



# Workforce Incentives – one part of the recruitment and retention jigsaw

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# Workforce incentives – we've come a long way

Recognition of need for:

- Flexible contracts
- Flexible working arrangements
- Housing and vehicles
- Salary packaging
- *Supportive management*
- Direct financial incentives

# Key features of effective PHC models

(Wakerman, Humphreys et al., 2006)

- Governance, management and leadership
- Adequate funding and appropriate funding mechanisms
- Linkages with other organisations
- Infrastructure
- Workforce supply

# Sustainability of Health Professionals



# Cross agency models

- GP superclinics
- NSW Health Ones
- New COAG initiatives
- Collaborations between DivGP and District/Area health services (Pilbara allied health)
- Overcome recruitment and retention (Roma medical services)
- Regional clinical/program expertise and care coordination (Katherine region NT)

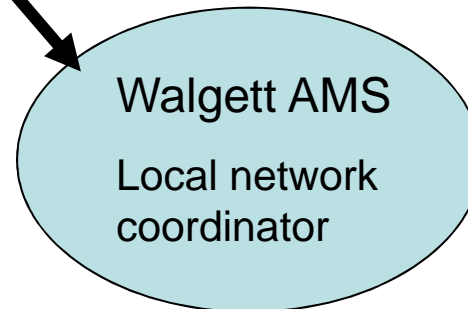
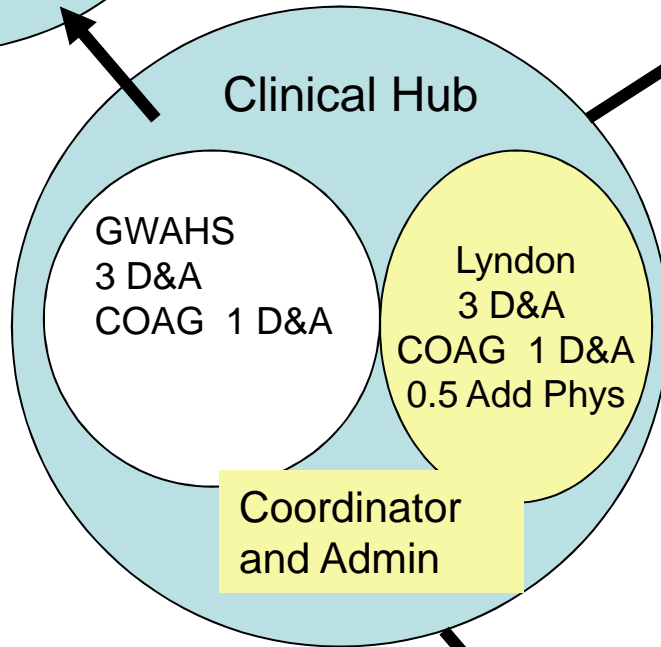
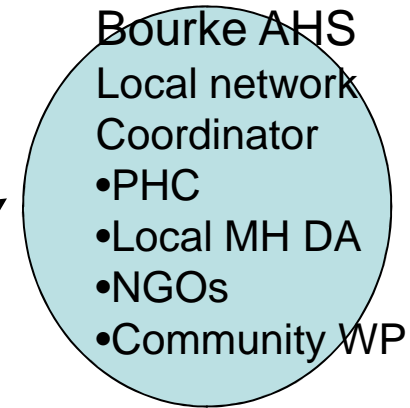
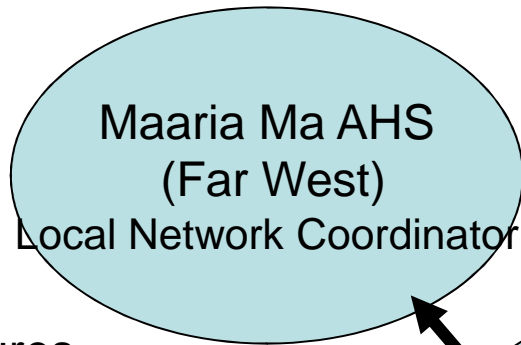
# Cross agency services

- Pooling resources
- Clinical expertise across a number of organisations
- Clinical supervision and mentoring
- Access to a broader range of services/disciplines
- Better engagement with Indigenous services and Indigenous clients
- Community capacity building (dependent on composition of arrangement)
- Potential savings (infrastructure, travel)

# Murdi Paaki Drug & Alcohol Network – what can we learn?

- COAG trial site
- CRRMH worked with agencies to establish the model
  - GWAHS
  - Lyndon Community (D&A NGO)
  - Bourke AHS
  - Walgett AMS
  - Maaria Ma AHS
- Funding agreements between DoHA and each agency to implement service network

# Murdi Paaki Drug and Alcohol Network



## Features

*Primary care led model*

*Interface across  
ACCHS, AHS, GPs,  
DivGP, NGOs*

*Build critical mass*

*Build clinical capacity –  
hub and sites (incl  
PHC)*

*Peer support and  
mentoring – local D&A,  
Mental health and PHC*

*Integrated care –  
referral pathways within  
sites and to hub*

# **Challenges** – establishment and implementation

- **Governance** structure of network/ coalition of organisations – not single entity
- **Accountability** by each organisation – how?
- **Contracts and entitlements (WFI)** – parity and equity
- **Line management** – internal v Network
- **Clinical governance** – employing agency v Network
- **Shift from specialist MH D&A model to primary care led model**

**Tensions – potential to impact on retention**

# Managing the challenges/ risks

- Partnership MoU
- Management Committee (quarterly meetings)
- Murdi Paaki D&A Network Partnership Strat plan – system responsibility and within network
- GW Aboriginal Health Forum (?)
- Clinical governance working group (across GWAHS)

# Other Realities

- Regional role – single employer and multiple masters (*supportive management*)
- Health Ones – slow - *governance and industrial issues*
- Sustaining change (*Roma medical - governance*)
- WF incentives – equity and parity

# Take Home Message

- WF Incentives facilitate workforce supply, but only a part of the recruitment and retention jigsaw – are they enough to overcome “dysfunctional” service arrangements?
- 2Johns Features for PHC apply to cross agency models
- Governance and management in the cross agency service environment is where we need to get clever