AHHA Submission to the Working Better for Medicare Review

Submission

01 March 2024

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to contribute to the Working Better for Medicare Review.

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

OUR RESPONSE

Q1. In your view/experience, what are the main issues regarding access to primary care, GPs and/or medical specialists, and their distribution across Australia?

Workforce shortages exist across many health professions particularly in rural and remote regions where there are thin or no markets, presenting a significant challenge for health services increasingly exposed to a diverse range of multifaceted and complex physical, social and ecological threats.

Access to education, employment, transport, housing and social infrastructure in these areas can all impact workforce distribution. In turn, health services access can impact the wellbeing of communities, as they can influence employment, investment and purchasing decisions within the local community. The decisions that are made about the way health care is provided thereby impacts the safety, vibrancy, and stability of those communities.

The complex nature of the system, including the various funding mechanisms and scope of practice restrictions, create issues for the workforce in terms of:

- Understanding and navigating the system.
- Delivering care with limited or inflexible resources.

Collectively, these issues create flow on effects for consumers in the affordability of and access to care.

Given this complexity, appropriately and effectively addressing the health workforce challenge requires coordinated effort across all levels of government, public and private sectors.

Achieving health system reform amidst ongoing workforce shortages, particularly in rural and remote areas, requires innovative ideas and models of care, underpinned by a strong evidence base, shared accountability and responsiveness.

Q2. How do the specific workforce distribution levers being reviewed help or support access to primary care, GPs and/or medical specialists? Please indicate whether you have:

a. General comments to this question:

It is necessary to note that each workforce distribution lever cannot be considered in isolation of the broad range of policies, both within health and across other sectors, that influence workforce recruitment, retention and access to health care.

Australia's healthcare system relies upon the skills, knowledge, professionalism, and wellbeing of its health workforce. This workforce is large and diverse, spanning more than 800,000 registered health practitioners working across 16 professions, health practitioners from self-regulating health professions, management, administration, support staff and many volunteers. Adequate health workforce supply is essential to ensure that consumer needs are met through effective, efficient and equitable health services. Although the scope of this review is limited to GPs and medical specialists, the importance and potential of other health professionals working in primary care to improve access must be considered, including allied health, oral health, emergency and nursing professionals.

The workforce distribution levers are a critical tool for ensuring this, through the considered distribution of practitioners to areas of unmet need across Australia, importantly in rural and remote

areas. A 2021 review[1] commissioned by the Department of Health identified that the DPA and MMM levers are effective in their calculation of community need for GP services and rurality of communities. However, the sustainable retention of the distributed workforce in these areas is reportedly poor, despite the number of programs and initiatives, identified on the Department of Health's website[2], available to incentivise practitioners to remain in these areas. This is to the detriment of accessibility.

Importantly, this is not an isolated issue of the healthcare system, but reflective of a wider community issue spanning across sectors. Beyond the professionally challenging clinical environments of rural and remote areas that are somewhat addressed in Federal programs and incentive schemes, there is a need to acknowledge the social factors of retention through wrap-around assistance. Research[3] has summarised that irrespective of renumeration offered, if practitioners felt lonely, isolated, or lacked an appropriate support network, they would leave their position in rural settings. Ensuring social connection and place integration are critical to the sustainability of the workforce levers in their success of distributing the workforce appropriately.

The connection between accessible health care and its importance to regional development was recently recognised at the Inland Growth Summit in Dubbo, hosted by Regional Development Australia Orana. Coming together to discuss health care, leaders from across diverse industries and sectors collectively identified the relationship between a thriving community and accessible healthcare, highlighting the value in evidence-based, place-based 'community connector' programs. Similar findings have been and are being explored in academia[4,5,6,7].

Q3. How do the specific workforce distribution levers being reviewed hinder or limit access to primary care, GPs and/or medical specialists? Please indicate whether you have:

a. General comments in response to this question:

Access to healthcare in high areas of need, particularly in rural and remote areas, would be worse without the supply of the International Medical Graduates (IMGs) and students through the workforce distribution levers. Their impact has been so significant that they are often described as the 'backbone' of these communities[8].

Yet, as demand for health services grows in Australia, there is a need to recognise the instability in the use and critical distribution of a workforce that is built from and dependent on overseas immigration. Beyond the ethical dilemma of drawing valuable workforce away from low- and middle-income nations and in contrast to international commitments, the COVID-19 pandemic exposed structural and systemic weaknesses in the way Australia's health workforce is organised. This notably includes the over-reliance on IMGs with the understanding that their distribution to areas of need is not a 'silver bullet'[9].

Concern has also been expressed[10] that the supply of practitioners through the workforce distribution levers has led to services becoming complacent in their local workforce attraction and retention efforts. An absence of workforce strategies and succession planning is an unsustainable and problematic practice that must be addressed to ensure a thriving workforce without dependence on IMGs.

In rural and remote areas where the burden of disease is 1.4 times greater than that in major cities, continuity of care is synonymous with health outcomes. Yet, there is an absence of accountability in the mechanism of the workforce distribution levers, enabling the opportunity to game for exemptions in rural and remote areas, facilitating an ongoing instability in the workforce. This is collectively to the detriment of the communities served by the workforce distribution levers, compromising the continuity and quality of care, and impeding overall accessibility to healthcare services.

Team-based care occurs when providers work together with a shared focus on a person's need and with collective ownership of the goals to be achieved[11]. In areas of unmet need, the way in which care is accessed and experienced differs from models in urban areas. While the levers centre on the distribution of GPs and medical specialists, those in rural and remote areas access primary care services from a range of providers, including remote area and practice nurses, Aboriginal Health Practitioners, and visiting locums. Implemented appropriately, team-based models of care can help to ensure that people in regional and remote areas receive continuity in care, despite tumultuous workforce shortages.

It is important to note, however, that issues in GP and specialist workforce retention are self-perpetuating and invasive[12] to other providers, cascading across sectors. While team-based care is promising, it is not the definitive solution the health workforce problem. Achieving health system reform effectively requires engaging in collaboration both across sectors and with communities to mobilise pre-existing resources for innovative solutions to ensure the right care, in the right place, at the right time.

Q4. How do the specific workforce distribution levers being reviewed impact the availability of training opportunities for primary care, GPs and/or medical specialists?

Health practitioners in rural and remote areas lack continuing education and clinical research opportunities. Capacity development in the rural and regional workforce requires a focus on supporting place-based models of care, supportive employment and supervisory structures, and flexible (and funded) education, training and research opportunities.

The levers may ensure a workforce is available, but they do not support workforce retention, partly due to 19AB moratorium loopholes and the absence of wrap around assistance to support health professionals and their families build a life in rural and remote areas. This includes support for the existing workforce who are relied upon to train or supervise new practitioners.

The distribution to high need and challenging clinical environments means that practitioners, often IMGs, require support to transition to these settings. This includes support to address feelings of isolation, including cultural isolation, concerns about safety and wellbeing, as well as the lack of continuing education and clinical research opportunities.

Support for supervisors is required as there can be a significant cost to the provision of training in rural and remote areas, due to the complexity of health funding mechanisms, high administrative burdens, high levels of unpaid care and workforce shortages.

Unfortunately, there are also very limited research opportunities in rural and remote areas, especially part-time or fully funded opportunities, which may disincentivise health professionals from practicing in rural and remote locations, as well as be a barrier to improvements to health services.

Q5. How do specific workforce distribution levers being reviewed impact the quality of practice for primary care, GPs and/or medical specialists?

Currently, rural and remote communities are serviced by fly-in fly-out models and short-term program trials which are not resourced adequately to create long-term solutions, but instead contribute to the instability of the workforce and wider community organisations and services as a whole. This in turn impacts the continuity of health services and thus, care quality.

In rural and remote areas, place-based approaches have been identified as the ideal method of improving quality of care to achieve better outcomes for people and communities, establishing the 'right policy mix' between local and national priorities[13]. Place-based approaches to health service design and delivery not only recognise that needs vary between communities, but also how assets and resources vary. This is particularly salient in rural and remote regions, with thin or in some cases no markets, who must adopt innovative ways to ensure people in their communities receive the right care at the right place at the right time.

Enabling team-based models of care, virtual care and collaboration between other sectors of the heath system is also important to improving quality, as outlined in our Blueprint for Health Reform[14] and supplementary reports:

- Enabling person-centred, team-based care[15]
- Effective and Sustainable Adoption of Virtual Health Care[16]

Q6. What are the possible solutions to the issues you have highlighted that could improve access to primary care, GPs and/or medical specialists? What needs to change about specific workforce distribution levers being reviewed or how they are used? Please indicate whether you have:

a. General comments in response to this questions:

Firstly, the intent and aim of the distribution levers must be made clearer. We propose that the intent must be foremost person-centred and outcome-focused; aiming to achieve better outcomes for people and communities. This requires the levers to train, attract and retain the workforce, and importantly, support local communities.

This also requires the levers to sit within, and effectively interact with, a coordinated policy package between health sectors (primary, hospitals, allied health, disability, aged care etc.) and other sectors (social, education, childcare, etc.), rather than being siloed to primary care, or particular professions.

Place-based approaches should be facilitated by supporting the workforce to effectively engage with national policy – identifying issues and engaging collaboratively to develop innovative local solutions. But building a thriving, resilient health workforce to address the needs of people and communities requires sustainability; therefore, adequate Commonwealth government support must be provided to implement solutions sustainably. Solutions will differ between communities, but success could be measured nationally based on outcomes for people and communities.

Measures to evaluate the achievement of outcomes that matter for people and communities must be developed, as traditional approaches of measuring outputs rather than outcomes do not capture elements of quality and safety, nor do they place the person at the centre of the care provided. While there is a clear focus on the number and distribution of health professionals, data does not currently and meaningfully capture information about accessibility, responsiveness, acceptability, quality and appropriateness of care. Suitably responding to unmet need requires a clear and informed understanding of where and why need is failing to be met.

The Mid Term Review of the National Health Reform Agreement[17] proposes that measures of primary care access should be collected, reported and evaluated, to inform distribution of the right workforce, in the right place, at the right time. Data must be publicly available to establish accountability and transparency mechanisms and enable place-based solutions to achieve outcomes that matter.

We must also recognise that it will remain challenging to attract and retain a health workforce to some areas. Instead of building a reliance on these distribution levers, other forms of care continuity must be supported. This may include information continuity enabled via data capture and digital systems or management continuity by enabling multidisciplinary team-based care.

Several recommendations of the Health Practitioner Regulatory Settings Review[18] (Kruk Review), notably recommendations 15,16, 23 and 24, offer solutions to some issues we have discussed above about supporting supervision, training and retention. It is noted in this review that:

> '*The lack of current, sectorally integrated, national, state and regional workforce data was highlighted as a priority for Australian governments, employers and regulators to assist with planning for current and future needs. This includes data on demand, supply, skills and location of health practitioners. The review was unable to identify an agreed and up to date set of data on the workforce. It pieces together the state of the workforce from the fragmented data available and feedback from professional bodies*.' (page 4)

To start addressing the fragmented data and information gaps, as well as other issues identifies in this submission, a national health workforce strategy is needed that goes beyond the adequacy, quality and distribution of the workforce as it currently exists. It must:

- involve a cross-jurisdictional and cross-sector planning approach;
- enable outcomes-focused and value-based changes in scopes of practice and place-based models of care for both regulated and unregulated practitioners, and across health service environments;
- coordinate education, regulation and resources at the Commonwealth, state, territory and regional service level; and
- embed long-term sustainability.

Other solutions are contained in the following:

- AHHA position statements on Health Workforce[19] and Rural and Remote Health[20]
- Recommendations in the Mid Term Review of the National Health Reform Agreement[21]

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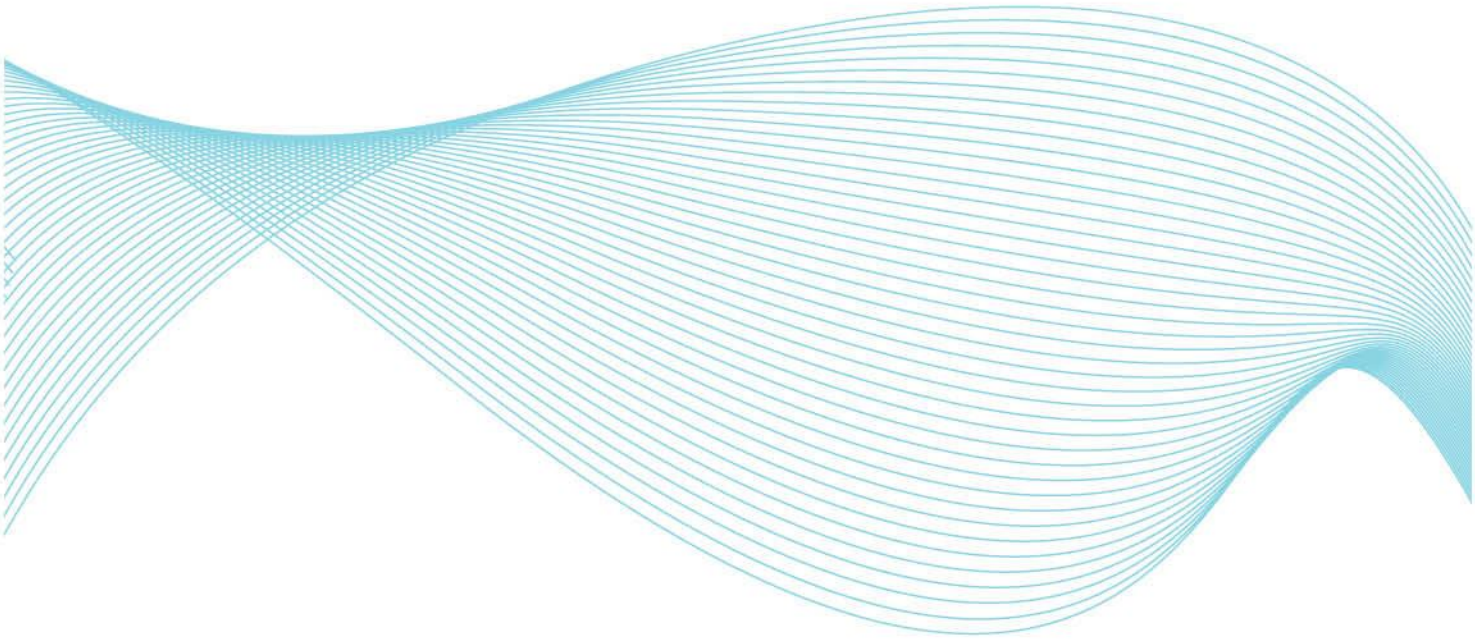

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