AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
ABN 91 028 693 268

29 October 2021

Dr Henrika Meyer
Chair, Rural Health Workforce Strategy Steering Committee
c/o Ms Simone Hurley
Senior Aboriginal Project Officer
Rural Support Service
PO BOX 3017,
Rundle Mall ADELAIDE 5000

E: Health.RuralHealthWorkforceStrategy@sa.gov.au

Dear Dr Meyer

Re: Consultation Draft South Australia's Rural Aboriginal Health Workforce Plan 2021-26

Thank you for the opportunity to comment on the initiatives outlined in the Rural Aboriginal Health Workforce Plan. The Australian Medical Association of South Australia (AMA(SA)) commends the principles outlined to attract, retain, grow and support the Aboriginal health workforce within regional local health networks and the commitment to meaningfully engage with Aboriginal people to ensure the strategy reflects their views about what is needed.

It is well documented that those living in regional and remote areas have poorer health outcomes and life expectancy than those living in the city – despite the fact that 30 per cent of Australians live in these locations.[1] The situation is even worse for Aboriginal and Torres Strait Islanders, among whom the burden of disease is 2.3 times that of non-Indigenous Australians, due a range of complex socio-economic and health factors to be addressed in the National Agreement on Closing the Gap.[2]

In addition to these factors, access to appropriately trained medical practitioners is an enduring problem in rural and regional areas. As the AMA has noted elsewhere, despite training more medical practitioners per head of population than most countries in the Organisation for Economic Co-operation and Development (OECD), Australia is still reliant on international medical clinicians to provide services in rural and regional areas.[3] This situation has been exacerbated by the COVID-19 pandemic border restrictions which have limited the ability of international doctors to work in Australia and curtailed movements between states to supplement the regional workforce.

[1] Australian Institute of Health and Welfare (2018) "5.2 Rural and remote populations" Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
[2] Aboriginal and Torres Strait Islander Health Performance Framework. Australian Institute of Health and Welfare, 18 November 2020, https://www.indigenoushpf.gov.au/report-overview/overview/executive-summary
[3] Australian Medical Association Rural Training Pathways Policy Position Paper, 2020, Downloads/Rural_training_pathways_for_specialists_2020.pdf. See also National Indigenous Australians Agency, Closing the Gap 2020, https://www.niaa.gov.au/indigenous-affairs/closing-gap.

Postal: PO Box 685 Fullarton SA 5063 175 Fullarton Road Dulwich SA 5065
Phone: (08) 8361 0100 Fax: (08) 8361 0100 Email: admin@amasa.org.au Web site: www.amasa.org.au

The themes and objectives of the Rural Aboriginal Health Workforce around providing a culturally safe workplace; valuing the skills and experience of Aboriginal people; implementing appropriate recruitment practices, education and training opportunities, and retention strategies; and providing collaboration and support for Aboriginal people in the health professions and health leadership are important pillars.

In addition, we support the co-design approach to developing health services that meet the needs of Aboriginal people in rural and remote areas – this is the gold standard approach to developing person-centred care. This not only results in services that are more 'user-friendly' and are more likely to be used by Aboriginal people, as the Australian Commission on Safety and Quality in Health Care notes, it is likely to improve the quality and efficiency of services.[4]

The under-representation of Aboriginal people in the regional health workforce is concerning and we support efforts to increase the numbers of Aboriginal people in regional health roles. We agree that efforts should be made to upskill the existing Aboriginal workforce to undertake more complex roles where appropriate and to train more Indigenous people in health roles in general. Initially, the plan should include a focus on community-based support workers as this can be achieved more quickly than training for more complex roles and these can provide a steppingstone to further study. However, we note that this focus on community-health care should be in addition to, not a replacement of, high-quality clinical care.

Rural health practitioners, including Aboriginal health workers, should have access to rural training pathways such as the rural generalist pathways to ensure they are equipped to meet the clinical demands of rural practice. This requires adequate supervision by suitably qualified people and paid leave to attend training events in regional centres or metropolitan areas.

We agree that there is a need for improved data to underpin rural workforce planning – particularly with respect to the distribution of specialist care. Many specialties which require a high acuity and high-tech infrastructure are limited in the type of care that can be provided in regional hospitals. A nuanced method of mapping demand for services in rural and regional areas is required, recognising the specific types of specialist services that can be provided locally while providing access to high acuity care in metropolitan centres.

In addition, we need a dynamic 'stock and flow' analysis of the future workforce that includes international inflows as well as net exits. Workforce planning on the basis of population, as is the practice in most OECD countries, is not appropriate in the Australian context. It is well documented while there is not an undersupply of graduates in many specialties, there is a maldistribution, concentrated around the best remuneration structures and working conditions – namely the east coast. Attempts to recruit and locally train doctors in regional areas have not been successful as a rural workforce retention strategy.

As the AMA(SA) and the Rural Doctors' Association (SA) have noted, it is vital that any rural workforce strategy appropriately remunerates rural doctors and supports adequate supervision and training. While we commend the South Australian Government's 2018 election commitment to addressing the rural workforce challenges, we note that this is yet to make an impact, as evidenced by negotiations stalling over General Practitioner (GP) contracts with country hospitals.

[4] Nous Group, Review of key attributes of high-performing person-centred healthcare organisations, Australian Commission on Safety and Quality in Health Care, Sydney, 2018

South Australia's regional public hospitals rely on expensive fly-in fly-out locum support in many areas, which is out of step with the remuneration offered to permanent doctors. Adequate remuneration is needed to reflect the significant out-of-hours work that comes with being a country doctor; these doctors also need support to manage the broad clinical demands that are at once a key attraction and challenge associated with working in regional and remote areas. As we have noted elsewhere, the number of GPs applying for country practice training has plummeted along with the number of supervisors to teach them.[5]

Thus far, the proposals presented to incentivise clinical engagement in rural and regional areas have been overlooked and we are concerned that this draft strategy continues to overlook what is the single most important aspect of building a sustainable – Aboriginal or general – rural workforce: appropriate compensation.

We would be pleased to discuss these recommendations in further detail. Please contact me at any time to discuss the issues raised in this letter by contacting EA Mrs Claudia Baccanello on 8361 0109.

Yours sincerely

Dr Michelle Atchison
President

[5] *medicSA,* AMA(SA) October 2021