



Change: do it yourself or have it done to you

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Thanks very much, Julie.

I have two observations. I have a whole new feel for pharmacists. I'm looking there in future. And Julie—how fit is she. Thanks very much for inviting me. I want to talk about for a little while—my background, as Julie said, is actually one of those strange beasts that came out of primary health care and into major teaching hospitals. It's a different grounding, and actually I think a good one for people to be in teaching hospitals. And my experience with rural health has mainly been in my role as helping rural health services. I've either been sent in by departments of health or I've been invited in. And in my experience, those who have invited me in because they want to facilitate a change process are those services that have been most successful. So I've never worked in the country. You might say "What a nerve", but I have some experience of organisational processes in the country.

So I'm going to talk a little bit. My view is essentially from maternal and child health because I've worked in women's and children's hospitals. I was going to talk a little bit about the context in which I observe rural health services operating, some of the strengths that I've seen in rural health services that in fact you could teach metropolitan health services, some issues that I think you need to address, and some good models that I have learned from and some suggestions.

Okay. So, the context. I think at the moment I'll just say safety, safety, safety. The sorts of things that I am seeing is an increased community awareness of and expectation for quality and safety. This has become a very bit agenda item. Federal and state governments are extremely concerned about quality and safety. And boards are now being held to account, so clinical governance and all the terms of clinical governance have become pretty standard in other responsibilities of the boards.

Interestingly enough, basically the only boards that have been sacked in the UK and in Australia have actually been generally over quality issues rather than, funnily enough, funding issues, which they used to be sacked for.

This is a quote from a friend of mine, Jim Birch, who until recently was the chief executive of health in South Australia. And when I said to him, "What do you think the most important thing is for rural health?" he said it's quality. He said, in the end departments of health are faced with terrible political problems if there are problems with quality and safety. The consequences are huge.

I think the problem with this is that I have observed that there's actually not that much help for rural health services. We have extremely city-centric universities. I heard someone talking about the training as part of the recommendations process. The training processes don't recognise the differences for rural and regional health services. The teaching hospitals are incredibly city-centric, and certainly professional accrediting bodies are also city-centric.

And I've seen first-hand a complete lack of harmony between what the requirements of these training and development organisations are and what it is that rural health services need.

Workforce recruitment and retention issues I think are absolutely—well, you know they're horrific for rural services. And you've got to pay people if you're going to attract people. And in fact I've seen situations where because of the levels, you know, the struggles that you have for seniority, et cetera, in the country, you're actually getting less than people in the city, where there's lots more support around. So these things are actually operating against you, and at the same time, of course, you've got increasing demand and much tighter funding.

The thing that I think is fantastic are my observations about rural health services though is you really do get it in relation to primary health care. You get it much better than metropolitan health services. You have a very good local focus and participation in your health services. Your focus is on your

population, not just on the individual. You see the patterns easily and you respond to it. You have a multi-skilled workforce. You have to be multi-skilled, and you make it that way.

And some of the best models I've ever seen for multi-disciplinary and multi-agency work are happening in the country. Barriers do seem to be a lot more broken down in the country health services than in the metropolitan areas. So I think that's a really strong part of the rural health scene. I think there are models of care and training and quality improvement programs working, despite all the problems. Some absolutely fantastic models of training and quality are in place.

There is I think fortunately pressure on the colleges from both the ACCC and also the Australian Health Ministers' Advisory Council to actually loosen up, not in a derogatory term, their very rigid notions of training and development for some of the medical practitioners. And I think if it works, there's potential for this national registration system by the COAG in the COAG reform. So there's hope on the horizon for some of the sort of city-centric training programs.

I think my observations, and also when talking to some colleagues of mine who I've worked with for some time who are in the rural health area, here's some observations that may or may not make you feel uncomfortable. But some of the risks for rural health to me are that there are some pretty huge egos in some relatively small ponds that can, I've said, place the focus of service development on empires ahead of safe care. And I've seen that happen in two or three of the country regions that I've worked with.

And what can happen is that colloquial competition between towns and regions can actually reduce collaboration that can strengthen both towns or three towns and regions. That's something that is a risk. It's not always happening, but it's a risk.

Another observation is that there are some key people that have very disproportionate influence in some small communities. And community participation, when informed and equitably engaged, is incredibly powerful. Community participation which is ill-informed and inequitable is actually quite dangerous. And that's a significant risk. If community participation is ill-informed and manipulated, it's even worse.

And I guess the other thing is that with key people, very influential people, people on whom small towns can depend, the enmeshment of those small towns, the relationships within them, can actually reduce objectivity and indeed it can create fear to participate if you're not agreeing.

Other risks. Isolated practice reduces critical mass and opportunity to identify quality issues. So if you are only seeing a few of a particular disorder or a few of a particular health issue, then the chances of actually picking up quality issues are much lower. And, look, there are quality issues in the city too. I mean, I just find the statistics staggering. Somebody told me yesterday that more people die from errors in American hospitals each year than died in the whole Vietnam War.

Now, these are huge things going on, but what's actually going on is that the quality and safety processes are pretty tight in these places now, and they're picking them up, they're picking up their quality issues before government does. Sometimes what's been happening is the Department of Human Services across Australia have actually been picking up the quality areas of the country before the county has, and that's a significant risk.

I think distrust of outsiders can reduce innovation. The "us and them" attitude to city hospitals can reduce support from the city. They're pretty standoffish as it is, so they just choose not to get involved. And dependence on locums has taken the focus perhaps off the development of a sustainable workforce. So those are risks.

On the other hand there are really strong models, and the strong – the really good models that I have seen and have tried to come to terms with all of these issues has been where there's a very clear delineation of the roles of services between the local, regional and metropolitan services, models which actually create networks across local, regional, city. It's sort of an amoebic organisational forum, and there's some really good ones that I've seen operating. They have very clear referral processes and



protocols, so they know when they're going to transfer to each other and under what circumstances and they all sit together and they agree to protocols. So the protocols are relevant for local people and relevant for the city transfer hospitals and regional transfer hospitals.

They're backed up by very strong and sustained educational and training support. So usually when these sorts of models are engaging the metropolitan hospitals and training programs, they've managed to drag responsiveness out of those training programs. They're backed up by very sound quality data and reviews. So, what you can see is the local services and the regional services start to actually be part of a collection process for quality data rather than the only collection process, so that the critical mass is better, they're able to start to identify some of their own quality issues.

I've called it amoebic organisational arrangements because what happens in these really strong models is that people are enabled to come and go across services and regions, so city hospital people go to the country, country people come to the city, country experts from one locality go to another one, regional specialists – regional services share specialists. There's no boundaries in these really good models. And most importantly, boards require in these really good models that the quality networks and the linkages for their isolated specialists are actually addressed. They pay and support these people to be involved in these amoebic organisations and to actually ensure that they have the training and support they need.

So, I guess some of the stories, some of the places where I've been involved where I've seen this sort of thing has been a program where I was involved in a country health governance framework in South Australia. This was a situation where South Australia, a bit like Western Australia, a very small population outside of the city of Adelaide, a very city-centric state, and the country regions certainly didn't have the level of power and policy development in that state that they needed. They didn't want to lose their local responsiveness or their regional relationships, but they wanted more power. And their work on governance was actually led by the chief executives officers and the boards of the regional health services to increase collaboration across a range of issues, including things like quality and safety, but also financial management, human resource workforce and retention strategies, most importantly, to be able to increase their power at the state level to try and get some more money into rural health.

So they actually led their change from within. It took them a while, but they've actually got the organisational structure and framework within the existing organisational arrangements for the South Australian Department of Health that they started off to get. It took them probably a year-and-a-half to two years, but they got there. Almost all of the recommendations of the work that that group of CEOs and board did are actually in place.

I talk about Nigel Stewart's program. Probably a number of you have already heard about it. He calls himself, or his service, the best little paediatric service in the country. And I put that up to say that that's what he decided to be. He wants to be and maintain the service as a little paediatric service, one which is capable of responding to the regional level. Changes that were brought about by Nigel were actually led by Nigel, the paediatrician, because he wanted to ensure far more effective referrals between the Port Augusta Hospital and the Women's and Children's Hospital in Adelaide. He wanted to educate and influence the people at the Women's and Children's Hospital in Adelaide and the University of Adelaide because they were not being responsive to the sorts of service arrangements and training and development requirements of the Port Augusta Hospital and other local regions around the area, and he wanted to educate and engage doctors to stay in Port Augusta. And he actually set up a training program between the University of Adelaide Women's and Children's Hospital and Port Augusta Hospital that's still maintained now. And he gets registrars and, interestingly enough, they want to be trained in the country and live in the country.

The North-West Tasmanian Obstetric Service I was actually asked by the department to come in and look at that service. But we designed the program with maximum participation. They wanted to increase their critical mass and safety and increase education positions and engage staff. And they had to create a regional program to operate in two hospitals to do that, rather than separate the two hospitals and not have enough critical mass in either of them.

The far and mid-north collaboration on obstetrics, which was led by the chief executive officers in that area, wanted to ensure sustainability of services in the region, and they've developed a set of programs and principles and ways of working across the whole region—actually it's across two regions—to increase their sustainability and workforce development strategies.

There are a number of others that I know of—surgical services in the Hills and Murray-Mallee area and the iron triangle in South Australia have also been led by the rural people and dragged the universities and teaching hospitals into the rural regions.

So, my suggestions are, lead it yourself. You've got to actually recognise the environment that you're in. There are big issues. Lead it yourself. Identify the issues across your boundaries, including the city. So, develop and understanding of how you can do it with other people. Develop collaborative strategies, service models and referral protocols, et cetera. Support them with appropriate resources. So, that's—boards need to understand the importance of that. Start telling people about them and building a profile of how it is that you are changing yourself and responding to these issues, because that will raise up the ante, raise the knowledge and get the attention that you need for funding and bring your communities along with you with that really good plan so that they're part of the political process in attracting funding.

So that's all I'm going to say. Thank you.

FACILITATOR: Just before Kathy takes her seat and I bring up our next speaker, Andrew Podger, I just want to get one more second from you on that last point about—start telling people about them and building profile. A couple of conversations I was having yesterday, people were talking about the importance of promoting the good side of rural and remote practice as part of the attraction and retention.

KATHY ALEXANDER: Yes.

FACILITATOR: And if I would suggest the use of local media is critical. Could you put your hand up if you're a student, just so Kathy can see? These are all students—medical, nursing and allied health—and we've had a lot of presentations with great analysis of the problems and a number on the positive side but not a great deal. And I just wonder if you could say one more thing about that?

KATHY ALEXANDER: Telling the stories?

FACILITATOR: Yes.

KATHY ALEXANDER: Yes. Well, it's interesting because I guess one of the things that I'd say, as a consultant, is that I don't hear the rural stories. I tell the rural stories, but I don't hear the rural stories. I think you stick to your own conferences too much. I think that there's models of primary health care, service integration, quality development that are absolutely exemplary that in fact they should be using in metropolitan health services, and they are nowhere near it. They're not even any near it. They're not anywhere near the collaborative approaches, the multi-disciplinary or multi-skilling approaches. They're not into—they don't understand that kind of dragging of resources into a particular issue like country people do.

So, I guess what I'm saying is that I think that there are things to tell. There are perhaps other skews or points that you should make about them, but you should be telling them in some different places than the ones that you're telling them in so that policy is recognising what's going on in the rural areas.

FACILITATOR: Thank you very much. If you could take a seat at our table. And another round of applause, please.



Presenter

Dr Kathy Alexander, former South Australian Telstra Businesswoman of the Year and with a national reputation for stakeholder engagement and community participation in social planning, has extensive experience in leading change, both in large and complex organisations and smaller community organisations and businesses. She has held positions as Chief Executive Officer (CEO) in major teaching hospitals and community health services and has provided consultancy services in planning and change management in public and private sectors.



As CEO of Women's & Children's Health, which governs two of the world's leading teaching hospitals – the Royal Children's Hospital (RCH) and The Royal Women's Hospital (RWH) in Melbourne – Kathy led a financial recovery program resulting in \$15m productivity gains over four years of record activity, and increased funding of over \$20m for the RCH following a study of paediatric costs and payments. Kathy was responsible for leading the development of a successful capital bid to the state government for construction in 2005 of a new \$250m women's hospital. She also initiated planning for capital redevelopment at RCH. Prior to going to Melbourne, she led the Organisation Design Project to amalgamate the Adelaide Children's Hospital with the Queen Victoria Hospital as the Women's and Children's Hospital (WCH). She also led a major program to engage consumers and the broader community in hospital planning processes.

Kathy has a strong background in public health and health promotion. As CEO of two large community health services, Kathy developed a strategic planning framework for community health that set the agenda for community engagement in health promotion planning and practice in Australia.

Kathy is an outstanding communicator, with highly developed skills and experience in strategic planning, financial and business management, change management and high level policy development and advocacy. With qualifications in psychology and public health management and with more than 20 years' experience in leading health and community organisations, Kathy's work has been recognised with several national best practice awards and leadership positions on a number of Boards.