MONASH University

Office of Research
School of Rural Health

10 November, 2005

Health Workforce Study
Productivity Commission
P O Box 80
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Dear Sir/Madam

This is a follow-up to my submission to the Productivity Commission Medical Workforce Review.

Thank you for the opportunity to comment on the Productivity Commission Position Paper *Australia's Health Workforce*. This document provides a comprehensive synthesis of submissions relating to the health workforce and builds upon the extensive expertise and existing knowledge of the key issues. While I have not had as long as I would like to read and assimilate the contents of this Position Paper, I do wish to follow up on my original submission and comment on just a few aspects relevant to the workforce situation in rural and remote communities before the closing date.

I welcome and endorse the value of several aspects of this report, particularly:

- the consideration of all aspects of health workforce training across an articulated continuum and the inter-relationships between education and training of health workers from different discipline areas. There is no doubt that inter-professional education provides an excellent paradigm for appropriate training of health workers required to undertake much of the health care activity characteristics of rural and remote communities;
- the proposal that frameworks make explicit provision for specific consideration of rural and remote requirements and issues. There is now sufficient evidence to indicate that rural and remote communities do have their own specific and idiosyncratic characteristics that impact upon the provision of health care, the needs of health professionals, and health outcomes for residents of these communities; and
- the importance of, and need for, evaluating the impacts and outcomes of specific rural education, training and incentives programs.

The real issue for attracting health professionals to rural areas is whether there are adequate incentives for rural practice.

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First, it is clear that remuneration in relation to the nature of work conducted is a key factor affecting take up of rural practice. In the case of general practice, both the Relative Values Study and the Viable Models project highlighted the need to remunerate according to the nature and complexity of activity undertaken. In relation to block funding, I would caution against pursuing the competitive tendering process in rural areas, given evidence of its impact in Victoria during the Kennett years – "it would seem that a number of what were once generally regarded as essential building blocks for quality – service integration, strong nexus between service planning and delivery, highly-motivated and well-trained staff, philosophy of public service and communal benefit, and active consumer participation – are in the process of being discarded or marginalised" (Ernst J, Glanville L & Murfitt P, 1998: Issues in the implementation of compulsory competitive tendering in local government in Victoria. *Urban Futures*, 24: 1-6.)

Secondly, professional satisfaction is of paramount importance. The attraction of rural practice has lessened given diminishing attraction of procedural activity (as today's graduates feel inadequately prepared and less supported in this role), excessive on-call and after-hours care, lack of locums, inadequate remuneration, fear of limiting one's career path, and indemnity issues. Many of these issues can be addressed more easily than others.

Thirdly, increasingly important among considerations relating to where to practice for all health professionals are non-professional factors relating to spouse and family, lifestyle aspirations and cultural considerations. In order to fulfill these considerations, health professionals make their decisions on their perceptions of the ability of places to fulfill their needs – for commercial, family, educational, social and cultural, recreational satisfaction etc. For many prospective graduates, it is in regard to this set of considerations that there is even less incentive to go rural now.

This is the main point that I wish to highlight. In my original submission I stressed the importance of community and regional development issues as they impact on choice of where to take up practice or career. Unfortunately I feel that the significance of this has not been appreciated – on the contrary, it has been dismissed by the statement that this is "well beyond the remit of this study" (p.183). Such a response ignores a vitally important component of the solution to workforce recruitment and retention, and reflects a largely metro-centric perspective that does not sufficiently appreciate what it is like to live and work in rural and remote communities.

The rural and remote context is an integral part of the framework within which the Productivity Commission is seeking to develop specific incentives associated with increasing recruitment to rural and remote areas. The reality is that many of the factors that affect recruitment relate not to the training programs but to the attractiveness and context of rural places and the extent to which practitioners can obtain personal and professional satisfaction from working there. Supply is only one aspect of workforce shortage and does not guarantee recruitment to non-metropolitan areas. Neither does indenturing people to work in areas that they would otherwise not choose, as history shows in relationship to teachers. Therefore it is vitally important to consider the context in which health professionals graduate, something that is missing from Figure 6 in the report.

In relation to education and training, while I think that devolved training (such as through the Regional Clinical Schools and University Departments of Rural Health) may provide students with excellent first-hand clinical exposure during undergraduate training programs and assist in providing support and retention of practitioners, nonetheless, in the absence of any evidence I

remain unconvinced that by itself it will increase the attractiveness of rural practice and thereby facilitate better recruitment.

A collective response from all government departments is required to address the need to increase the attractiveness of taking up and remaining in practice in many rural and regional communities, for both practitioner and families, together with adequate infrastructure and community resourcing. Alternatively, in the absence of such a holistic approach to solving the problem of rural workforce supply, positions need to be extremely well-remunerated to compensate for limited local services and resources (for example, the Western Australia Country Health service north west medical practitioner agreement) such that health professionals rotate in and out of communities after a period of time.

In conclusion, the response to your brief will fall short if it only considers professional issues without 'place' issues. The need to ensure adequate remuneration in relation to the nature and complexity of activities undertaken, professional and personal satisfaction (including procedural activity, on-call, lifestyle etc) is not in doubt. However, the value of incentives and reforms impinging upon these specific issues will not achieve the end-goal (namely the adequate recruitment and retention of appropriately trained health professionals) unless they are accompanied by integrated programs addressing issues relating to community development. The community issues that currently create disincentives and barriers to the adequate recruitment and retention of an appropriately trained medical workforce in rural and remote workforce are important for all professionals.

Yours sincerely

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