Health Workforce Queensland

RURAL WORKFORCE FORUM

RDAQ Conference 2022

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Welcome – Dr Ross Maxwell,
HWQ Chair and Session Sponsor

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I would like to begin by acknowledging the First Nations people as the traditional custodians of the lands on which we are meeting today.

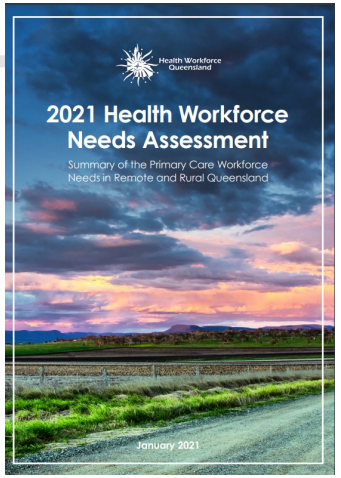
I would also like to pay my respects to Elders past, present and emerging, and extend that respect to all First Nations people present today.

HEALTH WORKFORCE QUEENSLAND

State of the Nation - range of reports, policies and developments which have impacted primary health care

Minimum Data Set report has been provided - summary of the current medical workforce in remote and rural Queensland

Health Workforce Needs Assessment - in collaboration with more than 20 partner organisations



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GENERAL PRACTICE SUSTAINABILITY

STRATEGY VS REALITY

SARAH VENN

General Practice Sustainability

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'the historical model of rural general practice (small, owner-operated, loosely connected) no longer meets the needs of communities, and is now a feature that both detracted from GPs being recruited to rural practice and challenged the capacity for them to participate in reform initiatives' (AHHA, 2020).

NATIONAL HEALTH WORKFORCE STRATEGIES

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NATIONAL MEDICAL WORKFORCE STRATEGY

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- **Income disparity** between GPs and specialist disciplines impacting career choice
- **Increasing numbers of medical graduates** however **geographic maldistribution** remains
- **3x more doctors per capita in cities** than rural and remote areas
- Need for **more Aboriginal and Torres Strait Islander doctors**
- Need for greater **self- sufficiency** and reduce reliance on locums and IMGs in some locations

NATIONAL MEDICAL WORKFORCE STRATEGY

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- A proposed **planning and advisory body** representative of jurisdictions and major workforce organisations for **collaborative national medical workforce planning**
- Grow the **Aboriginal and Torres Strait Islander medical workforce**
- Reduce barriers and **improve incentives** for doctors to work and train in **rural and remote communities**
- **Grow the number of GPs and rural generalists**,
- Enable **greater flexibility for doctors** across their professional life

PRIMARY HEALTH CARE 10 YEAR PLAN

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Quadruple Aim:

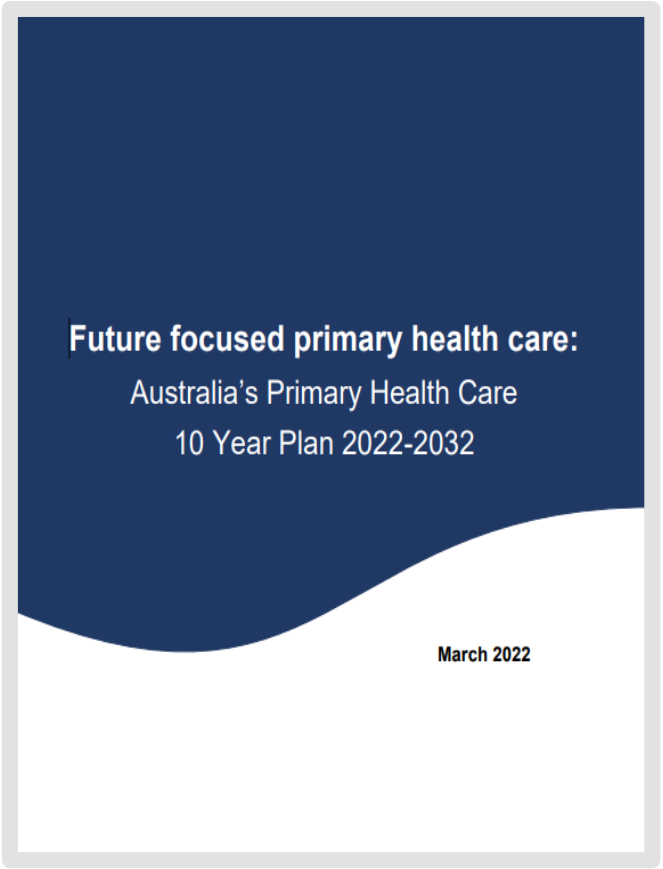
1. Improve experience of care
2. Improve health of populations
3. Improve health system cost-efficiency
4. Improve work life of providers

Three reform streams:

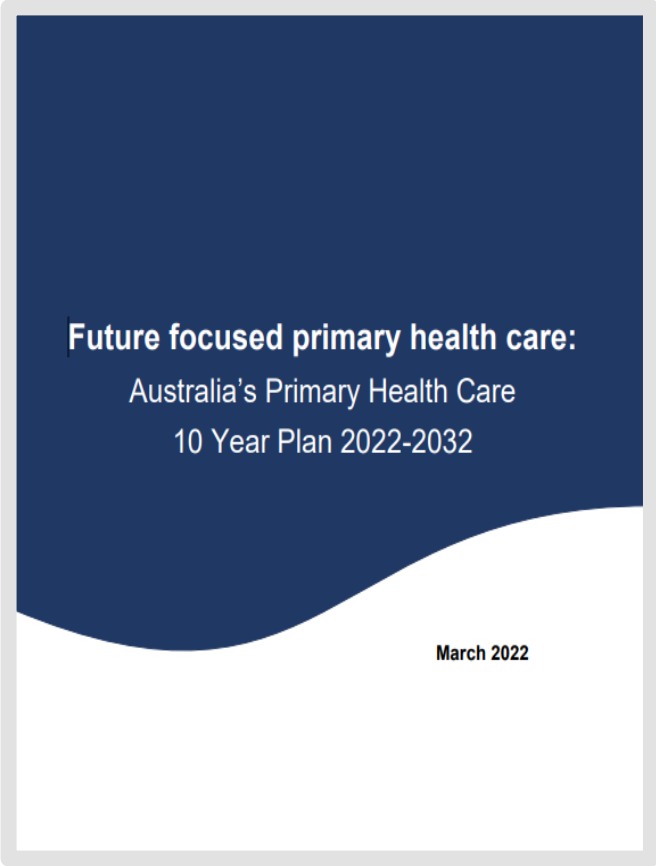
Future focused health care Telehealth; digital integration; technology and precision.

Improve access to **person-centred primary health care.**

Plan and commission **integrated care, locally delivered.**



PRIMARY HEALTH CARE 10 YEAR PLAN



The Plan proposes ***funding reform*** *over time to* ***support outcome-focused and multidisciplinary care and to address the challenges faced by older Australians, people in rural and remote communities, Aboriginal and Torres Strait Islander people, people with disability*** *and other population cohorts who face barriers to accessing appropriate care.*

SO WHAT IS THE REALITY?

*"Execution is the ability to **mesh strategy with reality,** align people with goals, and achieve the promised results."*
- Larry Bossidy

REALITY FOR RURAL GENERAL PRACTICE

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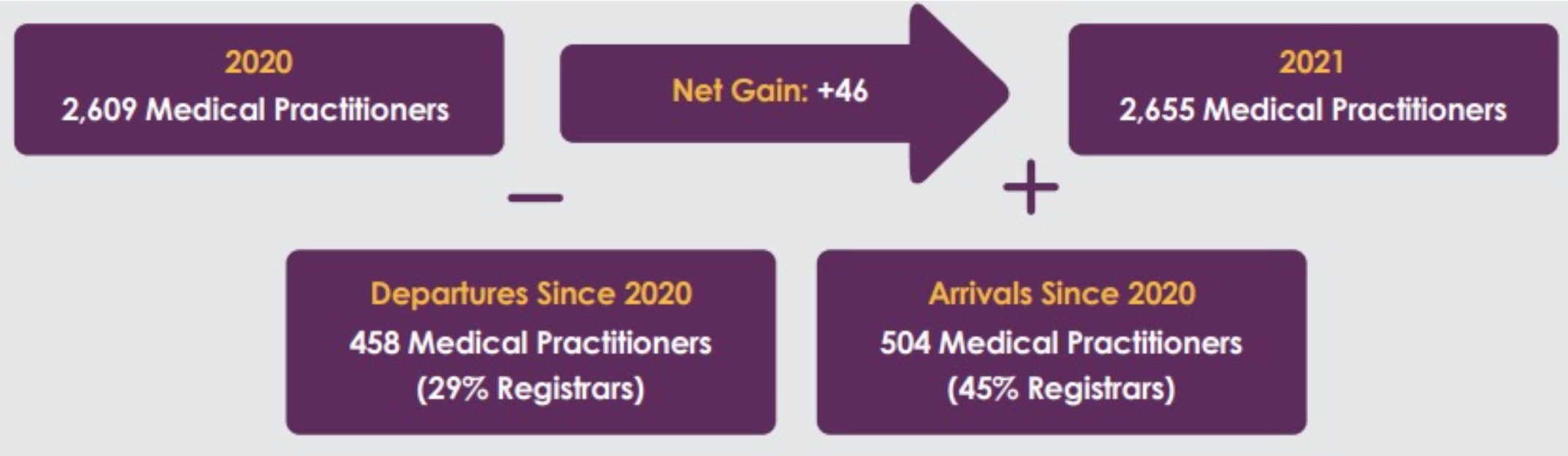
The prospect of **significant wage reduction, lack of non-transferrable leave entitlements,** together with the **lack of work-life balance** are contributing to prevocational doctors **choosing another speciality over general practice** (AMA, 2016).

Workforce shortages and service sustainability issues are unique challenges associated with location, such as **travel distances required to access services, and long wait times** compared to metropolitan areas (AIHW, 2020).

Poor employment opportunities for partners and **limited education choices** for family members also contribute to underlying **issues impacting recruitment and retention** of the workforce (Primary Health Care Reform Steering Group, 2021).

Fragmented funding arrangements, insufficient access to workforce data, **split governance and accountability between various levels of government** are barriers **magnified in rural and remote** (HWQ, 2020)

MEDICAL PRACTITIONER DEPARTURES



By RA classification, the proportional turnover of medical practitioners was highest in Remote locations (RA5) with approximately **a 25 percent turnover** rate, compared to Inner Regional locations (RA2) with a **17 percent turnover.**

MEAN YEARS OF EMPLOYMENT IN REMOTE AND RURAL QLD

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Mean years of employment at current practice by RA Classification

INTENTION TO LEAVE

Approximately 20% of medical practitioners working in Remote and Very Remote Queensland self-reported intent to leave their current location in less than 12 months.

Reasons behind leaving

- GP training requirements
- Impending retirement
- Management and support
  - Poor management
  - Work demands and burnout
  - Lack of support
  - Poor collaboration between primary and secondary providers

REALITY- HWQ SUSTAINABILITY SURVEY FINDINGS

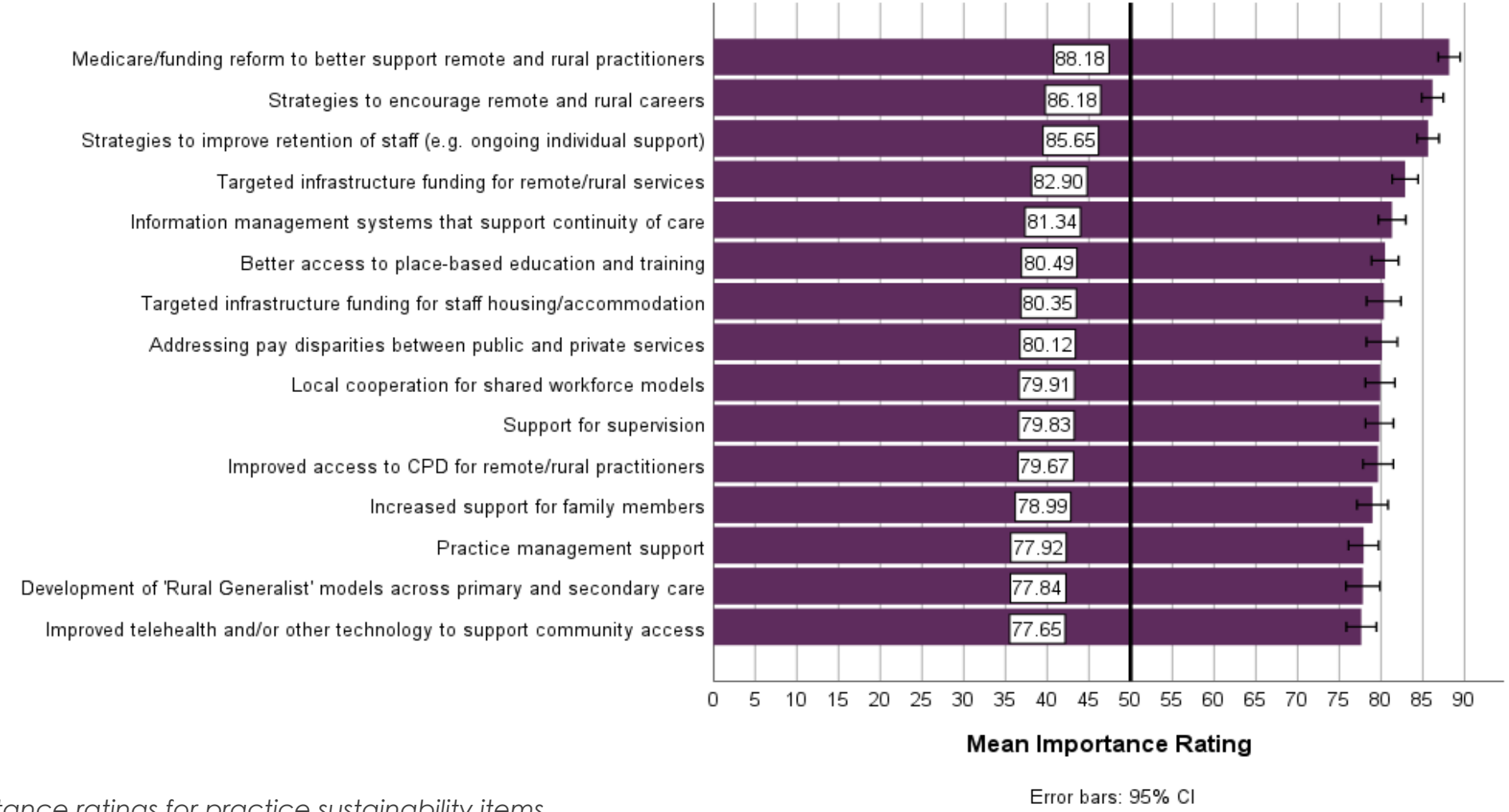

Figure: Mean importance ratings for practice sustainability items

REALITY- HWQ SURVEY FINDINGS

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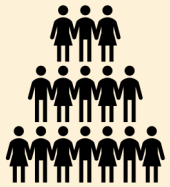
Workforce



- Recruitment of more health staff and **develop pipeline**
- Adequate and affordable **locum supply** (holidays for existing staff, emergencies)
- Improve **retention** (“Longer term” focus)
- **Workforce instability** affecting continuity of care and team culture

REALITY- HWQ SURVEY FINDINGS

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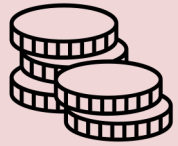
Higher Medicare rebates for remote and rural

More funding for remote and rural services

Incentives to attract and retain staff

Funding and Incentives



REALITY- HWQ SURVEY FINDINGS

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Support

Education/Professional development

Management and processes

Integration in the community

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THE CHALLENGE OF EXECUTION

*"**Execution** is the ability to **mesh strategy with reality**, align people with goals, and achieve the promised results."*

- Larry Bossidy

EXECUTION - WHO IS THE LEADER?

"Leadership is the capacity to translate vision into reality."

Warren Bennis

'Delivering integrated change through this plan at local level ***will require commitment, collaboration and leadership*** *from all levels of government, from Primary Health Networks and Local Hospital Networks, from professional and stakeholder organisations, primary health providers, researchers and consumers.'*

Greg Hunt, 10 Year PHC Plan

WHO IS THE LEADER? WE ALL ARE!

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Strategic Leadership (Federal and State)

- Demonstrated commitment to **investing in Primary Care**
- **System Change** – **funding models** to support private general practice in rural and remote
- Access to **technology** to support virtual care and place-based training and supervision
- Strategies and incentives (carrot not stick) to **attract the future workforce to general practice** that address recognition and remuneration
- Regional training pathways and infrastructure that support **end to end training**
- **Aboriginal and Torres Strait Islander representation** and leadership in all education and medical settings

STRATEGY

COMMUNITY LEADERSHIP

- Advocacy
- Health Literacy
- Social and financial investment in essential workforce
- Promotion of regional opportunities

REALITY

Local Leadership (Regional, Local)

- **Joint place-based planning** and implementation – agendas left at the door and focus on community need
- Adoption of **innovation for sustainability** - including multidisciplinary and virtual models of care
- Quality **Housing** – quarantined for all essential workers to attract and sustain thriving rural communities
- Exceptional **Organisational Culture** – orientation to town and practice, family supports, flexibility, cultural safety
- Pipeline mindset – training practices that **welcome future workforce** with quality clinical placements

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THANK YOU

AUDIENCE QUESTIONS (QR CODE)

What's worked well for **RECRUITMENT** in your organisation?

What's worked well for **RETENTION** in your organisation?

STUDENTS – What's your most IMPORTANT consideration for your future recruitment?

*Fill in your responses and we will **collate and share** your ideas!*