Rural Health Workforce Incentives Workshop

Thursday 25 March 2010

Rydges Southbank Hotel, Brisbane

WORKSHOP

NOTES

WORKSHOP PROGRAM

0815 - 0830	**Registration**	
08:30	**Welcome**	Professor Peter Brooks, Australian Health Workforce Institute (AHWI)
8:40	**Introductions** Objectives of the day	Dr Janie Smith, Facilitator
9:10	**What's out there?**	Professor John Humphreys, Monash University Mr Robert Wells, Australian National University Dr Danielle Butler, Australian Primary Health Care Research Institute / Australia National University
10:00	Discussion and Q&A	Dr Janie Smith, Facilitator
10:30 – 11:00	*Morning Tea*	
11:00-11:25	**What's working?** • What are the trade-offs? • What incentives should be provided? • What are the important predictors?	Professor Anthony Scott, The University of Melbourne
11:25-11:45	**What's working on the ground?**	Mr Scott Wagner, Services for Australian Rural and Remote Allied Health (SARRAH)
11:45-12:00		Associate Professor Sabina Knight, Associate Professor Remote Health Practice / Previous Commissioner of the National Health and Hospital Reform Commission
12:00-12:15	**Reality Check' – so what is missing?** • Governance • Partnerships • Operational	Dr Kristine Battye, Kristine Battye Consulting
12:15-12:30	Discussion and Q&A	Dr Janie Smith, Facilitator
12:30 – 13:30	*Lunch*	
13:30 – 15:00	**Panel Discussion** • **Where are the incentives gaps?** • **What research still needs to be done?** • **What opportunities exist?** • **Discussion from the floor**	Group Panel Discussion • Mr Mark Cormack, CEO, Health Workforce Australia (HWA) • Professor Peter Brooks, AHWI • Dr Kristine Battye, Kristine Battye Consulting • Mr Christopher Cliffe, President, CRANA*plus* • Mrs Pattie Hudson, Queensland Health • Professor John Humphreys, Monash University • Mr Scott Wagner, SARRAH • Mr Rodger Coote, GPET
15:00 – 15:30	*Afternoon Tea*	
15:30 – 16:30	**Where to from here? Summary**	Mr Chris Mitchell, CEO, Health Workforce Queensland Dr Janie Smith, Facilitator

INTRODUCTION.

This Rural Health Workforce Incentives Workshop was a result of collaboration between the Australian Health Workforce Institute, Queensland Health, and Health Workforce Queensland.

The workshop provided a forum for researchers, scholars, Colleges, practitioners, consumers, Government and non-government personnel to discuss the incentives which are available across health workforce disciplines and other sectors, nationally and internationally.

Delegates were invited to challenge current thinking and consider new ways to attract and retain the rural workforce by:

- Examining whether the current incentive and support arrangements are working
- Considering other incentive options
- Informing government rural health policy and strategies
- Developing research opportunities
- Expanding collaboration opportunities
- Putting policy into practice by providing an assessment of current and potential initiatives

Workshop notes will be published on the Health Workforce Queensland Website: www.healthworkforce.com.au Notes from some of the speaker presentations will also be available from the site.

WELCOME.

Dr Peter Brooks: CEO - The Australian Health Workforce Institute

During his welcome, Dr Brooks made the following points:

- Health Workforce issues currently feature prominently on the national agenda.
- The health workforce is one of the largest workforces in both Australia and will need to continue to grow to keep pace with increasing needs.
- Provision of services to rural and remote communities will continue to be a major challenge.
- The focus of service delivery will shift to teams rather than individuals; health in general rather than medicine specifically; and the use of technology in service delivery.
- Increased career mobility will mean that health professionals may only spend a portion of their working life in rural and remote areas.

INTRODUCTION & OBJECTIVES.

Delegates were referred to the workshop objectives which had been previously circulated:

To bring together researchers, scholars, colleges, practitioners, consumers, government and non-government personnel to establish:

1. *What incentives exist across health workforces, nationally and internationally?*
2. *What is working well?*
3. *Where are the gaps in rural & remote workforce incentives?*
4. *What more can we do to attract people to rural and remote practice?*
5. *What research still needs to be done?*
6. *Where might research opportunities exist?*
7. *How can we further influence policy and research?*

Representative Groups – Delegates from the following stakeholder groups attended:

- Healthcare consumers
- Researchers and academics
- Medical education and training
- Government and non-Government agencies
- Rural Workforce agencies
- Private consultants

Issues.

During introductions, delegates indicated that they would be looking to address the following issues:

- What is an incentive?
- How do we differentiate between incentives; entitlements; and investments; and what is simply appropriate remuneration for rural and remote services?
- What role do incentives (financial and non-financial) play in securing equitable health care for rural and remote communities?
- What are the disincentives to living and working in remote areas and how can they be removed? This includes any 'perverse disincentives' which may be the unintended consequence of existing incentives programs.
- Which incentives work and which are less effective, particularly in the context of new workforce programs and policy environments? Are financial incentives necessarily the most effective?
  - How can we obtain maximum benefits from incentives?
  - What produces long term outcomes in terms of recruitment and retention?

- How can we recognise the true worth of rural medical service and add value?
- Do coercive mechanisms have a role in securing a rural medical workforce? How do workforce distribution measures (eg bonded scholarships) impact on the rural workforce and how do they relate to other incentives?
- How can we bridge the gap between rhetoric and 'on ground' service delivery?
- What are the best approaches towards the provision of incentives, and the best 'mix' of the various sectors, stakeholders and programs (financial, non-financial, public, private, formal, informal)?
- How can Allied Health and multidisciplinary teams be developed and supported so they can provide an effective continuum of primary care and provide opportunities for professional development and career advancement?
- What are the organisational and management issues associated with cross-agency models which will encourage people from different organisations to work effectively together?
- How can we use incentives to influence decision making, particularly with young people?
- How can we develop networks and support mechanisms which will encourage registrars and trainees to train and work in rural and remote areas? And how can experienced rural consultants and teachers be retained?
- How can we attract people to work in rural and remote mental health, and how can we incentivise the mental health workforce?
- What are the policy enablers for workforce outcomes?
- What will be the impact of increased student numbers on trainers and supervisors and eventually on rural workforce numbers?
- What are the roles of community and Local Government in recruiting and retaining workforce and services?
- Where are the gaps in research and policy development?

Other Comments:

- The current incentive system is an uncoordinated 'bag of lollies'. It has the potential to send messages which undervalue rural service. Many existing measures and policies aren't working, even in areas which are relatively close to urban settings.
- Need for a 'greenfields' approach, ie 'go right back to the drawing board'.
- There are differences between rural and remote communities in terms of needs and the way services are provided.
- We need to look to an integrated, multidisciplinary approach to service delivery.
- Service retention, especially in situations where there is a high staff turnover, must be considered in addition to workforce retention.
- A 'northern network' stretching across the north of WA, NT & Queensland, where there are common issues and environmental factors, is a proposal worth considering.
- There is evidence from Queensland Health that 'case management' of bonded scholarship holders is effective. This provides a career focus and ongoing student and family support.
- Rural and remote communities are diverse and there is no 'one size fits all' solution, but there is potential to learn from areas where systems and services are working well.

WHAT'S OUT THERE?

Mr Robert Wells (Australian National University); Professor John Humphries (Monash University); Dr Danielle Butler (Australian Primary Health Care Research Institute/ ANU

Speakers made the following points during their presentations:

- There are currently over 50 different incentives programs. These are mainly financial, broadly based, and centred around professions rather than community needs. There have been few measures targeted at increasing rural workforce in other health professions.
- It appears that the current policy approach is to continue with incentives programs.
- Medical school intakes have dramatically increased but it should not be assumed that these numbers will flow through to increased rural workforce numbers.
- Some incentives also generate perverse disincentives, eg provider number restrictions increased rural workforce but resulted in an increased reliance on Overseas Trained Doctors.
- Data plays an important role in determining policy, and priority should be given to the collection of accurate and relevant data and providing appropriate access to this information. There are methodologies available for the measurement of equity and access to primary health care.
- Workforce is the key to accessible health care in rural & remote communities. Currently there is an acute workforce shortage, but increasing workforce supply without addressing retention issues will not solve the problem. We need to examine the range of factors which influence retention (financial, professional, social, external) and target issues which can be practicably addressed. We also need to secure a sustainable workforce turnover which provides for continuity but also for fresh people and ideas.
- Monitoring retention is crucial and we need a national monitoring system based on agreed retention indicators.
- There are currently 'windows of opportunity' to influence health policy. Fresh approaches and critical analysis are needed.

Questions and Discussion.

(i) Where should investments be made?

Incentives should be reviewed but not necessarily abandoned. There is an opportunity to contribute to the current policy review. Policy should be evidence-based. Suggest that community development would be a useful investment – this would enable and empower communities to determine the most appropriate incentives for their particular circumstances.

(ii) Are there any studies about the possible impact of Gen Y on the rural workforce?

Data isn't available at this stage but it would be possible to gather. It is necessary to continue longitudinal studies, and to lobby for continued funding of student datasets to monitor intentions against actual outcomes.

(iii) There are issues around investing in itinerants as opposed to investing in local community members, who often don't get access to the incentives provided for the itinerant workforce.

Investing in communities and resources is worthwhile. Bonded service might not necessarily be the best recruitment and retention tool and could create resentment.

(iv) ***Is accommodation a key recruitment incentive?***

Local management and flexibility are important in determining what is appropriate for each community. Local health networks which incorporate primary care with hospital network and incorporate local funding flexibility will produce the best outcomes.

WHAT'S WORKING?

Professor Anthony Scott provided an update on the MABEL project and the implications of its initial findings for rural workforce recruitment and retention. The MABEL study aims to develop an understanding of what motivates doctors to work and remain in rural and remote areas.

Mr Scott Wagner (Services for Australian Rural and Remote Allied Health - SARRAH) presented an outline of the role of SARRAH and the issues associated with the recruitment and retention of rural Allied Health professionals.

Questions and Discussion.

(i) Have opportunities for refreshment (somewhere between locum relief and on-call situations) been considered as part of the MABEL study?

Not specifically at this stage, although data can be analysed in a number of ways and this may be possible at a later stage.

(ii) ***Need to look at the influence of family support in recruitment and retention. Anecdotal evidence suggests that family support, educational opportunities and employment prospects for partners play an important role in recruitment and retention, although the MABEL study findings don't reflect this.***

Data will be analysed in more detail in future stages of the project.

(iii) ***Is there evidence that rural doctors share some basic personality traits?***

Backgrounds may also be a contributing factor in recruitment and retention and both of these could be considered in the development of incentive initiatives.

'REALITY CHECK' – SO WHAT IS MISSING?

Dr Kristine Battye

This presentation focussed on governance and the relationship between policy and on-ground implementation, particularly with respect to cross-agency services, using a practical example (the Murdi Paaki Drug and Alcohol Network).

It was noted that incentives facilitate workforce supply but they are only part of the overall recruitment and retention 'picture'. Incentives might not be sufficient to overcome dysfunctional governance and service models.

Questions and Discussion:

(i) What role do opportunities for education and professional development play in retention?

This largely depends on individual needs but it still needs to be part of the retention package. There are cost issues which could impact on the provision of opportunities in this area.

(ii) We often struggle with the complexities of cross agency arrangements. There is a danger that local management may simply add another layer of complexity. How are we going to achieve consistency with respect to incentives, governance and professional support?

There are moves towards cross agency arrangements but governance will be a challenge. Also need 'teeth' to ensure appropriate mechanisms are put in place.

(iii) Focus is currently on hospitals but where are we going with respect to primary health care?

The proposed primary health care agencies play a very important role in service planning, but this will take time.

Other comments:

- Making people feel valued is an essential retention strategy
- Dealing with multiple agencies can be frustrating. Currently there are multiple agencies operating in parallel, and they don't appear to communicate with each other. A common agency would reduce duplication and inefficiency and provide the flexibility to provide appropriate incentives for difference communities.
- A single organisation can initiate and sustain change and provide continuity of care, clinical support and complex case management. Both overarching funding mechanisms and the organisation of service provision need to be considered.
- We need senior allied health people working in rural and remote areas and they may need the option of a fly in, fly out model to retain them in the rural workforce.

ADDITIONAL PRESENTATIONS.

NHHRC REPORT.

Associate Professor Sabina Knight

- The consultation phase revealed a lack of evidence about what works in terms of workforce incentives. Priority should be given to developing a broad, community-focussed evidence base which can be used to inform policy.
- One of the most significant aspects of the Federal Government's recent reform announcements is its intention to take responsibility for primary health care policy and funding. This will require a relatively long and possibly complex, transition period. The NHHRC recommended a primary care enrolment system for patients with chronic and complex disease including mental health and children with young families which could facilitate health care planning as well as primary health care organisations.
- There have been questions around how the Government will fund critical facilities such as small rural hospitals as they do not suit activity based funding.
- NHHRC report made a number of higher order workforce recommendations, including:
  - Preferential allocation of new training places in rural and remote areas
  - Preferential access to specialty training and then supporting these professionals to return to work in rural and remote areas if they so choose
  - Funding for clinical training and research (this will be necessary to cater for increased student numbers) and a dedicated remote and rural research fund
  - Infrastructure to support increased training requirements
- There is a window of opportunity to instigate meaningful change, but stakeholders need to be well informed and organised to maximise this opportunity.

Questions and Discussion.

(i) Is there a danger that professional turf wars will have a detrimental impact on the quality of the debate?

There is the potential for this to happen. There is also the danger that core messages will be obscured by petty point scoring.

(ii) How can the gap between evidence based policy and on-ground reality be bridged?

The NHHRC was reluctant to make specific workforce recommendations because of lack of evidence. We need to be much more sophisticated when we are presenting data and much less focussed on craft group anecdotes in our advocacy and lobbying. Unfortunately, many of the positive strategies may not be recognised because of 'shroud waving'.

(iii) Comment that lobby groups find it hard to get attention without 'shroud waving'.

Organisations need to be clear and transparent about what is needed, what they would like to achieve, and how to achieve it.

(iv) What is working on-ground in recruiting and retaining nurses?

Support for appropriate training to transition to remote practice. Critical factors also include responsive management and opportunities for refreshment. Being professionally valued and engaged, particularly at the policy and procedural level, is very important. Retention - If one team member leaves or is away, there is significant additional pressure on other team members. Connection to community is also a strong factor. Expectations are changing and there is a move to shorter term contracts, which may be unhelpful. Some factors cannot be controlled, eg family issues.

(v) The shift to university training courses for professions such as nursing has resulted in a shift from regions to cities. We need to re-invigorate rural and regional training facilities.

We also need to use the evidence that people who train in an area, stay in the area and translate this into incentives and policy.

HEALTH WORKFORCE AUSTRALIA.

Mr Mark Cormack, CEO

Health Workforce Australia is a newly-established Commonwealth Statutory Authority. Its principal task is to implement COAG agreements on hospital and health workforce reform.

Focus areas will include:

- Workforce planning, policy and research, using a coordinated approach.
- Consolidation of existing work and facilitating communication between stakeholders.
- Funding of clinical training, not only in the hospital environment, but in other areas, such as primary health care and aged care. This initiative has been driven by the increased student and graduate numbers.
- Overseeing a program of workplace reform, innovation and implementation, in recognition of the fact that traditional roles and work boundaries are in transition.
- International recruitment, which is not well defined at this stage, but will focus on achieving a better coordinated, integrated and more efficient recruitment strategy.

WORKSHOP SUMMARY and PANEL DISCUSSION.

Panel Members:

Mr Mark Cormack, *CEO, Health Workforce Australia*
Professor Peter Brooks, *AHWI*
Dr Kristine Battye, *Kristine Battye Consulting*
Mr Christopher Cliffe, *President, CRANAplus*
Ms Pattie Hudson, *Queensland Health*
Professor John Humphreys, *Monash University*
Mr Scott Wagner*, SARRAH*
Mr Rodger Coote, *GPET*

(i) What do We Know?

- The Australian population is ageing
  - By 2051 those over 65yrs will double
- Increasing burden of chronic disease
- Worse in rural and particularly remote and Indigenous health
- Nine per cent of Australians are already working in the health sector.
- It is the fastest growing employment sector in Australia.
- It is predicted that by 2025, 20 per cent of the Australian workforce will need to be engaged in health-related jobs, to deliver the present level of services.
- Increased demand for health workers
- Places significant pressures on a workforce already under stress

(ii) What Works?

- Responsive management - making people feeling valued; providing support; leadership
- Appropriate staffing levels; retaining experienced staff and succession planning
- Flexible programs which are tailored around community and professional needs
- Providing opportunities for ongoing education and career support
- Working environments (flexible arrangements; orientation; working hours; on-call arrangements; access to locums and opportunities for refreshment)
- Accommodation and vehicles are often more important than financial incentives
- Local Government and Community engagement - empowering communities to participate in decision making with respect to their health care needs, and in welcoming and supporting health care professionals
- Rural Clinical Schools build capacity and provide a sense of community and continuity
- Rural registrar training programs
- Role of Remote Area Nurses in providing primary health care in remote areas
- Return of Service Obligation models may be effective incentive BUT they may also send a message which undervalues/undermines rural health careers
- Engagement of communities. Local Government and industry and initiatives such as MPHS where communities take responsibility for their health care services and in welcoming health care professionals and making them feel valued and part of the community
- Registrar incentives are making a contribution to the training that is occurring to training in rural and remote areas (this has doubled in the past 4-5 years) Contributed partly to incentives and partly to obligation (eg OTDS)

(iii) What Doesn't Work?

- Financial incentives are not necessarily the most effective.
- Some incentives also have associated disincentives.
- Iterant workers are often eligible for incentives not available to the local workforce. We need to 'reward' the existing workforce as well as providing incentives to attract workforce to rural and remote areas.

(iv) Barriers and Gaps

- Lack of policy.
- Lack of evidence about what works – many programs have existed for a number of years yet there is no real evidence as to how effective they are.
- Lack of real data and longitudinal studies to date. We need to develop a base of evidence around the evaluation of incentive programs. This could include the adoption of mapping exercises and data collection and learning from international examples.
- Terminology and the relationship between incentives; entitlements; and appropriate recognition and remuneration for services needs to be clarified.
- Lack of coordination between funding mechanisms, resulting in inefficiencies and duplication
- Industrial relations and human resource management issues.

(v) Challenges

- How to measure the effectiveness of incentive programs.
- Achieving change management at all levels of the system.
- Improving data collection based around unique patient, practitioner, service and setting identifiers.
- Developing service models which will improve levels of care, focus on community needs and create positive workplaces.
- Transferring research into accessible information which can inform policy.
- Achieving effective governance and management structures; cross-agency coordination and communication; service integration and team building.
- Integration of primary and hospital care functions and improving on-ground communication and coordination between the public and private sectors.
- Training – specifically, how to accommodate increased graduate numbers and encourage them to spend time in rural and remote areas; also how to retain experienced preceptors.
- Linking primary care objectives to incentives programs.
- Overcoming the disconnect between policy and on-ground implementation.
- Integrating quality and safety into community control models.

(vi) Other Issues/Considerations

- There is currently a window of opportunity to influence policy in the context of Federal health reforms.
- Incentive programs have the potential to imply that there is an underlying problem. Incentives are often 'band aids' which are used to bolster a dysfunctional situation.
- Remote areas will need different policies and models to rural areas.
- Rural and remote workforce issues are shared by other professions (eg mining, teaching) and we need to learn from the experiences of those professions.

What level of services are we going to be able to afford in the future?

- This is a debate which we need to have. There needs to be a conversation with the community at large regarding what levels of service we want and can afford.
- The discussion must include acknowledgement of basic facts, eg. that 60% of the health care dollar is spent in the last 12 months of life.
- Need to rethink paradigms, such as withdrawing care in appropriate circumstances.
- This is where we need leadership from senior people in the community. Government is not going to lead this debate.
- Disagree - we elect Governments and it is their role to take leadership. This is already done in some ways every year when funding is allocated as part of the budget process.

Is it time to go back to the drawing board? Should we throw everything out and start again?

- This is an option.
- We may need to rethink our priorities and refine targets, as well as identifying disincentives.
- A number of options could be considered, including geographic provider numbers.
- These workforce issues are not confined to the medical field. They are common to all professions which require work in hot, isolated environments. In the Queensland education system for example, there is an incentives transfer system whereby people are rewarded for a term of work in rural/remote areas with preferential transfers.
- The Queensland Rural Bonded Medical Scholarship Scheme has provided some evidence that bonding and the 'stick' approach doesn't work. Greater support and a case management approach have resulted in increased applications for scholarship places and retention of graduate scholars in rural areas.

What is the most important thing that needs to be done?

- Building the capacity of the indigenous health workforce and improving indigenous health.
- Indigenous education and addressing the health problems which impact on education outcomes. Early intervention is necessary.
- Achieving structural change so that incentives are no longer required.
- Providing tangible management and support that is equitable across all sectors.
- Health services that are equitable, appropriate, available and determined by the community.
- Use of technology to deliver information and access care.

WHERE TO FROM HERE?

How do we leverage this workshop to achieve change?

- Need to act now as opportunities and issues are arising rapidly. Broad political directions may have been set, but not the detail, and there is an opportunity to provide input on design and implementation
- Need to ensure that what we ask for is achievable and credible
- Need to maintain a positive approach so that Governments will want to engage
- Adopt a 'whole of workforce' approach and perspective
- Stakeholders/organisations can use the information to inform their advocacy and policy
- Formation of a small Working Party to develop a position paper which includes a set of principles which can then be transferred to some exemplar models for the delivery of primary health care services.

Other Comments:

- The ultimate goal would be to achieve a situation where incentives aren't necessary and where rural and remote medicine is enough of an attraction in its own right. Incentives programs should have a sunset clause.
- The workshop has not considered incentives and support for Overseas Trained Doctors and this is a critical area.
- Need a systematic approach, analysis and review.
- One challenge will be to break down the task into smaller, workable units, without disaggregation and reverting to a craft group approach.