Limestone Coast regional leaders' forum output report

Mount Gambier, 12 September 2019

Output report

Health Performance Council

Government of South Australia
Health Performance Council

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Acknowledgement

The Health Performance Council acknowledges the Aboriginal peoples of South Australia and their ongoing contributions to and participation in the life of South Australia. We acknowledge and respect their spiritual relationship with their respective countries.

We also acknowledge the diversity of Aboriginal people in South Australia. Our Australian continent is known to have been inhabited for at least 55,000 years. The first inhabitants comprised over 270 different Aboriginal language/cultural groups across Australia, with 40 independent groups living in South Australia. Each group occupied its own territory and had its own unique culture, beliefs, laws, language, stories, ceremonies and art*. Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

** Source: Reconciliation SA, 2017.*

Disclaimer

This document incorporates views and opinions which are intended to represent in aggregate those of the delegates to the Health Performance Council's regional leaders' forum and which do not necessarily reflect those of any or all of the individual delegates or of the Health Performance Council, SA Health or the Government of South Australia.

Photographs included by kind permission of the participants.

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Summary

The Chair and members of the Health Performance Council hosted a forum in Mount Gambier for local leaders who have an interest in health, wellbeing and population health research. We enjoyed an open and engaging conversation, hearing directly about local healthcare and health outcomes issues for people living in the Limestone Coast region.

Some of the top priorities that emerged from the discussion were:

1. Attracting and retaining a skilled medical workforce to the region
2. Improving the general local infrastructure and service provision to increase the population in the region.
3. A need for localisation of strategic health service planning and delivery models.

We also noted other areas of concern that were debated, including inequitable health outcomes for Aboriginal people, indicators of poor regional population health, suicide, and the need for appropriately considering the language and digital literacy needs of people when providing information primarily online or only in the English language.

We thank all those who attended for their honest and valuable contributions, which we will take into account when setting our future programme of work. In the near term, some of the work the Health Performance Council will take forward in response includes:

- We will give strong feedback to SA Health in their open consultation on the Rural Medical Workforce Plan (July 2019).
- We will publish an updated second edition of our *Hotspots of potentially preventable hospital admission* report[1] providing more information for local health services, the federally-funded Primary Health Networks and the state's Local Health Networks.
- We will make updates to our *State of Our Health* statistic resource with breakdown of reporting by Local Health Network where the data allows. This is offered to local health economies as a contribution to their data analysis to allow localised strategic planning to harness the power of variations (comparing with similar communities inter-state, perhaps) to see if and where there are opportunities to improve, rather than justifying or explaining away any variation.

[1] https://www.hpcsa.com.au/statistics/potentially-preventable-hospitalisations

Introduction

The Health Performance Council is South Australia's expert health system monitoring and evaluation body, providing advice directly to the health minister about the operation and effectiveness of South Australia's health systems. Our reports are published on our website: https://www.hpcsa.com/.

We engage widely with stakeholders and communities to help decide our priorities for review, making particular effort to seek out stakeholder groups who are commonly less well heard. We planned this regional event to engage local leaders with health interests in a frank and open discussion about the particular health system interests in the Limestone Coast region. Our series of regional leaders' forum events were instigated following the success of our long-running series of *Aboriginal Leaders' Forum* meetings, which we co-host with the South Australian Health and Medical Research Institute's Wardliparingga Aboriginal research unit, and our occasional series of *Culturally and Linguistically Diverse Leaders' Forum* meetings held in conjunction with the *Multicultural Communities Council of SA*.

Proceedings

Welcome and introductions

The forum opened with an Acknowledgement of Country. The hosts and delegates introduced themselves, briefly recounting their diverse backgrounds and areas of expertise. We were pleased to welcome to the forum a mix of clinicians, health services executives, community leaders, researchers and community representatives.

Discussion

Health Performance Council members got the conversation started with a thought-provoking reflection of preventable mortality as a crude proxy for the performance of the health system. Delegates heard that regional South Australia had a level of mortality influenceable by the healthcare system much higher than and dropping more slowly than Adelaide, and contemplated findings that much of the difference was between Indigenous and non-Indigenous people. Delegates noted the Health Performance Council's strength in looking beyond a crude population average to consider deeper insights from the broader distribution and the need to look at particular groups of the population (see Figure 1 on page 5).

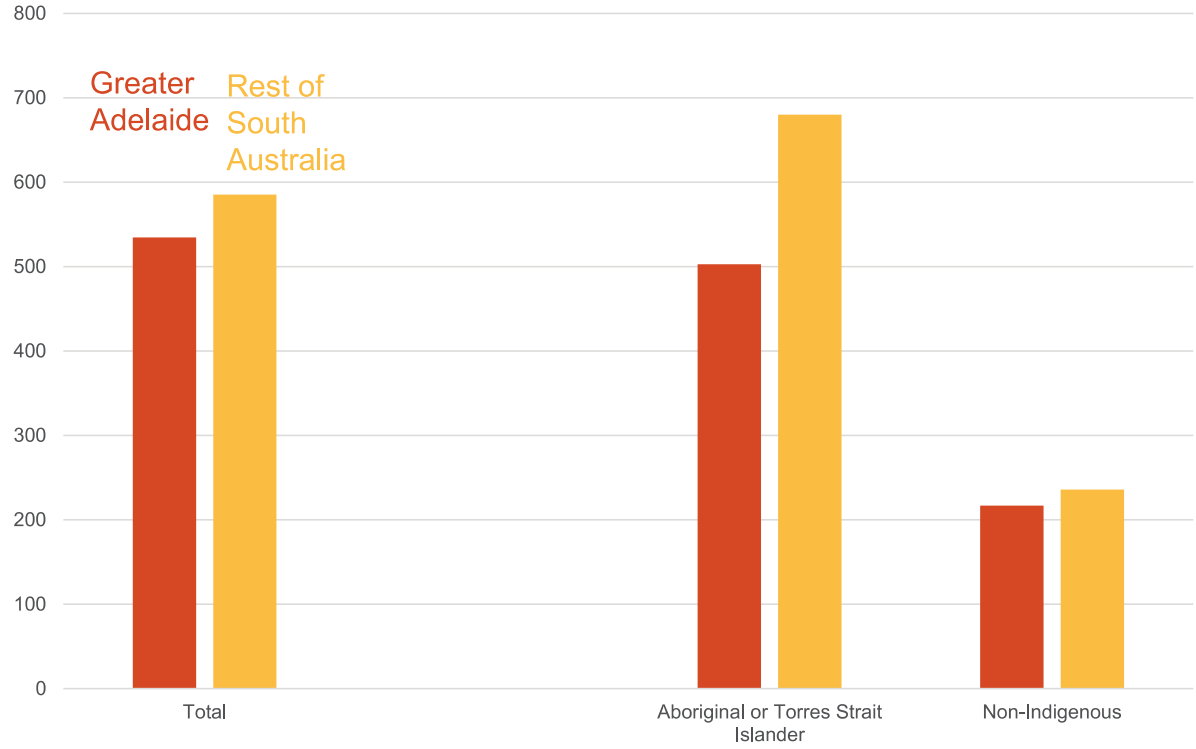
The hosts then opened up the floor to an open and frank discussion on issues that delegates considered to be of most importance for improving health outcomes for people living in the region and in other regional communities throughout South Australia. To help foster diversity of opinions and candour in the conversation, even when opinions might be seen as controversial, the proceedings were held under the *Chatham House* rule, wherein it is permitted to make full use of everything discussed but on a strictly non-attributable basis[2]. The discussion that followed was respectful, honest, free and at times contentious but never divisive.

[2] 'When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed' — The Royal Institute of International affairs ('Chatham House')

Figure 1: Example of looking beyond a crude population average to consider deeper insights from the broader distribution and the need to look at particular groups of the population.

Standardised death rate per 100,000 population, 2015-17

From: Stephen Duckett, 'Have we under-invested in Palliative Care?Aligning Policy Objectives and Payment Design in Palliative Care', Presentation to the Bob Hawke Prime Ministerial Centre and Palliative Care South Australia Forum, Grattan Institute, May 2019



Source: Australian Bureau of Statistics (2018), 'Causes of Death Data: Customised Report', (Canberra: ABS).

Key points

Delegates quickly converged on a consensus as to what were the core areas of concern for Mount Gambier and the Limestone Coast.

Workforce attraction and retention

Delegates discussed a shared concern at the difficulty in attracting medical professionals to take work in the region, the maldistribution of health professionals enduring in regional South Australia and being worse the further remote one goes.

> '[My job is] to encourage more kids [medical students] to come out here – it is really hard work!'

We heard of a 'brain drain' wherein doctors qualifying in South Australia were in large numbers heading back to Adelaide after gaining experience regionally in their early graduate years or indeed heading to the eastern states to work, further depriving rural South Australia of a qualified workforce. Many of the remaining medical staff in the area were approaching retirement age, not itself a concern except as to the eventual need for replacement with a less prevalent next generation. Perhaps, a suggestion that was made, the solution could be as utterly simple as ceasing to think of the issue as being a shortage of rural workforce and instead as an overcrowded metropolitan workforce: rather than the concept of taking a rural placement during metropolitan-centred vocational medical training, the group considered a flipped scenario where proportionally more training places are attached to rural health services with an opportunity to pursue metropolitan placements to develop specific clinical expertise.

But we also heard that there are too few jobs for health professionals in the regional areas. Rural internships in particular were said to be in too short a supply. Even where positions exist, we were told that the feeding of the metropolitan-centric bureaucracy makes for a delay of up to six months in filling a post. Visas were often a source of recruitment delay, indicating the need for inter-agency working; but recognising that immigration was a well-trod path to filling regional medical vacancies, delegates also grappled with the morality of thus depriving these workers' sending countries of a skilled workforce.

The forum considered the perceived or real barriers for junior medical staff to progress into senior metropolitan consultant roles in the future because of a perceived lack of peer networks and depth of clinical experience in rural areas. Other possible responses to improve the attractiveness of training in rural locations were discussed, which might include streamlined or preferential application processes.

Primary care specialists were also in short supply in the region, many of the long-standing workforce becoming 'burned out'. It was suggested that the health system could seek to be more compassionate and do better for stressed, running-on-empty colleagues. The split in responsibility for health between state and federal governments was not helping, as we were told that the result was often either a gap or else a doubling up amounting to a perceived misuse of public funds.

The low population in the regions was a mixed blessing, we were told. On the one hand, it necessarily provided opportunities — to develop skills in multiple medical specialties, something not available to those in Adelaide. But it made for difficulties too. How could hospitals provide training rotations when there were not enough supervisors? And how could more senior staff be encouraged to stay?

'To have registrar positions, you need to have a steady population'

Population attraction and retention

Thus did delegates turn their attention to the broader issue of the attractiveness of the Limestone Coast as a chosen destination to set down roots. Boosting the regional population was desired by state politicians of all colours, and there was concurrence that the discussions at this forum might just as well have been on attracting and retaining educators or other professions. There was a disconnect between rhetoric and actuality, the promotion of Mount Gambier as a great place to which to retire at odds with the slim range of services available in the area; it was suggested that more health services ought to be provided so as to obviate the large number of flights to Adelaide each day made by the Royal Flying Doctor Service.

'We can't all live in Adelaide and Melbourne, and yet that is where all the facilities are!'

New arrivals — especially those from overseas, and humanitarian immigrants even more so — were not well served with information: there was a need for better provision, including in translated form,

both before and after their arrival in the Limestone Coast. Refugees were frequently referred to hospital in Adelaide rather than locally in Mount Gambier for reasons which were unclear, the impacts including loss of income for two or three days as well as travel costs and difficulties arising from language barriers.

> '[Refugees often] don't have transport, don't know how to book accommodation — it is not just a language barrier'

Improvement in all manner of infrastructure lagged in such population growth as there was. Yet again did we hear the perception that there were better services and infrastructure across the border in Victoria. This could, however, provide an important 'opportunity locator' for the Limestone Coast health services, in that by having their own local data analysis to compare with a similar community in another state, there might be revealed where local health economies are applying their resources sub-optimally and give guidance on how to direct healthcare spending more optimally to save money. Combining data analysis with conversations between regional health economies, it was considered, will maximise value for our health care resources by guiding where to look, what to change and how to change.

Health planning localisation

We heard of a long-standing disconnect between the central SA Health bureaucracy and the rural workforce. The enduring effects of poor decision making centrally as long as two decades ago were remembered by the local medical population and asserted to be readily corroborated by a comparison with a relatively more thriving situation across the border in Victoria.

We were told too of a need to consider different funding models for regional South Australia, the model that works for Adelaide being inappropriate for the Limestone Coast and its ilk.

Other issues

We also noted a number of other areas of concern to delegates.

We heard that patients living with disabilities in regional South Australia were finding it harder to access healthcare services and often did not feel safe in hospital settings, a finding validated by research that a sizable fraction of clinical staff confess to not feeling comfortable supporting people with disabilities.

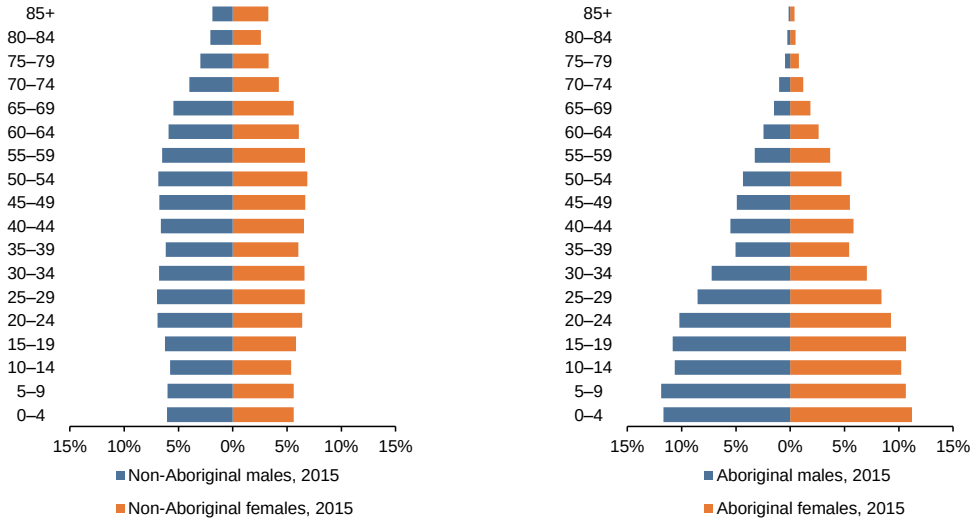
There was some disquiet too about so much of the Australian Government's My Aged Care[3] service being provided on the world-wide web, those people undergoing their aged care journey being, we were told, more typically than the average person insufficiently digitally literate to do so.

Concern was expressed at several indicators of population health being worse in regional areas than in Adelaide, such as rates of smoking in pregnancy and of being overweight or obese. Gender differences needed to be taken into consideration, a prevalent attitude of 'she'll be right, mate!' being a killer for men more so than women. And Aboriginal people in the area were being let down by a lack of cultural safety and inclusion, and those in prison were let down further by an unwillingness of the prison system to permit the undertaking of beneficial projects.

Although not a regional-specific issue, delegates recalled the very different shapes of the population pyramids for Aboriginal people in South Australia and for the whole population, the difference starkly demonstrating the continuing much earlier average age of death for Aboriginal people (see Figure 2 on page 8).

[3] My Aged Care is 'the Australian Government's starting point on your aged care journey' — source: https://www.myagedcare.gov.au/

Figure 2: Notable differences in the age and gender profile of the South Australian Aboriginal and non-Aboriginal populations



Source: Based on ABS data as interpreted in: Health Performance Council, 'State of our Health' indicator 1-1-2. From https://www.hpcsa.com.au/state_of_our_health/chapter_1/1_1, published 2018

Rounding off the forum, delegates reminded us that Mount Gambier was South Australia's most populous city after Adelaide[4] and ought to have a decent health service to be able to attract people to live in the area.

[4] Estimated resident population for 'significant urban areas': Adelaide – 1.327m; Mount Gambier – 30,000 (at 30 June 2018, to nearest 1,000 people). Based on Australian Bureau of Statistics data, *Regional Population Growth, Australia*, cat. no. 3218.0, published March 2019.

Participants

We are grateful to all delegates for their generous donation of time and insight. We also thank those others whom we invited but were unable to meet with on this occasion.

Regional leaders

- Anelia Blackie, Mount Gambier Migrant Resource Centre
- Martin Bruening, The University of Adelaide
- Ngaire Buchanan, Limestone Coast Local Health Network
- Peter Charlton, Australian Medical Association (South Australia)
- Sandi Elliott, Mount Gambier Private Hospital
- Kris Ghosh, Australian Medical Association (South Australia)
- Ken Jones, Flinders University
- Maureen Klintberg, Mount Gambier and Districts Health Advisory Council
- Ian McKay, University of South Australia
- Lynette Martin, City of Mount Gambier
- Andrew Meddle, City of Mount Gambier
- Helen Morley, COTA South Australia
- Barrie Moyle, Naracoorte Area Health Advisory Council
- Deb Paschke, Mount Gambier Private Hospital
- Heidi Rose, University of South Australia
- Narelle Winterfield, Pangula Mannamurna Aboriginal Corporation

Health Performance Council hosts

- Steve Tully (Chair)
- Rick Callaghan
- Stephen Duckett
- Ellen Fraser-Barbour
- Jennene Greenhill
- Lisa Jackson Pulver
- Brett Rowse

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- Jane Austin
- Andrew Wineberg

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