‘Health ready’ for all eventualities

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Now, our third speaker for this session this afternoon is Professor Chris Baggoley. Professor Baggoley is the Chief Medical Officer of the Department of Health and Ageing. He is the Principal Medical Advisor to the Minister and the Department of Health and Ageing. He plays a key strategic role in developing and administering major health reforms for all Australians. In particular, his close association with Australia’s medical fraternities and researchers will be crucial in the development of evidence-based public health policy. Professor Baggoley also holds direct responsibility for the Department of Health and Ageing’s Office of Health Protection. Prior to his appointment, he was Chief Executive of the Australian Commission on Safety and Quality in Health Care. He was a former Chief Medical Officer and Executive Director with the South Australian Department of Health. Other medical positions include things like Professor/Director of Emergency Medicine at the University of Adelaide at the Royal Adelaide Hospital, Director of Emergency Medicine at Flinders Medical Centre, and a range of other very important positions. In addition to his medical degrees, Professor Baggoley holds an Honours Degree in Veterinary Science from Melbourne University, a Degree in Social Administration, and has been awarded the Order of the International Federation for Emergency Medicine. Please welcome Professor Chris Baggoley.

Professor Chris Baggoley: Good afternoon everyone. I’m sorry you had to suffer that. I must trim that considerably! I, too, would like to pay my respects to the Karuna people and their elders, past and present. I’d like to pay my respects to the folks sitting way up there at the back. I think the people in the top rungs of the southern stand at the MCG get a closer view of the action than you. So if you can see anything from up there, well done, you. And Mick, I wondered why you had orange slides, but now having seen all the orange people around here, you’re clearly in harmony. Well done. The other thing, Dr Jenny May from New South Wales, highly valued and influential member of the National Clinicians Group, asked me to give her the plug. Consider that was it, Jenny.

The original plan was for me to talk about challenges faced by rural and remote sectors and disasters. Let’s talk about disasters, epidemics, industrial accidents, work-related health accidents, workforce shortages, safety and quality, telehealth, and the e-health record, and if I did that, you’d all miss your dinner tonight, but we had a coaching session with Gordon Gregory, and any of you who have been coached by Gordon would know you take that seriously. Mick and I went there. Sue didn’t, but she still behaved impeccably, and I guess I won’t. And so he said, let’s just narrow it to safety and quality because we’re covering many of the other areas throughout this excellent conference. And it really is an honour to be here.

Now, in spite of working in emergency medicine, as you’ve heard, in Adelaide for many years, I do have some regional and rural experience. In the late 90s, I provided and worked in the emergency department of the Mount Gambier Hospital, doing night shifts on weekends, just to get a sense of what it was like. Sometimes it was fun; sometimes it wasn’t. And I admired ... because not all the facilities were there. The paediatric backup, no paediatrician there, but the GPs, particularly the older ones, were just fantastic. And mental health by brave community workers and sort of remotely somehow or other from Adelaide. Not easy. And then I did do one weekend as the hospital doctor in Narracourt. Anyone here from Narracourt? Do I have to run, because I think I was a strikebreaker that weekend? Anyway, there were no disasters, and life moved on. So that was good.

Now Gordon put the safety and quality issue as one where systematic approaches to safety and quality could leave people in rural and remote communities feeling more at risk. Red tape safety and quality approaches, for example, national standards, could leave rural communities without services, and how safe would that be, and where’s the quality in that? Now, I don’t think it has to be like that. If you look at this slide, and this one comes from work, from authors in Canada, where they use the word

'privilege' as a verb. So clearly they're from a different country, but it highlights the dichotomy of women of childbearing age; what they value, of course, are the social issues in relation to childbearing, whereas clinicians may, in fact, look more at the clinical interpretations. So there's a tension there which needs to be considered.

Now, both Sue and probably Louise Sylvan this morning talked about the death rates and so on in the rural communities, and this is meant to be about a bright discussion. So let me move right on, and until you've heard this sort of material, but there was an important Senate inquiry into the factors affecting the supply of health services and medical professionals in rural areas, and that was in August last year. Now I'll come back to some of the comments that were made there as they touch on safety and quality. But what I did do as well is I read some articles. You know, I do that from time to time, particularly when I have a talk to give, it sort of keeps you on the toes, and I looked at this paper which comes out of the United States, and clearly you will have the slides, I am sure, at the end of this and I'm sure they're all referenced. And where there's sort of been talking very quickly about social and health outcome context to the eventualities to which the health system needs to be ready, this paper looks at the safety and quality context in the rural setting and comes up with four hypotheses about patient safety and medical errors and why they might occur, which I thought were interesting and a bit thought-provoking, certainly not earth-shattering.

But this one looked at the distribution of patients and errors and contrasted the rural with the urban setting, and pointed out that in the rural setting usually, and remember this comes from the States, but I think it resonated, that there was a greater preponderance of elderly patients, particularly with some hospitals having a nursing home mix. More medical injuries, more adverse drug events, and also more falls. Then they looked at the whole issue of volume, and the difference between the smaller volumes in rural settings and the larger volumes in urban settings, and having large volumes doesn't always mean that's a good thing. You can become blasé. You can take things for granted, and, in fact, that's what they call overlearning, and then make mistakes because you're not paying attention. Whereas if an event is not usual, it's not common, then, certainly, you'll be paying attention, but there's still the risk if you don't do something frequently, as may be the case in the rural setting, for example, a mixing of IV solutions which may be undertaken by a pharmacy in an urban setting, then in a rural setting that does lead to the risk that mistakes could occur.

The third hypothesis, and the fourth, both, in fact, relate to information flows. In this one, they talk about the issue of social embeddedness, where the community lives and works together and how that might affect information flow, and, often, it can be very positive. For example, a follow-up, what I call the positive hardware store sign. So if you've seen someone that wasn't so well, sure, you might have heard, but if the next day they're in the hardware, you know, getting the timber, then that's probably a good sign that they're better, even if your diagnosis wasn't right. They're better, and that's all that matters. The lab technician may know and spot an abnormal result because of a smaller community. Diagnosis may be easily made, but you can get complacent, and you can assume things. You can assume that people know each other, and you don't have to hand over everything, and that's potentially a recipe for getting some errors, and near misses can be overlooked or discounted. But this one needs no interpretation. Just stands to reason that, with the issue of transfer and transporting patients, then, if adverse events are going to happen, that's where they will occur.

Now this paper also, from the National Academy of Sciences in America in 2005, looked at quality through collaboration, the future of rural health care, and described those services they thought were core to providing good rural health care. The ones I've starred there are those where they've indicated that access is often severely constrained by long-standing shortages of qualified health professionals. And they then also went to the Institute of Medicine, which does a lot of work in safety and quality in health care, and there they looked at a strategy to address quality challenges in rural communities. Talked about the integrated prioritised approach for personal population health communities. Stronger quality improvement support structure, the support there being important. The human resource

capacity and how that can be enhanced. Stable financial rural health care systems and investing in RCT structure.

But if I take us now to Australian literature, and this one comes from John Humphreys. John and John Wakerman and Bob Wells and so on talked about solutions beyond workforce. I mean, workforce is important, and I'll briefly refer to that, but solutions beyond the workforce, and that's a very interesting paper where they looked at the sort of models that have been developed in rural services from discrete services, integrated services, the comprehensive primary health care services, and the outreach services, and linking them from rural to remote. And they talk in that paper about essential service requirements to sustain service provision, and, in fact, many of the issues that they talk about are exactly the same, and it's not surprising that the Institute of Medicine spoke about it in relation to quality care. So workforce, financial stability. Here they mention governments, management, and leadership, which I think is really important. Linkages both within an area and with external organisations and, of course, infrastructure.

Now this paper from Richard Hayes. Richard studied what he thought were the key determinants of quality in procedural rural medical care and looked at and spoke to health professionals and to patients and families. And, again, you can see, and almost reflect in that Canadian paper, but thank God, Richard didn't use the word 'privilege' as a verb! He saw what was important to health professionals and patients and families, and, in fact, this often reflects general health care attitudes. And families and patients assume that those caring for them have a handle on the technical matters. That's assumed, and they go looking for the other things which they are really concerned about. Richard put this also in a table, and if the structural issues were probably more those things that health professionals are worried about, the process ones were areas that the patients and families would be more interested in, and the outcome of both, of interest to both.

Now we've mentioned workforce, and, of course, that's important, and the Australian Government, not surprisingly, made a submission to the Senate inquiry, and as the Department of Health and Ageing, is my sponsor, you understand, every now and then I have to mention them. They provide information about GP head count over the last decade. They pointed out where the training background was that rural and remote GP workforce noticing the rapid rise of overseas-trained doctors, and, in fact, almost all increase up until 2008-09 was due to overseas-trained doctors. They noted the increased numbers of nurses that were employed, and they had more restricted data, and it was also a bit concerning for that of dentists, which showed an increase to 2005 and then down in 2006, but that's clearly old data, and that may well be superseded.

Now in her presentation to the Senate inquiry, Professor [Inaudible]Bolger Cox-Swarn?, we were colleagues at Flinders many years ago, made these comments, and while you can read, I think they're important. We know that the outcomes for rural Australians when it comes to cancer are worse than for those in metropolitan areas, and Sue has mentioned it, and this really is a major problem. In saying that, we've got to think about the way we do things. Now this fits in with the development of regional cancer centres and their work, and they're looking hard at what it is that they can do and what others should do.

But Gordon said we've got to be bright, and there is much to be bright about. If we take telemedicine, and Mick Reed spoke about this in the importance of making sure it links appropriately in the structural sense, in the community sense with those who are getting the telemedicine, but it was described here by Richard Moore. I've had a bit to do with Richard as president of the College of Rural and Remote Medicine, and it's always been a pleasure. He spoke of the benefits of teleoncology at the Senate inquiry, and if I take you to the last sentence: So the models of telehealth are about strengthening, securing and enhancing skills of people on the ground. If telehealth can do that, then what a contribution that is making to improving the safety and quality of care in that area.

Other examples of telehealth, again, from my sponsor. The Townsville Diabetes telehealth trial, and I wonder if that's one we're involved with? The Murrumbidgee Medicare Local is working with the National Health Call Centre Network to establish telehealth remote video conferencing capability, and when the Hume Medicare Local may expand this into the Uranna community. If we look at the Queensland Alliance for Mental Health, they spoke of the virtues of telehealth, and they said the reality in mental health services in rural, remote settings is that it must be a partnership between the generalist health care providers, the community agencies supported by a range of specialist options, including telehealth outreach services and emergency transport evacuation.

I think the longest night that I had in the Mount Gambier Emergency Department was with a patient who was psychotic, who needed to go to Adelaide. There was myself and a few nurses there. We called an evacuation, but, of course, it was that beautiful fog, as is often the case at Mount Gambier, so even come the daytime, that person wasn't ready to go. And I truly understood the issues there, and I was surrounded by all sorts of facilities and how difficult that would be in a remote area. There's the Kiama Mental Health trials, providing services to young people from mental health professionals in Wollongong, thirty kilometres away. And the Pharmaceutical Society of Australia supports telehealth and in certain circumstances in remote areas. I'd also note that through the Medical Specialist Outreach Assistance Program ACRM is delivering telederm and radiology online.

So Gordon, where's Gordon? Is he here? Coach Gordon. God, down the back—what's the use of a coach down the back? So things are looking up, Gordon. There's a high rate of injury in rural areas, and we know that, and this paper by Mitchell and Chong published on rural remote health in 2010 talked about that, and talked about the whole issue with, for rural residents. This is where I went to my colleagues, former colleagues in the Safety and Quality Commission and asked them about this whole issue of safety and quality standards making it harder, but how do things make it better in, for rural and remote areas, and they came up with a line? Network's work. And they, this, they pointed to this paper from PD Cameron and his colleagues, he's a former colleague of mine in emergency medicine, about the Victorian Statewide Trauma System associated with a significant reduction in risk-adjusted mortality. So if a state gets itself organised and provides support, then you know this, things are going to get that the care can improve, outcomes can improve. In relation to stroke, and while there are the issue around stroke units, again, here, the timely access to stroke unit care for patients in rural and regional Australia is the single most important recommendation to improve the outcome for stroke patients. And then networks work for acute coronary syndrome.

Now this afternoon you're going to be faced with many choices, including, God forbid, a juggling workshop and a plate spinning workshop, let along the non-concurrent sessions. Let me tell you, to skip the plates and the juggles, and go the presentation by Phil Tideman and Rosie Tiramaco, showing the impact of an integrated cardiovascular clinical network in rural centres in South Australia. It's at River Bank Four. It's on at 3:30. It's the best plug they can give. This slide is showing the impact of this cardiovascular clinical network. Phil, leading cardiologist in South Australia, has provided this network for all now of rural South Australia, and the shaded grey area shows the uptake over years complete now by 2009. The dark black line shows the rural thirty-day mortality after a heart attack, and you can see that was starting there at about 14 per cent. By 2010, it's in line with the urban or metropolitan thirty-day mortality because of the influence of the networks. All those squiggly grey lines in the background, I'll tell you, are exponential moving averages. Does anyone know about exponential moving averages? Some do. Talk to them, not to me. That's a juggling workshop!

So, finally, and this is where facilitators of sessions love the word 'finally'. I use it frequently in the one session. If we go to these National Safety and Quality Health Service Standards, which can be a point of concern for rural and remote hospitals because it does just relate to hospital care. Of course, and should we have different standards of care for rural and remote patients and urban patients? I don't think any of us would put their hands up to say yes for that. Certainly, not the consumers of health care. And I spoke to Margaret Banks, who's been heading this program because she's done something very bad in a previous life. She's at the Safety and Quality Commission, and she's noticed the difficulties expressed

about the implementation in small, rural and regional services, and she's pointed out, that in these services these things can be harder, because there's a smaller number of staff juggling multiple roles. So I don't think you need to go to a juggling workshop. You do it already.

That access to specialist staff can be hard. Yes, there's a lot of support you can get from a regional level, and, of course, we all have networks now, and the strategies to address these different standards can be focused and tailored to the setting. And Margaret finds out that a lot of small services are doing really well. The smaller the service, the simpler the risk assessment, and the simpler the solution, which she summarises here. In essence, look at the best available evidence, having the data, by the way, is always important, and Sue's message from that just goes not just for financial levels but for very local levels. Use your local hospital network. Understand the key risks facing a hospital and adapt things to the local context. And not, but also do they have a book about that, and, the book in relation to the small hospitals is open for consultation, and it's on the Safety and Colleague Commission's website and interesting feedback until the end of this month, but there's also an advice centre, and if you phone this number, 1-800-304-056, on a Sunday just to check if it works, you'll be disappointed! But if you phone it in the morning on a Monday, then you'll either get an answer immediately or be asked to leave contact details, and they'll get back to you, and they do. So over 220 health services representatives have registered with the Commission to participate in regular network meetings, and there are national network meetings particularly for small, rural, and community-based services. So I highly recommend that to you if you are worried about these standards.

Finally, almost, twice, a word from our sponsor. Taxpayers have paid $2.1 billion in 2012-13 for targeted rural health and ageing programs, and I've listed some of these here, and finally, finally, finally, I just like to thank those people with whom I spoke before I stood up and spoke to you.

Thank you very much.