

Robyn Williams: Thank you to the guys from Katherine. John Wakerman has a shack on the south coast of New South Wales which is a long way from Alice Springs where he's Director of the Centre for Remote Health. He's a public health medicine specialist and GP who's worked and lived in Alice Springs for 18 years. He was chair of the National Royal Health Alliance for three years and still practises as a GP. He's here to talk about incubating success in remote areas: John Wakerman.

Incubating success in remote areas

John Wakerman¹

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Thanks, Robyn. The shack's our weekender because it takes us a long weekend to get there. I'd like to acknowledge the traditional owners, not only as a courtesy for welcoming all of us here to this meeting, but also because I'm going to be speaking about innovation across remote Australia; particularly innovation in health. I think that we need to recognise that not only does this country have a certain grandeur, but it can be a pretty tough place to live and, for millennia, the first Australians have been innovating in this country and so it's nothing new.

What I want to do very briefly is give you a couple of examples of innovation in remote areas, and then I want to come back to some of the issues that have been raised in that really excellent and detailed case study that we've heard from Katherine West Health Board, to look at some principles that we can extrapolate from that, and then I want to perhaps address a little bit what Fred was asking and that is: What can we do about this situation? This very nattily dressed man was born in 1895 near Dimboola in rural Victoria and he trained as a mechanical and electrical engineer. And in 1926 he was employed by the Reverend John Flynn in the Australian Inland Mission to work on Northern Territory radio experiments.

Alfred Traeger moved between Adelaide and outback tours of duty and specifically worked on a means of communication that had to be cheap, durable, small and easy to operate, and so he used bicycle pedals to drive a small generator connected to a transceiver. These pedal radios were introduced into Queensland in 1929 and this really created a communications revolution for people living in isolated areas, and really allowed the Australian Inland Missions aerial medical service to take flight, almost literally. They'd been established in Cloncurry in 1928 and this is the beginning of Flynn's so called "canopy of safety". So innovation goes back a long way. This device was later sold overseas to Nigeria.

A little over 20 years ago, a bunch of health professionals got together in Alice Springs, mainly doctors—there was one nurse—Sabina Knight, was there—and they, over a period of time, developed a manual of standard treatments for common diseases seen in central Australia. This was to ensure consistency of best practice in terms of clinical management of diseases.

The first edition of the CARPA manual was put out in 1992. It's now part of a suite of manuals that are used throughout the Northern Territory. Now, standard treatment manuals, these sorts of protocols are nothing new and these weren't particularly new—these have been around for a long, long time; but the innovation here was not in the manual itself, but in the process that was used for developing the manual and the process that continues to be used. The traditional way of putting these protocols together is you get a bunch of experts who know all about a particular area, they write protocols, that then goes to practitioners, and literally these manuals sit on shelves and gather dust.

The innovation here was that there was a recognition that remote practitioners were experts in their own practice; and so the involvement of those remote practitioners to develop protocols with disciplinary experts for the use of remote practitioners has resulted in a very good result. The result is that when we've evaluated this manual 85 to 90 per cent of nurses and doctors and Aboriginal health workers, in the Northern Territory, regularly use the manual, and when we've looked at compliance with common protocols, compliance is in the order of 80 per cent; so we've got very good results—and a bit like Traeger's pedal radio, this has been taken up overseas and so our colleagues in New Zealand across the Tasman at the Institute of Royal Health have used that same process to develop their own manual, the kiwi calibre.

So I don't think there's an issue about lack of innovation in remote Australia. We have a long history, I think, of innovation in remote Australia. I want to come back now to talking about remote primary health care services like the Katherine West Health Board. I've been working for several years now with a team—with colleagues Professor John Humphreys, with Bob Wells and Pim Kuipers—looking at models of primary health care and what we can learn from successful models.

Of course, we know that no one size fits all, but we also know that effective models do share common success factors; and we've called these environmental enablers and essential service requirements. This relates, not just to the sort of remote primary health care models that we've just been hearing about, but across a whole spectrum of models from discreet GP type services right through to comprehensive primary health care and hub and spoke models—and for each of these, when we've looked at these in some detail, both the literature and done detailed case studies with services like Katherine West—but a bunch of other services as well—they all have these features in common: that they've aligned these contextual issues and also addressed in a systematic fashion these service issues. I just want to briefly touch on what I mean by that.

In terms of environmental enablers, those issues that need to be addressed to make sure the health service is established and sustainable. There needs to be a supportive policy; either a mainstream policy like Medicare or PBS, rural equalisation policy, like the Flying Doctor Service or More Allied Health Services, and preferably not the sort of ad hoc policy and ad hoc funding that I think we heard about in terms of Fred's first example where they, you know, got rid of a funding source and then there was a special grant.

Those are the ones that causes the most problems. We need to get commonwealth/state issues lined up as they did with Katherine West, but as we've talked to different services across the country, and the bureaucrats responsible for funding them, these relationships are quite complex. In some instances, good, in other instances, not very good, and often with unclear accountabilities about who's actually responsible—and community engagement is essential.

All of these services that we looked at, not just community-controlled health services, but even successful general practices in remote country towns, had some level of community involvement, can take different forms, and if—as in the case of Katherine West—you've got strong community control and community boards, this process needs to be funded. In terms of the actual service requirements, consistently good governance, competent management and strong leadership—and we've seen a good example of strong leadership here today—were strong priorities; and leadership, not just in the community, but also leadership within health services and leadership within bureaucracies and even political leadership. Political champions that can see this process through.

We've just heard a very good example of funds pooling and cashing out, but this can—whilst a good process, this can take quite a lot of time to negotiate the pooling process, to get different levels of government to identify how much money that they're throwing in, but it does—as we've heard—afford

a certain flexibility to the delivery of those services to meet community needs. Linkages are really important, particularly in terms of establishing services—so good linkages with health departments, with rural clinical schools, university departments of rural health, divisions of general practice and so forth.

In remote areas, I think we can never forget the importance of infrastructure, of physical infrastructure, clinics and visitors accommodation; but also the importance of good information management systems. Not only for clinical care, but also so that you can show your funders just how well you're doing and ensure the sustainability of the service. The interesting thing that we found when we went around and did some detailed case studies—and it emerged from the literature as well—was that when these different service requirements were addressed in a systemic and systematic fashion, the problem of workforce—the ever-present problem of workforce—wasn't gone, but it was of diminished importance in terms of the priorities that people gave to these service requirements.

So we know that there's a huge amount of innovation that goes on in remote Australia. It's a tough environment and people respond very positively to that tough environment—and the Productivity Commission recognised this in their health workforce report a few years ago. I don't think the problem is one of innovation; the problem, that this repeated search for innovation, I think, is part of the problem. We have this recycling of ideas rather than learning lessons from successful services like Katherine West and then generalising these across the country.

It's great that, you know, there are some good things happening in the Territory in terms of lessons learned from services like Katherine West that are—seem to be being generalised in the Northern Territory, but we really need to see national application of the very good lessons that we've learnt over many, many years. So what can we do about it? Well, I think it is an opportune time, not only because of the commitment to Indigenous health that Fred referred to, but also the fact that it's a time of policy review—we're yet to see whether there will be policy reform—and we can be advocating very strongly, and I would urge the Alliance to be advocating very strongly, to take away the structural impediments that get in the way of providing effective primary health care services like Katherine West Health Board.

It seems to me to make a lot of sense that for a country of 20 million people we have one health system, rather than nine. Makes sense in terms of efficiency and continuity of care—and it really obviates all the resources that go into working out who's responsible for what, the resources that go into negotiating who's going to pay for what, the resources that go into different levels of government, to finding how much money they are committing to the pool of funds that would go to a health service, as we've heard.

In terms of responding to local need, regional implementation of primary health care services—and I would argue, of secondary services as well—makes a lot of sense and I've got a quote here; this is from the National Health and Hospitals Reform Commission interim report, and I think they're right. I think they're on the money there. "A localised or natural regional approach to delivery of primary health care can meet community needs." So a regional delivery model makes a lot of sense for us.

I'll just urge one caution and that is: We've heard about a very successful health service here with a population in the order of 3000. Some of the discussions at the moment about regionalisation are arguing whether we need to have regions of 100,000 or 200,000 so whatever that figure might be, there needs to be a flexibility in that, it needs to be able to itself respond to local needs, and not lose some of the successes that we know about.

Community involvement is critical, not just community-controlled health services but I would argue any primary health care service, and the other issue that's come out again and again as a priority is around

strengthened governance through governance training, and also strengthened management, and I heard a paper earlier today about retention of our light health workers.

Management came out, again, in there as an important reason why health workers—those health workers—stay or not. Managers really need to be seen as a part of the primary health care team, an important part of the primary health care team, and be supported in terms of educational training—and this, in turn, will lead to improved HR practices and, one would expect, improve retention of the workforce. So in conclusion, I think we—in remote areas, I think we innovate a lot and, quite frankly, I don't think we need a whole lot more innovation. What we need to do is to apply what we already know works and make some of these structural changes that will make it easier for services like Katherine West to continue delivering their services in an effective fashion. Thank you.

Presenter

Professor John Wakerman is the Inaugural Director of the Centre for Remote Health, a Joint Centre of Flinders University and Charles Darwin University, in Alice Springs. He is a public health medicine specialist and general practitioner, with a long background in remote primary health care services as a medical practitioner, senior manager, researcher and active advocate for rural and remote health issues. He has specific academic interests in remote health services research and health management education.

