, Volume 7, Number one.

68. The commitments of the government to making public dental health services available to eligible patients will be of major importance.
69. The distribution of dentists and allied oral health professionals in rural and regional areas should be assisted in the medium term through the new dental schools at Charles Sturt and James Cook Universities and by the growth in undergraduate places elsewhere. Nonetheless, a system of incentives or managed practice rights will be essential to ensure that sufficient numbers of the new graduates practise in rural, regional and remote areas.
70. There is a multitude of challenges to be overcome to have some of the private dental/oral health workforce move from the wealthier parts of major cities into regional private practices, let alone rural and remote public dental services. More rural students in dental and oral health courses, excellent rural/remote undergraduate placement experiences, significant rural incentives for new and experienced graduates, vital rural communities and well-resourced health services are all essential elements of what needs to be in place.
71. The Alliance reiterates its call for undergraduate scholarships for students from rural and remote areas to study dentistry, oral therapy and oral hygiene; for professional and infrastructural resources in rural and remote areas to enable all dental schools to promote and support undergraduate training opportunities and new graduate placements; and for relocation incentives for city dentists and allied oral health professionals to live and work in rural areas.

Allied health

72. There are still major gaps in data relating to allied health professions and the need for their services. A benchmarking approach (ie checking on ratios of numbers of staff to patients) would help highlight the shortages, especially when account is taken of the great distances and number of communities single allied health professionals often have to serve. In these circumstances it is seen as grossly inequitable that the incentives available to nursing and medical staff – as well as to teachers – are not available to allied health professionals.
73. Despite data issues, it is clear that there is a serious continuing shortage of allied health services in country areas. The Australian Government should make further efforts to encourage rural people to study allied health disciplines, and State and Territory governments should increase the priority given to allied health positions in non-metropolitan areas.
74. Specifically, there is the need for an increase in the number of scholarships for rural people to study allied health.

Rural specialists

75. Although specialists are thin on the ground in rural areas, they play a critical role both in making it possible for rural people to avoid going to capital cities for treatment, and in teaching the next generation of students (eg through the University Departments of Rural Health).
76. The limited amount of data available indicates that the distribution of health specialists is becoming worse. In Victoria, 50 per cent of paediatricians in rural areas will have retired in five years.

The role of hospitals in workforce supply and distribution

77. Hospitals are key players in the health workforce system. They are not only places for the delivery of health care. They provide both the practice and industrial location for many people in the health workforce and the bulk of the training for a number of health professions.
78. Hospitals should be encouraged, including through the new Australian Health Care Agreements, to play a leading role in the development of multidisciplinary teams and pioneering new scopes of practice.

Nursing

79. The nursing workforce is the largest single part of the health workforce, including in rural and remote areas. The shortage of nurses in rural and remote Australia is very serious. At any given moment, a significant proportion of those trained as nurses within Australia are not in the nursing workforce. This attests to relatively poor rates of pay in nursing, the difficulties and conditions of the work, and perhaps a perceived low esteem of the profession.
80. There are still too few nurses to meet the future health needs of the Australian community. It has been estimated that an extra 3000 nursing undergraduate places need to be funded initially to address this shortfall, and the ANF is now calling for an additional 1000 places a year.
81. In addition to increasing the actual numbers of trained nurses, strategies need to be implemented to make nursing a more attractive career by removing some of the disincentives and improving pay and working conditions.
82. Work should be done with the States and Northern Territory to provide nurses in rural and remote areas with access to reliable information technology, and training and support for its use.

Health service managers

83. Some rural and remote health services have very limited management capacity and there need to be enhanced opportunities for management training. There are reports that many rural health clinicians move into management positions without any preparation and have to 'muddle through' – even though a manager's incompetence can be more dangerous than a clinician's. One of the other consequences is that the clinician workforce - often nurses - is depleted.
84. Improving the preparation of and support for health service managers is particularly important in relation to Aboriginal health staff. The joint ACHSE/Aboriginal Health and Medical Research Council of NSW management training program has been discontinued due to lack of ongoing funds, and at a national level it has been difficult to get agreement from the States to fund a national initiative in this important area.
85. The position of health service manager in rural and remote areas should be recognised as a specialist area of management and should be an attractive position with good career opportunities. Employers of health service managers, including governments, should

resource the positions appropriately, and managers in rural areas should be remunerated on a competitive basis with those in metropolitan health services.

86. Opportunities should be provided for career health managers to experience rural aspects of health management and a general rural orientation. Health systems should recognise the importance of providing career progression opportunities and good access to professional development for managers in country areas.

Ambulance officers and paramedics

87. The ambulance paramedical sector - particularly in rural, regional and remote areas - has been playing a leading role in the safe and supported expansion of scopes of practice.
88. The sector has had long-term recruitment and retention problems but, despite this, new flexible workforce roles have emerged to meet the needs of communities in rural and remote areas. With hospital emergency department resources becoming stretched and with the limited number of medical practitioners who can attend to patients outside their surgeries, paramedics are becoming first line primary health care providers, particularly in small rural communities.
89. This integration of publicly-funded clinical care by ambulance services and other local professionals has further potential to enhance services in rural and remote areas.

Maternal and child health professionals

90. Workforce planning should, as a matter of priority, seek to better meet the needs of mothers and babies in rural and remote areas. This is not only a social justice issue but one of the best possible investments in the future health of Australia. The challenge is for Australia to develop world's best-practice programs for supporting pregnant women and their babies in the first few years of life.
91. There is a shortage of appropriately qualified health professionals in rural and remote areas for maternity services. The loss of local maternity services shifts significant risk away from health services and onto families. There is an increased chance of birth occurring outside the appropriate care setting, a higher risk of associated complications, and greater costs in time and money to be borne by mother and family. These immediate costs are incurred through increased travel and accommodation away from home, with concomitant family dislocation.

The workforce and the evidence base

92. As discussed above, many parts of the rural and remote health workforce puzzle are not yet informed by a good evidence base. A small additional investment in targeted rural and remote health research would yield substantial benefits through greater certainty about health service program effectiveness, labour force gaps and duplication, and specific workforce incentives.
93. Improved research infrastructure and quarantined funding for rural and remote health research would not only help improve the evidence base and the research effort, but would also help support the recruitment and retention of clinicians to rural and remote Australia. It would allow clinicians to maintain and develop their research skills and interests while working in rural and remote areas.

Redesigning training systems

94. The best future for rural and remote health services will see a greater emphasis on multi-disciplinary teams, with individuals from a variety of health disciplines working together. This has important implications for how health professionals are educated and trained, and for the infrastructure that needs to be provided for their work. The variety of successful service arrangements already in place in rural and remote areas provides some evidence of how workforce reform should proceed in Australia and should encourage further developments in interprofessional education and professional development.
95. Any program designed to increase the exposure of health students to rural and/or remote areas will impact on communities, mentors, teachers in the field, as well as on students themselves. When added to the significantly increased numbers of medical students already required to have rural exposure, this will mean a substantial challenge for the existing clinicians and institutions who will undertake the mentoring and support. This challenge must be provided for and supported as part of the rural health workforce plan.
96. Governments should work with the universities and health professions to establish a national system of quality rural placements for health science students. Part of this would be enhancement of the network of University Departments of Rural Health (UDRHs), through the establishment of new and the augmentation of some existing UDRHs, to service regions that currently have no connection with a UDRH.
97. New and existing UDRHs should all have a strong multi-professional focus across their education and training programs, including where possible the promotion of joint placements of medical, nursing, dental and allied health students.
98. There should be an increase in the number of joint academic/clinical health positions in rural and remote areas, providing support to health science students, new graduates and local practitioners.
99. Consideration should be given to the introduction of a HECS reimbursement scheme for nurses, dentists, oral therapists and hygienists, allied health professionals and others who choose to practise in rural and remote areas.
100. The current system for training medical specialists should be scrutinised to determine what improvements are possible. The apprenticeship model tends to favour urban settings, where the majority of staff and institutions are located.