From evidence to action

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On to serious business though now. And I'd like to introduce to you the first of our speakers this morning and that is Bob Wells. He's the Director of the Australian Primary Health Care Research Institute and Co-Director of the Menzies Centre for Health Policy, which is a joint initiative of the Australian National University and the University of Sydney. He has a broad role to work across the ANU and areas of health research and policy analysis, including several projects in the fields of primary health care and workforce policy. Bob participates in national committees advising governments on research and medical training. He's a former First Assistant Secretary of the Department of Health and Ageing where he was involved in research policy, Commonwealth state relations, health workforce, rural health programs, safety and quality, and programs for better management of major diseases like cancer, diabetes, and mental health. He managed the Commonwealth's Health Workforce Programs from the early 1990s. He's chaired several workforce committees established under the auspices of the Australian Ministers Council, including working parties on National Medical Administration and Specialist Medical Training. And Bob has represented Australia internationally on medical workforce matters. To speak to us this morning about moving from evidence through to action, please welcome to the microphone, Bob Wells

Bob Wells: Thank you, and thank you for your welcome. I actually thought this was the light bit and not the heavy bit. But I certainly can't compete with the Move Through Life dancers, but I'll give it a try. What I want to talk about is how we can perhaps use some evidence which we have about sustainable health services for small rural communities, and fit that into the legacy of the health reform process and perhaps suggest some ways we can go about that. So I'm going to talk about what the evidence says about sustainable rural health in smaller communities, the outcomes from the health reform process, which I think are key things to achieving some progress in this area, and then try and put them together.

I'm going to draw heavily on work that John Humphreys and John Wakerman did in the mid 2000s. I was involved in that as well, but in a small way. And this was work funded through the Australian Primary Health Care Research Institute. What they did were three main things: first of all, analyse the evidence around the world on what are the features of small community health services that are actually sustainable over time—through good times and bad and that sort of thing. There were some in-depth studies of a number of trials within Australia of innovative approaches to funding and supporting rural health services in small communities of around 3-5,000. And their objective was to determine what are the features that suggest what is more likely to be a sustainable service and what might suggest what is less likely to be a sustainable service. So first of all we'll talk about the features of what seems to be successful.

The key thing that struck me from all this work was that it's to do with strong community engagement, from the outset. Get the community to agree what the needs are in that community and what services reasonably can be expected to provide those needs. If you don't get that, the obverse of the coin is you probably won't succeed no matter what else you do. A good governance structure that people are confident with that's accountable and, you know, is not built around, if you like, factions or particular enthusiasms of the day. I'll come to that shortly. And with some flexibility to apply funding, but within the mainstream programs. As distinct from a special, you know, pooling of funds or a unique funding opportunity which is set up for a trial. And then when the trial—when the funding finishes, the trial finishes, and so does whatever progress is being made. Perhaps I think the most important thing in this is what it tells you about what's likely to fail. And certainly enterprises that are based just on charismatic leadership without strong community engagement inevitably, from the literature and from some key Australian studies, will fail. They won't endure past the charisma of the person and often don't even endure as long as the person who drove it in the first place.

Unique funding arrangements. As I said, if you can't fit the funding model into the mainstream, the broad mainstream of funding, you're really asking for trouble. Because, you know, like Puff the Magic Dragon governments, move on. They get tired of different models and whatever. And you're then left up the creek without the paddle. Confused objectives and unrealistic expectations. I mean, communities can't expect the world, they have to have realistic expectations and have to be clear what they want to achieve. Poor governance and accountability. There have been many examples of where that has let the side down. And also professional dominance. If a system is designed in the interest of the providers of the services rather than the needs of the community, that's a pretty clear marker if one survives all that long.

Now turning to the health reform process. What did we get out of it? Well, some would say not a lot. But I think we got several important things. And two of them are, first of all, the notion of localisation or regionalisation. The establishment of local health networks and districts for the state systems, state territory systems, and the Medicare Locals for the primary care system largely funded by the Commonwealth. And the second key feature is a National Accountability and Reporting Framework and the creation of the National Health Performance Authority. We haven't had anything like that in this country. And I think having an independent body, which is independent of any particular government agency, which reports to the Parliament as a national entity rather than a Commonwealth entity to measure and comment on how the system's performing, is a big step forward.

So, what's the potential of Medicare Locals? Everybody says Medicare Locals will do everything. Maybe in time they will, but perhaps not quite from day one. First of all, I think the key thing about Medicare Locals is that they have a defined population. We've never had that in Australia in primary health before. So we can actually understand populations, what their needs are, what their features are. And have some groups that are in a sense accountable for tackling the problems that particular populations face. The Medicare Locals have their obligation in their funding agreements with the Commonwealth. And that's not just to look after the whole—the 61 Medicare Locals, average population around half a million. But they have to look after the pockets of population. And this is where I think in rural areas that Medicare Locals will probably be more useful in many ways than even in urban areas. Because they can identify local parts of their population which have different needs to other parts of their population and hopefully respond. And there is some devolved funding. Some of the programs the Federal Government used to run centrally, have now been devolved, for example, after-hours arrangements, etc. So there is some flexibility now for Medicare Locals to have to adapt their delivery arrangements, or what they will fund, what they won't fund, to meet local needs. And I think that's a significant step forward.

The National Health Performance Authority—it's public reporting which is important. It's not just some, you know, reporting within governments to the bureaucrats or whatever. It also measures not just the whole system but the parts of the system. And it's worked on its report on local communities recently which, you know, received some criticism. But nevertheless, it's the first time, again, we've had some way of assessing the need across the country, but with some measure of local variation. And I think, well, it's early days for the NHPA, it shows great potential for letting the public know what they're getting for their health dollars. And the more the public demands that, the more they will be accommodating in providing that, I'm sure.

So, putting evidence to work: first of all, it's clear that the one-size-fits-all approach, which the Commonwealth has treasured since federation and I was part of that when I was in the Commonwealth. Everything had to be national, and that meant it had to be the same as it was in central Sydney or wherever. But that's now been challenged, I'd say fractured, by the establishment of Medicare Locals and other arrangements. And within the Medicare Locals, as I said, there are opportunities for small communities to assert their needs and expect some positive response, even within a large geographic area of Medicare Local. And the independent national accountability allows governments to loosen the reins, even if only a little. And as I said earlier, we've seen that with some

evolution of some programs, such as after-hours care and some of the chronic disease programs, so it's a little bit. A little bit in our federation is a big step forward.

So that sets a pathway for the future. I think it's up to the local communities now to pick up what's available and to assert their needs. If you want to get more information on the work that the two Johns did, you can get that through the APHCRI website. Just, you know, search by authors would probably be the easiest way to find their works. And I'll point out that APHCRI is funded by a grant from the Australian Government Department of Health and Ageing.

So thank you.