



Ladies and gentlemen, our next speaker is Philip Davies, Deputy Secretary of the Department of Health and Aging and in your handbook of course there's a lot of background. I wanted to know about his rural connections. Now, he grew up in England. He's a Pom. We're not going to hold that against him because we've let go of those cultural attitudes towards our colonial masters. He then went to New Zealand. Well, we even like them. After all we were at Gallipoli with them.

He's now here, and to help him understand rural and remote issues he's gone on an extensive travelling program which includes Atherton, Queensland, Manilla, New South Wales, Karratha, WA, Katherine, Northern Territory, Kalgoorlie, WA, St George, Queensland, Walgett, New South Wales, Launceston, Tasmania. A glaring omission, ladies and gentlemen, is South Australia, and I put on the table, and I know Philip is keen to receive your invitation so he can visit you in oddly remote and hard to get to places and he is keen to come there, but he has taken an interest in small islands, including three months on St Helena in the mid-Atlantic, 5000 people, 49 square miles, no airport, and a ship every three months. So he's got something to work with ladies and gentlemen in terms of understanding remoteness. Please welcome Philip Davies.

## Policies and programs across internal borders

[Philip Davies](#), Deputy Secretary, Department of Health and Ageing

**PHILIP DAVIES:** Thanks Julie. It was a great introduction. You realise that whoever wins the cricket, I'm always happy.

Thank you very much for the opportunity to speak to you this afternoon. I'm talking about policies and programs across internal borders and you'll keep hearing that borders theme hopefully come out as I talk this afternoon. What I'd like to do is, in the time available to me, talk about the nature of the rural health challenge, the progress that we've made, and the opportunities that I see lying ahead. I stress these are personal views and not necessarily a presentation of government policy.

So if we start with the nature of the rural health challenge. From a rural health policy perspective, the Australian government's objective was captured really nicely as long ago as 1998 in the Healthy Horizons document and that is stated here:

Ensuring that people in regional, rural and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities.

That statement, simple though it seems, actually contains a couple of very important messages about the nature of the rural health challenge.

Firstly, it focuses on outcomes. It makes clear that the goal is health. That means more than just curative health services. It also means looking more broadly at the causes of ill health among rural people and seeking to address those causes. By adopting an outcomes focus, the statement also reminds us that we should focus on ends and not necessarily just on means. If the goal is health then we ought not to allow ourselves to be too constrained by established patterns of service delivery if they're no longer fit for purpose, and that echoes some of what Robert has been saying. The value of holding on to traditional roles, organisations, and institutions needs to be tested in light of their contribution to desirable health outcomes.

Secondly, that statement refers both to the health of individuals and to the health of communities and acknowledges the interplay between the two. Healthy people make healthy communities and vice versa. Already in the statement we can see hints of the importance of working across borders. The focus on outcomes encourages us to critically assess the value of existing professional and institutional boundaries, while the mention of healthy communities talks to a need to tackle health issues on both an individual and on a broader holistic basis. And I think Romlie summed it up very nicely by referring to the Indigenous concepts of physical, mental, emotional social and spiritual aspects all coming together in an holistic concept of self. Very much about crossing borders.

But I am getting ahead of myself here. First of all we need to explore the nature and scale of the rural health challenge, but I am sure most of the facts are familiar to most of you so I won't dwell on them too long this afternoon.

We know that on many indicators the average health status of people who live in rural and remote areas is lower than that of their urban counterparts.

If we look at life expectancy at birth, people living in major cities are expected to live almost seven years longer than people living in remote areas, and that is even after we've compensated for the known differences in age, gender and Indigenous status between rural and urban areas. Those differences don't account for that gap in life expectancy.

If we look very quickly at the causes of death, we see that (after taking account of age and gender) rural and remote communities experience much higher rates of death by diabetes, transport accidents and accidental drowning, and to a lesser degree respiratory diseases and intentional self harm.

If we look at risk factors we know that people living in rural areas are more likely to smoke and to drink alcohol at risky levels. They are more likely to be overweight or obese. And, in addition, rural, regional and remote Australia isn't exempt from health challenges that confront the country as a whole. So we have the growth in chronic disease and population ageing. Those issues impact nationally, but they are certainly no less marked in rural areas.

So while the challenge of rural health has much in common with the broader challenges faced by our health sector nationally, there are several aspects of rural health that are distinctive, most notably those relating to risk factors and larger Indigenous populations. The challenge of rural health is, if you like, a double whammy combining the general with the particular.

So how are we doing in rural health?

Governments, health professionals and most importantly communities themselves have been working together for a great many years to address the rural health challenge as I describe it. We have together achieved a great deal.

Since 1999 there has been a range of new initiatives in rural health. They include the Rural Health Strategy itself, elements of the Strengthening Medicare package, and more recently, several measures coming out of the Council of Australian Governments or COAG.

If we look across the spectrum of Commonwealth Government policies and programs over the years, it is clear that it is genuinely a multi-faceted, multi-pronged attack to improve the health status of rural communities.

Steps to make rural practice professionally and financially more attractive include measures to reduce workload pressure, support for locum relief, and opening up Medicare so that some services such as immunisation and wound management can be provided by practice nurses and now also allied health services funded under Medicare.

We are supporting people who want to pursue careers in rural areas through scholarships to rural students in a range of disciplines and a network of rural clinical schools and university departments of rural health.

We are looking at flexible and sustainable models of service delivery, programs to support the viability of rural pharmacies, small private hospitals, privately insurable health services and aged care in rural areas. These are things that are outside the Medicare Benefit Schedule, so not everything is being implemented through the MBS.

There's enhanced funding flexibility so small communities can tailor use resource use more closely to meet local needs and an increased focus on prevention and patient self management, really as a response to the high prevalence of avoidable morbidity and those risk factors I referred to earlier on.



So we've done a lot, and obviously the question is, are we having the desired impact?

Well, clearly the most important measure of success is the impact our efforts are having on the health of people living in the bush. The reality is that isn't easy to identify or even to assess in the short term. We do know that between 1992 and 2003 the reduction in death rates in regional remote areas was about the same as that in major cities, and death rates actually fell slightly faster in very remote areas.

The average annual improvement in the very remote areas was around the 5 per cent per annum, whereas it was around 3.5 per cent for men in most of the country and for women just over 2 per cent. So we are certainly no worse and in those very remote areas doing somewhat better than in the metropolitan areas.

There are a couple of notable exceptions. If we look at suicide for example, we see that while the rate in most of Australia has actually reduced slightly over that ten year period, it's actually increased quite significantly in very remote areas.

We've also seen the first early signs of positive trends in Aboriginal and Torres Strait Islander health status. Clearly there is a massive job to do, but I was struck last year by a paper in the Medical Journal of Australia by David Thomas and others which actually identified for the first time long term reductions in Indigenous mortality in the Northern Territory. But other than little snippets like this, we really do not have a lot of reliable data on recent trends.

In terms of prevention, we know that in 2000 child immunisation rates in rural communities were much the same as in major cities while rates of breast and cervical cancer screening in the bush were generally higher in rural areas than they were in major cities. Those two facts I think are a real tribute to our rural health services and our rural health professionals, and they represent a very sound investment in the future.

But in the absence of reliable and up to date data we can use to assess changes in health status attention inevitably turns to proxy measures, namely access to health services. Here there is a good story to tell.

The GP to patient ratio in urban areas is declining slightly and it's certainly rising steadily in all other parts of the country. So there is a move to the bush in terms of GP practice. Also, since we introduced Medicare rebates for allied health services in 2004, about a quarter of the services provided have been provided in rural and remote areas, which shows that it's not just GPs but it's also allied health professionals who are providing those services.

I'd like now to focus on the opportunities that lie ahead and return to the theme of policy and programs across internal borders. I'd like to focus on just three types of borders:

- geographic borders – how do we overcome Geoffrey Blainey's tyranny of distance in health care?;
- professional borders – to make prevention and treatment more seamless for people in rural communities; and
- service borders – to support more effective collaboration among the different parts of our complex health sector.

If we start with working across distance, one of the most enduring challenges for rural health is how to deliver appropriate services to widely dispersed populations across often vast geographic areas. You could however be forgiven that the tyranny of distance was a thing of the past. I looked up on Google Books the other day and I discovered there are roughly the same number of books listed out there with "death of distance" in the title as there are "tyranny of distance". So it makes you wonder, is there still a tyranny of distance or is it all over? Have we in fact overcome the tyranny of distance?

We are constantly reminded how modern computers and telecommunications are making the world a smaller place. We can nowadays perform a great many tasks online and we increasingly take for granted the fact that we can receive a great many services at a distance by telephone or on the Internet. We increasingly take for granted the fact that we can obtain products or services whenever and

wherever we want them. Of course health care is different. The very nature of health care means that the scope for remote delivery is inevitably more limited. I dare say the time might come when a remotely operated robot can change a dressing, can respond to a suspected heart attack at 2 o'clock in the morning, administer an injection, or plaster a broken ankle. But I suspect it's still some way off.

Having said that, there are some exciting developments which do offer the potential for more health services to be delivered remotely. Telephone call centres and tele-diagnosis are examples of channels that are already making a difference to what is available in rural communities. They are still in their infancy and we need to do more to make sure they work, and work properly, for everyone involved. One example is the fact that the Government now acknowledges that we need to make changes to the Medicare Benefit Schedule if telehealth services are to take off, and we are actively working on those issues.

The growth of remote services, or potential for remote services, will also bring into sharper focus the question of what precisely constitutes success in rural health services. If we focus on health outcomes rather than health services, as I have already suggested we should, then in some cases – and I stress “in some cases” – the need to maintain the level and form of physical presence of premises and practitioners in rural communities may well change. Indeed there is ample evidence that for some services the best and safest outcomes are achieved when services are concentrated in larger population centres. I think over the next few years patterns of health care delivery in rural areas will actually become quite fluid.

On the one hand, telehealth will mean that more and better services can be provided in remote areas, while on the other, the need to access to state-of-the-art diagnostic and treatment equipment, which keeps on progressing and becoming more sophisticated, may result in increased centralisation of other services. Balance between the local and the central will continue to shift over time and if we are to meet our objective of healthy rural, regional and remote communities, governments themselves will need to ensure their funding and regulatory mechanisms allow that adjustment, that balance, to evolve in line with changing patterns of services. I've already alluded to the need to amend the MBS to provide subsidies for telehealth services and that is just one example of how we in government need to keep abreast of what is going on to make sure we're helping, not hindering, desirable change.

I said I'd talk a little bit about working across professional borders, my second group of borders.

Traditional health services evolved in response to episodic conditions. For centuries, literally centuries, the focus of the medical practitioner was to deal with a series of isolated one-off incidents; a broken limb, an infection, the birth of a child, for example. Most of those problems were resolved satisfactorily and, to be honest, if they weren't, the patient's prospects of survival were probably not that good. But over the past 20 or 30 years, patterns of ill health themselves have changed dramatically and now as much as 80 per cent of Australia's burden of disease, and probably more in the country, is attributable to chronic conditions which people actually live with for many years. They are conditions that aren't immediately fatal but often require careful monitoring and management over a long period of time.

The changing balance between episodic acute disease on the one hand and longer term chronic conditions, is shifting the emphasis in health care from transactions to relationships; from treatment involving a brief one to one interaction with a doctor to programs of care that may involve a variety of professional skills and may extend over many years. The growth of team-based care, I believe, presents both challenges and opportunities for rural health.

On the positive side we know that professional boundaries are of necessity often less rigid in rural areas and that rural doctors, nurses and allied health workers are used to working collaboratively to meet patients' needs; collaboration typically based on established trusting relationships between professionals. On the negative side, regulatory or financial barriers can sometimes act to inhibit the appropriate collaboration that is needed to respond to the challenges posed by changing patterns of disease in rural areas arise..

One very small example of how those challenges can be addressed is provided by the Australian Government's agreement to allow registered Aboriginal health workers in the Northern Territory to



access Medicare subsidies for immunisation and wound management services delivered on behalf of a doctor. Elsewhere that is restricted to nurses. For those registered Aboriginal health workers we've extended that permission. That regulatory change in itself has removed a small but significant barrier to effective team-based care. It is a good example of how governments can respond flexibly to the needs of rural communities.

You do not need to delve too deeply into this issue of working across professional borders before the question of workforce substitution crops up; nurses prescribing medication, radiographers reporting routine x-rays and so on and so forth. You'll either be delighted or sorry to hear I'm not going to enter into that debate here today, but I do note Tony Hobbs's comments from yesterday, quoted in this morning's *Australian* newspaper, to the effect that rural doctors are already under pressure and a significant rise in ill health would probably force some care to be delivered by nurses and allied health workers instead of GPs. That I suggest is a question that rural communities need to consider, and consider seriously, in the months and years ahead.

Finally, a few words on working across organisational or service boundaries. I was at a meeting a while back where I was talking to a number of rural GPs about what they thought was needed to make working in the bush more attractive. Although clearly their opinions varied there were several consistent themes. They told me they wanted more and better administrative support. They told me they wanted better IT connectivity. They told me they wanted help with the cost of practice premises. They said they wanted easier access to locums. And (interesting this for self-employed people) they wanted paid recreational and study leave.

Now, I'm sure none of those comes as any surprise, least of all to rural GPs in the audience, and if I'd spoken to other health professionals working in rural locations I dare say I would have been told much the same. To me, looking behind those messages, I sense a desire to move on from the traditional model of self-employed solo practice and instead to be part of something bigger and more organised, to be part of a system, to be part of a network in some sense.

I also suggested a moment ago that we should be looking to increased adoption of new information and communication technologies to help health professionals work across geographic boundaries. We should be encouraging a growth in team-based care which cuts across service and professional boundaries. That's adding more complexity to – and putting even more demands on – the organisational and managerial resources of rural health care providers.

It's almost as if we are saying to hard-pressed rural doctors, "Not only do we want you to manage your current professional practice but now we also want you to worry about computer systems, co-ordinating team based care, recruiting nurses, organising leave for colleagues and so on and so forth". So we are at risk of making an already difficult environment more complex as we respond to those changing patterns of disease.

So I wonder, therefore – my final thought – whether we might see more rural practitioners coming together into larger groupings that are better able to deal with the changing demands on their time and skills. I know that many such groups already exist, often informally, in many parts of the country. There may be merit in putting them on a more formal footing. Groupings like those could perhaps employ allied health professionals and practice nurses, or at least offer them co-located premises, instead of relying on today's more ad hoc arrangements. They could also provide a better critical mass for investment in modern IT systems as well as establishing a basis for organising leave rosters, for professional development, and for recruitment activities.

While some larger rural communities might well be able to support that multi-disciplinary type of practice, smaller communities obviously won't. In those cases what we may need to consider is some form of virtual organisation where we may have, say, a podiatrist employed to work across four or five practices, or one hub practice that handles appointment bookings for a number of smaller satellite practices. The hub might even provide a basis for integrating separate funding streams from Commonwealth and State governments and then sharing those out amongst the distributed practices (Commonwealth and State governments, of course, being another important border within our health sector).

Breaking down some of the organisational boundaries that currently separate individual practitioners in the way I've described could well turn out to be a true win-win. Not only will it improve rural health professionals' quality of life by allowing them to focus more on their core role of patient care but it will also deliver economies of scale and efficiency savings which could increase the financial viability of some practices that are in fact currently marginal.

So to sum up, we're in a changing world and we need our health system to deliver changing services, and we as policy-makers and health professionals need to respond to those pressures for change. We have accomplished a great deal in rural health over the past few years but much remains to be done especially, as I've alluded to, in Aboriginal and Torres Strait Island health.

The pressures on rural health care providers are great but so are the opportunities to achieve positive change by working across some of the boundaries, whether they're geographical, professional or organisational, which currently characterise the sector. Again I think the story from the Red Cross is one we should all look at here. Rural communities, and the people like you who work in them and serve them, are often natural incubators for innovation. The old adage that necessity is the mother of invention seems particularly appropriate when discussing rural health service delivery, and I think events like this provide an ample demonstration of what can be achieved.

But much of that innovation needs to come from the bottom up, especially in rural communities where 'one size fits all' solutions are unlikely to succeed. The role of governments is to establish the financial and regulatory environment in which the enthusiasm, the commitment and the creativity of rural communities can flourish. And by working together in that way I'm confident we can continue steadily to bring about the positive changes in health status which rural Australians are entitled to expect.

## Presenter

Philip Davies joined the Australian Government's Department of Health and Ageing as a Deputy Secretary in 2002 and brings to the role more than 25 years' international experience in health care policy and management. As a member of the Department's Executive he has had responsibility for policy development and program management in a variety of areas, including medical and pharmaceutical benefits, health workforce, e-health, rural health, Aboriginal and Torres Strait Islander health and private health insurance. He is a member of the Executive Committee of the Health Services Research Association of Australia and New Zealand, he served on the Board of the National Blood Authority and chaired the Australian Government's Gene Technology Standing Committee. In December 2005 Mr Davies was also appointed as Transitional Director of the Joint Agency Establishment Group tasked with setting up the proposed Australia New Zealand Therapeutic Products Authority.



After graduating in Mathematics, Mr Davies worked for five years with the Department of Health and Social Security in London before joining Coopers & Lybrand (now PricewaterhouseCoopers) as a health care management consultant. In 1991 he transferred to Auckland, New Zealand and in 1995 he became a partner in the firm's consultancy practice in Christchurch, New Zealand.

In 1997 Mr Davies joined the New Zealand Ministry of Health as a Deputy Director-General, leading the development of policy and legislation underpinning the most recent reorganisation of New Zealand's health system in 2000. He then spent 18 months as a Senior Health Economist with the World Health Organization (WHO) in Geneva before moving to Australia.

Mr Davies holds a Masters degree in Management Science and Operational Research. He is also an Honorary Fellow of the Health Services Research Centre at the Victoria University of Wellington, New Zealand, and has provided consultancy advice on health policy to the World Bank and WHO.