Sustainable workforce and sustainable health systems for rural and remote Australia

Summary

- Adequate health workforce alone will not ensure optimal health service access.
- We consider what an effective and sustainable health system for rural and remote Australia might look like in 2025, briefly describe some of the barriers to achieving this vision and propose how these challenges may be overcome.
- More radical change is required on at least four fronts:
  - changing the prevailing ethos about rural and remote health;
  - addressing persistent gaps in workforce education and training;
  - delivery of comprehensive service models; and
  - accountability.

Lack of access to quality health care providers is one of the primary root causes of health inequity and is disproportionately experienced by people living in remote and rural communities.[1]

Recruiting and retaining an appropriately skilled health workforce in sufficient numbers is a central plank of rural health policies and programs globally. Currently in Australia, there is tension between national health workforce policy initiatives designed to address the rural workforce problem and several broader countervailing demographic, socioeconomic and political forces. National policies, on the one hand, offer various incentives to take up practice in rural and remote areas; have increased numbers of training places for doctors, nurses and allied health professionals; have provided rural student scholarships; have restrictive elements that account for the high proportion of international medical graduates in rural Australia; and have fostered the development of regional academic infrastructure designed to provide students with rural and remote-based training.[2] On the other hand, these initiatives are occurring against continued rural population decline, industry contraction (mining excepted), small town settlement demise, service rationalisation, and the ageing of both the rural and remote population and the health workforce.[3,4]

The evidence for whether current workforce positive initiatives are overcoming the health workforce maldistribution in Australia is inconclusive.[5] While trends show increasing numbers of doctors across both metropolitan and rural areas[6] and increasing numbers of nurses in all but very remote areas,[7] the changing aspirations and work patterns of recent graduates explain why the number of effective full-time workers does not show a commensurate increase.[8] In addition, changes in demography will result in shrinkage of the entire workforce and markedly lower rates of overall workforce entry.[4] It is too early to tell whether the significant increase in medical student numbers will result in increased numbers of doctors in rural and remote regions.

The current workforce shortage in remote and rural areas is reflected in and exacerbated by the significant disparity in health resource distribution between metropolitan and rural Australia. Available per capita expenditure data for both primary and secondary care utilisation amount to an estimated shortfall in excess of $2 billion.[5,9] Moreover, many small rural communities have experienced ongoing problems with maintaining health staff and hospital services, such as local birthing services.[10] This demise of local procedural services reflects not just population loss and ageing, but also the continued rationalisation of these services in regional centres as health authorities continue to be guided by fiscal policies rather than by those aimed at maximising the health and wellbeing of the population.[3]

At the same time, health status is, on the whole, worse in non-metropolitan Australia. For example, life expectancy decreases with increasing remoteness; it is 1–2 years and up to 7 years lower in regional and remote areas, respectively, compared with major cities. While much of this gap is due to the higher proportion of Aboriginal and Torres Strait Islander people in rural areas, the probability of non-Indigenous Australian men and women living to 65 years is 2%–3% and 1% lower in regional and remote areas, respectively, compared with major cities.[11] Thus rural and remote populations have the highest health needs while experiencing the poorest access to health and community services.

Where should we be in 2025?

To ensure equity in health outcomes, we need to provide accessible, appropriate, affordable health services, regardless of geography. A focus on health workforce issues alone will not achieve optimal health outcomes for all Australians. We envision a health system that privileges primary health care and disease prevention; that ensures coordinated care; and that employs a variety of service delivery models appropriate to context, each addressing an evidence-based set of essential service requirements.

In pursuing a national health reform agenda, the current Australian government has made explicit an appealing picture of what health services should be available in the future. There will be a greater emphasis on primary health care (PHC) and disease prevention, with a focus on chronic disease prevention and coordinated care for those with (expensive) chronic diseases to ensure effective secondary prevention. The new National Primary Health Care Strategy, the increased focus on prevention with the establishment of a National Preventive Health Agency, and many of the current health care reform initiatives

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reflect the planned, patient-centred, integrated, comprehensive PHC services, well coordinated with secondary and tertiary services, to which we should aspire.

Sustainable PHC services are likely to bring about the biggest improvement in health outcomes in rural and remote areas because they address outstanding issues in the broader environment that affect morbidity and mortality patterns in these areas,[12,13] they will improve patient access through the complex maze of the current health system and improved early intervention will minimise the need for expensive secondary care.[14,15]

Arguably, different models of service delivery and workforce configuration will be required to meet the different rural and remote contexts. These will range from traditional fixed services, to "hub-and-spoke" models, visiting services, and telehealth and telemedicine.[16] Regardless of the model, however, all services will need to be underpinned by a number of essential requirements — including adequate funding through an appropriate financing mechanism; sufficient number and mix of health professionals; adequate infrastructure, both physical and information and communication technology; strong internal and external linkages; high-quality management, governance and leadership; and rigorous performance evaluation.[17]

What are the challenges in getting there?

Many effective, sustainable rural and remote PHC models exist, together with evidence they can improve health outcomes and sustain an appropriate health workforce.[18] There is also evidence of how health policies and programs affect rural populations.[19] If we know what works and what does not, why are there continued barriers to achieving accessible, sustainable, integrated, comprehensive and adequately staffed health services in the bush?

One critical challenge is the predominant "deficit" view of working in the bush.[20,21] For too long, the media have focused on the negative views of rural and remote life. This view is often perpetuated by professional bodies and researchers advocating for "a better deal for the bush", and has ultimately made the problem of workforce recruitment more difficult.

Although health workforce reform remains integral to the provision of adequate and appropriate care in rural and remote areas, workforce problems need to be addressed in the context of other essential service requirements. The challenge of developing comprehensive teams of health workers and generalist programs of training across the nation[22] is embedded in the need to develop a rational macro policy environment; to provide adequate funding; to ensure strong management, governance and leadership; and to support strong community participation in PHC and Local Hospital Network governance. Our research has highlighted the importance of genuine community participation, which takes different forms in different contexts, in the provision of effective sustainable primary health services for rural and remote communities.[18]

Getting the policy settings right is necessary in order to, inter alia, attain greater clarity in federal–state accountabilities in the current reforms. Unfortunately, strong leadership for rural health care from politicians has often been lacking. Appropriate policy is also linked to ensuring adequate funding based on need and, importantly, the capacity to generalise successful models. We have previously described cases of successful Aboriginal community-controlled multipurpose services, hub-and-spoke visiting allied health services and discrete general practitioner-led primary care services.[18] With some exceptions, such as multipurpose services, Australian governments have displayed difficulty in generalising effective models and pilot programs into coordinated, national programs. Part of the reason for this has been the lack of consistent, reliable data from systematic, rigorous measurement of outputs and health outcomes as they relate to inputs. Rigorous health service evaluation can both contribute to health service quality improvement and inform evidence-based policy and practice.[16,23,24] Governments also need to move away from the dominant silo mentality to a genuinely whole-of-government approach in order to meet the health needs of rural and remote communities and address the underlying social and economic determinants of health.

How will we overcome these workforce impediments?

Even with strategic policies to guide rural and remote programs, their implementation remains notoriously slow in Australia.[25] Indeed, incrementalism remains the norm. More radical change is required on at least four fronts.

Changing the prevailing ethos about rural and remote health

We need to provide a "realistic job preview" for the potential rural and remote health workforce that better describes both the challenges and positive attributes of living and working in the bush. There is ample lived experience and documented evidence about the joy of rural living[20] and about increased job satisfaction and work engagement.[26,27] We need to build on these strengths and not focus solely on the challenges.

Workforce education and training

There is a need to address persistent training gaps for allied health and nursing professionals, both at an undergraduate and postgraduate level, appropriate to context. For international medical graduates, improved and consistent orientation and preparation is needed.[28] There is also scope to explore the benefits of alternative workforce roles, including generalist training and providers such as physician assistants and nurse practitioners.[29] Initiatives such as full-year rural generalist internships are needed to expand and strengthen rural medical generalist training. These initiatives can all build on existing rural and remote academic infrastructure. Many of the pieces of the education and training puzzle are in place — Rural Clinical Schools, university departments of rural health, the RAMUS (Rural Australia Medical Undergraduate Scholarship) scheme, and so on. There is evidence of the effectiveness of increasing rural exposure and training in rural environments for medical students[30]

and other disciplines.[31,32] These programs need to be better integrated and expanded to improve geographical coverage and to enhance involvement of non-medical disciplines with a view to creating team-ready graduates.

Comprehensive service models

Addressing workforce in isolation from other essential service requirements is not effective. A systemic approach that ensures adequate funding, infrastructure, effective management and governance, community participation, and professional development opportunities has been shown to minimise recruitment problems and result in workforce stabilisation. Rural and remote health services have always been incubators of health service innovation (Royal Flying Doctor Service, telehealth, multipurpose services, "cashing-out" to compensate for lack of Medicare income in areas with few doctors, de facto "academic health science systems" with close collaboration between researchers and health services, etc). At the same time, information and communication technology infrastructure in many locations is not adequate for current education and service delivery needs. It is hoped that the rollout of the National Broadband Network, and associated telehealth initiatives introduced in July 2011, will enhance service access. At the same time, this must not be viewed as a panacea to workforce recruitment problems, but rather as an adjunct to support effective teams on the ground.

Accountability

Evaluation of health services will be enhanced through agreed indicators and benchmarks for health inputs and outputs. The availability of reliable national health and workforce data and improved monitoring and evaluation will provide essential information to policymakers, practitioners and health consumers about the impact of current and future investments. While there are existing mechanisms of accountability to some communities, for example the election of community boards of Aboriginal community-controlled health services, with this additional information all communities will know what type and level of services they can expect in a given location. Improved monitoring and evaluation will provide evidence about program effectiveness and value. An improved measure of access will also assist with equitable resource allocation and help to determine the effectiveness of health service development.

Conclusion

While recognising the unique characteristics that distinguish urban, rural and remote Australia, we need to be more cautious about the "city versus country" division, which appears to have been exacerbated by recent national political tensions over balance of power. We also recognise the realities of political power and the struggle over limited resources. Nonetheless, metropolitan and rural Australia remain closely interdependent. Ideally, a bipartisan acceptance that the national health of the population and economy is a function of thriving cities, country towns and remote settlements may lead to a more sustainable economic base for non-metropolitan communities.

The vision of an effective and accessible rural and remote health system is attainable and a number of policy settings are in place. Rural and remote health workforce difficulties are not insurmountable. They can be overcome by changing the way we view and talk about rural and remote areas. These are places of challenge and opportunity. The challenges of fewer health resources, greater sickness and obtaining access to a range of services are undeniable. However, the rewards of rural and remote practice can be great and the opportunity to effect change in small rural communities can be enormous. The potential for fostering innovative service approaches, the possibility of solving problems at both individual and community levels and the amenity of a rural lifestyle are all positive aspects that attract and retain health workers. Evidence indicates that professional satisfaction with rural and remote practice is at least as high as in metropolitan areas.[27] We need to dispel the notion that take-up of rural and remote practice is a "sentence for life"! It has been the most rewarding and formative stage of a lifelong career in health for many doctors, nurses and allied health professionals.

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