Workforce Shortage or Dysfunctional Service Models?

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"Workforce Shortage or Dysfunctional Service Models?" Fairly provocative statement I would suggest given this audience.

Here is 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" is said in the same way as one might say "There's a drought", with the implication that there is 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 lack of supply. But we know it is a multi-dimensional issue impacted by:

- Government policy - Training places
- Decisions by individuals - Training completion, Transition to work, participation
- Client related - Increasing demand and changing demographics
- Systems-based - Models of care, Retention

And I would add to the list service delivery models and management processes.

Workforce Shortage: Multi-dimensional

- **Policy** - training places
- **Individuals** - training completion, transition to work, participation
- **Clients** - increasing demand, changing demographics
- **Systems** - Models of care, Retention, ***Service delivery models, Management processes***

Is the Workforce Shortage Real or Perceived?

The first point I want to make today is that we have very little understanding of what our workforce shortage is in rural and remote Australia because:

- The high turnover or churn of health professionals gives a perception of a workforce shortage but is this real?
- The lack of relevance of some of the indicators used for workforce planning and modelling

Workforce Shortage: Real or Perceived?

How do we know?

- High turnover - "Churn"
  - Allied health 42% in position < 2 years (Fitzgerald et al., 2002)
  - Doctors: QH- 32%,GP 15% over 12 mths (source: Health Workforce Qld, 2005/06)
- Relevance of indicators?

Indicators

The indicators that AHWAC was using to determine the adequacy of the present workforce are shown here:

Workforce Indicators – "adequacy"

- Vacant funded positions
- Service waiting times
- Reduction in level of service provision
- Poor patient outcomes linked to reduced/changed staffing levels
- Practitioner to population benchmarks
- Excessive hours of work
- Extent of total supply provided by other staff
- Views of stakeholders

However, I query the applicability of some of these in the rural and remote environment.

Vacancy rate: What does this mean when health services 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 personnel are working in a capital or provincial city or delivering services under a hub and spoke model in rural and remote Queensland, or NSW.

***Service waiting times, reductions in levels of service provision*, poor patient outcomes:** What's this mean when there has never been a service, limited service, or it's a service provided on an "as needs" basis

Population benchmarks – well there's not a lot around. There are various benchmarks for general practice, there's benchmarks for Indigenous Health Workers, and very limited benchmarking for allied health.
Robyn Adams did some benchmarking for physio, and there is Rob Curry's planning work in the Territory, which has formed the basis for the North West Queensland Allied Health Service operating out of Mt Isa, and the Katherine Regional Aboriginal Health Related Service.

The NSW Mental Health Clinical Care and Prevention program has developed population benchmarks for mental health services based around models of care. This bottom up approach is a very good start where the model of care is along the lines of a biomedical model. However, non-clinical time needs greater consideration to cater for outreach service models.

Workforce planning

We have very little understanding of what our workforce shortage it. 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, and then determine what and where the shortfall exists.

Workforce planning: Determine and describe the model of care AND the model of service delivery to plan the workforce requirement and skill mix –

Then determine what and where the shortfall exists

Dysfunctional Service Model

Today I don't want to harp on about workforce shortages, rather I want to focus on how we build sustainable service models for functionality. But first we need to get some agreement on what is a dysfunctional service so we know what we don't want.

Dysfunctional service model:

"A model of service delivery that does not support or enable health professionals to provide **effective** care to individuals and communities on a **sustainable** basis"

KB definition

My definition of a dysfunctional model is one that does not support or enable a health professional to provide effective care to individuals and communities on a sustainable basis

There are plenty of examples:

- Overseas trained doctors lobbed into remote communities, working as a solo practitioner, with 24/7 on-call, with no orientation to remote practice, Aboriginal culture and minimal understanding of the Australian health system
- The Clayton's Service. Allied health professionals flying in and out of a town once a fortnight. On the ground for 6 hours, sees 6 or 7 clients. There's a 12 month waiting list and no mechanism in the community for local follow-up. Powers that be can tick the box and say we provide this service, but it's Dysfunctional because the service model is inadequate to meet need, and creates distress to the health professional because they are having little impact, there's high risk of creating job dissatisfaction and resignation.

Examples of Dysfunction

- Overseas trained doctor "lobbed" into remote community, 24/7, no orientation to remote practice, Aboriginal culture, Australian health system
- Clayton's allied health. In and out same day (fortnight/ month), excessive waiting list, no local care plan, doesn't meet local need, breeds job dissatisfaction

Sphere of Influence

To develop sustainable and functional health services and build our workforce, we need to put our efforts where we have some control or of influence, and this is around:

- Training environment
- Maximizing participation
- Re-engineering the service model to promote retention and build service capacity

Sphere of Influence

- ***Training environment*** – completion rates, transition to work, local recruitment through pipeline
- ***Maximize participation***, (support re-entry, flexible work arrangements)
- ***Re-engineering*** for Retention and service capacity

Training environment
We 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, impacting on training completion rates, transition from training to work, and recruitment to your service by having an effective training pipeline.

Participation
Maximising participation by providing a flexible work environment, can support re-entry of health professionals. A model that the NSW CW Division of General Practice is seeking to progress under the Rural Private Access Program is the concept of an Allied Health Industry Network.

Within the Central West, there is a 'sleeper' allied health workforce that is not working because of family or lifestyle choices. The majority of these people are women, and seek flexible working conditions close to where they live. Whilst private practice offers flexibility there are a number of barriers including:

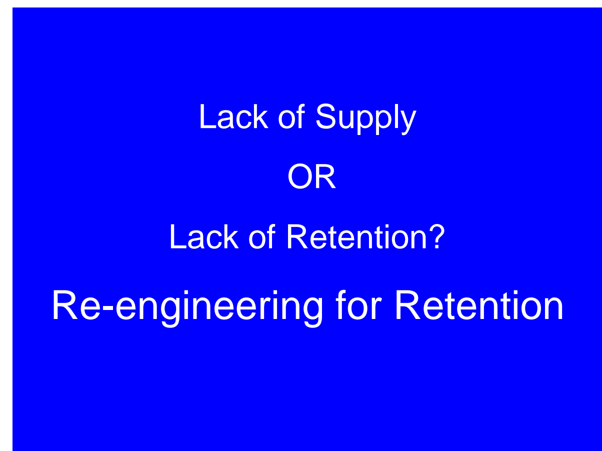
- Perceived business risks,
- Lack of business skills,
- Business establishment costs,
- Lack of support structures because working in isolation,

The Industry Network model is seeking to:

- Support re-entry through provision of business and practice management advice, and support in the process of business set-up,
- Provide flexible employment and subcontracting arrangements to suit individual practitioners seeking to work or resume work in the Central West,
- Establish clinical networks for professional support
- Broker work contracts with external agencies to develop a market for the AHPs
- Optimise funding streams to enhance access to primary care

Re-engineering for Retention

But WHERE we can really get some bangs is by re-engineering for retention.



There is plenty of evidence to tell us why health professionals leave rural and remote practice and why they are so mobile.

Drawing on the literature for allied health, nursing, general practice, dentistry and mental health it boils down to 3 domains:

Professional Domain

- Job dissatisfaction – contributing factors policy, management and administration, interpersonal relations and working conditions
- 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 paths
- Difficulty accessing to professional development and access to post-grad education
- Excessive travel (for outreach services)
- Lack of orientation to rural/remote and Indigenous culture
- Remuneration not reflective of isolated practice

Personal factors

- Accommodation and housing
- Spouse/partner employment opportunities
- Access to quality education (children)
- Child care

Community factors

- Establishment of social networks
- Local facilities

Why aren't we applying the evidence to develop sustainable models?

Evidence not applied: Why?

- Under resourced
  - Retention strategies
  - Operational budgets
- Lack of flexibility in award conditions
- Fragmented funding – fragmented service provision

Under-resourcing
I'm not telling anyone here something new when I say "Rural and remote health services are under-resourced for what they are expected to do".

The big losers are
Retention strategies. Professional development, study leave, time out of the community, accommodation subsidies –looking at around $12,- $14,000 per year per staff member. State and Territory Health Services – or their policy people or bean counters baulk at this, but we know investment upfront creates savings in recruitment costs, locum fees or nursing agency fees, ***not to forget continuity of service provision.***

Operational budgets. The operational budget (travel, accommodation, office running costs) for a hub and spoke service in remote Queensland is around 60% of personnel costs, when the budget is developed on a bottom up approach. But compare that to the flat 15% or whatever the relevant state funding formula is, and then we understand why rural health services run vacancies to subsidize their operational costs.

Lack of flexibility in award conditions
Lack of flexibility in award conditions in some states, precludes the application of retention strategies.

Fragmented health funding leading to fragmented service provision

How often do we see state funded and commonwealth funded health services operating in the same environment, employing small staff teams, providing similar services to dispersed populations, but with differing criteria about who they can can't service.

And all of them having difficulties in recruiting and retaining staff.

Would retention be improved by having one agency as the auspice and employer of the health professionals, so create a critical mass, with the other agencies purchasing services to meet the needs of their clients?

Policy implication: Health service provision in rural areas costs more than urban areas, therefore State and territory health services require a different funding formula to urban and provincial services.

Policy implications for state and territory health services and Australian Government:

- *Rural and remote health services require different funding formula to urban services*
- *Flexible employment arrangements for rural and remote locations*
- *Removal of artificial boundaries created by state and federal health funding to promote efficient, effective and sustainable models of health service delivery in rural and remote areas*

Application of the Evidence

Lets apply the evidence.

The sustainability of health services hinges on the retention of health practitioners, so how do we plan, or re-engineer for a sustainable health service?

Using the evidence from the literature, this diagram reflects the professional and personal domains that have to be met to support sustainable health service delivery. Diagram 1

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 model across the Primary health care continuum.

This interface presents opportunities to establish a critical mass of health professionals for provision of primary health care across a clinical services network- like a hub and spoke arrangement, as well as at a local level.

It enables the development of systems to manage internal relief, back fill, on-call, and reduce after hours burden.

It provides the opportunity to utilize key local resources like GPs, local generalist nurses, Aboriginal Health Workers, ambulance officers, aged care, child care, teachers, and NGO workers to promote service delivery across the continuum.

We can develop a multidisciplinary team (sourced from the agencies in the interface), with effective information management systems to support models of integrated and shared care across sectors.

In addition, we need to recognize that medical practitioners (and other health professionals) are unlikely to financially commit to the purchase of practice facilities in rural locations and that alternative strategies for the provision of infrastructure are required, such as the Easy Entry Gracious Exit model developed by the NSW Rural Doctors Network.

At a practitioner level, we need service models that address personal support needs inclusive of appropriate housing, professional development, career pathways, safe work hours, rosters that enable work/life balance – which we can develop through the critical mass concept.

Meeting these needs requires collaboration across service agencies, other workforce organizations, local government and the community.

Examples of Where the Evidence Has Been Applied

Today I am going to present 2 examples of what happens when the evidence is applied.

Remote Cluster, Far west NSW: Integrated Service Model

Maari Ma, GWAHS, RFDS, UDRH

- **Increased resources** to the Cluster through Commonwealth
- Significant **expansion in breadth and frequency** of services across Cluster
- Integrated **Chronic Disease Strategy** coordinating activity across agencies

Remote Cluster, Greater Western Area Health Service

The Remote Cluster of the Greater Western Area Health Service is situated in far west NSW and includes the city of Broken Hill, and communities of Wilcannia, Ivanhoe, Menindee, Dareton, Wentworth, Balranald, Tibooburra and White Cliffs. In this Cluster there is a unique agreement between the Greater Western Area Health Service and the Maari Ma Aboriginal Corporation where health services to the communities are managed by Maari Ma. In addition, RFDS partner in service delivery and the UDRH has a training and research role.

This integrated service arrangement has resulted in:

- Increased resourcing to the cluster through commonwealth funding to Maari Ma
- Over the last 5-6 years, significant expansion in the breadth of services provided across the cluster – particularly targeting chronic disease and child and maternal health, GP and medical specialist services
- Development and implementation of a chronic disease strategy that coordinates activity of health professionals across the agencies

In terms of how it lines up with the sustainability criteria:

- Formal agreement underpins the interface between the Area Health Service and the Aboriginal Community Controlled Health Service, with provision of medical services under a purchaser provider arrangement with RFDS
- It has established a critical mass of health professionals based in Broken Hill that outreach to the smaller towns
- The Chronic Disease Strategy provides a structure framework for practical integration between visiting and local practitioners – so there is a primary health team based approach to service provision, as well as skill development
- There is an information management system under development
- UDRH has established a Diploma in Primary Health care, and this provides a local training pathway for Aboriginal people to become health practitioners, is increasing Aboriginal participation in the health workforce, and developing a career path
- GWAHS provides housing for the RNs in the communities, but as is the case in most services I've come across there is no housing for the AHWs
- Whilst the RNs and Primary Health Care workers in the community are managed by Maari Ma, they are employed by GWAHS. Therefore entitlements are subject to the awards underwhich the Area Health Service operates. This is presenting a limitation to developing a more flexible response to the challenges of maintaining the nursing workforce in the smaller communities.

Sustainability Checklist

✓ Formal agreement underpins interface
✓ Critical mass in Broken Hill- social/community infrastructure
✓ Chronic Disease Strategy
 ✓ Practical integration with local health practitioners
 ✓ Primary health care team
 ✓ Building skills
✓ Information management capacity being developed
✓ UDRH – training pathway
✓ Increasing Aboriginal participation
✓ Career path
✓ Housing for RNs in communities
✗ Housing for PHWs in communities
✗ Flexible awards

North and Western Queensland Primary Health Care – allied health

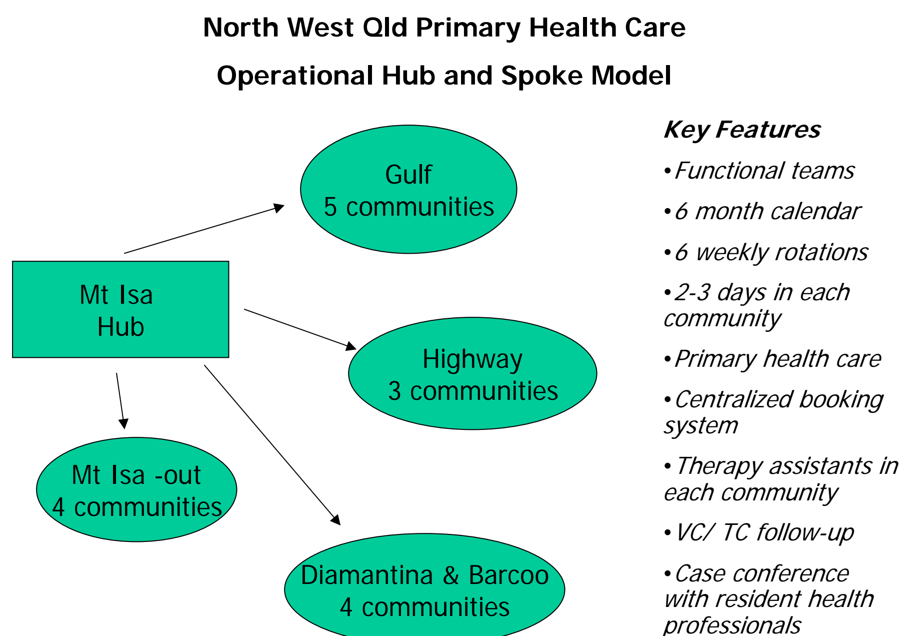
I have to declare a bit of bias in this model because of my involvement in its development. The implementation of the model and growth in capacity of the service is a credit to Kelly McTaggart, Joanne Symons, Elaine Ashworth, Christine Franklin and Karen O'Rourke and the great team of people that work out of Mt Isa.

In 2002, North and Western Queensland Primary Health Care established an outreach allied health service based in Mt Isa, funded under the Commonwealth Regional Health Strategy. It provides a raft of allied health services across 6 disciplines to communities in North-west Queensland.

In 2003, it received additional RHS funding to expand its services into the Diamantina, Boulia and Barcoo Shires. More recently, additional funding through HACC and PHCAP has seen the expansion of services to Mt Isa city itself and additional service provision in the communities.

The service model sought to respond to community priorities about HOW an outreach service should be provided to promote access and utilization – key points being regular and reliable, consistent personnel and staying for more than a day.

Superimposed on this was the application of the research that identified the key professional and personal factors to be addressed in the service model to support retention of the allied health professionals.



The effectiveness of the recruitment and retention strategy is demonstrated by:

- Retention of several of the initial nine recruits in the service 4 years later, and others beyond three years
- Ability to recruit additional staff as the allied health service expanded
- Creation of a management structure to cater to the expansion, providing a career path within the service
- Good reputation as an organization seen to "look after" staff, catering to professional needs within an innovative albeit challenging service model

This was facilitated by:

- Greenfield site – develop a positive organizational culture and staff selected with aptitude for remote practice
- Division of GP – more flexibility in employment packaging

Effective recruitment and retention

- Retaining staff > 3 years
- Recruit as service expanded – 9 positions in 2002 – over 20 positions 2007
- Created management structure (Team Leaders) – career path
- Good reputation – cater to professional needs

Facilitated by

- Greenfield – organizational culture, staff selection
- Flexible employment packages

How does it stack up against our sustainability model?

- In terms of an interface it is less formal than the Maari Ma model but has collaborative arrangement with other agencies operating in the North West that enables the AHPs to work in the QH clinics, access records, work in the schools and work through and with the local health workers, teachers, aged care and child care workers
- Has its own critical mass that enables backfill and internal relief, but also adds to critical mass within Mt Isa to develop peer support networks and links with other providers for service provision across agencies
- It is developing a training pipeline through linkages with universities to enable student placement
- It is building local workforce capacity through training and upskilling of local Aboriginal Health Workers, childcare workers, aged care, teachers and teacher's aides to deliver programs for clients between visits
- Working as a primary health care team – internally and externally – with the other agencies in the interface

Within the personal domain, retention strategies provide:

- Housing subsidy
- Paid professional development
- Paid Study leave
- 6 weeks annual leave – the beauty of flexible employment arrangements

Sustainability Checklist

Professional

✓ Interface for collaborative service provision (Mt Isa HSD, Wu Chopperen, Bush Children's, Ed Qld, RFDS – clinics, records, working through and with local health practitioners and workers)
✓ Critical mass
  ✓Internal backfill
  ✓Peer support across agencies
  ✓Service provision within disciplines across agencies (eg. Speech)
✓ Training pipeline – student placements
✓ Building local workforce capacity– AHWs, childcare, aged care, teacher's aides
✓ Primary health care teams – internal and external

Sustainability Checklist

Personal

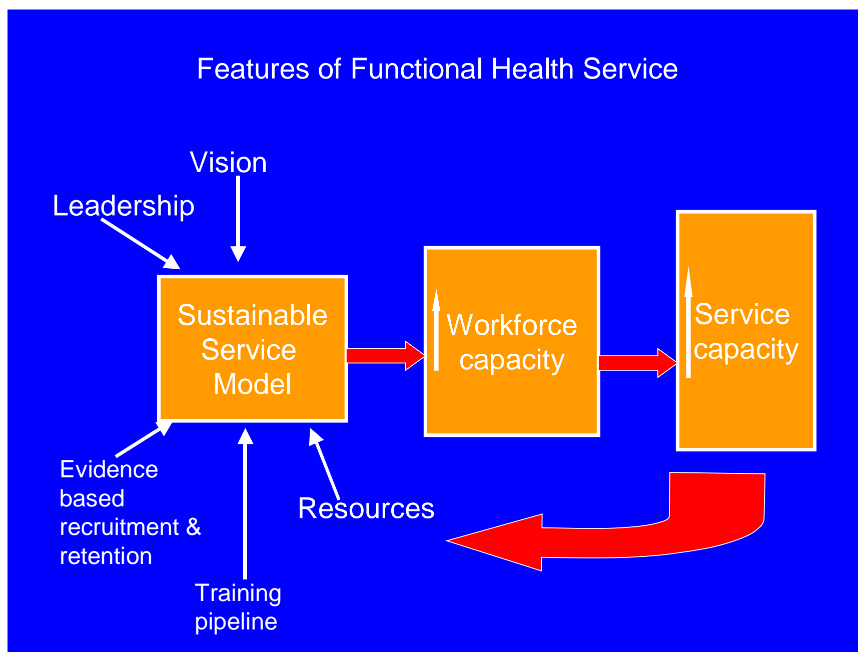
✓Housing subsidy
✓Paid professional development
✓Orientation to Remote Practice (Grad Cert or similar)
✓Study leave
✓6 weeks annual leave

Conclusion

So what are the common features of these models that have been able to build workforce and service capacity in very challenging environments are:

- People in the driving seat with a Vision of what they want to achieve
- Strong leadership to forge these collaborative and integrated services
- Source the resources to enable the application of the evidence to ***build a sustainable service model as a platform*** for increasing workforce capacity and service capacity.

What we have seen from these examples is that when a functional service demonstrates it can do it – more resources come to support further expansion.



Definition of insanity:
"Doing the same thing and expecting a different outcome"

Take Home Message:
Service models need to be engineered for sustainability to build our rural health workforce to maintain and expand health service provision to people living in rural and remote Australia

What's our take home message?
We can't keep doing what we are doing and expect a different outcome.

We need to engineer out models for sustainability and that means putting the rubber to the road and develop and implement collaborative and integrated services if we are to build our rural health workforce, so that we can maintain and expand health services to people living in rural and remote Australia.