Health workforce turnover in remote Indigenous communities—who stays, who goes?

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Aim

Health workforce geographical maldistribution is a persisting global issue linked to inequitable access to health services and poorer health outcomes for rural and remote populations. Anecdotal reports suggest that the primary health care (PHC) workforce in remote NT Indigenous communities is frequently characterised by undersupply, high turnover, low stability and high use of short-term (agency) staff. A lack of reliable quantitative studies limits evidence available to guide workforce policy improvements. This study seeks to quantify current resident PHC workforce supply, turnover and retention in remote NT communities with a predominantly Indigenous population.

Method

Analysis of NT Department of Health 2013-2015 payroll and financial datasets. Main outcome measures: staff headcounts, annual turnover rates, 12 month stability rates, 12 month survival probabilities, median survival, and ratio of agency nurse full time equivalent (FTE) to number of nurse positions in each remote clinic.

Results

In 2013-2015, 53 remote health clinics were staffed by NT Department of Health personnel. Most clinics were small, with a median of 2.0 NT Department of Health employed nurses, 0.6 Aboriginal Health Practitioners, 2.2 other employees providing or supporting PHC. On average, there was an additional 0.4 FTE agency employed nurse also providing PHC in each centre. Few communities had a resident doctor.

Mean annual turnover rates were extremely high, irrespective of whether turnover was defined as no longer working in any remote clinic (66%) or no longer working at a specific remote clinic (128%). Stability rates were low, with less than a fifth of nurse and Aboriginal Health Practitioner employees still working in a specific remote clinic 12 months after commencing. On average, staff in remote clinics stayed less than 6 months. A substantial proportion of nurse positions were filled by agency nurses.

Conclusion

Health services in remote, predominantly Indigenous NT communities are small and currently experience very high nurse and Aboriginal Health Practitioner turnover, low 12 month stability rates and considerable use of agency nurses. Further, there are substantially fewer Aboriginal Health Practitioners providing care in these remote communities than the available positions. These staffing patterns, also found in other remote settings in Australia, not only contribute to a lack of continuity of care for vulnerable remote Indigenous populations with complex health care needs but incur higher direct costs for providing primary care services, thereby compromising both long term service sustainability and population health outcomes. To address these deficiencies it is imperative that
investments in implementing, adequately resourcing and evaluating staffing models which stabilise the remote primary care workforce occur as a matter of priority.

**Presenter**

Deborah Russell is a Research Fellow at Monash Rural Health, Bendigo and came to academia with a background as a rural general practitioner. Her specific academic interests include rural and remote health services research (models of care, understanding and measuring access to health care) and health workforce supply, distribution, recruitment and retention. Her PhD ‘The patterns, determinants and measurement of rural and remote primary health care workforce turnover and retention’ positioned her as an emerging leader in her field. Her publications have significantly influenced current thinking about rural medical workforce retention methodology and rural workforce policy more broadly. Deborah remains passionate about improving equity of access to health care resources, currently having important roles on an ARC grant ‘Assessing the impact and cost of short-term health workforce in remote Indigenous communities in Australia’ and in the rural stream of the MABEL CRE in medical workforce dynamics.