

NATIONAL RURAL HEALTH ALLIANCE INC

PUBLIC SEMINAR

‘KEY ISSUES IN RURAL AND REMOTE HEALTH’

CANBERRA

FRIDAY, 20 OCTOBER 2006

A SYSTEMATIC ANALYSIS OF SERVICE MODELS IN RURAL AND REMOTE HEALTH:

Professor John Humphreys, Lead Researcher, APHCRI Project

JOHN HUMPHREYS: Thank you, John, very much, and I'd like to thank the Alliance for inviting us here today. The title is probably somewhat grand and if I were to translate it in simple terms, it would be what works well where and why in relation to health services in relation to rural and remote Australia. I'd like to acknowledge the work of John Wakerman who really led this project, and Bob Wells, who is also in the audience, and my other colleagues, Pim Kuipers, Judith Jones and Phil Entwistle for the work that they've done.

As I say, this was quite an ambitious project and quite innovative because it's the first systematic review of evidence in relation to primary healthcare services relevant to rural and remote Australia. I guess the starting point in this is the issue that is well-known to us all and I won't dwell on it, but it was summarised in the Productivity Commission recently. I suppose that starting point is acknowledgement that the provision of quality healthcare should be available to all regardless of geography, regardless of socioeconomic status. And we're aware that there are many, many rural communities across this country that do not currently receive optimal healthcare.

So the problem is precisely this: how do we best provide primary healthcare services to these small rural and remote communities, many of which simply fall between the cracks? There are situations where the population and the service infrastructure are sparse and where the need for health services is really quite great. There are something like 3.5 million Australians currently who live in these sorts of communities, so if you imagine almost the population of Melbourne or Sydney that is poorly serviced in relation to health services or inadequately

serviced in relation to health services, you're talking about quite a significant issue.

I think the other side of this is that trying to address this issue requires some fairly creative and innovative sorts of responses, and let me just quote from one of the papers that we came across:

Providing services for people in rural and remote areas where the population and service infrastructure is sparse presents particular challenges for both the government and the community sectors. These include additional costs, lack of service infrastructure and service options, transport difficulties and difficulties in recruitment and supportive staff.

So they are issues in fact that we've already heard this morning. So what is the context that we're talking about? I think it's fair to say there are two fundamental geographical dimensions that we're talking about here. One is the notion of location and one is the notion of population size. Variations in size, variations in compositions of communities, and the degree of isolation of different communities results in considerable differences and the need for and the abilities to sustain health services.

What I've tried to do in this diagram here is illustrate how the problem differs as you move from large concentrations of population through to small communities widely dispersed. It's not a case of a public/private divide at all. It relates much more, if you like, to the range and threshold requirements that underpin the ability to provide a service. So where you have concentrations of large populations in closely settled areas, the options to provide services are much greater than when you move into those dispersed isolated small communities. And they don't have to be in the centre of Australia or the far north west. They can in fact be in regions within the small states, such as the Mallee region in north western Victoria, for example.

So what's the background to the problem? Well, I suppose summarising it - I won't dwell on it at all - there is significant evidence that the health status of many of the residents of these communities is poorer. There's substantial evidence - and the National Rural Health Alliance has done some useful work in its position papers looking at the fact that there are substantially fewer healthcare resources allocated to many of these places.

The other thing we know is that Commonwealth and state governments - and I have to say particularly the Commonwealth government in the last decade - have funded a series of innovative sorts of models, projects and programs. But many of these have been pilots, they have been trials, they have been demonstration projects, and this has characterised governments of both political persuasions, ranging from some of the social justice projects in the early nineties through to many of the things that were funded through the RHSET program and the GPET program in the mid-nineties and continuing today to many of the projects that are funded. I think the issue though is summarised here, and I quote again?

What is required is not another round of regional projects, but rather the gathering and dissemination of systematic evidence of what really works in practice and how it can be rolled out to settings where integration is poor.

The RHSET program alone, for example, funded something in the order of 700 projects, and it would be interesting to ask the question what actually happened to those? Where are they now? And which of those was actually rolled out either in program development or translated into the sorts of sustainable services that we want. So the focus of this in many ways was to move beyond pilots, yet more demonstration models, to say, “What can we learn from what’s already out there?”

The other point to note is that within the realm of the policy arena is that there’s been a very strong emphasis on workforce rather than service models, rather than comprehensive primary healthcare, and for a variety of good reasons. So I suppose part of this exercise was to see what we could contribute in terms of providing solutions. We recognised from the outset the heterogeneity of rural and remote Australia, so we’re not advocating a one-coat-fits-all solution. There is no one model.

Secondly though, we are guided very strongly by the fact of the need to base our policies, programs and solutions on evidence - evidence-based policies, evidence-based programs - not my ideas, not my speculation, not my description of what I think is a good model. And the value of systematic review is quite unique in that the methodology enables studies like ours to be replicated by anyone who has either got the money, the time or the stamina to do it.

They’re very comprehensive studies and in our case we looked at literature from the advent of the first National Health Strategy in the early nineties. They are underpinned by scientific mores of research relating to validity, consistency, reliability and transparency of evidence. So everything that we produce is there for you to see. We can provide, for example, the listings of the 9000 articles which we started with for people who, as I say, have the stamina to go through them.

So a little bit about the methodology very quickly. First, we looked at all published Australian literature since the first National Rural Health Strategy. It’s published literature, both black and grey, and it was guided by the Australian Primary Healthcare Research Institute parameters. The goals of this organisation funded through the Commonwealth department were to strengthen the knowledge base of primary healthcare by conducting and supporting research on the organisation, financing, delivery and performance of primary healthcare. It was also to facilitate the uptake of research evidence and to increase research capacity. So we worked within those broad parameters.

We were guided by a reference group, some of the members of whom are here in this audience today, and we're very grateful for the contribution that these people made. They didn't just come with expertise, but they came with representation and significant insight into this interface between the need for knowledge and the ability to translate that knowledge into policies and programs. We started, as I say, with over 9000 initial retrievals of the literature and we reduced it through considered inclusion and exclusion criteria and much deliberation to something like 161 relevant publications that we felt could inform this question of what works well, where and why.

The focus of the research questions is really around four broad dimensions: firstly, those key rural and remote primary healthcare models and policy changes that have taken place in the last decade or so; the barriers and the facilitators of successful implementation of reforms; the characteristics of appropriate service models relevant to rural and remote Australia; and the ability to generate what we called evidence informed principles to guide effective and sustainable models.

I'm conscious of time and I'm not going to be able to deliver a great amount of detail, but let me give you some broad outline of what we found. I suppose there were four broad areas of results that we worked within. One was the fact that there very few comprehensive evaluations of health services. For all the literature out there, for all the presentations at national conferences, for all the articles that were written, our ability to find comprehensive evaluations, models that had been described through formulation, implementation and evaluation including an economic consideration of the costs and benefits were very, very few. And I think for those of you in the audience who are interested in research, there's a real opportunity here.

Secondly, everyone's model is the best model. Local people are concerned about their model, their needs. But when we looked at the results we found that the models could be grouped. There were lots of similarities and commonalities across the models. Thirdly, we were able to provide or generate some very good exemplars of models that seemed to work particularly well, and so we focused on those because success breeds success. And fourthly, we found that it was possible to generate some evidence and form principles to guide the future research policy formulation and program implementation relevant to this.

So let me just give you some sense of the documentation. I'll give you a website at the end where you can follow up in detail. What we did with some degree of discretion but also in a very considered way is to try and summarise these models, and we found that they fell broadly into five types which we've described as discrete services, integrated services, comprehensive primary healthcare services, outreach services and virtual outreach services that tended to form within the information technology, tele-health, tele-medicine variety there. And for each of these we could find various examples, if you like, that were differently named, differently derived, relevant to different sorts of communities. When we examined each of these models we found there were particular drivers, if you like,

particular things that led to the evolution and the development and the funding of these particular models.

So in the case of the discrete models, for example, it tended to orient very much towards – perhaps I could move to the next slide because it might illustrate it a little better. But discrete models tended to focus very much on medical workforce issues and the need to attract, recruit, retain doctors into areas that were difficult to recruit to. So there was a very definite workforce imperative here, and that was the real driver. Many of these sorts of discrete models were able to exist in those rural and remote centres that were more populous and perhaps in closer settled areas. So the environmental enablers, while important, weren't as significant as they were in the remote areas.

As we move through to different types, you can see that they relate to the geographical context. We start to work with smaller populations in more isolated and remote areas. In the case of integrated models, these are places where they're small in size. It's difficult to sustain discrete services, whether allied health, nursing, preventive medicine or whatever. So there was a real imperative here to start to bring people together in an integrated fashion to ensure that the community could be delivered comprehensive appropriate primary healthcare services. It was important too to minimise the need of residents from these centres, to access the larger centres or the metropolitan areas, so access became fundamentally important. Single point-of-entry became important for families and for groups needing primary healthcare.

As we move to even more isolated services such as some of the indigenous communities, we were able to identify comprehensive primary healthcare such as the Aboriginal community controlled models in the Northern Territory. These were very, very suitable to the particular needs of those indigenous communities and they brought with them a much stronger focus on looking upstream; in other words, at the determinants of health, so that they really embraced this notion of primary healthcare in the broadest sense of the World Health Organisation.

Finally, as we moved to those very tiny hamlets and villages that often fall between the cracks, you could see the role here of virtual outreach. So when we tried to put this together, we developed this situation of bringing the context together. The context we recognise in all its diversity. The models, if you like, adapt to place. And what we found then was that characterising these successful models were a variety of environmental enablers and certain prerequisites.

So what we're saying is that we need to develop a systems response. Local solutions are fine, but if they're not sustainable for one reason or another, or if they're not comprehensive or appropriate to the needs of the population, they really haven't solved the problem.

The environmental enablers were three-fold. One is the need for supportive policies, and I have to commend and I think the team would want to commend the Commonwealth government in leading the way into the first National Rural

Health Strategy because they provide, if you like, that broad umbrella around which state government health organisations started to build their responses to the needs of rural and remote communities. So policies do drive programs, and it's very important in the development of the next Healthy Horizons Mark III or whatever that it takes account of the significance. It's not just a glossy document; it's actually very, very significant.

Secondly, Commonwealth-state relations - how often does this come up? And it's come up again this morning. Whether we like it or not, we are one nation sharing commonality of health problems. I'm a bit of a centralist myself. I think states are only useful for State-of-Origin matches. I think they get in the way of a lot of other things, but that's me, okay? And I'll be shot down by others. But I think we have to ensure that we can streamline what happens between whatever number of tiers of government we have, whether it's Commonwealth to regional, Commonwealth to state, state to regional, and so on.

And thirdly, it's about change. Nothing is forever. Sustainability is the ability of people, places and organisations to adapt to changing environments. So community readiness is fundamentally important. It's not generally well done by people that come in and say, "I know what's good for you". It's about working as a community in a collegial collaborative way to prepare people to adapt to change.

So these, if you like, are the esoteric environmental types of things that we often take for granted until they're not there, and then you get hostilities, resentment and opposition. Put those things in place though, and the local champions, the local organisations, the local consumers, are much more able to put into the place the sorts of things that are likely to meet their healthcare needs.

So what are some of the essential requirements? Well, I'm not going to dwell on these. They're all pretty obvious. They're not all equal in weighting and some would need to be in place before others. But firstly there's the issue of workforce. And one of the interesting things about models was how few of them actually dealt with the issue of workforce. They all assumed that the workers would somehow magically appear. So here is the model predicated on the fact that we have an endless supply of dentists, allied health professionals, nurses, GPs, and so on. So for example when we look at the evidence-based principles, we dissect workforce into the fact that it has to be the appropriate range and composition with the skill base that's required, whether that's an indigenous health worker, a mental health counsellor, an allied health physiotherapist, a GP or whatever.

There have to be measures in relation to recruitment. What are the things that would facilitate recruitment? Having gained health workers, how do we keep them there? There have to be measures in relation to retention of these workers. And there has to be built into the model the notion of succession planning. Things might be okay at time T, but in time T+1 when you've got ageing practitioners who leave, what measures have you put into place to groom new registrars into the practice or new young allied health professionals, et cetera, et cetera.

There's the issue of funding, for example, and it's not just about the amount of dollars; it's the financing stream that enables continuity of financing and flexibility of funding so that those resources can be used in the most appropriate way by the health professionals in relation to the needs of the community. There's the issue of governance, management and leadership, and one only has to look at the current issue around Papua New Guinea/Australian government/Solomon Islands about how important governance management leadership is.

We often depend on rural and remote champions, and I'm sure each of you here has a champion out there who's worked their butt off year after year keeping the health service afloat. They are fundamentally important people. But we need to groom new champions. We need management structures, government structures, in which there's a sense of ownership, empowerment, responsibility and accountability, so that the health service works.

There's the issue of linkages. Discrete services are fine in metropolitan and large regional centres, but they still need to be coordinated across with related services so that the patient doesn't get thrown to the wolves or have some extended kind of timeframe seeking rehabilitative care, palliative care, or whatever. And there's the issue of infrastructure and I won't dwell on that; that's been talked about already in relation to dentistry this morning.

So where to next? What do we do with this? Well, obviously one of the things we feel that we've done is to provide significant new knowledge, this notion of knowledge support. You've got to know what the evidence is like in the first instance, and sometimes synthesising and reviewing material saves a lot of effort from people and enables them to generalise rather than talk from a sample of one or a sample of two. So you can look at your own situation vis-a-vis that across the country.

Secondly, and very importantly, is the issue of decision support. How is this knowledge going to be used to inform policies, to inform programs, to build about solutions? And I must say I was impressed with the previous speakers in relation to dental health that they had thought through feasible solutions that would work, and I think that's what we need more of in the academic world. We need to bring the academics more closely aligned to policy makers and health service providers to do that. In that sense, I think we've got to look at the notion of implementation. We're still characterised very much by this whole area of implementation gap. We really don't want any more pilots.

We have to ask ourselves the question why did many of those successful pilots not get funded into the future? They were shown to work. What went wrong? How can we build pilots into programs that are sustainable and alleviate some of the angst and frustration of healthcare providers, funders, governments and so on? In our case, one of the processes was to engage with bureaucrats, with experts in the field through the reference group to enable them to inform the process of the way

the knowledge was presented, but also so that they have some sort of sense of how this might be translated into policies and programs.

Well, obviously I've done little more than skirt around the topic today, but this is one of 12 funded projects from the Australian Primary Healthcare Research Institute based at the ANU. If you go into the APHCRI website, the report is not yet there, but it should be there by the end of this month. I think Nick Glasgow informed us it would be available next month when all the reports have been formatted and so on. But that's the website for APHCRI and I think you'll be interested not only in our own report, but that of some of our colleagues who are looking at primary healthcare services or other dimensions of this, because I think it provides a useful point of entry for those of you who have interests in this broader systematic approach.

So, in conclusion, let me just thank you for your attention and hope that I've whetted your appetites a bit. I will call on John Wakerman and Bob Wells to answer all the tricky questions, of course, but if people do want to follow up on this, the document will be publicly available and if you want to replicate the study, we'd welcome that too. Thank you.
