

Communiqué

16 June 2010

Progressing rural and remote health research

Leaders of Australia's rural and remote health research communities met in Brisbane, 9-11 June 2010, and reached general agreement about the way forward for their sector over the next five years.

The 80 invited participants at the 2nd Rural and Remote Health Scientific Symposium reflected positively on progress made since the first such Symposium two years ago. David Perkins, Convenor of the Symposium Steering Committee, reported favourably on the high degree of trust exhibited within the rural and remote health research sector. The sector had demonstrated its capacity to produce quality research outcomes - agreed to be the most critical characteristic of all for research efforts. However there is still a need for the development and maintenance of stronger partnerships: between researchers and the rural and remote community, researchers and clinicians, and researchers and policymakers.

One of the highlights of the Symposium was the opportunity it provided for some 'succession planning' in rural and remote health research. The session for emerging researchers was regarded as valuable and a significant success.

The majority of participants in the Symposium believe that rural and remote health research should be recognised as an important, competitive and valued part of Australia's research sector overall. Since the emergence of 'rural and remote health' as a discreet entity in Australia some 20 years ago, its research sector has moved from being largely defensive and focused on rural and remote deficits, to one with an emphasis on building on the strengths of rural and remote lifestyles, people and services. The strength and confidence of its research sector is attributable in part to the coherence of the rural/remote health entity as a whole, to which some well-established and reputable organisations have contributed - such as the four that auspiced the Symposium.

With increasing confidence, capacity and understanding, the rural and remote health research communities are now more outward-looking, ready to challenge themselves and to be involved in current policy issues. Increasingly, their focus is on helping to transform the health sector rather than merely describing it.

As well as strengthening its partnerships, another major challenge for the rural and remote health research sector over the next five years is to increase its responsiveness, both in terms of the science and substance of its agenda and how it seeks the adoption of results into practice and policy.

The Symposium was provided with updates on research in critical areas such as the health of Aboriginal and Torres Strait Islander people, mental health in remote areas (including some consideration of suicide), the capacity of e-health to improve services and outcomes, creative models of care, and the importance of cohort studies – including those relating to complex interventions.

The central recommendation from the Symposium was that there should be a high-level organisation with the capacity to coordinate the rural and remote health research effort and build from its findings into practice and policy.

Discussions about this at the Symposium were in terms of a virtual ‘national institute’, but further consideration in the days immediately following the event saw the emergence of a proposal for a Partnership Centre for Better Health. This recognises the existence of the Partnerships program being developed through the National Health and Medical Research Council and the rural and remote networking about it that pre-dated the Symposium. The Symposium’s main recommendation is a timely strengthening of the call for rural and remote health research interests to be specifically recognised in the Partnership Centres program. (A copy of the media release on the subject is attached to this Communiqué.)

The proposed Partnership Centre would be virtual so as to maintain the dispersed nature of rural and remote health research capacity, not centralising it in one particular place or organisation. The overall focus of the Centre’s work would be strongly interdisciplinary.

The Centre would synthesise rural and remote health research, enhancing the effectiveness and profile of the research. It would foster high-quality research on such matters as service improvement, workforce issues, epidemiology, health systems design and complex interventions for needy groups. It would encourage links between researchers, communities and policy makers. It would collect and analyse data, identify research gaps, bringing together in an inclusive fashion the agencies involved in rural and remote health research. It would pool qualitative evidence on the social determinants of health and on community-led initiatives to address them. In the current environment it would help evaluate health reform as it is rolled out, with members of the research and clinical workforce actively providing input to this.

A particular challenge for the Centre would be the development of an agreed set of indicators of the effective impact of both the research itself and of the knowledge translation based on it.

The establishment of the Partnership Centre would help confirm the rural and remote health research sector as one with equal status to other research groupings within Australia and strengthen the case for rural and remote health research to attract an appropriate proportion of research resources.

The new Centre should quickly gain the credibility required for researchers to offer it data and evidence. Its success might be measured in terms of the number of PhDs and postdoctoral fellows in the rural and remote health research field, and through evaluation of the knowledge translation effected in the sector. The Centre would also play a key role in leadership and training to support the next generation of rural and remote health researchers.

Delegates to the Symposium agreed to try to ensure the appropriate inclusion of rural and remote health datasets in the proposed National Health Survey announced in the Federal Budget.

The Symposium’s agenda saw it focus on the science involved in rural and remote health research, on its substance, and on questions relating to its adoption into clinical practice, health services and policy.

Throughout the Symposium there was a strong emphasis on the need to understand difference between various communities – most particularly where Aboriginal and Torres Strait Islander communities are concerned. This is critical both to allow the local community to be closely engaged in the research undertaken and to ensure that the researchers involved avoid cultural and community errors.

In rural and remote health research, the context provided by a particular place or community is often supreme. Whereas evidence from a randomised clinical or service trial can be replicated anywhere, context will determine how a particular service is best funded, delivered, regulated and evaluated, and the role in it of particular health professionals.

Despite the importance of local context, the majority of those at the Symposium agreed that seeking partnerships, including with international researchers, was a priority for them for the next five years. People at the Brisbane event were delighted to be able to welcome Professor Jane Farmer, from Inverness in Scotland, as one of the keynote speakers. Professor Farmer led discussions about international comparisons of ‘rurality’ and other indicators.

Participants at the Symposium agreed that the quality of research undertaken is paramount. Some of them argued that it is a mistake for researchers to try to fashion a particular piece of research for a particular policy at a particular time. Rather, individual researchers should be given time to engage their passion and to work with others with similar strong interests. This would result in the completion of high quality research which could be taken up by policymakers if and when it became of relevance to the policy agenda. This approach is based on the principle that the gradual accretion of evidence into accepted wisdom is what helps to change people’s worldviews. Research is picked up when the window of policy opportunity opens. Historical examples were given, such as the 20 or more years it has taken for widespread acceptance of the decentralisation of medical education, and the 10 or more years for the acceptance of multidisciplinary training and practice.

Rather in contrast to this approach, the Symposium spent some time considering the capacity of rural and remote health researchers to contribute to the current health reform agenda. Notwithstanding the critical characteristics of research context and quality, it was agreed that health researchers have a role to play in the development of smart, evidence-based policy.

For there to be a strong and close relationship between researchers and the public service (the policy makers), personal relationships need to be built and maintained. This requires efforts to overcome the ‘churn’ (rate of turnover) in public service personnel and the constraints imposed by the timelines for research funding and government project procurement. Given the strong impact on health services and outcomes of the approaches of the various jurisdictions in Australia, these relationships need to be with the State/Territory public services as well as the Commonwealth’s.

To be able to play their role more effectively, researchers need to understand the complex realities of policy development, which is affected by both scientific and political ‘evidence’, by advocacy and vested interests, by *ad hoc* and entirely unpredictable personal and/or political events, and by the fact that many policies entail the redistribution of resources – which means there will usually be losers.

Many of the general principles relating to rural and remote health research and policy change were illustrated in the Symposium session on the health of Aboriginal and Torres Strait Islander people. This session emphasised how ‘subversive racism’ (“a high level of low-level racism”) and sleeper issues such as mental health impede efforts to deal with the unacceptable and preventable burden of disease.

The specific focus in this session was on programs designed to reduce the number of smokers in Aboriginal communities. The general principles which support success in such programs include cultural security, leadership and control from the ground up, a supportive macro policy environment, local community capacity, and realistic levels of funding.

The Symposium included significant discussion of how the notion of ‘rurality’ is defined and for what purposes. It was generally agreed that ‘rurality’ is a function of some combination of remoteness, population size, population concentration, socioeconomic status, the amenity values of particular places, and the trajectory of local change (declining, growing). The point was made that particular classifications are used for particular purposes – for example, ASGC-RA is being used for the distribution of GP incentives, not for the overall distribution of the health dollar.¹ Researchers need different classifications for different purposes, such as for the distribution of health behaviours (eg those which tend to cause injury).

For policy makers there is an inherent conflict between the researcher’s dictum that every place is unique and the discipline imposed by policy making processes. The dictum needs to be interpreted so as to be useful within the practical compass of national, state and local government policies.

Discussions at the Symposium maintained the precept that ‘rural’ and ‘remote’ are separate descriptors as they relate both to health and health research. It was suggested that the difference between the two is a matter of degree for some characteristics such as location and social determinants, but with qualitatively clear distinctions with respect to service and practice types (eg the existence of procedural GPs in rural but not remote areas).

People at the Symposium argued the need for rural and remote health researchers to maintain a focus on the overall purpose of their work: to contribute to improved health and wellbeing of people who live and work in rural and remote areas. Health research can contribute directly to improved health practice – and through that to improved health outcomes. It also contributes to outcomes through the range of state and national policies that impact on health.

Context, then, is supreme, but partnerships with others in different places are of great value.

And good partnerships require good human relationships. In her survey of the attitudes of patients to their primary care professionals, one of the presenters at the Symposium reported that the patients interviewed focused on the relationship they had with their clinician - only mentioning the clinical skills of the clinician when prompted to do so. The good relationships required for quality research include the almost metaphysical one between researchers and the places and people with which and with whom they are working:

“There can sometimes be a tendency to see rurality as a visitor – not as someone who lives and works there.” - Jane Farmer

Note: the 2nd Rural and Remote Health Scientific Symposium received financial support from the Australian Department of Health and Ageing and Queensland Health.

¹ On the question of the present GP incentives, it was suggested that it might be more important to research the sort of incentives which would be most effective e.g. for travel home, for a locum, for CPD - rather than the distribution of the current set of incentives.