

Integration of health care services across the rural/metropolitan divide

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My talk is actually about Rural Health Services, Metropolitan Services, Primary Health Care Services and Hospital Services so I had a call from the Rural Health Alliance about where on earth are we going to fit you within this conference and I think that actually is a message in itself, is that we're so used to talking about little bits of the health system and what I am going to talk about is actually following the patient's journey and that is so important to patients with chronic disease because they do move out of their rural community and into metropolitan communities.

They do move away from their primary health care provider and into the hospital system. And this is my old hat where I was working at the Department of Rural Health which is based in Lismore, part of the University of Sydney. Now I work at beyondblue but I won't talk about that. This project was developed by the Australian Rural Health Education Network which is the network which links all the 11 university departments of rural health across Australia.

So, we had researchers from every one of these centres involved in this project and if there's anyone here involved with NHMRC and wants to talk about what it's like to go through about 13 ethics committees to do a project you're more than happy to say how that can nearly kill any kind of national research project. And if you're interested in any information about ARHEN, Joy who is the scribe out the front can help you, and there's also a booth here, so, acknowledging all the researchers who are involved in this project.

What we did was we looked at national data around rural people who leave their communities, so basically, leave their communities and their GPs, their primary health care provider, leave that community to go to a large regional or a metropolitan hospital to seek care. What I should say here is the communities that we looked at were seven communities across five states and they were all small rural or remote communities, so we're not talking about regional centres here, we're talking about small communities.

The project was funded by the Department of Health and Ageing, and all bang to them for being interested in this issue. What we did was from each community we identified patients who had travelled out in the previous year so we interviewed them. We also interviewed hospital staff from the hospital that they actually went to in the city or the regional centre to look at their views and how they saw the system working and we interviewed the GPs also to see about how they saw the system working.

Then we also looked at actually the individual patient records which were held by both the GP or the primary health provider or the hospital and can I say we included in these primary health care providers, we did have some bush nurses and Aboriginal health workers, AMSs. So, this is just nightmare slide and I do apologise but what I wanted to say from this is that this is the national data and I will explain it in a second. This is what we did when we looked at the National Hospital Morbidity Data Base and we actually looked at, for the first time and I can't believe no one has ever done this.

But what we did was we looked at here the RRMA of – and I assume here that everyone knows what RRMA is – of an individual patient – individual patients. So, this is national

data for a whole year so RRMA 1 and 2, I'd say, are metropolitan; 3, 4 and 5 classified as rural; 6 and 7 are remote. So, this is where the person lives, along this axis. Then along the top axis we have where people were admitted to. So, what is the RRMA of the hospital that they were admitted to.

And I just think it's actually interesting that we'd never actually – the data was there and we'd never actually looked at it before, like where are our patients going. So, you know, no surprises here. If you're a RRMA 1 person and you live in a metropolitan area, you go to a hospital in a metropolitan area. But if we look at RRMA 3, 4 and 5 which are the green – and I am trying to make it a bit simple – but a lot of these people also go to metropolitan hospitals which are the white and the blue.

Now, I am just going to summarise this because we have so many graphs like this but I just wanted to put that up there to show the richness of the data that we have so you can forget about that now. But I will just summarise it that 47 per cent of patients who go to hospital and are from a small rural or remote community, go to a regional or metropolitan hospital so they travel away from their community so that's about half leave. About half of these go to a metropolitan hospital and half of these go to a regional hospital.

So, really, all I am trying to say there is this is a big issue for rural communities is that whole transition of care to a metropolitan or distant area. I have also done this where we look at it from the hospital's point of view and what we find there is if you look at metropolitan hospitals, they get about 10 per cent of their patients come from a rural area. So, to them it's a little issue. So, to us, a big issue because half of us have to travel out. For them a small issue. Only about ten per cent of their patients come from a distance. So, they've got other things to worry about.

Maybe one of the areas we need to look at is regional hospitals because if you look at regional hospitals, so RRMA 3 in those big regional centres like Dubbo, they get about a third of their patients coming in from those small rural communities and the remote communities. So, they might be a bit more open to this issue. So, I am just going to talk about two tiny little parts of this project because the information we have is quite a lot.

With chronic disease we want to encourage people to seek help, seek hospital care as soon as they can so that their seriousness of whatever their issue is means that they'll be able to recover from the hospital treatment. So, what I've been trying to say there is that when rural people go to hospital we already know that they tend to be sicker already. They wait, they wait, they wait so let's maybe look at some of the reasons, some of the barriers that actually might stop them accessing services just like everybody else.

And I feel like I am preaching to the converted here but let's have a look. If we look at the average cost with transport and accommodation and what the patient has told us, so in the green one which is a rural centre, it actually doesn't cost them very much to get to the hospital for care. If we look at RRMA 6 remote, it costs about \$200 and RRMA 7, it's costing them about \$880. We also know that these areas, these remote areas, have the lowest socio-economic status so we are asking the people who have the lowest socio-economic status to pay the most amount of money to get hospital care and then we wonder why they don't go and why they're so ill and why they have to wait until they're air evacuated.

Also, I mean, I think time is also an issue. The RRMA 7, so the very remote areas, tend to get flown out so that is why actually their travel time is a bit shorter. But if you look at the remote communities, the RRMA 6 that we looked at, it was about an average of 8 hours and that was because people who were ill enough to have to go to hospital, were sitting on buses for eleven hours to get to hospital.

Okay, so this is the biggie probably for us and it's what happens when they get back to their community. They've gone into the city or to a large regional centre for hospital care and then they come back. Did they need to get follow-up services? We found that 50 per cent of all our patients needed to access any kind of follow-up care because they had some kind of chronic condition.

What this shows is how many were able to get those follow-up services locally on the left and how many actually then had to travel again to receive some kind of follow-up services. And I think things like, you know, even if it's simple like getting your stitches out and we had a lot of stories about GPs complaining that they knew their patients went back to hospital, travelled all the way up back to hospital to do things that they could have done, the GP could have easily have done for the patient.

And when we go to the hospital our outpatient care is included. It's included in your care. It's free, fantastic. But if you're a rural patient you've either got to pay your own money to get back to the hospital, to transport yourself back to the hospital to get your free care or you stay in your community. You go to the GP but all of a sudden it's not free and I think that's a real mismatch that we can't actually shift our outpatients out and actually make that an outpatient episode in the community.

That's not a recommendation, that's just a "why doesn't it happen?" Another big issue for chronic disease, of course, and the transitional care from moving from your primary health care provider to your hospital and back is communicating across the sectors and everybody knows how appalling, kind of, the communication is. But let's look at it in our situation. Now, I don't want you to worry about the absolute numbers because some of these people did actually go in for emergency so, of course, they wouldn't have GP or referral letters.

So, what we're looking at here is actually referral letters from the primary health care provider and whether they were in the records, whether they were in the GP's records that he's got a copy of his own referral letter and whether it was in the hospital's records, whether they actually received it. And if you look at the RRMA 7 you will notice that there's actually a big disparity between the open bar, so the GP's having a copy of that referral letter, and then the hospital is actually receiving it.

And that's because actually a lot of it was given to the patient. You know, in those communities they gave a letter to the patient but the patient did not give it to the hospital so that's poor communication there. This is the other way round. So, now we're looking at discharge summaries and I don't have to tell anyone in this room about discharge summaries but again, there is a disparity between having it in the hospital record and being received by the GP.

But I think the big one that blew me away was this one about what was the form of the discharge summary and I couldn't believe – maybe in my own ignorance – that there was this many handwritten discharge summaries in 2003, when we did this study. I mean, the people, the clinicians, are still having to sit there and write a discharge summary and we heard stories about boxes of discharge summaries waiting to be written in basements. None of these hospitals but we did hear stories.

So, I just think that, you know, that whole – the technology that we have and we're still writing summaries. And then we looked at actually how the discharge summaries got from the hospital to the primary health care providers. Most of them were mailed, no emails. We had some faxes, some were sent with the patient but what I – sorry?

MALE SPEAKER: ...(inaudible)...

No, that was unclear from our point of view, not from theirs. So, I mean, isn't that amazing. We're still writing discharge summaries and we're still putting them in the mail. I never send anyone a letter any more. I email people. So, those were just two points that I wanted to get across because I actually think they're important when considering chronic disease. And these are the issues that the patients identified.

So, travelling to receive hospital care is an issue for many rural patients. It's an issue for half of rural patients who have to seek hospital care. They have to travel, they have to leave their families. There are barriers to patients accessing the care that they need. Okay, as a society we might say, "Look, that's too bad," and you know, that's what I find talking to people about it. They go, "Look, that's the choice that you make if you live in a rural or remote area."

And I've actually given a similar presentation – not this data because we didn't have the data yet – at a Health Care Integration Conference and they just looked at me like, "You've got to be kidding. We can't even get the metropolitan hospitals working with the metropolitan GPs. You have to go away for about ten years." So, that I think, that's where we need to do a bit of advocacy is that this is important, that our patients are also considered by metropolitan hospitals, that they can't get in and that they're not going to come in until they're so serious that they need to be air evacuated and then they wonder why they have long lengths of stay and wonder why we have higher mortality.

And my ultimate statement, our communication systems are archaic. I mean, where is the leadership around changing the system? Where are the incentives to encourage our clinicians so maybe you can tell me why is it this way? Is this the choice? Is this how people want to work? And what is the impact of this on the management of patients with chronic disease and the health outcomes?

We did not look at health outcomes as part of this study. What we looked at is what patients said was their experience. So, I made some recommendations to revisit integration between the primary health care and hospital sectors. There are State Government programs and Commonwealth programs that are looking at this and really this study that the Commonwealth funded and the State Governments participated in – five States participated in – so, you know, there is some kind of willingness to look at the issue and to involve us.

But there's been heaps of pilots. How about actually looking or how about the State based organisations of the divisions taking on a bit of this role because at the moment it seems that hospitals work with their local divisions. But the hospitals don't just get their patients from a local area. They come from around the place. Okay, so I also said that we need to ensure that the infrastructure is established to allow the sectors to communicate but maybe I am way off there.

Maybe the reason that we have handwritten summaries is because that's how people want it. And recognise that follow-up care can be provided in a patient's community. That's the big one, that the follow-up care can be provided there and should be provided on an outpatient basis. If you go see a GP after your hospital care for an outpatient then why can't it be free and considered part of outpatients. Thank you.

PRESENTER

Kim Webber works as a Senior Research Fellow at the University of Sydney's Department of Rural Health in Lismore. Kim's work with the University of Sydney focuses on rural health research and policy analysis, particularly viable service models for small rural communities. She is Chief Investigator on the national research project 'General Practice/Hospital Integration Issues in Rural and Remote Australia', a project that was commissioned by the Australian Government Department of Health and Ageing. The project is being auspiced by the Australian Rural Health Education Network (ARHEN). In addition, Kim works with beyondblue: the national depression initiative to bring a rural focus to their work.

