AMA DISCUSSION PAPER 2004

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH
HEALING HANDS – ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE REQUIREMENTS

The Australian Medical Association (AMA) monitors Aboriginal and Torres Strait Islander health. The health of Aboriginal peoples and Torres Strait Islanders remains appalling, especially compared to the rest of the Australian population, and to other Indigenous groups internationally.

But good things are happening in some Australian communities. Reproducing these successful programs in other communities needs money and people with the necessary skills. Our health is influenced by what we eat, how we live and exercise, our access to work, our social support networks, our ability to deal with crisis in our lives, and our access to health services and other infrastructure.

No single intervention can solve the crisis in Aboriginal and Torres Strait Islander health. It is clear that changes are needed if Aboriginal and Torres Strait Islander people are to get access to high quality, integrated primary health care services.

This Discussion Paper on Aboriginal and Torres Strait Islander Health focuses on the Aboriginal and Torres Strait Islander Health Workforce as a key component in the provision of health services. The AMA commissioned Access Economics to produce a report, upon which this short Discussion Paper is based. The full paper is available on the AMA's website: www.ama.com.au. The Discussion Paper provides an estimate of the Aboriginal and Torres Strait Islander Health Workforce shortfall and the recurrent funds needed to train, employ and support the shortfall in health professionals.

Additionally, we suggest the number of dedicated, fully funded, training places that need to be provided over the next 10 years to Aboriginal people and Torres Strait Islanders. Comparable countries: USA, Canada and New Zealand have higher numbers of Indigenous health professionals. Though disparities remain in these countries, they have been able to make much larger improvements in health for their Indigenous populations than has occurred in Australia. Increasing the number of Aboriginal and Torres Strait Islander health professionals to a level comparable to these countries is likely to result in better health outcomes for our Aboriginal and Torres Strait Islander population.

The AMA believes that Australia should make a commitment to achieving this parity of numbers of health professionals and calls upon the government to identify and fully fund these places, including the support units that are essential to ensure that most Aboriginal and Torres Strait Islander students make it through to qualification.

I have also included some good news stories – examples of the very significant improvements in morbidity, mortality and indicators of future health problems. Developing the Aboriginal and Torres Strait Islander Health Workforce will be an important key to improving Aboriginal and Torres Strait Islander health.

Dr. William Glasson
Australian Medical Association Federal President

AMA

Aboriginal Health painting **Jillie Nakamarra**

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

WHAT IS ALREADY KNOWN ON THIS TOPIC

The health status of Aboriginal peoples and Torres Strait Islanders in Australia is unacceptable. In 2003 Professor John Deeble calculated that the primary health care services provided to Aboriginal peoples and Torres Strait Islanders was under funded by $300 million per year. There is an Aboriginal and Torres Strait Islander health workforce shortage.

WHAT THIS DISCUSSION PAPER ADDS

Using a new methodology Access Economics has estimated that the current primary health care services provided to Aboriginal peoples and Torres Strait Islanders is under funded by $400 million per year.

There is a critical shortage of health professionals providing services to Aboriginal peoples and Torres Strait Islanders (430 doctors and 450 others). The cost to fund these additional training places to address the total shortfall of all health professionals would be $36.5m/year ($167m over 6 years).

The AMA believes that to improve the health of Aboriginal peoples and Torres Strait Islanders it is critical to increase the proportional representation of this group employed within the general health workforce.

To increase the proportion of Aboriginal peoples and Torres Strait Islanders working as health professionals to non-Indigenous levels 928 doctors, 149 medical imaging professionals, 161 dentists, 2570 nurses, 275 pharmacists, 119 occupational therapists, 59 optometrists, 213 physiotherapists need to be trained.

An additional 2000 Aboriginal health workers are also required.

The AMA is calling for the allocation of fully funded training places to close this gap. A program to close this gap would take at least 10 years to enrol sufficient students. All efforts must be made to ensure those who enrol have the best possible chance of completion. To do this the AMA is calling for the Australian Government to:

- Provide full scholarships for all the students. The cost would be approximately $6 million a year for the first 4 years rising to $10 million thereafter.
- Fund Aboriginal and Torres Strait Islander Support Unit services modelled on the successful Indigenous Health and Education Unit at the University of Newcastle.

DEFINING THE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKFORCE

In this Discussion Paper, we use the term "Aboriginal and Torres Strait Islander health workforce" to mean the health workforce that provides services to Aboriginal and Torres Strait Islanders regardless of how or where they access the service. This might be through mainstream services or through specialised Aboriginal and Torres Strait Islander health services. It is not limited to health professionals who are themselves Aboriginal and Torres Strait Islanders or to health professionals who work exclusively in Aboriginal and Torres Strait Islander health.

Is the present Aboriginal and Torres Strait Islander health workforce able to meet the goal of Aboriginal and Torres Strait Islander health? Economic analysis tells us that it is not sufficient to simply have enough health professionals. We also need enough support services and appropriate health infrastructure. In short, the right mix of resources is the key to effective health care. This Discussion Paper outlines the workforce shortfall, the infrastructure shortfall and the overall funding shortfall.

THE GOAL FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Any attempt to state the goals of health care succinctly invites the risk of over-simplification. Health care is complex in both its goals and its delivery. Stated as simply as possible (with the attendant risk of over-simplification), Access Economics suggest that the goals for health outcomes are:

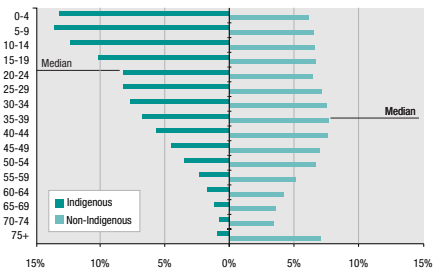
- to increase disability-free years of life;
- to manage chronic health conditions and end of life; and therefore
- to maximise quality of life subject to the constraints of illness and ageing.

The goal for Aboriginal and Torres Strait Islander health is surely for Aboriginal people and Torres Strait Islanders to have the same expectations as other Australians in relation to disability-free years of life and access to health care for chronic conditions, including at the end of life.

PRESENT HEALTH STATUS

The Aboriginal and Torres Strait Islander population is much younger than the non-Indigenous population (a median age of 20.5 years compared to 36 years), reflecting higher birth rates and much shorter life expectancy. Using a benchmarking approach, Access Economics concludes that Aboriginal peoples and Torres Strait Islanders overall have health status broadly on a par with non-Indigenous Australians aged 50 to 54.

Age Structures Of The Aboriginal And Torres Strait Islander And Non-indigenous Populations



Sources: ABS 3201.0 and 4704.0.

In short, despite the Aboriginal and Torres Strait Islander population being a much younger population, it is a less healthy population.

IN SEARCH OF A BREAKTHROUGH

At best Australia has been treading water on the issue of Aboriginal and Torres Strait Islander health. In some areas the data even indicate deterioration in the relative health status of Aboriginal peoples and Torres Strait Islanders compared to the general Australian population. The health workforce is occupied nearly full time dealing with the serious health problems of Aboriginal peoples and Torres Strait Islanders and has little time to dedicate to preventive health care.

If the health service providers want to create some momentum towards improved health outcomes, they need to boost disease prevention and early treatment programs. This will require extra effort - with a strong emphasis on health education and prevention within comprehensive primary health care. Such a strategy would involve the careful targeting of key risk factors with a view to reducing both morbidity and mortality. The workforce requirement calculations are based on the present services provided to 50 to 54 year old non-Indigenous Australians. In addition, Access Economics suggests that the extra effort needed over the short and medium term to kick-start the disease prevention cycle would require an extra 15% be added to the workforce requirement calculations. The figures presented in the Discussion Paper are therefore the base calculation + 15%.

In search of a breakthrough on Aboriginal and Torres Strait Islander health

THE RIGHT MIX OF RESOURCES

Aboriginal and Torres Strait Islander Health Workforce shortfall

To estimate the shortfall in access to medical practitioners, Access Economics compares the estimated requirement of 1,350 full time equivalents (FTEs) with the estimated current access of 920 FTEs, giving a short fall of 430 FTEs. It is a more difficult task to estimate the shortfall in access to other health professionals and health workers. In the absence of a more robust computational methodology, Access Economics assumes that the unmet need for allied health professionals is at least of a similar order to that for medical practitioners.

	Shortfall
General practitioners	250
Medical Specialists	180
Total Medical Doctors (general practitioners + medical specialists)	**430**
Allied health including nurses and dentists	450
Total Health Workforce Shortfall	**880**

Infrastructure

It is self evident that it would be an ineffective strategy to recruit additional medical practitioners and other health professionals, and then fail to provide the necessary health infrastructure to support the increase. In this context, infrastructure would comprise the health facilities used in the delivery of health services and all the equipment (fixtures and fittings) used within them.

Health infrastructure is not limited narrowly to hospitals and medical equipment. It encompasses health facilities in the wider community and general (non-medical) equipment such as communication and computer equipment.

Infrastructure can be funded as an up-front capital cost or financed on a pay-as-you-go basis. Access Economics believes that infrastructure costs are easiest to understand when expressed as an ongoing annual charge – as a percentage of recurrent costs. Based on broad experience of modeling costs in the health sector, Access Economics considers that a robust infrastructure parameter is 35%. Taking the shortfall of spending in the Primary Care Sector to be approximately $400 million per annum, $120m per annum of this would be the annualised cost of the additional infrastructure required by the higher staffing levels.

Training

It will take time to improve health workforce shortages. There are long lead times between any increase in undergraduate places and net additions to the fully qualified workforce. In the short to medium term, the only parameters that have much impact on workforce shortages are our ability to compete in the international labour markets for skilled professionals (both to hold our own and to attract some from abroad) and the extent to which we can hope to retain older health professionals in the workforce.

Given the overall health workforce shortages, the AMA does not think it at all realistic to expect that Australia can solve the shortfalls in the Aboriginal and Torres Strait Islander health workforce by taking health professionals from other areas within Australia. Furthermore, success in improving Aboriginal and Torres Strait Islander health will require health professionals with special skills and knowledge.

To train the shortfall identified is a medium to long-term solution and will take planning and commitment. Therefore it is imperative that we embark on this additional training as soon as possible.

The Additional Primary Care costs

	2004/5
Medicare + other medical	$130m/year
PBS	$85m/year
Dental and other health professions	$115m/year
Medical consumables, non-PBS medicines and appliances	$65m/year
Total on integrated PHC (including prevention)	**$400m/year**
Training (additional to Total on PHC)	$36.5m/year ($167m over 6 years)

ABORIGINAL PEOPLES AND TORRES STRAIT ISLANDERS IN THE GENERAL HEALTH WORKFORCE

Aboriginal peoples and Torres Strait Islanders are massively under-represented within the health workforce. Estimates published jointly by AIHW and ABS[1] indicate that, in 2001, there were 8.16 health workers who are themselves Aboriginal and Torres Strait Islander per thousand Aboriginal peoples and Torres Strait Islanders, compared with 22.84 health workers who are non-Indigenous per thousand non-Indigenous people. As the Table below shows, there are some health occupations where a very large increase (tenfold or more) in health workers who are Aboriginal and Torres Strait Islander would be required before Aboriginal peoples and Torres Strait Islanders to be represented pro rata to the Aboriginal and Torres Strait Islander population.

The shortfall of Aboriginal peoples and Torres Strait Islanders in the general health workforce

	Numbers in 2001	Pro rata	Gap
Medical imaging	14	163	149
Dentists	13	174	161
Nurses	789	3,359	2,570
Retail pharmacists	10	285	275
Occupational therapists	7	126	119
Optometrists	5	64	59
Physiotherapists	29	242	213
Aboriginal Health Workers	853	2000*	–

* 2001 government estimate of shortfall

The USA, Canada and New Zealand all have more health professionals and, despite continuing disparities, have made greater improvements in health for their Indigenous populations. Although at this time there is no scientific evidence that these facts are connected, the AMA suggests that increasing the Aboriginal and Torres Strait Islander health professionals to parity is an important way to improve the health of the Aboriginal and Torres Strait Islander population in the medium to long term. The AMA believes that Australia should make a commitment to achieving parity of numbers of health professionals as one of a number of strategies to help rectify the Aboriginal and Torres Strait Islander health emergency. The AMA calls upon the Government to initiate a training program to achieve parity: such an affirmative action program would require the identification and full funding of the required places for Aboriginal and Torres Strait Islander students. This would need to include the support units which are essential to ensure that most enrolled Aboriginal and Torres Strait Islander students make it through to qualification.

[1] *Health and community services labour force 2001*, AIHW (Cat. No HWL 27) and ABS (Cat. No. 8036,0), 2003.

TRAINING PLACES REQUIRED

Workforce planning is complex and requires knowledge of the age distribution of the present workforce when estimating numbers needed both to replace those leaving the workforce and the necessary increase. However there are so few Aboriginal and Torres Strait Islander members of all these professions, except the Aboriginal Health Workers, that the number of places needed for replacement will be trivial in comparison with those required to increase the numbers. The figures for Aboriginal Health Workers are based on the government's 2001 estimate of the shortfall, as the methodology used for the other professions does not apply. In addition there will be a large number of Aboriginal Health Workers retiring over the next 10 years and this is reflected in the proposed increase in training places.

We present a stepped increase in training places recognising the difficulty to recruit Aboriginal and Torres Strait Islander students. These training places do not have to be new places, rather present training paces allocated to be filled by Aboriginal and Torres Strait Islander students. Therefore the number of places should not be limited by the difficulty faced by training institutions to increase training places.

Training places required to fill the short fall in 10 entry years

	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	Total/short fall
Doctors	50	50	50	50	100	100	100	100	100	100	800/928
Medical Imaging	10	10	10	10	15	15	15	15	20	20	140/149
Dentists	10	10	10	10	20	20	20	20	20	20	160/161
Nurses	125	125	125	125	250	250	250	250	500	500	2,500/2,570
Pharmacists	20	20	20	20	30	30	30	30	30	30	260/ 275
Occupational therapists	10	10	10	10	10	15	15	15	15	15	125/119
Optometrists	4	4	4	4	4	8	8	8	8	8	60/59
Physiotherapists	15	15	15	15	15	30	30	30	30	30	225/213
Aboriginal Health Workers (additional training places)	250	250	250	250	250	250	250	250	250	250	2500/2000
Total number of places	**494**	**494**	**494**	**494**	**694**	**718**	**718**	**718**	**968**	**968**	**6760/6474**

Training costs

Training costs	Extremely hard to estimate. Initially at least, allocated places should be already funded places and therefore the Affirmative Action places would be at no additional cost to government. Over time there will be a need to increase places because of the overall workforce issues. We have therefore included the cost of the increased places required for the Aboriginal and Torres Strait Islander Workforce not the General Workforce increases required to increase the Aboriginal and Torres Strait Islander numbers in the general health workforce.									
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
	$36.5m	$36.5m	$36.5m	$26.0m	$18.5m	$16.5m				
Living expenses	Either as scholarships or through more innovative and culturally appropriate residential provision. $20,000/person/year.									
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
	$5.9m	$5.9m	$5.9m	$5.9m	$9.9m	$10.4m	$10.4m	$10.4m	$10.4m	$10.4m
Support Units	At least 10 units required: approximate cost $10 million/year									

RECRUITMENT AND RETENTION OF STUDENTS

Recruitment and retention of Aboriginal and Torres Strait Islander students will be the limiting factor. If places are not filled in one year they should be transferred to the following year.

All possible barriers to entry and completion of the course must be reduced so long as these do not reduce the standards of those who graduate, as it would be unacceptable to all to create a sub-class within these professions. Therefore all identified places must be fully funded. Options should be developed to provide culturally sensitive environments for these students.

An alternative to full scholarships to pay all living expenses might be to create a culturally appropriate accommodation unit and to meet their living expenses through scholarships.

At the very least all training facilities with identified places must be funded to provide Aboriginal and Torres Strait Islander Support Unit services as per the Indigenous Health and Education Unit at the University of Newcastle.

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