Contemporary rural health workforce policy in Australia: Evidence-based or ease-based?

Arthur T L Cheung
Fifth Year Science/Medicine
Graduate Certificate in Governance and Public Policy
University of Queensland

Arthur has a passion for health policy, public and global health. During his medical studies he has been President of Towards International Medical Equality (TIME), President of the Manali Medical Aid Project, and Queensland State Representative on the National Students Committee for Doctors for the Environment Australia. He currently sits on the Board of the Australian Youth Affairs Coalition amongst other pursuits.

Introduction

Australia has a history of a rural health workforce shortage. This shortage was originally perceived to be within the context of an overall oversupply of health practitioners throughout Australia, an assumption that is now believed to be erroneous. Likewise, interest group support for Government policy responses to the maldistribution has waned over time. Regardless, Australia has consistently experienced a shortage of health workers in rural areas.

This article critiques the development of contemporary rural health workforce policy in Australia against theories of policy development, highlighting the introduction of section 19AB (the "ten year moratorium") in 1996 to the Health Insurance Act 1973 as a turning-point for the selection of policy instruments.

The Australian Healthcare System

Medicare is Australia's universal healthcare system. The provision of medical care by medical practitioners in Australia is regulated through Medicare Provider Numbers (MPNs). A doctor must obtain a MPN in order to charge fees for professional services rendered outside of salaried hospital positions. [1]

In 1996, the Australian Federal Government introduced an amendment to the Health Insurance Act 1973 (the Act), restricting access to MPNs by foreign graduates of an accredited medical school (FGAMS; a term which includes international students studying at Australian medical schools) and overseas trained doctors (OTDs). For simplicity, this article will hereafter use the term OTD to refer to both OTDs and FGAMS. Under the amendment, OTDs must wait a minimum period of ten years from the date of their first Australian medical registration before being eligible for a MPN. This requirement, introduced under section 19AB of the Act, has subsequently been referred to as the "ten year moratorium."

By 1999, Government policy began to utilise section 19AB exemptions as a means to address rural health workforce shortage. OTDs willing to work in Districts of Workforce Shortage (DWS) were given access to MPNs. [2] These DWS are determined by the Federal Government's Department of Health and Ageing (DoHA), and consistently have primarily been rural and remote areas.

Policy introduction: The Ten Year Moratorium

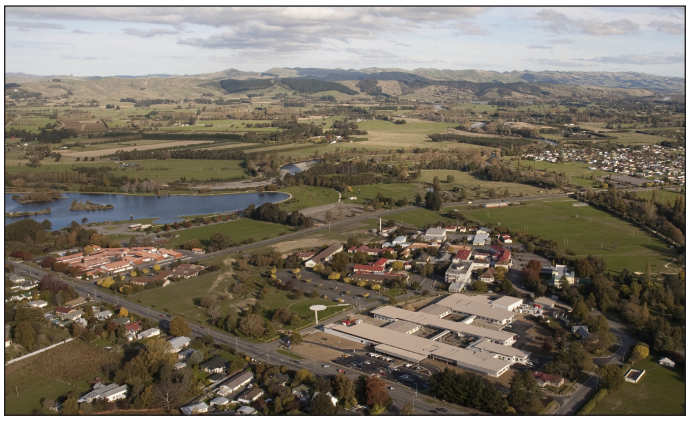
Issue identification

The introduction of section 19AB was undertaken within the context of a perceived oversupply of urban doctors and ballooning costs to the Government through Medicare's fee-for-service system. [4-6] These costs were a result of the introduction of Medicare in 1984, which caused private health insurance rates to plummet, shifting responsibility for healthcare costs from individuals to the Federal Government. [7] Accordingly, the bill introducing the moratorium was the consequence of a 1996 Budget decision. [8]

Policy analysis and policy instruments

In line with the budgetary issues identified, the express goal of the policy was to "reduce one of the major growth pressures on Medicare, making it more sustainable in the longer term." [9]

The Government was therefore preoccupied by the first of two



fundamental parameters in healthcare: cost and equity of access. [10] Although by 1996 the rural medical workforce shortage was well documented, the focus on cost was justified by the perception that the shortage was due to misdistribution in the context of overall oversupply. [9,11] The Health Minister stated that it was ridiculous to recruit OTDs for areas of need when there were Australian Trained Doctors (ATDs) who could provide services there. [12] Additionally, there was a strong belief by the Department of Health and Family Services that healthcare costs would increase in proportion to the number of doctors. [13]

While the goal could be achieved in many ways, framing the issue as doctor oversupply led to the preference for a supply-side solution. In the words of then Health Minister, Dr. Michael Wooldridge, "Health has a demand curve that is relatively inelastic. People will demand much of it, regardless of the price. If we wish to keep that affordable, which it is barely, then we have... to look at the issue of supply." [14]

In light of the urgent nature of the budgetary issue, the Government was not willing to impose quotas on the numbers of medical students training in Australia as the six year delay in the impact of such a policy was simply too long. [15]

The Government initially sought to restrict MPNs by requiring ATDs to undergo postgraduate (specialist) training in order to access MPNs. Section 19AB was only introduced in a change to the Health Insurance Amendment Bill (No 2) 1996 (the Bill) after it had already been presented to parliament. [5] This is of interest when taken with the Health Minister's claim that the principal savings from the Bill would come from the OTD provisions. [15] Unsurprisingly, Dr. Wooldridge went on to say that the Government had not quantified these savings. Perhaps, with cynicism, this is symptomatic of an over-confident governing Coalition neglecting complete policy analysis.

Althaus, Bridgman and Davis [3] describe five analytic frameworks for policy: economic, legal, social, political and environmental. The primary decision parameters in this case lay within the economic framework. Analysis using other frameworks also reinforced the view that Australia's health budget could be best controlled by decreasing doctor numbers through restricting access to MPNs. [4]

Under legal and social considerations, when questioned why the Government did not reimpose a quota to restrict OTD access to the Australian Medical Council examinations, the justification given was

that the imposition of a quota on OTDs who were actively recruited by Australia would be unfair and discriminatory against a large number of Australian citizen OTDs. [14]

Under the political framework, it was questioned how the governing Coalition could reconcile a restrictive policy with their liberal economic ideology. The Government considered health a special case due to its inelastic demand curve and the disparate knowledge levels between consumer and provider. [15] Such a case was deemed inappropriate for a competitive market model. Furthermore, while the newly elected Coalition was less adverse to alienating the ethnic lobby in targeting OTDs than the previous Labor Government, party ideology alone is unlikely to have accounted for the selection of policy instruments given that the Labor Party "berated the Government for not implementing even tougher rules limiting the rights of OTDs." [6]

Finally, the Government utilised the political defence that the moratorium was bringing Australia into line with the policies of comparable countries. [12] Thus the proposed solution stood: restrict OTD access to MPNs.

Consultation

Consultation on the proposed moratorium was largely left to the Senate Community Affairs Legislation Committee to undertake in preparing its report to the Senate.

This committee received 96 submissions, including submissions from the Australian Doctors Trained Overseas Association (ADTOA), the Australian Medical Students' Association (AMSA), the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP), the Rural Doctors Association of Australia (RDAA) and the Department of Health and Family Services. Its report concluded that the OTD measures were widely supported. [13]

While the Labor opposition report aired concerns that the moratorium would aggravate the rural health workforce shortage, [16] the primary concern of the Australian Democrats was the inadequacy of workforce data essential to planning for a rural medical workforce. [17]

In ignoring concerns highlighted in a number of submissions, and in announcing that "there will be a ten year moratorium" prior to amendment of the Bill to include this moratorium, [12] it is reasonable to conclude that the Government viewed consultation merely as a tool to validate the policy. This tokenistic approach to consultation detracts from its potential value in testing the strength of the Government's policy analysis.

Coordination

The coordination stage of policy development involves ensuring that policy is consistent and coherent across the many activities of a government. This typically involves certification of costings as accurate by a central finance agency. [3] Costings for the impact of section 19AB were deemed unnecessary [15] and so such a certification was not possible.

The ten year moratorium is also peculiar in that the policy problem was initially identified by the Treasury in budgetary discussions, while the policy solution was developed within the health portfolio. [7] Thus the policy arose from coordination itself. Despite this, the level of subsequent coordination for this policy appears to have been minimal.

Decision

In Australia, cabinet decisions are pivotal to policy development. The Government's fait accompli attitude to consultation and debate on section 19AB supports this description.

However, this view understates the influence of the Opposition. The Opposition raised this issue during debate on the Bill: "It seems that Ministers are oblivious to the fact that it is Parliament that makes the law and not Ministers. It [publicly announcing legislative changes before debate with voting having taken place] is a practice which holds the Parliament, and thus the people, in contempt and it is wrong in principle in that it encourages retrospective legislative provisions." [14] Indeed, it was only with support from minority parties in the Senate that the Bill passed.

Implementation and evaluation

The estimates of the Australian Medical Workforce Benchmarks study which underpinned the notion of a workforce oversupply were soon called into question. [18,19] In 1997 it was already predicted that the Government would succeed in reducing costs to Medicare, but at the expense of exacerbating the rural health workforce shortage. [6]

Australia had experienced a decade of medical workforce policy aimed at reducing supply, [20] including the capping of medical school places and reducing migration [21,22] when the workforce should have been growing in line with population growth. [23] It soon became apparent that areas of need would not be filled by ATDs. [24] Evaluation of the moratorium policy thus turned to how Government could remedy its mistake. This marked the beginning of a decade of incrementalist Australian rural health policy.

Subsequent developments

In 1999, the 5 Year OTD Scheme was introduced at the Australian Health Ministers' Conference. [25] This scheme waived the remaining balance of time on MPN restrictions for an OTD who had completed five years of general practice service in a DWS. [26]

Already in 1999 it was observed that the rural health debate had become centred on the role of medical practitioners, possibly due to framing of the issue by interest groups, and that a focus on public health infrastructure was lacking. [27] The Government defended this on account of its direct role in funding medical services through Medicare, while allied health was a State responsibility. [28] The division of powers between Federal and State Governments is a major constraint on policy instruments selection. Regardless, a plethora of alternative policy instruments were neglected in favour of utilising the existing moratorium framework.

Subsequent policies, such as More Doctors for Outer-Metro Measure in 2002 and Medicare Plus in 2003, further deepened the reliance on the moratorium as an instrument for addressing the rural health workforce shortage. [29] The haphazard approach of adding policies to patch defects in previous policies resulted in, by 2004, "a bewildering array of Australian policies and guidelines, differing surveillance and stewardship of OTD programs; enormous inconsistencies in terminology, lack of national coordination; with poor communication." [23]

The current situation

It is estimated that 41% of the Australian rural workforce is currently composed of OTDs. [30]

The AMA, AMSA, RDAA and RACGP no longer support the moratorium. [31-34] Loss of support for the moratorium is largely due to its failure to establish a stable rural health workforce, the questionable ethics of recruiting doctors from developing countries, and the inappropriateness of sending those who are often the least equipped to live and work in rural locations without adequate social and professional support. The ADTOA goes further in labelling the moratorium a blatant form of discrimination which contravenes the international charter of Human Rights. [35]

Reflection: Approaches to policy development

What does the progression of rural health workforce policy, leading to the current reliance on OTDs to service rural areas, say about the processes used to develop health policy in Australia?

The policy cycle

Althaus, Bridgman and Davis [3] advocate for the use of the policy cycle as a prescriptive notion, where policy development undergoes issue

identification, policy analysis and instrument selection, consultation, coordination, decision, implementation and evaluation. New issues identified in evaluation completes the policy cycle. This approach is the standard model of policy development taught in Australian policy studies.

The value of the policy cycle approach in the context of health policy development lies in its ability to disaggregate the complexity of the health system improvement into manageable steps. However, good process does not guarantee good policy. The policy cycle says little about the approach within each of its stages. For example, the inadequate/inaccurate evidence base used to justify the introduction of section 19AB, and the subsequent incrementalist mindset in policy analysis and instrument selection to address the rural health workforce shortage, both contributed to the eventual failure of contemporary rural health policy in Australia, despite use of the policy cycle.

Incrementalism

Under incrementalist conceptions of policy development, problems are addressed through small changes to existing programs and policy instruments. [3] However, in this case, the use of OTDs had become "a substitute for effective planning." [36] Dror [37] thus describes incrementalism as an ideological excuse for inertia and anti-innovation. Although the rural health workforce shortage is a complex problem that may "require a tentative solution to be understood," [38] the continued use of incremental solutions seen in Australia does little to solve the root problem.

Rationalism

A rational model of policy development requires agreement on goals and a clear understanding of methods. [3] Such an environment often exists in health policy. In the era of evidence-based medicine (EBM), both practitioners and the public expect an evidence-based health policy (EBHP) approach. Davies and Nutley [39] give the view that 'the research community in healthcare is truly global, and the drive to evidence-based policy and practice is pandemic.' Within Australia, the Rudd Government and its utilisation of the National Health and Hospitals Reform Commission clearly shifted the focus to the EBHP approach. Banks [40] observed that evidence-based policy is gaining momentum in Australian policy following "explicit endorsement by the Prime Minister and senior Ministers."

However, substantial reform in the name of rationalism but on the basis of flawed analyses or in the context of inadequate resources for implementation, may be dangerous in the healthcare setting. As Lindblom, [41] one of the early developers of incrementalist theory, later states, the size of step in policy making can be arranged on a continuum from small to large. Policy need not be at either extremity of this continuum.

Mixed-scanning

Etzioni [42] proposes such an alternative. His method of 'mixed-scanning' utilises overarching fundamental decisions combined with smaller incremental decisions that test and/or prepare for larger changes. Etzioni argues that rationalism is utopian and requires greater resources than decision-makers command, and that incrementalism ignores innovations while overlooking the fact that incremental decisions are made within the context of more fundamental policy shifts. Mixed-scanning limits the details required in fundamental decisions while avoiding the stagnation that accompanies incrementalism.

Whilst mixed-scanning is a logical approach, Etzioni overstated its departure from prior practice or thought. [43] In the light of Lindblom's description of a continuum of incrementalism to rationalism, Etzioni's argument for rationalistic models to be "rejected as being at once unrealistic and undesirable" seems to create a false dichotomy between rationalists and incrementalists in order to categorically deny their worth. For example, EBHP is a rational but non-comprehensive approach, just as EBM is not an insurmountable task for its practitioners. Mixed-scanning is essentially a practical application of Lindblom's acknowledgement that policy steps lie on a continuum.

Regardless of Etzioni's innovative significance, it would be imprudent not to consider the diminishing marginal utility of hard rationalism in comparison to mixed-scanning. A flexible application of the mixed-scanning approach is undeniably more cost effective.

Conclusion

In the development of Australian rural health policy, the mixed-scanning model should ideally be utilised to develop evidence-based policy within the overall process of the Australian policy cycle. Although this would require an increased self-awareness of approaches to policy from Australian politicians and public servants, perhaps it can remedy the ongoing rural health workforce shortage that is the legacy of our incrementalist past.

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Conflicts of Interest

None declared.

Correspondence

A Cheung: arthurtlcheung@gmail.com

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