Robb Health Lecture 2014

Presented by

Associate Professor Jane Mills RN, PhD, MEd, MN, BN

Director, Centre for Nursing and Midwifery Research

Deputy Dean, Graduate Research School

James Cook University

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Professor Annabelle Duncan, The Honourable Fiona Nash, Professor Rosemary Bryant, Professor Kim Usher, distinguished guests, ladies and gentlemen. Before beginning my address this evening I would like to acknowledge the traditional owners of the land on which we meet tonight, the Anaiwan people and their elders past and present.

It is a great honour to be invited to the University of New England to deliver this evening's Robb Health Lecture. While preparing for this event, my thoughts turned to the members of the College and their interests. The lovely Rhonda Wilson very helpfully sent me links to the Robb College Facebook page and to this year's fundraising project – in support of Buy a Bale - to give me some insight into the College and its members. At home, I sit on the FNQ Hospital Foundation Board and we are always thinking of new and novel ways to fundraise. I don't think I could talk them, however, into being nearly as adventurous as you! The quote I chose to accompany the picture really exemplifies to me the spirit of your unselfish endeavor. I love the way our Governor General, Sir Peter Cosgrove, exhorts us to look through the eyes of our kids; to engage with the world as it is now; and to celebrate our connectedness with each other as Australians.

Seeing you all, literally - **all** of you - in such familiar rural settings led me to reflect on my life as a rural woman and some of the values and ideals – your culture - that I also share. Even for those of you in the audience who didn't grow up on a farm or in a small rural town, but who finds yourself now in country Australia as a university student, will be influenced by this context, by the people with whom you now study and live here at Robb College – a type of rural cultural osmosis.

You see, as humans we are the malleable sum of our experience – our knowledge and skills grow and change throughout our lives because of the way we interact with the symbols of our social worlds. Your life as a rural Australian is preparing you for life after university in unique ways that I believe will provide you with an undoubted advantage over your city slicker cousins. But before we get to that, if you will indulge me a little, I'd like to share with you some of my life experiences and explain how they have shaped the person

I am today. We will then examine some of the big ticket issues in rural health which impact on us all before returning to you, the audience, and how being a rural Australian is preparing you sub-consciously for the next big adventure – your professional life.

Personal experience

I was born in 1966, the eldest of five children, and part of the fourth generation to live on a small mixed farm in northern Tasmania. My father was one of eight, and left home at the end of year 10 to go shearing. It wasn't long before Dad had saved enough to start out as a contractor, eventually returning to the farm and buying out my grandparents. Just like your parents and grandparents, mine aspired to a better life for their kids, so they made many sacrifices to send us to a private school.

All five of us attended Scotch Oakburn College in Launceston, with many of us boarding after Mum and Dad sold the family farm and moved to a larger property in the Fingal Valley on the east coast of Tasmania. As kids we all worked on the farm; we learnt (far too young) to drive in an old ute, we picked up in the shearing shed. We stitched the top of bags as Dad harvested blue peas, and we could move a mob of sheep by ourselves without getting into too much trouble. When I and my next sister Nikki finished school we had just moved to the new place and there was no money for university. We were, as they say, asset rich and cash poor. In the conversations that went on at the time about 'what to do next', Dad very pragmatically pointed out that I didn't have enough qualifications "to work as a check-out chick in Woolworths" before announcing he had phoned my Aunt and lined up an interview at the Royal Hobart Hospital where I could train as a nurse.

At the time, I was pretty unimpressed with this patriarchal approach to my career planning but I didn't have any other options. Off I went to become a nurse, as did Nikki when her time came the following year. As you can tell from the big grin on my face in this photo, taken when I was in third year, I loved being a nurse. Within a short space of time, I couldn't imagine being anything else. Once registered, I jumped on a plane and took off to London for a year where I worked in lots of different places including the Royal Opera House in Covent Garden, brushing with fame when I gave opera singer, Placido Domingo, a Vitamin B injection in his gluteus maximus.

It wasn't long before I returned home to the bush, working as a remote area nurse on the west coast of Tasmania before finally taking **myself** off to university to get a Bachelor of Nursing in 1991. Thus began my love affair with the academy and, in particular, qualitative research. Both my Masters and PhD theses investigated matters concerned with rural nursing, and with developing supportive relationships in the workplace.

Along the line, I ended up marrying a grazier – and so back to the land for me - only this time as a wife, a stepmother and a mother of two, myself. Marrying Hew meant moving to the far North Eastern tip of Tasmania, trying to learn how to shoot tiger snakes, cell graze, and deal with all of the million and one tasks a rural wife and mother has to do. In 2000 we sold our property in Tasmania and bought a cattle station at Mt Garnet, South West of Cairns in Far North Queensland. Of course, not long after we bought the place, we plunged into drought. We gradually de-stocked waiting for a wet season that didn't arrive for nearly three years. Once the drought broke we had to decide – do we sell, or do we restock? Land prices had taken off in the Cape and so we decided to sell and move to town. People often ask us, do you miss the land and I answer, yes, we do in many ways, but the timing was right for us and there are no regrets – just lots of great memories.

So what does this story - about me - have to do with you? If you were a qualitative researcher you would say that I am an 'insider' to the field of rural health. My story is your story in that I grew up in the bush, before returning to live and work as an adult, as a health professional, as a mother and a landowner. The sum of these experiences gives me a much deeper understanding of the social world of rural Australia; I can see the factors that influence individuals' interactions and the obdurate reality of this world. And, make no mistake: that reality can be worse than tough – a fact that you have all recognised in your choice to support 'Buy a Bale'. So let's move now to the reality of rural health, the dark underbelly of the bush, so we can establish the context that many of us will work within during our professional lives.

Rural health

Australian Governments have agreed on nine National Health Priority Areas or NHPAs (AIHW, 2013). Many of these priority areas will be familiar to you, either because you are a health sciences student, or because of the health promotion and media campaigns

associated with each of these areas of focus. The first four NHPAs were established in 1996 as part of Australia's response to the World Health Organisation (WHO) global strategy of *Health For All by The Year 2000 (World Health Organisation, 1981).* Diabetes was quickly added in 1997 and asthma in 1999. Since then a further three priority areas have been targeted that reflect changes in the burden of disease on the Australian community. Arthritis and musculoskeletal conditions, obesity and dementia were added to the list because it was believed investment would generate significant gains in the health of the population (AIHW, 2013).

In the next part of my address, I want to examine the NHPAs from the perspective of rural health. Each year, the Australian Institute of Health and Welfare produce a report called *Australia's Health*. Happily, the 2014 edition of this report was released recently and it is from this document that I have largely drawn my information for a Score Card examining regional or rural, and remote area health as compared to major cities (Australian Institute of Health and Welfare, 2014).

First of all, let's refresh our memory about where Australians live. According to the Australian Standard Geographical Classification ARIA+, Australians live in one of five areas. As this pie chart shows, (Figure 1) the large majority of our population is in a major urban city, with numbers decreasing in inner regional areas, outer regional areas and then remote and very remote parts of the country (Australian Institute of Health and Welfare, 2014).

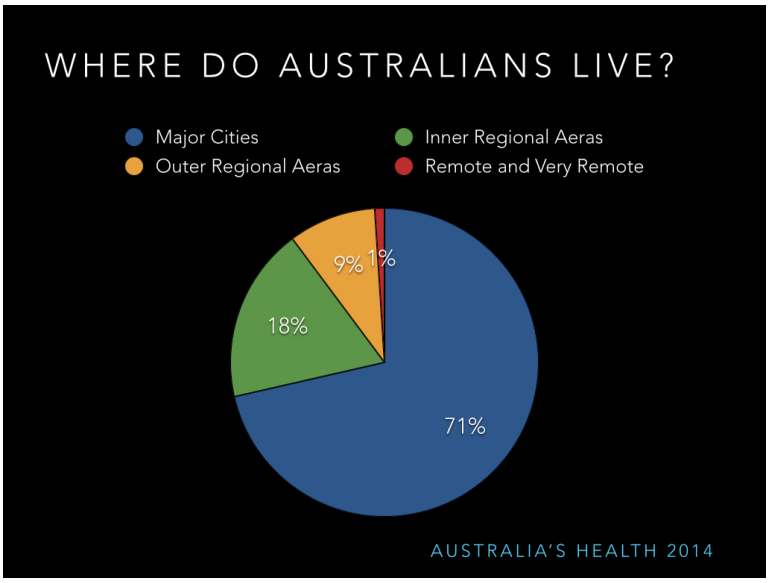


Figure 1: Australian population by area type

Another way of visualising who lives in rural and remote Australia is to map the ARIA+ classifications. In this slide, (figure 2) you can see 71% of the total population live on a red dot with an additional 18% in the yellow areas. Just in case you are wondering, that yellow area includes Armidale, which is classified as inner regional. This leaves just 11% of the population spread over the rest of Australia's land mass, most of which is the blue and purple of remote and very remote areas. Considering this stark mal-distribution in combination with the vast distances required to access many parts of our country, an obvious question is raised for many of us: "If you are not living on a red dot, how is your health?"

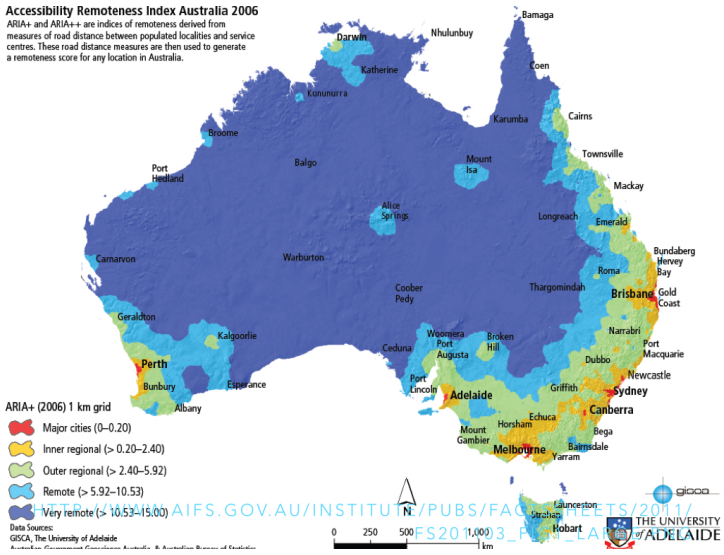


Figure 2: Accessibility remoteness index

The simple answer to that question is, 'not so good'. Using a standard measure of deaths per 1000 population, as you can see from this graph, (in figure 3) the further you live from a red dot, otherwise known as a major city, the greater the chance you have of dying this year. According to the Australian Institute of Health and Welfare: "the main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (for example, emphysema)" (Australian Institute of Health and Welfare, 2014, p. 25).

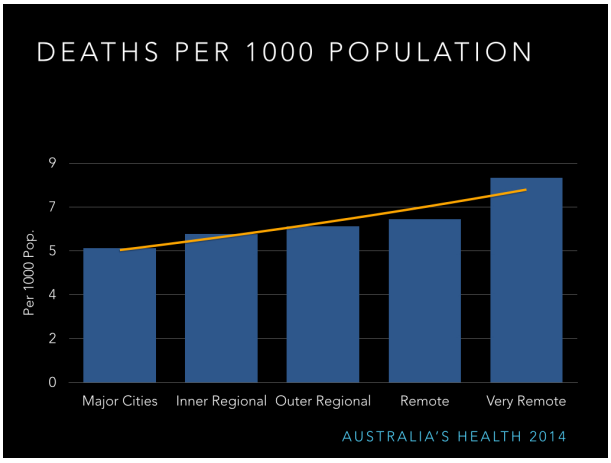
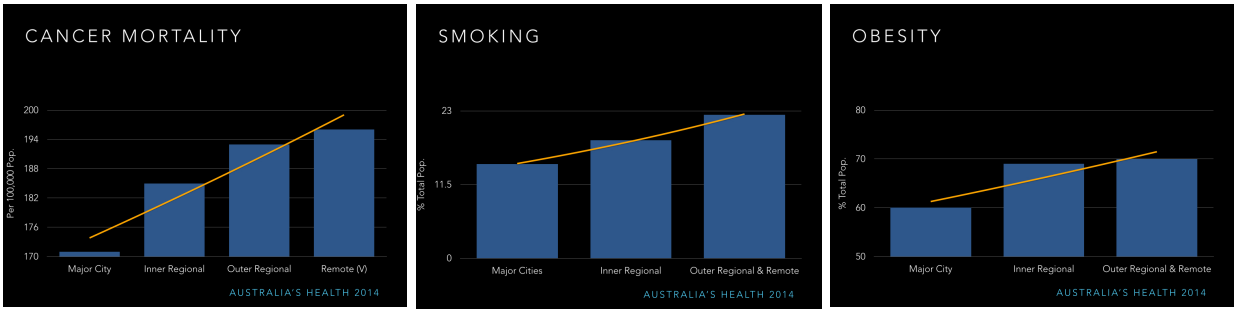


Figure 3: Morbidity by proximity to a major city

If you are unfortunate enough to have a diagnosis of cancer, your chance of survival decreases dramatically the further away you are from a major city (figure 4). There is a general consensus in the literature that access to mainstream cancer treatment services is the reason there are higher death rates outside major cities. However, findings from a recent mixed methods study by (Emery et al., 2013) indicate that the length of time between initial symptoms and diagnosis is also a contributing factor.

Of course, we also need to consider pre-disposing factors for acquiring a cancer diagnosis or, in fact, any illness that fits under the nine NHPAs. As you can see from this slide (figure 5), the smoking rates are much higher in regional and remote areas compared to major cities. This trend continues when we look at rates of obesity (figure 6) in the Australian population and, importantly, when we look at rates of heart, stroke and vascular disease. Coronary heart disease accounts for the highest number of deaths in Australia with 11,733 men and 9,780 women succumbing to this condition in 2011(Australian Institute of Health and Welfare, 2014). As you can see from the scorecard so far, the contributing factors to acquiring and dying from a cardiovascular disease are much more prevalent outside of a major city (figure 7).



Figures 4,5 and 6: Cancer mortality, smoking rates and obesity rates by region type

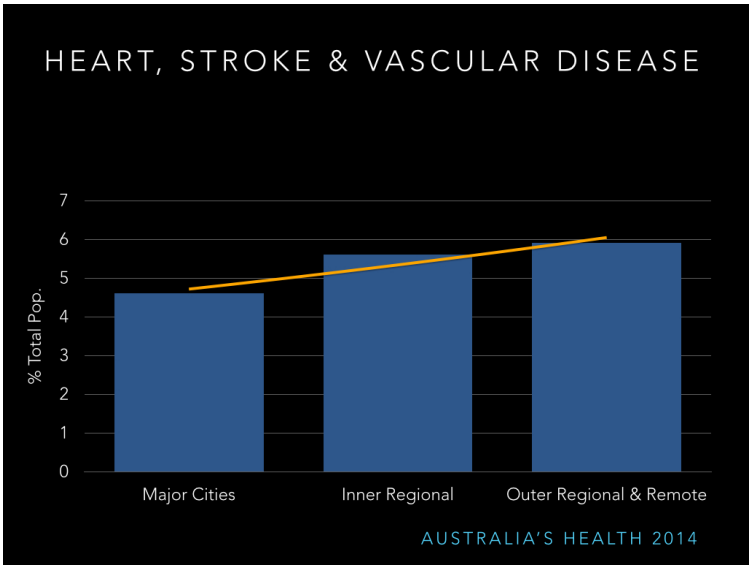


Figure 7 heart stroke and vascular disease rates by region type

When we look at Indigenous people's health in comparison to all Australians' health across key indicators in outer regional and remote areas the picture is even bleaker. You will notice that in this slide (figure 8) I have also included levels of psychological distress and diabetes, which, in the total Australian population, is fairly consistent across geographical areas. In the case of psychological distress, all Australians averaged a prevalence rate of 10.8% as compared to 30.1% for Indigenous Australians. Overall, Indigenous Australians have higher rates of smoking, heart disease, stroke, vascular disease and diabetes when compared with the total Australian population; this disparity is particularly so in regional and remote areas of Australia.

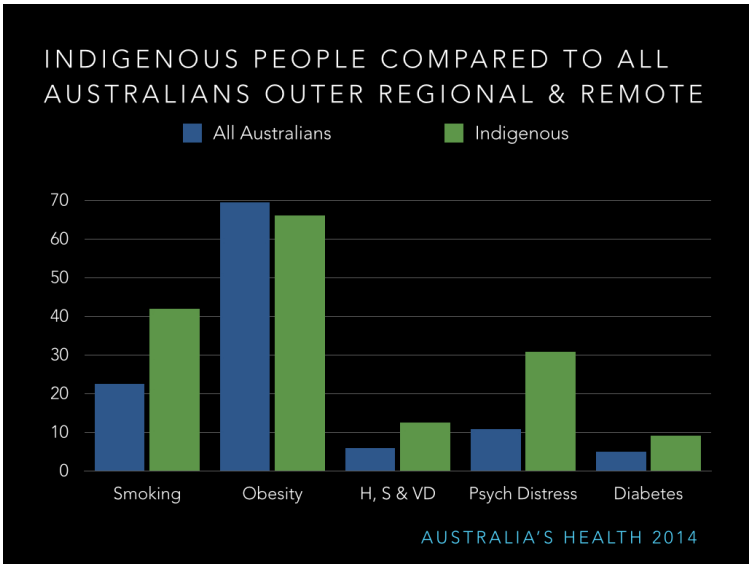


Figure 8: Health and wellbeing of Indigenous people compared to all Australians

An important contributor to population health is the availability and accessibility of health services. In particular, high quality primary health care services are essential for preventive care: for screening and managing acute and chronic illnesses; and for providing a link to specialist services. A recent systematic review of the literature (Carey, Wakerman, Humphreys, Buykx, & Lindeman, 2013) from the Centre of Research Excellence in Rural and Remote Primary Health Care Health has produced an excellent matrix of dimensions and demarcations of the role of primary health care services in Australia. This matrix is useful because it illustrates the complexity and diversity of services provided outside tertiary hospitals in this country, reminding us of the 'specialist generalist' nature of rural and remote clinical practice.

Rural and remote health care is delivered by a range of practitioners including nurses, general practitioners, Aboriginal and Torres Strait Islander Health Workers, allied health practitioners and dentists across a variety of locations. In 2005 The Productivity Commission produced a far-reaching report on Australia's Health Workforce (Productivity Commission, 2005). The mal-distribution of health care professionals was illustrated very effectively in a graphic contained in that report (Productivity Commission, 2005, p. XXVII). Using 2011 data drawn mainly from the census, I have recreated the intent of this original graph (figure 9) to give us an up-to-date picture of who is providing healthcare services in rural and remote areas (Australian Bureau of Statistics, April 2013; Health Workforce Australia, 2014, November 2013). As you can see, nurses are by far the largest health workforce group in Australia, with fairly consistent numbers per 100,000 population regardless of location. The same can't be said however for other health professionals with people living in major cities having far greater access to clinicians providing both tertiary and primary health care services than those living in regional, let alone remote areas of Australia.

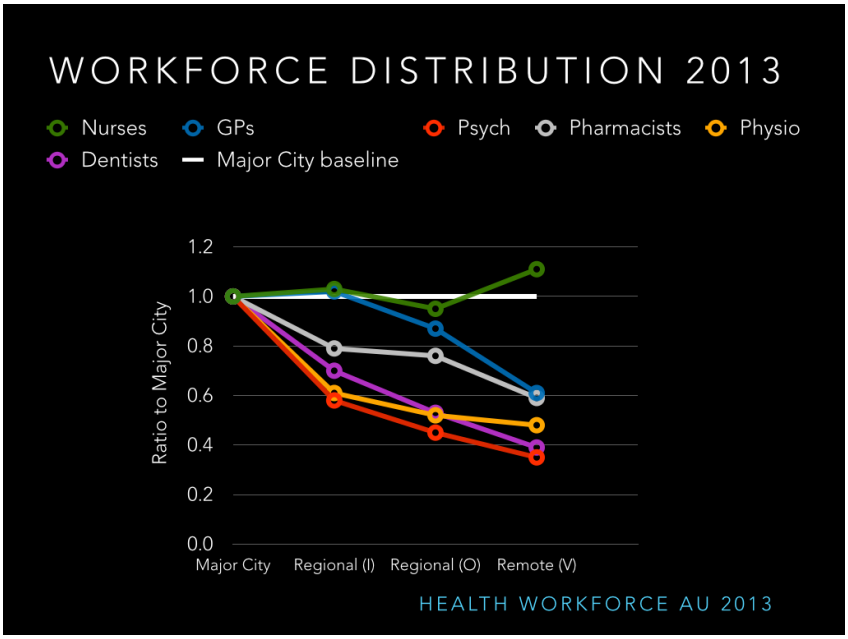


Figure 9: Health workforce distribution

When I was recreating this graph for you, I was struck by the absence of data in the original Productivity Report about Aboriginal and Torres Strait Islander health care workers or practitioners. This group of clinicians has only just achieved national registration status in July 2012, which means there is very limited data available with regard to their numbers, however the most recent Australian Health Practitioner Regulation Agency (AHPRA) report indicates that the large majority of registered Aboriginal and Torres Strait Islander health practitioners are located in the Northern Territory, followed by NSW (Australian Health Practitioner Regulation Authority, 2014). What is known from the most recent census is that there is an inverse mal-distribution of Aboriginal and Torres Strait Islander health practitioners compared to clinicians other than nurses, with the large majority of this group working in remote or very remote locations (Australian Health Practitioner Regulation Authority, 2014).

There are two key messages that I wanted to communicate to you tonight in relation to Australian rural and remote health. The first of these is that a lack of access to primary health care services in areas with geographically dispersed populations affects the overall health and wellbeing of the populations living in those areas (Australian Institute of Health and Welfare, 2014, p. 321). One of the greatest challenges in our country is cost-effective delivery of models of health care that will ensure equitable access to health services close to where we live. There is a great difference between aspirations for equal access and equitable access. For those of us who choose to live outside a major city there are trade-

offs; the joy of living in the country is offset by a very different level of service provision, be that in health, education, infrastructure or transport. We understand that we won't have equal access as our city cousins; it is a fundamental human right however, and our right as Australian taxpayers, to have equitable access to services we need to ensure our health and wellbeing.

The second key message that I would like you to take away with you tonight in relation to rural and remote health is that a root cause of the problem of inequitable access to primary healthcare is the mal-distribution of our health workforce (Larkins et al., 2014). In the past decade the number of undergraduate students enrolled across the health disciplines in our country has increased dramatically. We are producing much greater numbers of doctors, nurses, allied health practitioners and Aboriginal and Torres Strait Islander health practitioners than ever before – so supply is not the issue. Instead, the issue is recruiting and retaining staff who want to live and work in rural and remote areas.

So, if we return to our scorecard for Australian rural and remote health we can see that, while we are not quite at the bottom of the list, we are not doing nearly as well as those who live in a major city. When I was considering Australia's health indicators, and the dichotomy that comparing major cities with regional and remote area presents, I was reminded of a very interesting moment in Australian history that many of you are likely familiar with - the so-called Bulletin Debate between 1892 and 1893. Henry Lawson and Banjo Patterson (who appear very lifelike in this shot from Madam Tussard's in Sydney) engaged in a literary debate about the relative value and merits of 'the bush'. Lawson took the negative with his poem titled *Up the Country*, and Patterson took the affirmative with his response *In Defense of the Bush*. This debate continued with poets aplenty chiming in on the harshness of life outside of the city, and Patterson defending the bush traditions of mateship, resourcefulness and independence - much of which contributes today to our national identity (Australian Government, 2011).

Like Lawson, so far tonight we have examined rurality and remoteness in a far from positive light, however I believe there is much more to growing up and becoming educated in the bush than meets the eye. So, inspired by Banjo Patterson, let us now turn back to you, my audience. You see, the only solution for the problems we face lies in capturing the

imagination of the next generation of health professionals and in inspiring them to return to the bush. I use the word ‘return’ deliberately because research shows that people who have grown up in rural and remote Australia - some might say enculturated there - are much more likely to return to the bush to live and work later in life.

Professors Murray and Wronski call the strategy needed to encourage this phenomenon the ‘rural pipeline’ (Murray & Wronski, 2006) and it is in deploying this rural pipeline that regional universities such as The University of New England, and my own employer, James Cook University, really come into their own. As a nation we need to invest more in the regional universities that educate a local workforce across the full range of health disciplines with the aim of reducing the mal-distribution. This investment must include the all-important transition-to-practice phase in a new health professional’s working life, which, to date, has been both underdeveloped and under-researched. This is particularly true for nursing and midwifery.

So, what are the characteristics that make graduates of regional universities stand out from the crowd? Other than the content we teach you in class, what other knowledge and skills give you an edge in the workplace over graduates raised and educated in a major city? Resourcefulness is a characteristic that differentiates rural and remote graduates. I particularly like the definition of ‘resourceful’ provided by the Macquarie Dictionary, which incorporates the simile, ‘ingenious’ – having inventive faculty. ‘Ingenious’ really encapsulates many of the creative and innovative strategies and solutions that people from the bush must come up with all the time. In my experience, just keeping the power and water operational can be an exercise in resourcefulness in the bush. Necessity really is the mother of invention, and the skills you learn when you have to improvise or come up with a workable Plan B are readily transferable into the workplace.

This ingenuity often comes from a place of independence and autonomy. Many things need doing in the country but there are rarely many people around to do them. So you get on with the job. And you keep on with the job until it is done. The sorts of monotonous jobs that rural children do – drenching sheep, marking lambs, stacking bales, checking troughs and fences – train you well. You develop perseverance, a trait that is often the difference between success and failure. Perseverance is not such an easy thing to learn or to

practise in the city where gratification is instant, and everything you could possibly need is at hand, or can be bought or outsourced easily enough.

When important jobs upon which livelihoods and families depend come down to one person, that person must step up. In the country, risks are high and small daily decisions can have big consequences. Two minutes too many on the lucerne and the cattle will blow. Five minutes too late getting to the flooding creek and $80,000 worth of machinery and pumps are gone. High stakes risk analysis is commonplace; the ability to make decisions and the guts to take responsibility for those decisions are a necessary part of rural living. Bush dwellers cannot be risk averse, which, in turn, promotes resilience, because things do not always go right and you must keep going, even when things are all wrong.

A bush ‘education’ produces traits like resilience, resourcefulness and perseverance, of which I have spoken but, as Aristotle once said, ‘the whole is greater than the sum of its parts”. That ‘whole’ in the country is community. And growing up in the country, learning in the country, you know how to be a member of a community. This means you have a strong sense of identity and connection with others. You understand the importance of empathy, of patiently listening to others. This understanding of community comes from growing up in a much smaller and interconnected group of people. In many ways, understanding community means that you also understand mateship a national trait that emphasises equality, friendship and, I would add, the type of support you are providing through your fundraising campaign this year.

The enduring qualities I have outlined have long been associated with the bush and the people who live there. A lot of these qualities are borne out of the hardship and inequities of rural and regional living. Healthcare is one of these areas in which people have had to cobble together their own services and solutions throughout Australia’s history. In 2014, the divide between country and city still exists – not as extreme as in the 1800s, but more than worrying enough. As individuals, you - students and future health professionals - have the power to improve life in the bush simply by ‘being there’. And by being there, you might find yourself part of what some people are calling the ‘New Bush’(Kernaghan, 2007).

"As I travel around the country I am seeing something new emerging across regional Australia. It is a new way of doing things, taking the great traditions that made the bush what it is today and blending it with the new. There's innovation, new technology and new potential, it's almost as if there's a quiet revolution going on…some people call it the new bush."

LEE KERNAGHAN

In our era of new technology, crowdsourcing and social media, we can see how the goodwill, good work and good ideas of many people – acting together for a greater purpose - can make a big difference towards solving problems that had seemed insurmountable in the past. Newly-qualified health professionals are perfectly-placed to contribute to the 'new bush'. By committing to work for a life, a time, or even a short stint in rural and regional areas, health professionals can help to build strong healthy communities, not only in the towns in which they live and work, but also in the professional health communities to which they belong. I challenge you – simply - to consider 'being there' for rural and regional Australians.

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