



So, it gives me great pleasure now to welcome our first speaker who will be asking the question, “Workforce shortages or dysfunctional service models.” Kristine Battye is a principal with Kristine Battye Consulting and her work history includes work with allied health services in Mount Isa. Please welcome Kris.

Workforce shortages or dysfunctional service models?

[Kristine Battye](#), Principal, Kristine Battye Consulting

Thanks, Julie. I would like to acknowledge the traditional owners, the Wiradjuri people, and I’d like to thank them for their welcome here on Wednesday afternoon. Workforce shortage or dysfunctional service models? A fairly provocative statement, I would suggest, given this forum. Here’s another one. We hear the statement “There’s a workforce shortage” as a reason or excuse for the lack of delivery of a particular health service.

“There’s a workforce shortage.” It’s said in the same way as “There’s a drought.” With the implication that there’s not much we can do about it other than try some sort of mitigation strategy, like put in a water tank or bring in overseas health professionals. The workforce shortage is largely blamed on a lack of supply but we know it’s multi-dimensional.

It’s impacted by Government policy in terms of the number of training places, it’s impacted by the decisions of individuals as to whether they’ll finish their training, whether they’ll move from training to work and what sort of hours they want to work. It’s impacted by the clients and the increasing demand and changing demographics and it’s systems-based. We’ve got models of care and retention that impact on our workforce supply and our shortage and I think that the things that we need to think about here are our service delivery models and our management processes.

Is the workforce shortage real or perceived? The first point I want to make today is we have very little understanding of what our workforce shortage is in rural and remote Australia because of the high turnover or churn of health professionals that gives us a perception of a workforce shortage. But is this real? And I think the reason we don’t know really what the shortage is is the lack of relevance of some of the indicators that are used for workforce planning and modelling.

The indicators that our work was using to determine the adequacy of the present workforce are shown here. However, I query the applicability of some of these in the rural and remote environment. Vacancy rates. Well, what does this mean when management delay advertising and recruiting to positions as a way of saving money or perhaps, of more concern, running vacant positions so that the saved salary can be put to the operational budget because the funding formula is the same whether you’re trying to deliver a service in a capital city, a provincial city or delivering services under some sort of hub and spoke model in remote Queensland or New South Wales or probably anywhere else.

Service waiting times, reductions in levels of service provision and poor patient outcomes linked to reduce staffing levels. Well, what does this mean when there’s never been a service? It’s been a limited service or it’s a service provider on an as-needs basis. Population benchmarks. Well, there’s not a lot of those around. There are the various benchmarks for general practice, there’s some benchmarks for the Aboriginal health workers and there’s very limited benchmarking for allied health.

Robyn Adams has done some work with physiotherapy and there’s Rob Curry’s planning work in the Territory which formed the basis for the Mount Isa model and the Katherine model. The New South Wales Mental Health Clinical Care and Prevention program has developed population benchmarks for mental health services based around models of care and this bottom up approach has been a very good start where the model of care is along the lines of a biomedical model.

However, non-clinical time needs greater consideration in this modelling, I think, to cater for outreach service models. We have very little understanding of what our workforce shortage is but the critical point is that we need to determine and describe the model of care and the model of service delivery in

order to plan the workforce requirement and skill mix. Then we can start to determine what and where the shortfall exists.

Now, today I don't want to harp on about workforce shortages. Rather, what I want to do is focus on how we can build sustainable service models for functionality. But first we need to get some agreement on what a dysfunctional service is so we know what we don't want. And my definition is one that does not support or enable a health professional to provide effective care to individuals and communities on a sustainable basis.

And there's plenty of examples around but two I will put up. It is the overseas trained doctor, lobbed into a remote community. Works as a solo practitioner, 24/7 on call, no orientation in a remote practice, no orientation to Aboriginal culture and minimises the standing of the Australian health system.

The other one is, you know, a Clayton's service, the service you have when you're not having a service. The allied health professional or mental health worker: they fly in and out of town once a month or once a fortnight. They're on the ground for six hours and they might see six or seven clients but there's a 12 month waiting list and there's no mechanism in the community for follow up. The powers-that-be can tick the box and say, "Yes, we provide a service," but it's dysfunctional because the service models in that are work to meet need.

It's creating distress to the health professional because they know they're having very little impact and they've got this mountain of a waiting list to get over. So, it's creating a high risk of job dissatisfaction and resignation. So, if we're going to try and develop sustainable and functional health services we've got to build our workforce and we need to put our efforts where we have some sort of control or influence and this is around the training environment, maximising participation and re-engineering the service model to promote retention and build service capacity.

Now, most of us here today may not be able to directly influence the number of training places but we can influence the training environment that young or new health professionals are operating in, which will impact on training completion rates, transition from training to work and recruitment and hopefully to your own service by having that effective local trading pipeline. Maximising participation by providing a flexible work environment can support re-entry of health professionals.

A model that the New South Wales Central West Division of General Practice is seeking to progress under the Rural Private Access Program is the concept of an allied health industry network. Within Central West New South Wales, there's a sleeper allied health workforce. It is not working because of family or lifestyle choices. The majority of these people are women and they're seeking flexible working conditions close to where they live.

Whilst private practice offers flexibility, the allied health professionals identified a number of barriers. These include perceived business risks, like, no one is going to come; or a lack of business skills, you know: "I can't do a BAS, I can't do a pay roll". They're concerned about the business establishment costs and the lack of support structures with the risk of working in isolation.

So, what the industry network model is seeking to do is to support re-entry of these health professionals through the provision of business and practice management advice and support in the process of setting up their businesses, though it can provide flexible employment and subcontracting arrangements to the individuals. It can establish clinical networks to provide some professional support and it can broker work contracts with external agencies to develop a market for the allied health professionals as well as optimising funding streams to enhance access to primary care.

But where I see that we can really get some bangs is by re-engineering for retention. There's plenty of evidence to tell us why health professionals leave rural and remote practice and why they are so mobile. And drawing on the literature from allied health, nursing, general practice, dentistry and mental health, it boils down to three main domains: the professional domain, the personal domain and the community.



Job dissatisfaction is the biggest loser and the contributing factors here are policy, poor management practices, excess administration, poor interpersonal relationships and working conditions. The other big losers are around a lack of access to clinical supervision and mentoring, heavy workload and burnout, lack of backfill and locum relief, professional isolation and working as solo practitioners, lack of career path, difficulty accessing professional development and access to post-graduate education, excessive travel, your know, spending more time driving than you do seeing patients, lack of orientation to rural and remote practice and Indigenous culture, and remuneration not reflective of isolated practice.

From the personal side, the big issues there are around accommodation and housing, employment for spouse and partners, access to quality education and access to childcare. At a community level, people want to be able to live in places where they can establish social networks and where the community can offer some of the facilities that we've talked about in the personal domain.

So, why aren't we applying the evidence to build sustainable models? And I don't think I'll be telling anybody here anything new when I say that rural and remote health services under-resource for what they are expected to do. And, again, the big losers are retention strategies and operational budgets—I think I've been probably been watching too much television, but anyway.

Professional development, study leave, time out of the community and accommodation subsidies as well as mentoring. We're looking at \$12 000 to \$14 000 per year, per staff member. State and Territory health services or their policy people or bean counters balk at this but we know that investment up front is going to create savings in recruitment costs, locum fees and nursing agency fees. And it might also have an impact on continuity of service provision.

The operational budget for a hub and spoke service in remote Queensland is around 60 per cent of personnel costs—when that budget is developed from the ground up, you know, from what it costs to get this group of people to these communities on a regular and reliable basis and overnight them or keep them in the community for two or three days. Now compare that to the flat 15 per cent or whatever the relevant funding formula is and then we understand why rural health services are running vacancies to subsidise their operational costs.

We also have difficulty applying the evidence because of the lack of flexibility and award conditions in some States which precludes the application of retention strategies and fragmented health funding leading to fragmented services provision. I wish Philip Davies was still here.

How often do we see State funded and Commonwealth funded health services operating in the same environment, employing small staff teams, providing similar services across dispersed populations but with differing criteria about who can and can't use their services, and all of them having difficulties in recruiting and retaining staff. Would retention be improved by having one agency as the auspice and employer so we can create a critical mass with the other agencies then purchasing services to meet the needs of their clients?

So, I think we have some policy implications here and maybe some of these could be put forward or developed up as recommendations, the first being that rural and remote health services require different funding formulae to urban services, we need flexible employment arrangements for rural and remote locations and we need to be able to remove the artificial boundaries created by State and Federal health funding to promote efficient, effective and sustainable models of health service delivery for rural and remote areas.

Okay, now let's apply the evidence. The sustainability of health services hinges on the retention of health practitioners; so how do we plan or re-engineer for sustainable health service. Using the evidence from the literature, this diagram has been developed in conjunction with Health Workforce Queensland and it reflects the professional and the personal domains that have to be met to support sustainable service delivery.

To re-engineer for sustainability we need to create an interface between the public, private, Aboriginal community controlled and NGO sectors that can underpin an integrated service delivery across the

primary health care continuum. This interface enables the opportunity to establish a critical mass of health professionals, the provision of health care across that continuum, whether it's some sort of hub and spoke arrangement or at a local level.

The interface provides the opportunity to establish systems for internal relief, backfill and managing on-call after hours, it provides the opportunity to better utilise local resources like GPs, local health workers, the general nurses, for ambulance officers, and people working in the NGO sectors in aged care. We can develop a multi-disciplinary team, source from the agencies in this interface and support them with information management systems that will enable integrated and shared care across the sectors.

In addition, we need to look at the personal support needs inclusive of appropriate housing, professional development and career paths. As well, we need to look at safe work hours and rosters that enable a work-life balance and this we can achieve through our critical mass. So, meeting these needs, I see as a collaboration across the service agencies, the other workforce agencies, local government and the community.

Today I am going to present two examples of what happens when the evidence is applied. The first is a remote cluster in the Greater Western Area Health Service. The remote cluster is situated in far west New South Wales and it includes the city of Broken Hill and the communities of Wilcannia, Ivanhoe, Menindee, Wentworth, Balranald, Tibooburra and White Cliffs. That's a huge geographic area. It is not as big as Katherine but still huge.

In this cluster there is a unique agreement between the Greater Western Area Health Service and the Maari Ma Aboriginal Health Corporation where health services to the communities are managed by Maari Ma. In addition the RFDS partner in service delivery and the UDRH is a training and research role. The integrated service arrangements that have been developed under this agreement have resulted in increased resourcing to the cluster through Commonwealth funding, largely to Maari Ma and the RFDS.

Over the last five to six years we've seen a significant expansion in the breadth of services that have been provided across the cluster, particularly those targeting chronic disease, child maternal health, general practice and medical services and this has been underpinned by the development and implementation of a chronic disease strategy that co-ordinates the activity of the health professionals across those different agencies.

Now, in terms of how this lines up with the sustainability criteria, well, they've got a formal agreement in place that underpins this interface between the Area Health Service and Maari Ma, with provision of medical services under a purchaser-provider arrangement with the RFDS. It's established a critical mass of health professionals that are based in Broken Hill and they are outreaching to the smaller communities. The chronic disease strategy is providing a structured framework for practical integration between the visiting and local practitioners so that they're developing a primary health care team and it's also supporting skills development at the local level.

There's an information management system under development. The UDRH has established a diploma in primary health care and this is providing a local training pathway for Aboriginal people to become health practitioners. It's increasing Aboriginal participation in the workforce and it's developing a career path for them. GWAHS, the Area Health Service, provides housing for the RNs in the community but as is the case in most services I have come across, there is no housing available for the private health care workers.

Now, whilst the RNs and the health workers in the communities are managed by Maari Ma they are still employed by GWAHS, so the entitlements are subject to the awards under which the Area Health Service is operating, and this is presenting a limitation to developing a more flexible response to the challenges of maintaining the nursing workforce in the smaller communities.

The second model I want to talk about is the north-west Queensland Primary Health Care Allied Health Service and I've got to declare a bit of a bias because of my involvement in the development of



this model. The implementation and growth and capacity of the service is a credit to Kelly McTaggart, Jo Simons, Elaine Ashworth, Chris Franklin and Karen O'Rourke as well as the other bunch of people that are working at Mount Isa. In 2002 North and West Primary Health Care established an outreach allied health service. It's based in Mount Isa. It's funded through the Commonwealth Regional Health Strategy. It provides a raft of allied health services across six disciplines to communities in remote north-west Queensland. In 2003 it received additional Regional Health Service funding to expand its services down into the Diamantina, Boulia and Barcoo shires. More recently it has received further funding through HACC and PCAP to expand services to Mount Isa city itself and additional service provision to some of the communities.

Now, this service model sought to respond to the community's priorities about health outreach services: that they should promote access and utilisation. The key points coming from the communities was that they wanted regular, reliable, consistent personnel, and they wanted them to stay for more than a day. This slide shows the features of the services. Superimposed on this was the application of the research to address the professional and personal actors that need to be put in place to support the service.

The effectiveness of this model is demonstrated by the fact that there are still several of the initial nine recruits employed in the service, four years down the track, and others have been there for beyond three years. Don't forget it only started operating in 2002. It's been able to recruit additional staff as the allied health service has expanded and there are now over 20 positions located in Mount Isa. It has created a management structure to cater to the expansion and so there is a career path in the service. It has a good reputation as an organisation that looks after staff, catering to professional needs, albeit in a challenging service model.

I think this has been largely facilitated by the fact that it was a green field site so we could develop an organisational culture that reflected primary health care principles and also enabled the flexibility to recruit staff with the aptitude for remote practice. Because it was auspiced by a Division of General Practice there was more flexibility in developing employment packaging. In terms of sustainability the interface in this model is less formal than the Maari Ma/GWAH's model but it has collaborative arrangements with the other agencies that operate in the north-west that is allowing the allied health professionals to work in the Queensland health clinics; they access records, they also work in the schools and they are working in the aged care facilities and in the childcare services.

It has its own critical mass so that they have been able to develop their own backfill and internal relief but this is also adding to the critical mass in Mount Isa that is helping to develop a peer support network as well as links with the other providers for service provision across the agencies. It is developing a training pipeline through linkages with unis to take students. It's building local workforce capacity through trading and upskill of the local health workers, childcare workers, aged care workers, the people I talked about before.

But I think that the important thing is that it is also a two way process, that, you know, the Aboriginal health workers are adding a lot to the allied health professionals' experience and understanding to work up in the Gulf particularly. They are also working as a primary health care team both internally as well as externally with the other agencies in the interface, which means the other agencies Mount Isa. So within the personal domain the retention strategies provided include a housing subsidy that is ongoing, paid professional development, mentoring support, paid study leave, orientation of remote practice, six weeks' annual leave, which is again I suppose the flexibility of a flexible employment arrangements.

So what are the common features of these models that have been able to build workforce and service capacity in these challenging environments? I think they are very similar to the ones that were put forward yesterday by the people that presented the Border Cancer Care Co-ordination Project. It's about people in the driving seat with a vision of what they want to achieve, strong leadership to forge collaborative and integrated services, people that, you know, these leaders that can source the resources that are required to apply the evidence to build a sustainable service model as a platform for

increasing workforce capacity and service capacity. What we've seen from these examples is that when a functional service demonstrates that it can do it, more resources come to support further expansion.

So what's our take home message? Well, we can't keep doing what we are doing and expect a different outcome. We need to engineer our models for sustainability and that means putting rubber to the road and developing and integrating collaborative and integrated services if we are going to build our rural workforce so that we can maintain and expand our health services to people living in rural and remote Australia. Thank you.

FACILITATOR: Ladies and gentlemen, just before I introduce our second and final speaker before afternoon tea at 3.30, if someone has a question I think put it now because after we head into our next area it's always hard to remember your question for the speaker before. I have a quick one and then I'll come to you, sir. Is it possible to get a copy of this paper?

KRISTINE BATTYE: Yes. I've got to actually write it so it's not just talking and has a few references and things like that added to it, but I'll be writing that for Gregory, yes.

FACILITATOR: So you'll be able to get it through the Alliance?

KRISTINE BATTYE: Yes.

FACILITATOR: It's just, if I may just quickly say, I thought that was excellent. It was full of so much information, it's something you really want to look at on paper. I've got a gentlemen and then a woman here. Your name and where you're from?

GORDON TAYLOR: Gordon Taylor. I actually work here in Albury at the Aboriginal Health Clinic. I was previously a GP in Yarrawonga for 15 years and I'm also on the board of the local regional training network which is Bogong for training GPs. Look, it's more of an observation. It's really exciting to see your work there and see the things that you are saying here. One of the critical things we have at the moment is that in private practice, which still provides the overwhelming majority of primary health care work for patients in Australia, that there is no money to be made in employing doctors.

At the moment I am an employee. I am quite happy to be an employee. I was previously an employer for 15 years and with the shortage of GPs that there is, the only way to employ people is to employ at the very top rate, basically, to the point where you might have to pay someone more to do the job that you're doing yourself, and at that point your business is effectively bankrupt.

FACILITATOR: Just before I go to Kristine, do you have a suggested solution – recommendation?

GORDON TAYLOR: Absolutely. Well, the point is that there is lots of good work occurring, there are people putting effort in, but I'm afraid it still comes down to the jobs that we've still got to recommend, we've still got to push the point of making our professions interesting, making them so that we can build up our own pride in our professions, we have people coming through afterwards, we are enthusiastic about training our students, and they want to follow us, and at the moment if you are in the medical degree you'll end up getting three times as much in speciality practice as in general practice.

I'm not suggesting that we increase general practice to three times what it's currently being paid, but what I am saying is that at the moment that people are voting with their feet and there is no conscription. We need to go and support all of our professions such that this is a desirable thing that people will aim to do. We can't regulate excellence but you can encourage it. I believe that what you're saying there, all those things are there, but without the money to back it up to make it possible, it won't occur.

FACILITATOR: Thank you very much. Kristine, do you want to make a comment or response?

KRISTINE BATTYE: My response to that is again maybe we do need to look at our models and, you know, is the private practice model in rural and remote Australia the right model? You know? Do we need to look at what the market forces are telling us – and again the presentation yesterday by John



Menadue about universal health care? You know, do we really need to start thinking about a whole new look at the way that health services are funded in Australia and again think about does the urban model apply to rural and remote? We know it doesn't apply to remote. We know there is no access to MBS or very little access to MBS in remote North Queensland or in the Territory. Do we need to really start to talk about those sorts of questions now and not –

FACILITATOR: I am sorry. I have to – but please keep the conversation up outside. I'll have one more question and then I must go to our next speaker and if there is any more time of course we'll take more questions. Your name and where are you from?

JENNY MAY: Jenny May. I am a GP academic at Tamworth. I guess it's a commendation but also a question. Obviously the second model particularly that you are describing is providing a number of health services and hopefully health outcomes to the population in that area of Queensland. How can we go about evaluating these models so that we can get the message back to the bureaucrats to have the evidence, I guess, so that these can be sustainably funded models?

KRISTINE BATTYE: I think the first model, the Maari Ma model, Maari Ma/GWAHS/RFDS model, is a model that is more easily evaluated under standard patient outcome type measures because it's very much focused around the chronic disease strategy and I would recommend that as one model that really needs to be seriously evaluated to be able to measure outcomes. I think the second model is more challenging because its working on the basis of either self-referral or referral by teachers, health workers, doctors working in those communities and self-referral, and what we are finding happening in that model is about keeping people out of aged care institutions or delaying them going into aged care facilities.

It's about being able to keep kids in the community rather than shooting down to Mount Isa for kids with developmental problems and things like that, things that aren't easily measured in our medical model but things that we need. I think that the other thing that we need to do in addition to being able to measure our primary health care models that focus around disease, we need to put more emphasis on being able to measure the prevention side of it and where primary health care is really working, and I just don't think we have the capacity at the moment to do that. That's where I think we need to put a lot more work.

FACILITATOR: Can I just say – I didn't mean to cut you off. I'm just in this bloody time management mode, but if you could give some thought to a recommendation, perhaps I could come to you again at the end of this session, because lurking behind Mr Davies' presentation yesterday I think there was hints of a move towards corporatised general practice and I wasn't quite sure what he meant about it. I don't know if you noticed but he made one reference to corporatisation, I only know the city better than the country but there are these huge corporate centres now and many GPs and allied health professionals and nurses are all employed and so was he hinting at a private sector model with government subsidy? Can you help me?

KRISTINE BATTYE: I don't think he's necessarily looking at a private sector corporate arrangement but maybe an NGO type or not for profit entity where people are still being employed, revenue is being made, but that gets turned back into service provision and not necessarily medical service provision. It might be by other things, and in some ways it's really what community controlled health services are doing, but I think it is about ramping that up.

FACILITATOR: Thank you very much. Could you give Kristine a round of applause?

Presenter

Kristine Battye is a director of Kristine Battye Consulting Pty Ltd, which she formed in 2001. Kristine's background is in agricultural research and she worked as a reproductive physiologist from 1984 to 1994. She made a career move in 1994 and commenced working in project development, management and evaluation in the health sector, predominantly in rural NSW with the NSW Central West Division of General Practice, and rural and remote Queensland with the Northern Qld Rural Division of General Practice, now known as North and West Qld Primary Health Care.



Since the establishment of her consultancy, Kristine has undertaken a range of projects for not-for-profit organisations, the Commonwealth, Qld Health Service Districts, and local government organisations. Her focus of work includes regional health service planning under the Regional Health Strategy, the Indigenous specific Primary Health Care Access Program, and Rural Private Access Program, as well as internal and external evaluations and reviews of health services and programs, policy development for rural and remote workforce recruitment and retention, and application of a community development approach to health service re-engineering. Kristine has participated in the development of a health response for the Cape York COAG trial, and the Murdi Paaki COAG trial in western NSW. In collaboration with North and West Qld Primary Health Care, and Health Workforce Queensland, she has participated in the implementation of a number of the innovative models of health service delivery. Kristine has an eclectic publication list and has presented at numerous conferences.