Submission by the Australian Nursing and Midwifery Federation

Review of section 19AB of the Health Insurance Act (the Act) and district of workforce shortage (DWS) classification system

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 326,000 nurses, midwives and care-workers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The ANMF welcomes the opportunity to provide feedback on the review of Section 19AB of the Health Insurance Act (the Act) and districts of workforce shortage (DWS) classification system from a nursing and midwifery perspective.

Overview

6. Residents of rural and remote areas on average have lower incomes, more health risk factors, poorer access to local health services and higher burden of illness compared to those living in metropolitan areas.[1] The social determinants of health for this population result in complex health needs. Rural and remote communities continue to highlight shortages of general practitioners, as do many communities in lower socioeconomic metropolitan areas. Access to primary healthcare has become increasingly difficult as medical practitioners choose to work in specialty areas rather than general practice,[2] and out-of-pocket costs to visit a general practitioner spiral.[3] The Australian Medical Association (AMA) suggests the demand for general practitioners (GP) has risen over time. Still, supply has yet to keep up, especially in rural and remote communities, with the AMA predicting a shortfall of 10600 GPs by 2031-2032.[4] Many communities, such as those in rural and remote areas, are already experiencing this gap,[5] and despite large financial incentives, or levers such as the 19AB rule, recruitment and retention of GPs has not grown,[6] resulting in poorer health outcomes and patient experiences and reduced or delayed access to primary healthcare with subsequent increased burden on other health services such as emergency departments (ED).[7] The inability to see a GP also results in reduced access to medical specialists, diagnosis and treatment because GPs are the only health practitioner who can issue a referral.

7. In this submission the ANMF has responded to the consultation questions relevant to nursing and midwifery or more generally, as they impact all health disciplines. The lack of evaluative data and analysis relating to Section 19AB of the Health Insurance Act (the Act) and the districts of workforce shortage (DWS) has limited the ANMF's response to many questions and brings into question the transparency of any actions undertaken relating to the Act. Section 19AB appears to have changed since its inception, making the criteria and application of the Act unclear.

Consultation questions – has section 19AB and DWS met their objectives?

Question 1. What impact has Section 19AB and DWS had on the distribution of the medical workforce to areas of workforce need.

8. Section 19AB of the Health Insurance Act (the Act) restricts access to the Medicare Benefits Schedule (MBS) for 10 years by medical practitioners trained overseas, except for those overseas trained medical practitioners applying to work in a DWS. This approach is aimed at assisting workforce distribution.

9. Ideally the consultation paper would have included accessible information and data on the current distribution of the workforce being discussed and shown the DWS. The Health Workforce Locator map[8] is of limited use. Without this information it is difficult to provide objective comment. Anecdotally, the ANMF hears often from members regarding the lack of general practitioners (GP) in regional, rural, and remote Australia, as well as the shortages in areas with lower socioeconomic profiles. Members highlight the impact this has on the community's ability to access affordable and appropriate health services close to where they live.

10. The ANMF is concerned about an approach that supports placing overseas trained medical practitioners into isolated areas, where they may be the only general practitioner and where they have limited or no support. It seems negligent to place practitioners with limited knowledge or experience of rural and remote healthcare in an Australian DWS. Such an approach is irresponsible at best and places the safety of the medical practitioner, other health practitioners and members of the community at risk. Nurses and midwives who are members of the ANMF express this concern finding that in the interest of the person receiving healthcare, they are required to provide extensive support and guidance regarding medical practice. This adds to their workload and becomes an ethical question about their scope of practice.

Question 2. What impact have changes to the DWS (i.e. area designations and specialties in scope) had on distribution of the medical workforce to areas of need?

11. The ANMF acknowledges that the 10-year residency status moratorium is outdated and requires review and amendment to aid access to primary care in rural and remote locations. The practice should also reflect current developments and needs in health care including the promotion of multidisciplinary teams and the changes in disease profiles. As previously stated, the lack of current data and information regarding areas of DWS limits the response to this question. However, anecdotal evidence suggests that little has been achieved through Section 19AB of the Act, except increasing the workload and burden on nurses and midwives.

Question 3.

A) How could Section 19AB be improved or supported to better meet its objectives?

12. Section 19AB of the Act is outdated and would not appear to be achieving its stated aims given the actual and predicted shortages of GPs in rural and remote locations, although as previously noted it is difficult to know this without supporting evidence regarding Section 19AB.

13. If the Government wishes to continue to use Section 19AB it would need significant revision. This section of the Act should not be promoted as a solution to rural and remote shortages of medical practitioners, especially given the lack of transparency regarding the evaluation and outcomes of this approach.

14. It would be more helpful if overseas trained medical practitioners and other medical practitioners were expected to work in multidisciplinary teams with nurses, nurse practitioners and midwives who were enabled to work to their scope of practice in primary health centres that employed block funding models and that did not rely on MBS funding. Primary health centres that currently exist or are attached to small rural hospitals and facilities in DWS could serve this purpose and provide more supportive environments for health practitioners as well as accessible and affordable healthcare for communities.

Ideally, these environments would be open to all nurses, midwives, and medical practitioners, including those recently graduated and serve as teaching environments for students. Connectivity is improving through technology and can offer health practitioners working in DWS access to more experienced or specialist health practitioners who can provide advice and supervision especially when combined with new modes of artificial intelligence (AI) in diagnostics.

Question 4.

A) What would be the implications of removing Section 19AB?

15. It is not likely that in 2024 there would be too may implications on either the medical or the nursing workforce by removing section 19AB. It may result in some areas losing a medical practitioner but if funding was channelled into other models of care delivery, this could result in minimal impact and better access to PHC.

B) What are the alternatives to Section 19AB for achieving more equitable distribution of the medical workforce?

16. Reconsideration of the models of care used to deliver primary health care (PHC) is needed especially in areas of workforce shortages, including the need for legislative and cultural changes that allow nurses and midwives to work to their scope of practice and as equal primary healthcare providers and members of the multidisciplinary team (MDT). The ability for nurse practitioners (NP) and endorsed midwives to refer and order diagnostics, would reduce the need for GPs to be present and offer expanded access to specialist services. It must be acknowledged that nurse and midwife led models of care along with paramedic services provide quality primary healthcare to communities that have no or limited access to a GP. Further, such services must be funded as an ongoing solution rather than the current view that these are stop gap measures. The introduction of MDTs and the use of technology to enhance face to face and remote services in rural and remote areas must be supported and enhanced. Whilst technology should never replace face to face healthcare, it can assist in screening, diagnosis and communication. It offers the MDT who are physically present, the ability to access specialist and GP services (if needed)

remotely via televisual communication, allowing members of the MDT to be with the person seeking specialist services while speaking with a specialist medical practitioner virtually. This already occurs in areas across Australia. Technology requires funding and commitment for ongoing support and education, for all members of the MDT. It also requires ongoing funding for infrastructure, maintenance and other on costs for equipment and web-based services.

Question 5. Has the impact of the DWS been different (positively or negatively) when compared to other distribution levers?

17. Without access to current and historic data, analysis, and evaluation it is difficult to address this question. Costly incentive measures have not been successful, demonstrated by the current and predicted shortage of GPs and specialists in rural, remote, and lower socioeconomic areas. Funding for such incentives would be better spent on new models of multidisciplinary care that are block funded and salaried. Medical practitioners who are trained overseas could still be required to undertake a placement in these areas alongside other medical and non-medical graduates and be salaried along with the rest of the MDT.

Consultation questions – how appropriate is section 19AB?

Question 6. How relevant/appropriate is Section 19AB and DWS for achieving current government policy objectives?

18. Without access to current and historic data, analysis, and evaluation it is difficult to address this question. Based on available information, 19AB seems to hold little relevance.

19. It is unclear why the DWS, which is based on the ratio of specialists to population (although this appears to have changed over time to include medical practitioners) is used to determine the need for placement of overseas medical practitioners. Initially the distribution priority areas (DPA) would seem a more logical guide for determining areas of need however, currently only areas classified as MM1 are excluded, so this lacks specificity.

Question 7. What are the benefits of s19AB in supporting access to medical professionals in areas of workforce shortage?

21. As previously mentioned, there are current and predicted shortages of medical practitioners in rural and remote areas. Without other data or evaluation on DWS, there is little evidence with which to identify benefits. There has been some suggestion based on historic research that those who have grown up in rural and remote areas and who return to work as medical practitioners are more likely to be retained.[9] This influenced the concept of rural medical schools and bonded places. It would be more useful to focus on new models of care that were not reliant on privately practising and sole medical practitioners.

Question 9.

A) To what extent do areas of workforce shortage rely on OTDs and FGAMS for their medical workforce?

22. The data to inform this is unobtainable, however, several ANMF members working in rural and remote locations tell us that overseas trained medical practitioners are often professionally and personally isolated with limited support and knowledge of the context in which they find themselves and the health issues facing the community. There is also a lack of knowledge regarding the scopes of practice of non-medical health practitioners which impacts negatively on the team approach to healthcare.

B) What are the implications?

23. Nurses and midwives are compelled to provide professional support which is unrecognised by health services and administrators and outside of their scope of practice. This places them under additional professional and workload stress. The lack of understanding regarding the way MDTs operate and knowledge of the scopes of practice of other members of the MDT, challenges the operation of the healthcare team and the provision of effective and holistic primary care.

Question 10. How should the Section 19AB, DWS and other distribution levers best work together to achieve government policy objectives?

24. The maldistribution of the medical workforce across all Australian jurisdictions, has resulted in a higher demand for nursing and midwifery led services, and a greater reliance on the paramedic workforce. Moreover, in rural and remote areas, like the Northern Territory, far North Queensland and Western Australia the emergence of Aboriginal and Torres Strait Islander Health workforces increasingly fills a void left by GPs. These tend to be viewed as 'makeshift solutions' and are seen as 'gap fillers' while other, often expensive incentives and untested methods are proposed and piloted in an attempt to attract GPs to remote and rural locations. Nurse and midwife led care in the context of the MDT must be viewed as an ongoing solution, where NPs and endorsed midwives can prescribe and refer to other health services and where consumers are not disadvantaged financially or geographically. The MDT is not an autocratic model of care and GPs must be viewed as equal members, able to work remotely using technology but where their physical absence does not block access to other primary care services.

Question 11. What other levers (positive or negative) are most likely to achieve objectives of:

A) equitable distribution of the medical workforce.

25. At some point, Governments must accept that all positive and negative levers designed to attract GPs have been expensive and largely unsuccessful in addressing workforce shortages in rural and remote communities. It is time to look toward other regulated health practitioners and models of care, many of which are in place, to support the health needs of rural and remote communities.

B) reducing reliance on OTDs outside of major cities?

26. Governments and administrators must pivot in the way they view and fund PHC: This is key to ensuring distribution of workforces and reducing reliance on medical practitioners in private practice for access to and management of healthcare. This can be achieved in several ways including,

- A move away from private and sole practitioner models of care by allowing nurse practitioners and endorsed midwives to work to their scope of practice as equal, independent members of the MDT,
- Embracing models of block funded, multidisciplinary care that do not rely on the MBS or GPs for access to health treatments, specialist referral, diagnostics, and health services,
- Ensuring members of the MDT can work to their scope of practice and understand the scopes of practice and role descriptions of other members of the team,
- Embracing technology including AI that allows MDTs to work with team members and specialists who are remote but can still allow nurses and midwives to maintain face to face episodes of care with people living in remote and rural communities.

Consultation questions – How appropriate are the assumptions that underpin the DWS?

Question 12. How appropriate are the current DWS area designations in identifying areas of workforce shortage?

27. It would seem the DWS is unfit for purpose. Given that this is about specialist access, it is unclear why it is an appropriate measure for placing overseas trained medical practitioners into primary care positions. It may be more appropriate to use the DPA although this only excludes placement in metropolitan areas and therefore obsolete.

28. With the increasing availability of diagnostic assistance through AI and sharing of test results through secure internet platforms, communities can be less reliant on the physical presence of a medical specialist. Nurses and midwives are skilled and educated in assessment and are used to conducting case conferences using video links to speak with patients, families, specialists, and GPs from a variety of locations, for example from the clinic or a person’s home. In many instances specialists only need travel to a location for short periods of time (days per month) to see lists of more complex cases who have been prioritised in consultation with the MDT.

Question 14.

A) How could the DWS classification be modified to better meet its objectives?

29. The DWS functions under outdated modes and approaches to primary healthcare. This should be reconsidered bearing in mind the Scope of Practice review currently underway. Any method must be fit for purpose and incorporate all medical and non-medical health practitioners functioning within a PHC MDT. Any system must be a part of quality improvement cycles and evaluated properly and transparently to explain and justify resource allocation and be able to demonstrate it meets the health and safety needs of the community.

B) What would be the best geographic level at which Districts of Workforce Shortage should be classified (e.g. Statistical Area Level 3, Remoteness Areas, Local Government Areas, something else)?

30. This would need to be considered alongside the data showing socio-economic status, and the number of regulated primary healthcare providers across geographical areas to identify gaps.

Question 15.

A) Are there better alternative approaches for identifying Districts of Workforce Shortage?

31. More transparent approaches are needed to determine the gaps in Australian healthcare so they can be evaluated using a multidimensional lens and shared with Australian communities.

B) If better approaches could be implemented, how would they operate?

32. The use of multiple platforms and data sets is required to provide an accurate and useful way of identifying areas of need in Australia. For example, the Modified Monash Model combined with the Socio-Economic Indexes for Areas (SEIFA) data sets, could offer a more targeted approach to workforce management. Understanding the spread of all health practitioners who can work as PHC providers (or at least nurses, nurse practitioners, endorsed midwives, midwives, Aboriginal Healthcare practitioners and GPs) across the nation, could provide further depth for identifying and reporting areas of need.

Conclusion

33. Section 19AB of the Health Insurance Act and the DWS are outdated and lacking in validity. Attempts to attract and retain GPs and specialist medical practitioners to rural and remote locations using costly funding incentive levers have been unsuccessful and left those living in these communities disadvantaged. Many rural and remote communities have limited or no access to a GP. Nurse and midwife led models of care and paramedic services have frequently filled the void left by GPs and should be acknowledged as providing ongoing and successful solutions. New models of MDT care and referral pathways must be explored, expanded, and financially supported, so communities are not dependant on privately practising GPs for primary healthcare and referral to specialist medical services and treatments. Section 19AB and the DWS levers should be evaluated in light of the scope of practice review, currently underway, taking into consideration the rapidly developing world of medical technology and connectivity, including the use of AI in screening and diagnostics and the implications for hybrid access to medical specialists where appropriate and accessible referral pathways are in place.

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