Inter-state collaboration to enhance remote health care

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To Mick Reid now, who has many years of experience in both the public and private sectors in Australia. In the public sector, he was Director-General of Health in two states. For five years, until 2002, he held the position of Director-General of New South Wales Health. More recently, until 2010, he spent three years as Director-General of Queensland Health. Between these two appointments, he held three significant others. One was Director of Policy & Practice Program at the George Institute for International Health principally working with the Chinese Ministry of Health. From 2006 to 2008, he was appointed as Director-General of the Ministry for Science & Medical Research in New South Wales with the responsibility for planning and coordinating science, innovation and medical research. In 2008, he took up position as Chief of Staff to the Australian Minister for Health. So, when not engaged in the public sector, Mick is Managing Director of his own consulting company, Michael Reid & Associates, which has undertaken numerous health and science projects throughout Australia, for governments in Asia and the Pacific, and with the UN organisations. Michael was a Senior Advisor at McKinsey & Company from July 2011 through to October of 2012. He holds adjunct professorships in the Faculty of Medicine at the University of Sydney, the Faculty of Health Sciences at the University of Western Sydney, and he is Deputy Chair of the Royal Flying Doctor Service of Australia, and on the Board of the National Health Performance Authority. A man with vast and broad experience; could you please welcome him: Mick Reid.

Thank you very much, and I'd also like to acknowledge the traditional owners of the land, past and present. Thank you very much for inviting me here to the conference today. And what I'm going to do is tell a story. And I want to tell a story about a project which is proceeding called The Remote Health Project. The brief we were given in doing this project, which took place during the second part of last year, was by the four Director-Generals of Health, which I'll come to in a minute, was not to develop a major strategy document, not to develop a major policy statement around remote health, but what are a limited number of practical initiatives that could be done which lend themselves to Commonwealth and state interaction and collaborative approaches, which are a way that's possible and appropriate, which are designed to improve health services?

So, we have tried to identify a small number of very practical things which we think can be done across Australia in terms of response to that. The process, and there are many people in this room who were part of this process, I should add, from a number of jurisdictions. The brief was conducted under the joint auspices of the CEOs of South Australia, Queensland, WA, and Northern Territory. And we established a series of committees in each of the four jurisdictions, which were given responsibility for a broad topic to go forward on within their jurisdiction. And they held a number of workshops in order to develop those initiatives. We involved a number of other agencies: HWA, CRANA , the Royal Flying Doctor Service, you can see I've changed the National Rural Health Alliance to the NHRA - so, if you are wondering about the change of name ... DoHA and a number of state-based organisations including the AMSs. And having developed all that, we got formal sign-off of our strategies by the CEOs of those four health authorities.

We decided to focus on remote Australia, and we focused there mainly because we were trying to get something that was manageable. We tried to focus there, as I'll show you later, because, as you know, the complexities at Commonwealth/state-based NGO interaction are the greatest. And we focused there because that's the part of Australia where the states provide the majority of funds around the primary health care to complement the other services which aren't in those remote locations.

And it's the area where the secondary health services become the default providers of primary care. And once they become the default providers of primary care, that further undermines the private sector's capability of working in those areas. So, that's where we took remote. We know it's home to about 87

per cent of Australia's population. That doesn't include Warrnambool, in Victoria, or those types of places. And we know that Aboriginal and Torres Strait Islanders make up about 88 per cent of the population. We know about the health disparities there in those communities.

So, we identified 10 initiatives, and I'm going to broadly describe these 10 initiatives to you. They are categorised under these headings. So, there's one about recruitment and retention, one around service planning, one around education and training, one around telehealth, and one around defraying infrastructure costs.

In terms of the promoting, recruitment, and retention. And remember, we're trying to get strategies of interstate collaboration, things that lend themselves to working together rather than each state and territory doing its own thing in its own way. And for those who work in state/territory health organisations, you know there's a replication of many things that occur in every state and territory health organisation around Australia. So, the first one was: how do we get a single brand? In a sense, a brand of remote health employment, which would enable a collaborative approach to recruitment, and which would be particularly relevant to overseas recruitment. It would facilitate portability of employment across remote locations, between jurisdictions. And we are working with HWA, who are going to help develop this strategy. So, when someone is seeking to gain experience within Australia, who's from overseas, there would be a brand where they could experience the remote health of the top end of Australia and the top end of South Australia, and enable the portability of movement between those places, something which is not present at the moment.

We thought, secondly, how do you actually protect the brand? It is insufficient to get the recruitment strategies in place. And we have to have a consistent approach to employment. We have to have a consistent approach to common orientation. We have to have a consistent approach to support and mentoring. And we've got to do very simple things like how we start to standardise the Drugs and Poison Acts between the various states and jurisdictions. How do we start to standardise legal guidelines manuals between state and territory jurisdictions? All of which are variable and based on state-based legislation or based on state-based policies.

So, the first two was, how do we get a better recruitment and retention experience within Australia? And one about the brand, no about protecting the brand. And then, the second one, which in some ways the most complex, but in other ways the most important, came to the issue of collaborative service planning. This strategy took place at the early days of the Medicare Locals establishment. So, there are further discussions, which we're having with some of the Medicare Locals around some of these. But it's clear that in remote locations where you have state-based service providers, private sector service providers, NGOs, fly-in fly-out, or who are there, community controlled organisations, that the notion of having a single plan is difficult to achieve. And the notion of how you can have that single plan, which has a common approach to service provision, without threatening any of those organisations is critically important. So, this strategy was how you start to work to get a consistent, single health plan for remote communities. Now, the Medicare Locals are currently doing that in their boundaries of Medicare Locals, but remember, that's a much bigger footprint than what we're talking about in these remote locations.

And so, we're already trialling this and working this up in parts of Northern Queensland to see how this works. We're having community controlled organisations, state-based organisations, Medicare Locals sitting down to get a common approach to planning. And when an additional dollar comes in to those communities as agreed arrangements for who will hold that dollar and who will provide the service on behalf of all the organisations. As you know, that does not occur at the moment in a consistent way anywhere in Australia. So, developing those single plans is absolutely critical. And, also, we were just having discussions about what are a range of both monetary or non-monetary incentives to encourage and enable people to sit around the table to develop those plans. These are locally developed, locally owned, but they start to get the commonality about where you want the additional investments to occur and who owns them.

Strategy four was, how do you base those plans upon a definition of core service provision? NT has probably done the best work of this around the country, where they have a core level of service provision. And the use of that as a fundamental underpinning of those plans, we think is very important.

Moving now to education and training: there were four strategies we identified here. The first one was the commentary of many that it's very difficult to enable, and encourage, and facilitate junior doctors, nurses, and allied health workers to have remote experience during their training process. And we know from other evidence the importance of intern placements in terms of judging future employment strategies. We know that. There's a lot of evidence we have on that, but we really don't have the consistent approach to do that at the moment. And, in fact, we fly people from different parts of the country, in the medical arena, for their intern experience.

So, what we're looking at here, and there's a study already commenced here, is how we have a Darwin-based prevocational training centre to facilitate junior doctors, and allied health, and nursing in remote experience during their training periods. It's not a full blown medical school, or nursing school, or allied health school. It's a place to facilitate that prevocational training. And, as I say, there's a study under way to test that out at the moment.

The sixth one was a very simple one because, remember, we're after practical initiatives. And there's a tool called PaRROT, which has evolved in Queensland, which really helped primary care workers in having a better handle on how to manage complex care provision in chronic disease. And so, this is an e-based training program and skills-based training. It's working very effectively within the Queensland arena now, and since this recommendation, has already started spreading into other states. And the intention here is to provide this nationally, not just provide it into remote locations. E-based learning techniques to enable it to occur.

The seventh one, which was a complex one, because there are very strong and different opinions around this. And so, part of how you provide, when I come to how you provide some information to us, I'd be very interested about this. And this was to further enhance the role of what we call community workers in remote Aboriginal communities. Some states call them Navigators. And they are mainly there to assist to coordinate services to work with communities, families, consumers, carers. They are mainly there to coordinate much better the fly-in fly-out services. And they are there to essentially navigate the community on the behalf of providers to enable the best take-up and use of the service provision.

We know that, often, when the fly-in fly-outs come in, in some communities there's poor planning for their arrival. And in some communities, there's poor follow-up after their departure. And so, this work is how you have community based workers to encourage and enable those things to occur. The beauty of that is, it facilitates a far more defined role for the health workers in the clinical service provision, which is where we're heading under the National Registration Arrangements. So, number eight, as relates to that, is how you actually enhance training and support to assist the health workers attain competency standards for National Registration. And this is how we actually put funding in that to enable that to occur across the top end of Australia and South Australia.

The ninth one is around telehealth. A classic example of where each state and territory is developing its own telehealth capability, some states quicker than others. In some places, it's being supported and enabled by Commonwealth funding arrangements. But for very many services, it's not yet supported. But the real issue here is, why are we doing this on a state-based approach? This is an area that absolutely lends itself to having a service which is based in Cairns, or wherever, providing the top end of Australia and the top end of South Australia around specialist services. But it's also a service, probably even more important, that enables GPs, and nurse practitioners, and other remote nurses to talk to each other and to talk to other allied health workers in a way that is not enabled at the moment.

So, there's a group that are looking at the moment, across Australia, how we actually enhance telehealth services for service provision. But it also has that flow-on impact about how we can use it for remote branding, in terms of the orientation and the support and the mentoring, and how we can use it for e-learning, in terms of the PaRROT and the other e-learning things that could occur.

And the tenth one, which is kind of a bit of a wish, but it might be a longer term strategy. Again, each state and territory develops its own architecture, develops its own service types for health professionals and staff. It's often at immense cost structures, which inhibit the extent to which we should be providing those services. And OATSIH out of DoHA, who has done an amount of work which is how we get common architecture around these, and defray a lot of the capital costs in a way that is culturally appropriate to the communities in which people are living, whether it's in the remote north or further south. And so, they were the strategies. Again, they may not be the top important things to be done, but they were strategies which were thought there would be benefit in having interstate collaboration around it. We've talked with DoHA about this. These are service provision strategies, so they're not part of the group who put it together, but, of course, they're very supportive of the whole approach.

So, where are we now? That report was signed off by all the CEOs of those four jurisdictions, as I said. They're now in the process of implementing them. Many of the workforce initiatives are being taken up under the auspices of GNARTN, which is the Greater Northern Australian Regional Training Network. And the CEO, or the chair, of GNARTN is also the chair of the Remote Health Project. Health Workforce Australia is very supportive of the workforce based initiatives, and the overall coordination is being done through WA Health by Melissa Vernon, who is up here. Wave, Melissa. [brief laughter] And I would encourage you, and that's her email address. Many of you are part of the process which led to these initiatives being identified. Anyone who has particular interests in taking them forward, I would encourage you to contact Melissa. It is something which will only be successful if it really realises that element which the CEOs of Health Services asked of us, that it be practical, and implementable, and done quickly. Thank you very much.