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# **Weaving healthy communities**

**The story of the  
7th National  
Rural Health Conference**

by  
RH Walker

July 2003

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Price of Paper: Free

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Rural Health Information Papers  
ISSN 1329-9905

*National Library of Australia  
Cataloguing-in-Publication data*

Walker, Ray.  
Weaving healthy communities: the story of the 7th National Rural Health Conference.

ISBN 0 9577630 5 0.

1. National Rural Health Conference (7th : 2003 : Hobart, Tas.). 2. Rural health — Australia — Congresses. 3. Rural health services — Australia — Congresses. 4. Medical policy — Australia — Congresses. 5. Aboriginal Australians — Health and hygiene — Congresses. I. National Rural Health Alliance. II. National Rural Health Conference (7th : 2003 : Hobart, Tas.). III. Title. (Series : Rural health information papers ; 6).

362.1042570994

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# Introduction

The National Rural Health Alliance (NRHA) organises the National Rural Health Conference every two years so that stakeholders in rural and remote health can meet to review progress in the overall area of rural health and in their particular area of interest, exchange views, improve knowledge, identify new issues, form new networks and alliances and establish priorities for action during the following two years. The conferences are one of the NRHA's most important activities and are the only national opportunity for all the stakeholders in rural health to meet with each other and express their combined views to the rest of the Australian community.

The format of the 7th National Rural Health Conference gave everyone who attended it an opportunity to follow their own interests by allowing them to choose the paper presentations, discussions, symposia and events they would participate in. As a result every one of the 930 people was able to construct their own unique experience by selecting the bits which interested them from the full range of conference activities. Therefore a comprehensive report of the conference does not mimic the experience of an individual attendee. Rather, it is an attempt to make the content of the conference as a whole more easily accessible to those interested in the rural health issues covered.

To present a comprehensible overall view of content of the conference this document tries to include the essence of every documented presentation. Rather than simply following the chronological order of the conference, the papers presented at the conference have been placed in 13 broad topic groups. These topic groups contain a summary of the content of presentations and resulting recommendations made to the conference drafting committee. Presentations by keynote speakers and symposiums together with any resulting recommendations are in separate sections.

The full title of a paper or other presentation can be found by looking up their name in the references. This will allow anyone interested to follow up individual detail in the complete conference documentation available from the CD and website of conference proceedings.

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## The history and place of National Rural Health Conferences

The first National Rural Health Conference was held in Toowoomba, Queensland, in 1991. This broadly-based conference brought together the stakeholders in rural health. It resulted in the first major national statement on rural health issues, *A Fair Go for Rural Health*.

The success of a multi-disciplinary group in planning that first conference showed that if the actions needed to address the full range of rural health concerns were to succeed the sector must have a continuing, effective and co-ordinated voice. This recognition led to the formation of the National Rural Health Alliance (NRHA) later in 1991.

The NRHA organised the second National Rural Health Conference in Armidale, New South Wales, in 1993. At that conference the Commonwealth Minister for Health announced that a national Office of Rural Health was to be established and a National Rural Health Unit funded to co-ordinate and disseminate rural health research.

The 3rd National Rural Health Conference took place at Mount Beauty, Victoria, in 1995. Since then National Rural Health Conferences have been held every two years: the 4th in Perth, Western Australia, in 1997; the 5th in Adelaide, South Australia, in 1999; the 6th in Canberra, Australian Capital Territory, in 2001; with the latest, the 7th, being in Hobart in 2003.

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## Acknowledgments

I would like to thank the staff of the National Rural Health Alliance for their support during the preparation and publication of this document. NACCHO kindly gave permission to use their report of their 3rd Aboriginal Community Controlled Health Symposium which appears as Appendix A. I am responsible for any errors and omissions in this document and if I have misrepresented those who contributed to the conference I ask their forbearance.

# The context of the 7th National Rural Health Conference

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## The policy environment

It has always been a challenge to provide high quality health care to all parts of Australia. Adapting to the major changes in the structure and nature of Australia's economy and society during the closing decades of the 20th Century placed significant strains on people living in rural and remote Australian communities. Dissatisfaction with the effects of the changes and difficulties providing suitable levels of health care led to rural health professionals and communities agitating for professional organisations and governments to recognise the shortcomings in the health of people living in rural and remote Australia, and in the provision and availability of health services.

As governments responded to these pressures during the 1990s they established programs and made investments aimed at significantly improving the health of those who live in rural and remote Australia. These include:

- improving the structures and funding of health services in rural and remote Australia so they can deliver services of the highest possible technical standard which are more accessible and more responsive to people's needs;
- National Rural Health Strategy statements, leading to Healthy Horizons;
- specific Commonwealth funding for rural and remote health. In the 2000–01 Budget the Commonwealth allocated \$562 million over 4 years for rural and remote health, with significant funds becoming available in 2003/4;
- enhancing professional support for and development of rural general practice, including through Divisions of General Practice;
- establishing and building the capacity of University Departments of Rural Health and Rural Clinical Schools;

- paying more attention to rural mental health; and
- acting to strengthen the support for and professional development available to rural nursing, pharmacy and allied health.

While there is no doubt that Australian governments have paid it increased attention, rural health it is but one aspect of maintaining the viability of Australian rural society. Governments, of necessity, provide services and support to the whole community according to their evaluation of the changing matrix of needs, aspirations and constraints which they, and the society they serve, are facing.

Thus rural health must always establish its claims for attention both within the overall health sector and within governments' overall social, economic and environmental priorities. Within the overall health system governments respond to specific rural health concerns while taking account of system-wide concerns about the continuing viability of private practice and improving the availability of health services in disadvantaged areas, which include the outer metropolitan areas of the major cities. In 2002–03 the health system in rural and remote areas had to respond to the demands generated by the major drought and bushfires.

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## The rural health environment

Despite significant investment in rural health over the last decade the people living in rural and remote Australia are less healthy than those who live in metropolitan areas. The health services which rural and remote Australians use are harder to get to and have more gaps in them. Correcting these deficiencies will continue to require services and funding arrangements specifically tailored to meet the national goal of ensuring that rural and remote Australians are no less healthy than other Australians.

Although the majority of Indigenous Australians live in the cities, the proportion of Indigenous people is higher in rural and, especially, remote areas. They die much younger and are much less

healthy than other rural Australians. At the same time they receive fewer services from the health system. Improving the health status of Aboriginal communities is an urgent challenge.

Rural Australians have higher levels of certain diseases and illnesses. Non-metropolitan residents have higher death rates for all major causes of death except for cancers and mental disorders. The most significant causes of premature death are: pneumonia and influenza; accidents; diabetes; and stroke, heart and vascular disease. Other identified rural and remote health concerns include: asthma; cancer; arthritis; healthy aging; support for children and young people; substance abuse; oral health; and increases in overweight and obesity.

Improving individual and community health in rural and remote Australia continues to require individuals, service providers and policy makers to be able to use the best available information at individual, local, regional, state and national scales based on high quality research to develop, maintain and access a full range of effective health services which are efficiently delivered by a skilled and responsive health workforce.

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### **The new health care environment**

The 7th National Conference was held at a time when the Commonwealth and the State Governments were setting the broad parameters of the health system for the next 4 to 5 years.

The Commonwealth Government is concerned about its ability to fund the Pharmaceutical Benefits Scheme because of its increasing cost over the long term.

The current Medicare arrangements are under strain as the proportion of bulk-billed patients continues to drop. This has led to significant concerns about whether Australia will continue to have a universal health insurance system. The NRHA strongly supports the principle that people have universal access to affordable care irrespective of their location. The Alliance believes Medicare should be restructured to ensure that rural people pay no more in out-of-pocket costs than city people, while recognising the real costs to medical practitioners of providing services in rural and remote areas.

The Commonwealth and the States are negotiating new 5-year agreements under the Australian Health Care Agreement to apply from July 2003. These new arrangements will

determine the nature of public hospital services available to the Australian community.

These major issues will have significant implications for the structure and costs of the Australian health care system with clear implications for the nation's capacity to provide an effective health care system in rural and remote areas.

The NHMRC is developing its priorities for the next research triennium to apply from July 2003.

Despite the underlying importance of these new agreements to begin in 2003, there was very little discussion of them at the conference. In part this is because the structure of the conference did not accommodate such discussions.

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### **The themes of the conference**

The conference sought to promote a whole of life approach to improving health, particularly in rural and remote Australia. It aimed to bring community, professional and government interests in health, education, the arts, environment, transport, community services, and economic development together with people and ideas from rural and remote areas. This was expressed by the conference motto: "The Art and Science of healthy Community—sharing country know-how".

Despite the progress made over the past decade the health of rural and remote Australians still lags behind that of their city compatriots. The conference sought to encourage the necessary continuing effort through tapping community experience and knowledge, learning from the past and by emphasising inter-sectoral, inter-professional and inter-governmental collaboration.

The opportunities for interaction and cross-pollination between consumers and providers, and between all professions involved in rural community development and the health of people in country areas were intended to enable the conference as a whole to identify the barriers to enabling rural Australians to be as healthy as other Australians. The resulting conference recommendations make demands on participants, their communities, their professions and their governments as they work toward this vision. They also provide a charter for the work of the NRHA over the next two years.

The structure of the conference sought to identify the priorities and directions for future work by

means of an interlocking series of themes and activities.

The opening of the conference dealt with the conference's overall theme by providing a compelling insight into how the nature of community we live in determines if we can live a healthy life.

The first full day of the conference, had the theme "Community Place", and was intended to examine and discuss how physical and environmental factors enable communities to be healthy.

The second day had the theme "Community Voice", and recognised that good rural health needed users and providers to understand each other and work together.

The third day had the theme "Community know-how", and pragmatically recognised that some of the community's know-how is evidence-based and some of it is based in myth, habit, discourse and intimate experience. Communities and practitioners use all these types of know-how from time to time.

To reach its conclusion and recommendations the conference included four types of activity. Firstly, twenty keynote speakers provided insights into various aspects of the conference themes. Secondly, the presentation of papers educated, challenged and promoted discussion among participants. The Infront Outback Stream for refereed research papers made a key contribution here. Thirdly, the "Art of healthy community" activities gave opportunities to experience and conceptualise the themes through an alternative group of intuitive and creative activities. Finally, all the conference participants had opportunities to be involved in drawing up the conference recommendations.

The conference recommendations were considered at the "From Energy to Shared Action" workshop the day after the conference. This workshop established an agenda and work program for the NRHA and other bodies to promote and encourage the actions the conference had recommended.

Immediately before conference a symposium organised by the National Aboriginal Community Controlled Health Organisation (NACCHO), in collaboration with the Australian Indigenous Doctors' Association and the Congress of Aboriginal and Torres Strait Islander Nurses, provided an opportunity to review

progress in Aboriginal and Torres Strait Islander health services (report at Appendix A).

At the same time a symposium on procedural rural medicine, organised by RDAA, ACRRM and the State Rural Workforce Agencies, considered issues associated with reversing the decline in the numbers of GPs providing obstetric, anaesthetic and surgical services to rural communities (press statement at Appendix B).

The results of both of these symposiums informed the considerations of the conference.

The winners of scholarships and awards presented at the Conference are listed in Appendix C.

# Opening and Keynote speakers

The 7th Conference began on the evening of 1 March 2003 with an Opening Ceremony performed by the Palawa people. Shelagh Lowe, the convenor of the Conference Organising Committee, Nigel Stewart, Chair of the NRHA and Vivian Schenker, the Conference Chair, welcomed conference participants.

The Hon David Llewellyn, Minister for Health and Human Services, Tasmania, welcomed Conference participants to Tasmania. Alderman Rob Valentine, Lord Mayor of Hobart, welcomed participants to the city.

Senator the Hon Kay Patterson, Commonwealth Minister for Health and Ageing, officially opened the conference.

On the morning of 2 March 2003 Mr Lawrence Paratz, Regional Managing Director, Telstra Country Wide, Southern Region, formally opened the Trade Exhibition held concurrently with the Conference.

The keynote speakers provided insights into some of the broad policy and operational contexts which affect the national effort to make sure that people living in rural, regional and remote Australia are as healthy as possible. These presentations were intended to give the Conference opportunities to identify important issues and to develop common ground so the Alliance and its members would know their work was advancing the real needs of rural, regional and remote Australians.

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## **Keynote 1—Florence Manguyu~People, poverty and prosperity in health**

Good health is everyone's right. In developed countries many people now live a healthy long life. But 50% of the world's 6.2 billion people live on less than A\$3 a day with 1.2 billion people living on less than A\$1.5 a day and 70% of those are women and children. This poverty causes disease and death. Where the population grows faster than the economy, poverty, particularly urban poverty, is endemic.

In underdeveloped countries people die very much younger and mothers are very much more

likely to die in childbirth. Nearly all of those infected with the three major diseases of poverty, namely, HIV, tuberculosis and malaria live in underdeveloped countries.

People can overcome this situation if they have adequate food and clean water in safe environment with good sanitation, there is universal literacy and the status of women is raised. Then people will not accept poor health, disease and death. They will form partnerships to overcome them. A global partnership is needed to overcome the malnutrition, disease and premature death of the world's poor. This partnership must involve everyone: local communities, the poor, the professions, different organisations and private for profit business.

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## **Keynote 2—Henry Councillor~Healing the divisions**

The health of Aborigines living in rural, remote and urban Australia is much worse than that of other Australians. The nation has fundamentally failed to deliver adequate health services to Aborigines, their economic status, environment and lifestyle also contributes to their poor health. This need not be the case, eg New Zealand and the USA have both increased the life expectancy of their native populations by about ten years.

Because mainstream health services have not talked to Aboriginal health organisations, key areas of government have paid little attention to Aboriginal health. Nevertheless NACCHO believes that when Aborigines are given the power to design and control their health services they do make a difference.

Resources should be allocated to Aboriginal health on the basis of their clear need to reach the same level of health and to have the same access to services as other Australians. Achieving these goals will need benchmarks for services, accountability for achievement and the removal of cultural barriers to Aborigines accessing and receiving care.

There are examples which show that the way forward is meaningful, ongoing and lasting partnerships between Aboriginal community

controlled health organisations and mainstream agencies.

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### **Keynote 3—Mike Montgomery~State of the regions: environment, population and health**

In Australia the regions which are most globally competitive capture a large share of Australia's economic output and income. Less competitive regions are falling behind. Younger skilled workers migrate to the cities while older, less skilled workers leave the cities for lifestyle regions. Soil and water degradation and drought are adversely affecting regional communities.

There are critical shortages of health professionals and rural health workers in the regions. There are looming national shortages of nurses, pharmacists, surgeons and general practitioners and experience shows these shortages will be most sharply felt in rural areas.

Australia lacks the ability to effectively plan for its future health worker needs in accord with community needs and priorities. For example, Commonwealth Government policy since 1992 has resulted in a national shortage of general practitioners. A national enquiry is needed to assess the adequacy of Australia's medical workforce planning processes and to see if we can put mechanisms in place that can better meet regional Australia's future needs.

Local Government is doing a great deal to attract doctors and other health professionals to regional areas but it could do more with direct Commonwealth government support.

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### **Keynote 4—Louise Sylvan~Consumers, community and social capital**

The Australian Consumers Association regards health as a key concern for its stakeholders.

Social capital is one of four types of capital; the others are human capital, natural capital and produced and financial capital. Social capital is a measure of the connections between people, their participation in communal activity and their resulting co-operation to achieve shared goals.

In recent times markets and prices have been becoming the dominant way of organising society. Market-based relationships mean there are often no social relationships between consumers and suppliers, many activities previously undertaken by voluntary community

groups have been taken over by corporations and a person's activity as an individual rather than as a member of a group has been emphasised. A market model of a health consumer as simply a purchaser of services is inadequate.

Social capital plays an important role in the health sector. In the sector there is a consultative approach to health promotion. There is community involvement with and even control of program and project delivery. There is good data on ways of achieving outcomes which actually increase social capital for communities. The strong social capital in rural and regional communities gives them greater cohesion.

The challenge for this century is to ensure that markets operate within acceptable social limits.

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### **Keynote 5—Nigel Stewart and Megan McNicholl~Maintaining the momentum in rural health**

Australia has to maintain its investment in health. Despite progress over the past decade rural health is still fragile. Support should be directed toward developing infrastructure and linkages to enable people to provide services on a continuous basis.

Education remains a priority with students aiming at rural practice needing support, particularly in the areas of accommodation and moral support.

People in rural and remote Australia are under stress from natural causes such as drought, flood and bushfire and from economic and social changes. Investment in health services to enable people to survive the immediate crises and to deal with the stress caused by these circumstances is a clear priority. This investment must not be confined to emergency situations but continue during recovery periods.

The enormous increases in the cost of public liability insurance threaten to undermine volunteer activity and community cohesion which is a necessary part of rural health in rural Australia.

Expenditure by government on families is an investment and has to take realistic account of life in rural and remote Australia.

Health policy has to actively support the contribution which rural Australia makes to the

nation. The health needs of Aborigines and of males need to be dealt with better. Providing satisfactory health services in rural and remote areas will need the efforts and support of friends in the city.

NRHA should produce a thoughtful paper on drought and its implications.

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### **Keynote 6—Juanita Rayner, Fiona Hadden, Jon Lane, Olivia O'Donoghue, Karina Vila, Carly Dolinski~Rural health professionals of the future**

The National Rural Health Network is the peak body for undergraduate health clubs and has been involved with rural health promotion and improvement since 1996. It represents 18 rural health clubs which bring together almost 5000 undergraduate students studying medicine, dentistry, pharmacy, allied health and nursing. The Department of Health and Ageing funds it.

It is a member of NRHA and has links with the relevant professional, education and health sector peak bodies. Its priorities are to ensure that a high quality rural health workforce results from the support provided to rural health students, Indigenous health receives priority and that Indigenous health students are recruited and retained, careers in rural health are promoted to rural high school students, and interest and participation in rural and remote nursing practice is encouraged and developed.

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### **Keynote 7—Danielle Wood, Rachael Treasure~Unleashing the rural voice**

Danielle and Rachael are both writers who were born in Tasmania, went away and worked as journalists and have returned to Tasmania with husbands named John.

During her undergraduate studies and as she worked as a jillaroo and a rural reporter Rachael became aware of how quiet the rural voice is in mainstream media and how rural issues are stereotyped and oversimplified. She is one of those who feel there is rich and vibrant future in the rural community. Her book *Jillaroo* tells of the human side of agriculture. It recognises that while farming can give rise to human conflict and generate ill health and even suicide it also has a lighter side and a vibrant future. She wrote her book for people who are not readers and for those who are too tired to read.

Danielle Wood grew up in family of lighthouse keepers in Tasmania. But she wrote her book in Broome. Her book is a celebration of place set in contemporary and historical time. It deals with coming to terms with our sense of place and with our history in the 21st century. She says the novel really sings Bruny Island.

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### **Keynote 8—Larry Towney~Three Rivers Men's Program: the power of the yarn**

Mainstream services seldom have an ability to respond to the needs of Aboriginal communities in culturally sensitive and appropriate ways that contribute to the resurrection and honouring of Aboriginal knowledge and skills that contribute healing within the Aboriginal community.

The objectives of Centacare's Aboriginal men's programs are to empower the men to work towards self-determination and improve quality of life and relationships. The programs deal with the underlying issues: loss of culture from colonisation; loss of identity; the need to understand one's identity and a need to feel secure in one's identity.

The Aboriginal Men's Program uses narrative approaches in a community setting. Men are invited to regular gatherings, including overnight camps, in culturally significant settings where meaningful conversations develop. This is a traditional way of dealing with issues. Over time, the talk deepens, traditional practices are remembered, language revived and healing and self esteem starts to grow.

Each member is asked to stand by a set of principles: respect your aims and the objectives of the program; respect and acknowledge the roles of women and children within the community; fight against domestic violence and sexual abuse in any form; teach younger men respect; mentor younger men; alcohol and drug free camps; and commitment to the language reclamation program.

The success of the program needs understanding of the real issues Aboriginal Australia faces, connection to spirituality and values, commitment, passion, vision, hard work, actively correcting those who don't understand the real issues and heaps of barbecues.

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## **Keynote 9—Sarah and Roger Strasser~Australia viewed from “up over”**

The Strassers had recently moved from Moe in Gippsland to Sudbury in northern Ontario.

Australia and Canada are both large countries with their populations concentrated along one edge of the country. Canada shares a long border with the USA and it is important for Canada and Canadians to differentiate themselves from the United States.

Rural and remote health issues of the two countries are similar. In northern Ontario there are perennial shortages and turnover of health professionals but there have been some successes. Medical services in a remote town have been stabilised. North Network provides specialist clinical telehealth services to sixty different sites in northern Ontario. There are two well-established general practitioner training programs producing 30 graduates a year.

The Northern Ontario Medical School, where Roger works, is developing using the concept of the life cycle of a doctor in Northern Ontario. This takes career progression from encouraging high school pupils through undergraduate and postgraduate training to specialist training. Undergraduate training takes place in small groups using patient-centred, case-based learning, a focus on skills and knowledge for competency, and emphasises the whole health team and learning in settings outside the major centres.

Sarah works in a First Nations community health centre which combines traditional medicine with modern medicine. This centre includes a traditional medicine room and a traditional healing room.

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## **Keynote 10—Nigel Stewart~Members of the council of the National Rural Health Alliance**

Nigel Stewart, Chairperson of the NRHA, presented the people who represent the NRHA's member organisations on the Council.

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## **Keynote 11—Fay White~The voice of healthy community**

As health is inextricably linked to the quality of people's relationships, it follows that healthy communities are convivial. The relationships people form as they actively participate in community arts can contribute to achieving a healthy community. Community arts activity provides identified health factors such as participation, creativity and identity together with factors such as freedom, understanding and affection which also benefit individuals.

Music and singing and exercise all have similar individual health benefits. Making music and singing in groups can also make a strong contribution to social capital.

With their low cost, small infrastructure requirements and great benefits, the participatory arts have great potential to contribute to health in the community.

The health benefits of community arts should be recognised. The data which show these should be brought together, published and brought to the attention of both health and arts organisations so they can understand their relevance. The community arts sector should be funded adequately and permanently but not from primary health funding. At all levels participatory arts should be delivered through partnerships. Community workers should receive training in creating these partnerships.

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## **Keynote 12—John McGrath~Politics and community well-being**

People become politically active when they become dissatisfied with their situation or experiences. They then develop a passion and build a drive to actually make a difference and to actually get people to stop and listen to their concerns. If the results of passion don't work it is necessary to become radical.

Australian health services will not change unless those involved become radical and stand up as a group and tell the funders that the services are not good enough. All illnesses, including mental illnesses, must be taken seriously.

The way forward is through partnerships which include local government, the non-government sector, service providers, community groups, health professionals and any others who contribute to community life. The partnerships

must overcome obstacles to sound working relationships, such as small town rivalries, which limit recruitment and the availability and quality of services in rural and remote communities.

Those who are involved with rural and remote health and with mental health need to be both brave and passionate if they are to achieve the goal of better outcomes for people who are ill and to create a system which breaks down the barriers to achieving this goal.

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### **Keynote 13—Kim Snowball—The Journey to Healthy Horizons**

The vision of Healthy Horizons is that people living in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities.

There are three reasons for having a national rural health strategy:

- People living in rural, regional and remote Australia experience poor health outcomes with those of Indigenous Australians and those living in the most remote areas being the worst.
- Health risk factors are currently much higher in rural, regional and remote Australia and health outcomes will not improve unless these risks are reduced.
- A good policy and planning framework enables the sector to show the quality of its performance to everybody and to share its successes.

The nature of rural health generates a need for specific policy responses because:

- Rural regional and remote communities, and hence their needs, are not homogeneous.
- Smaller, thinly spread communities lead to difficulty achieving economies of scale and significant logistical problems, so rural health priorities need to be plainly stated and have widespread support to effectively compete with other pressing and politically sensitive funding priorities.
- Critical success factors need to be identified and made visible.

Healthy Horizons has been a very useful vehicle for action and has helped many groups to organise their thinking about rural health issues.

There are seven goals. It is intended to:

1. Improve the highest health priorities first.
2. Improve the health of Aboriginal and Torres Strait Islanders living in rural, regional and remote areas.
3. Develop a National Rural Health Research Agenda with a focus on applied research.
4. Develop even more flexible and co-ordinated services and emphasise prevention.
5. Maintain a skilled, responsive and culturally sensitive health workforce.
6. Develop flexible funding arrangements based on the best available indicators of need.
7. Achieve recognition of rural, regional and remote health as an important component of the Australian health system.

These goals are supported by eight principles.

1. *Primary health care.* This provides the opportunity to keep people healthy within the community setting.
2. *Public health.* This forms the basis for preventing illness and determining the health of Australia's whole population.
3. *Capability of communities.* Communities require social capability and physical capacity so they can improve and maintain their health.
4. *Community participation.* This forms a basis for the success of programs and services to maintain and improve the health of individuals, communities and special groups.
5. *Access.* Ensuring culturally appropriate access to comprehensive health services is fundamental for everyone in rural, regional and remote Australia.
6. *Sustainability.* Sustainable communities require healthy people and a good system of health care.

7. *Partnerships and collaboration.* These are essential for effective service delivery and successful health improvement programs.
8. *Safety and quality.* There will be no compromise on the safety and quality of health services provided to people living in rural, regional and remote Australia.

The combination of the strategies set out in Healthy Horizons with the framework for rural health information being developed by the Institute of Health and Welfare together with its accompanying baseline studies of national health performance indicators, mortality and injury will enable the sector to begin to gauge its progress toward achieving the ultimate vision.

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### **Keynote 14—Norman Swan~The media as a change agent**

To get something into any type of media—print, radio or television—you must attract the attention and meet the needs of your target audience. A target audience has three components: the people in the wider community you wish to reach, the journalist who reports the story, and the gatekeeper who decides if their news organisation is interested in reporting the story. The most important step is to attract the interest of the gatekeeper. In almost every case a gatekeeper will want the story to have an emotional component. Ensuring that the story involves people best does this.

Journalists love exploding myths and providing new information. They like stories to have a wide impact and be relevant to daily life. It is their job to convince the gatekeepers that the story is worthwhile.

To get the most effective media exposure you must develop and maintain personal relationships with journalists. They like to deal with people they know who understand their needs and can be relied on to help them meet these. You can use this to create effective two-way relationships with journalists where in return for you making your expertise freely and quickly available to them you can have access to them.

You have to accept that the media will make mistakes when they report your story. To minimise the chances of error you must be absolutely clear about what you want to say. Don't be garrulous, write down the three things you want to say and say them. A television grab

averages 6 seconds and you need to say what you want to say in that time.

People respond to what they see and hear emotionally first and rationally only later. So the gatekeeper and consequently the journalist are always attracted by stories which will generate an emotional response. Such changes in emotions are caused by people's perceptions of risk. It is most important to recognise that the media prefers negative stories because people perceive loss more emotionally than they do gain.

Active partnerships and relationships with media will contribute to overcoming the media's tendency to focus on negative stories and get exposure for positive stories which would otherwise be neglected.

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### **Keynote 15—Mohan Krishnamoorthy~Patient-centric health care delivery**

As part of its flagship activity over the next 3 to 5 years Commonwealth Scientific and Industrial Research Organisation is investigating the contributions which Information Communications Technology (ICT) can make to rural health care delivery. The research has an aspirational goal: "How can CSIRO assist in bringing city quality health care delivery and services into rural areas? How can we improve the equity of access for health and well-being everywhere? How can we conquer the tyranny of distance to ensure that health care everywhere is only a heartbeat away?"

Published statistics show that the structure and funding of health services is unsatisfactory. There are more public hospital beds per 100 000 people in rural areas. The rates of specialist and GP consultations are higher in the capital cities. There are twice as many practitioners per head of population in the cities. Expenditure per bed is higher in cities but expenditure per person is higher in rural areas, indicating that access to care from the more expensive higher specialisations is less accessible in the country. Innovation is needed to overcome these structural imbalances.

ICT has the potential to improve health care delivery by a variety of means: rethinking and transforming the pattern and manner of delivery of health services, allowing and facilitating better access to health information and data, increasing and enhancing access to health services and education services, and delivering and increasing

the amount, type and speed of information that is being delivered.

One possible approach would be to establish a virtual health care system where health service providers form a virtual organisation, service providers use best practice guidelines, patients are completely at the centre in terms of receiving rapid responsive treatment, relevant training is always available and resource use is optimised.

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## **Keynote 16—Phil Koperberg~Looking ahead**

Over the last twelve months the impacts of drought and bush fires had made significant demands on community resilience. These days a simple accounting of the amount of property destroyed cannot be used to compare the relative severity of contemporary and historical bushfires. Modern methods of managing bushfire risk and fighting actual fires are much more successful in preventing destruction and loss of property. The key to this success is due to both better fire-fighting techniques and a better informed community.

The experience of the NSW Rural Fire Service is that a well informed community leads to better outcomes. The more community involvement, the more success. High quality community involvement requires the best possible consultation, using the best possible information, based on the best possible analysis of the situation.

It was necessary to produce as much information as possible and deliver it directly to the community, for example through meetings and letterbox drops. The information provided to the community must be truthful. Direct contact motivates people to gain the skills to protect themselves and their neighbours. Skilled and informed participation by community members has been the most significant contributor to successful property protection.

Communities also must be consulted after bushfire events. This enables agencies and the community to make a realistic assessment of their successes and failures. It provides the basis for coming to terms with loss and enables everyone to learn how to do better in future.

Engaging self-interest is the most effective way to encourage communities to respond positively to challenges.

# Conference presentations

The conference papers, symposiums and the discussions they generated formed the core of the conference activities. They provided opportunities for the participants to share knowledge, discuss issues and make recommendations for future actions.

The conference papers are not presented here in the order or headings under which they appear in the conference program. Rather, the papers have been grouped into thirteen topics which cover aspects of providing health services to individuals and communities where they live and the development, maintenance and support of an appropriately skilled workforce. Linking related presentations within these topics across the conference identifies areas where the participants could have opportunities to deal with shared concerns which were not immediately apparent at the conference.

Under each topic heading, or a subheading, each paper has been briefly summarised. The author's name(s) are in brackets at the end of the summary. The names identify the paper's title in the listing of References. The author's name and the title of the paper, keynote address or symposium can be used to find the full text of the paper on the CD "Rural and Remote Health Papers 1991–2003", produced by the National Rural Health Alliance Inc. in July 2003 or at the Conference Website:

<http://www.nrha.net.au/nrhpublic/publicdocs/conferences/7thNRHC/introduction.htm>.

To give some feeling for the discussion generated by the presentations, any related recommendations made at conference sessions are set out in this report after the summaries of the papers. These recommendations are presented in the form in which they were provided to the committee that drafted the conference recommendations.

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## Aboriginal health

### Providing culturally appropriate services

There are examples of the issues and sensitivities involved with providing various culturally appropriate services at local, community and national scales.

Eight to ten per cent of Inala's population was Aboriginal in 1994 but less than 1% of them attended the Inala Health Centre General Practice (IHCGP). Five strategies to improve contact were developed using quantitative data and community consultation. By 2001–2002, 23 per cent of the total IHCGP consultations were with Indigenous people. Community participation and cultural differences must be taken into account when access intervention programs for Indigenous people are being developed. (Hayman, Noel)

Currently Indigenous Australians may not know about or have access to suitable palliative care services. Posters intended to increase awareness among Indigenous Australians of the existence of palliative care services in a culturally sensitive way have been developed and published. They were developed from designs of Indigenous artists in consultation with the community. Indigenous staff needs training in palliative care and non-Indigenous staff need cultural awareness training. Some Indigenous health services are keen to be involved in similar projects, particularly to produce suitable pamphlets. (Taylor, Andrew)

Aboriginal and Torres Strait Islander males are currently living 20 years less than non-Aboriginal and Torres Strait Islander males. The framework to improve the health and well-being of Aboriginal and Torres Strait Islander males has been developed by a working party of the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH). It seeks to compliment and enhance current activity rather than isolate Indigenous male health issues from existing approaches. It takes a comprehensive health care approach to improving the health status of Aboriginal and Torres Strait Islander males. Interventions need to be made across the

continuum of care and be underpinned by a high quality workforce and appropriate research. After its acceptance by the SCATSIH the framework is to be put in place for 3 years. People are happy now it is up and running. (Adams, Mick)

A simple recall system managed by local Aboriginal health workers achieved significant improvement in diabetes care and significantly decreased hospital admissions in a high need population. Information helps people with diabetes understand the disease and its complications. Electronic information kiosks in Indigenous settings can be used to disseminate health messages. (Hayman, Noel)

The Port Lincoln Aboriginal Health Service gives significant priority to Chronic Disease Self Management projects and programs. (Borg, Judith)

A video produced for the Ceduna hospital provides Aboriginal community members with information on appropriate ways to behave in a hospital. (Weetra, Colin)

The installation of swimming pools at Burringurrah and Jigalong, two remote Aboriginal communities in WA, led to significant reductions in perforated ear drums (by up to 50% in one community) and in the occurrence of skin sores (by up to 80% in one community) among children under 16 years. As well, the communities benefited from the increased opportunities for recreation and social interaction which the pools provide. (Tennant, Mary)

Program approaches which are likely to result in delivering effective primary health care to Indigenous Australians include community empowerment to drive health service reform, better access and cultural appropriateness, care plans with strong consumer participation and flexible funding which meets local needs and priorities. Commonwealth programs for rural and remote areas are using these principles. (McDonald, Mary)

#### *Participants' recommendations*

- There should be targeted funding to provide health information on diabetes for Indigenous children using culturally appropriate touch screen technology.
- State and Territory governments have to give priority to training for Aboriginal

Health Workers on diabetes prevention and management.

- Strategies have to be developed to promote the incorporation of Chronic Disease Self Management into the organisational planning of health programs and practices even though recognising that this will increase costs.
- Projects to produce and disseminate further culturally sensitive palliative care information to Aboriginal Medical Services have to be undertaken.

#### **Developing an Indigenous workforce**

“Gettin’ em n keepin’ em” is a report of the Indigenous Nursing Education Working Group formed by the Deans of Nursing, the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Congress of Aboriginal and Torres Straits Islander Nurses (CATSIN). Indigenous people enter nursing but do not remain in the profession. The reason for this appears to be racism. To overcome the current high rates of separation, Indigenous nurses need suitable support and other nurses need to be educated about Indigenous issues and ways of life. All curriculums must contain material on relevant Indigenous issues and relationships. (Goold, Sally)

The NSW rural and remote Aboriginal nursing strategy aims to increase the number of Aboriginal nurses employed within the NSW Public Health System. Research and consultation have identified state, interstate and international programs that were effective in increasing Indigenous participation in the nursing workforce; barriers for Indigenous people undertaking educating and training for nursing; and issues that impact on Indigenous people in the nursing workforce. Early indicators are very positive. (Lovett, Raymond)

As part of its workforce planning the South Australian Department of Human Services wants to increase the numbers of Aboriginal human services professionals delivering health services in the Eyre, Northern and Far Western Regions. A culturally appropriate unique Centre of Learning situated at the Pika Wiya Aboriginal Health Service in Port Augusta will provide culturally appropriate academic, personal, peer, social and administrative support to help Aboriginals graduate from university or TAFE institutions. (Heyne, Nick)

### *Participants' recommendations*

- Nurse registering bodies should not re-accredit curricula unless Aboriginal and Torres Strait Islander history, culture and health issues are separately and visibly included.
- The New South Wales Aboriginal rural and remote health strategy should be applied nationally.
- There are capable people living in rural and remote communities who could be trained and supported to carry out health worker roles. They need better outcomes from primary and secondary education so they can proceed to training programs and be confident to work as health professionals.

### **Indigenous control of research and service delivery**

The “NACCHO Ear Trial” was a successful national randomised trial of treatments for Suppurative Otitis Media managed and carried out by the National Aboriginal Community Controlled Health Organisations (NACCHO), utilising James Cook University (JCU) as the legally required administering agency, using specially trained Aboriginal community health workers supported by a continuously available project officer. It has shown that with appropriate relationships and management Aboriginal communities can participate effectively in health research which is community controlled and not just community-based. (Couzos, Sophie)

The achievements of the Tasmanian Aboriginal Centre in developing an Aboriginal Primary Health Care Service in Tasmania in a hostile environment have shown that best practice covers:

- organisational forms and practical solutions which grow from the people themselves;
- addressing real needs and encouraging better health and emotional well-being through social cohesion;
- strict financial accountability so the government can't shut down the organisation;
- taking a holistic approach to social problems, building the capacity of the community to undertake housing, educational, business development and cultural activities; and

- actively asserting the right to Aboriginal self-determination.

Further development of community health and well-being requires:

- Whites to treat Aboriginal rights seriously;
- funding to be provided so as to meet community priorities;
- Aboriginal health services to concentrate on primary health care services, health promotion and illness prevention;
- politicians to show they respect Aboriginal culture; and
- greater government investment in Aboriginal health with all Aboriginal health being considered to be part of rural and remote health services. (Sculthorpe, Heather)

The goal of the National Strategic Framework is to ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population and one that is enriched by a strong living culture, dignity and justice. The objective for the Western Australian Framework Agreement signed by Aboriginal and Torres Strait Islander Commission (ATSIC), the Western Australian Department of Health, the Commonwealth Department of Health and Western Australian Aboriginal Community Controlled Health Organisation (WACCHO) is to improve health outcomes for Aboriginal and Torres Strait Islander peoples in Western Australia through a co-ordinated approach to the planning, funding and delivery of health and related services. The major challenges for the partnerships in Western Australia are:

- revising the 1999 Aboriginal Health Plan together with making regional Aboriginal Health Priorities the first priorities for mainstream health plans;
- establishing regional agreements that commit or compel the partners to be able to enhance the resources and the service provision within the regions;
- ensuring that regional planning funds are going to be adequate to pay for planning and the identified Aboriginal health priorities;
- establishing regional Aboriginal health structures to ensure the collective voice of Aboriginal Community Controlled Health

Organisations and develop business planning;

- increasing funding to recruit and retain Aboriginal health workforces in the regions;
- access to a Senior Medical Officer in other regions so that they are able to assist with policy, to assist the doctors that are coming into Aboriginal Medical Services and the nurses and to be able to give WACCHO proper policy advice; and
- regional Aboriginal Health Priorities being effectively embraced by the whole of government in the regions. (Kickett, Darryl)

#### *Participants' recommendations*

- That more national research in Aboriginal health be promoted using the NACCHO Ear Trial as a model.
- That the financial incentives and other special measures available for the improvement of health outcomes in regional, rural and remote Australia be extended to Aboriginal Australians wherever they are situated geographically in recognition of the continuing disparity between Aboriginal and non-Aboriginal health status and recognising that definitions—including definitions of remoteness—imposed from outside Aboriginal Australia do not reflect the realities of Aboriginal Australia.
- We, the Kimberley delegates, recommend that the Alliance actively encourage and promote presentations from Aboriginal communities and Aboriginal Community Controlled Health Services, which allows them to discuss issues affecting their communities and promote community derived solutions.
- The Alliance to also increase the number of Aboriginal presenters and to provide funding for Aboriginal community representatives to attend the Conference.

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## Looking after yourself in the community

This group of papers describes programs which are aimed at enabling people to take responsibility for managing their own health and well-being.

Tasmania has higher rates of cardiovascular disease; at the same time it lacks dieticians. In rural areas the Community Nutrition Unit works collaboratively with local health and community workers, community members and local government to better deliver advice on nutrition and encourage people to eat healthier food. The outcomes are being monitored. (Ward, Alison)

Stroke survivors throughout Queensland were surveyed using a postal questionnaire so as to compare recovery success and to compare the experiences of survivors from rural and remote areas with those from metropolitan areas. The questionnaire information and language was developed using focus groups and in-depth interviews with stroke survivors. The results will be used to equip stroke survivors with skills to drive their own recovery. (Barker, Ruth)

A three-year demonstration project is attempting to develop and demonstrate new approaches to chronic disease self-management within rural and remote communities. Initial outcomes suggest the process of goal setting; patient education, symptom monitoring and reporting can produce more active participation by patients with chronic conditions. This has led to increased uptake of appropriate preventative and primary care services and increased levels of patient self-management skills and ability. This may lead to fewer unplanned calls on acute services and improve the health of the overall population. (Harvey, Peter; Misan, Gary)

The Department of Veteran's Affairs (DVA) Men's Health Peer Education Program is a national program which raises awareness of men's health issues by encouraging members of the veterans and ex-service community to share responsibility for managing their own health and well-being. Volunteer peer education facilitators provide information, not advice, and encourage their peers to seek assistance from appropriate health professionals in areas including: choosing and communicating with a GP; respiratory disease; heart disease and stroke; diabetes; prostate cancer; depression and suicide; and alcohol related problems. (Westbury, Helen)

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## Looking after people in the community

Family members and volunteers continue to play a significant part in providing both emergency and continuing care and rehabilitation in home and community settings.

In a home setting family caregivers are fundamental to the delivery of community care but caring can come at a considerable cost to the carer's health and well-being. (Warmington, Rosemary) (Dow, Briony)

Care-workers' contributions should be acknowledged, particularly when they are expected to play an active role as, for example, in the case of early discharge from hospital. Caregivers should be treated as part of the health service system with the right to information, training, input into decision-making and financial compensation for their work. (Dow, Briony)

Support for caregivers can come from peer support networks and their community. (Warmington, Rosemary) Although when people are caring for a partner, personal coping strategies and resources were the best predictor of both psychological health and life satisfaction. This suggests that coping with caregiver stress was more indicative of personal factors within the individual rather than external factors such as formal supports. (Rutherford-Kitson, Anne)

Voluntary organisations provide services on community, regional, state or national scales which support the individual, social, economic and clinical needs of people with chronic illnesses, while the public sector concentrates on delivering acute care, less flexibly and with increasing concern for cost efficiency. As services are decentralised to the community and people participate more in their own long-term health care voluntary organisations become more important. Voluntary organisations are moving from an altruistic role toward a highly developed professional role competing for consumers and resources in the market, and are paying more attention to entrepreneurial activities. (Ristevski, Eli)

Volunteer Ambulance Officers provide an example of the issues which come up delivering services through volunteers in large scale networks. They have strong horizontal networks with their communities but would like stronger vertical networks with both their ambulance

organisations and their communities. Ambulance services need to ensure that their volunteer management processes provide practical support such as training and clinical support, but deliver them in a way which strengthens the networks necessary for ongoing volunteer satisfaction. Ambulance services should facilitate a sense of connection with the local community, and avoid centralised policies that inhibit this. (Fahey, Christine; Walker, Judi)

### *Participants' recommendations*

- The range of issues that impact on family caregivers highlights the cross-portfolio nature of the caring role and the need to develop a whole-of-government approach to family carer policies within a central framework. This framework needs to include carers in acute situations (example palliative care). Such a framework would include:
  - recognition of carers as co-providers of services;
  - training for carers;
  - measures to assist carers find better ways of managing care in the home;
  - inclusion of carers as partners in service planning;
  - inclusion of carers in the clinical process and decision making process as it relates to their caring role;
  - recognition of carers' needs in the assessment, care planning and clinical processes;
  - respite provision including recognition of the carer's need to maintain their own interest and pastimes on a long-term basis because current research shows that carers rarely use their respite for rest and relaxation; and
  - adequate financial compensation/income support for caring by family members.
- When volunteers, such as volunteer ambulance officers, deliver services there must be a general agreement and understanding that the workforce is managed to effectively include them.

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## Living together in the community

### Creating supportive groups and networks

Action to increase social cohesion through paying attention to a specific need is important in many circumstances. For example, a fishing club for frequent users of Charleville District Health Services has provided a model of a better setting for social interaction between socially isolated disadvantaged people who had difficulty in other groups. The other groups serviced those who were more socially competent and self-motivated. (Carroll, Jill; Baker, Carmel) Similarly, the Mallee Track Health & Community Service has developed a community-based pathway for rural adolescents to reach their local health services and to socialise through a Community Health School Link Program complemented with opportunities to socialise with other young people at a youth-friendly drop in centre. This combination provides needed opportunities for early intervention. (Denner, Bernard)

Supportive social networks help people who move to or live in rural and remote areas respond positively to their communities. In a remote mining town community-led social support services, friendship and activity groups provide a model for helping new residents to avoid social isolation and develop friendships and participate in community activities. Resources should be provided to encourage the development and sustaining of more such groups. (Honczarov, Natasha; Wooldridge, Kathy) These needs can link community members. The family support needs of rural female GPs and rural registrars are also the needs of other women in rural communities. Many significant needs are difficult to meet through normal health funding and would best be met by addressing the overall needs of rural communities for sustainable community development. (Wilson, Erin; Cheney, Helen)

Living within a community means you must be prepared to give and take. In rural communities mid-age women's leisure choices are undertaken within a framework of constraints which are both explicit and implicit. While physically and metaphorically they inhabit an aging conservative social space it usually does not limit their choice and actions. Women clearly show their capacity to make choices and negotiations which optimise their well-being. (Warner-Smith, Penny; Brown, Peter)

### Participants' recommendations

- Seeding funds should be made available for small group programs for the socially excluded in rural and remote areas.
- If health services adopt a policy that recognises the value of early intervention for our youth then we can provide opportunities to meet their needs within current health structures. Such community-supported initiatives provide the resilience that some of our young rural people need so they can cope in their adolescent years.
- Children's and youth health need their own co-ordinator/advocate/manager in health services and their own strategic plan and child/youth-dedicated services.
- There is a need for community-based strategies that can provide assistance to all re-locators—not just professionals. These community-based strategies need to assist in co-ordinating social support services for re-locators and in identifying new re-locators to guide them to find assistance.
- A support network for human services providers in rural and remote communities that crosses disciplines is needed. There are a lot of good services for professional groups but little or no cross communications between these groups.

### Providing opportunities

There are other examples of community activities working to remove constraints and improve the life opportunities for people.

In Tasmania community-based groups were encouraged to deliver a service which gave isolated older people opportunities to eat a meal in the company of others. The project aimed to reduce their social isolation and improve their nutrition. (Dermody, Jackie)

In rural WA the Midwest Health Service's Bookstart Program is an attempt to reduce the demand for remediation of literacy and language delays by providing a book, library bag and information on local library to infants at their 7–9 month health check. The project actively involves diverse groups in informal partnerships. (Cameron, Lisa; Hall, Maeva)

Australian youth suicide rates are among the highest in the world. Male youth suicide rates in small rural towns and remote areas are

extremely high. Systematic research has not yet determined which of the problems experienced by many rural youth are related to suicide. The principles of effective suicide prevention includes shared responsibility by all groups involved, a variety of approaches targeted to reach each of those involved and evidence-based programs which are evaluated. It is essential that activities must do no harm. There are signs that if a community owns the problem and the solution, adequately supported, planned, continuing Life Promotion Programs can be effectively mounted through community controlled primary health care services. (Dudley, Michael; Harris, Martin)

### **Communities and change**

Two papers looked at how rural and remote communities might respond to changing circumstances.

Corporate farming is either amalgamating small family holdings into larger units employing contract staff or individual farmers are being contracted to produce specific products. These changes are threatening three forms of social capital: bonding, as residents set individualist priorities; bridging, as active community members become fewer and linking, between formalised social structures. If communities are to respond to these changes the role of local government in supporting civil society must be formally recognised and appropriately financed. (Talbot, Lyn)

Year of the Outback had shown that the key to the ongoing survival of outback communities is positive discrimination in terms of government policy, investment and the ability to resource them to meet their own needs. People in the outback need to commit to sustaining community beyond 2002 by being innovative and brave, and being prepared to take risks. (Young, Rosemary)

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### **Living as a practitioner**

Health professionals who practise in rural and remote areas must cope with many stresses.

Those who are working as isolated individuals or who are poorly supported or integrated into their organisation face the most challenges. But even these practitioners could cope better if they were better prepared, perhaps during their training, for life as a rural practitioner.

A joint general practice screening and counselling service in WA was evaluated using

focus groups. The results showed that general practitioners have some difficulty getting confidential general practice care and anti-depressants are widely prescribed. General practitioners can learn from each other about handling personal ill health. Doctors could be better prepared as undergraduates and as registrars to manage their life as independent rural and remote practitioners. (Roach, Sally)

Welfare workers in rural communities face many difficulties in managing confidentiality, personal and family safety, workplace issues and living and working in the same community and the implications for individuals of lack of anonymity. Their employers need to take account of an individual's ability to cope with the pressures of living and working in a rural community. Organisations should support their practitioners both in their professional roles and as individuals. Professional education should include training. In addition governments should fund replacement staff, better pay and protocols for managing trauma experienced by workers and their families. (Green, Rosemary)

Rural practice can be made much more attractive if it takes place in an environment which recognises the needs and concerns of the practitioners.

Recent moves to re-establish general practitioner services in North Western NSW have been successful because they provided practitioners with an environment which met their concerns more closely. Walgett and Brewarrina are the most socio-economically disadvantaged Shires in NSW with amongst the worst health outcomes nationally. They are chronically under-served by medical and other health professionals. Under the Commonwealth/State Health Ministers' "worst first" strategy the NSW Rural Doctors Network established, in consultation with the community, a separate not for profit entity, Rural and Remote Medical Services Ltd (RARMS) to upgrade medical services in these shires. It has tested varying approaches to doctor employment (direct employment, independent contractors and providing practical services to the doctor on a fee basis), negotiated a new VMO arrangement at Walgett Hospital covering after-hours workloads, given greater income certainty and improved financial incentive structures, worked with stakeholders and governments to improve housing and other infrastructure. This has increased the volume, range and stability of medical services. (Lynch, Mark)

Recognition of variety among practitioners also makes professional practice more attractive. Medicine is a culture that has a male defined hierarchy and point of view that controls medical time and resources and disregards gender. Key women players put women back into the equation through collective action through networking, resourcing and mentoring among themselves, through personal contributions, and by understanding how women do medicine and how medicine traditionally operates. Women are seeking to achieve fair and flexible professional recognition and representation in decision making roles in ways which are intelligible to current structures but lead to greater recognition of their ability to contribute and ways of working. (Schwarz, Imogen)

#### *Participants' recommendations*

- Research on doctor “self care” along the lines carried out by WACRRM needs to be extended across all rural and remote health professions.
- There should be consideration about going across professions for help (eg GP to psychologist).
- Education and recruitment strategies have to provide appropriate training and support for the complex personal and professional issues arising from rural welfare practice. Organisations need to make a commitment to the role, training, supervision, and support, including replacement when the social welfare worker goes on leave.
- Professional organisations, AASW and AIWCW must work to advocate for a better workplace, and for protocols for effectively making a safer workplace. They could also encourage rural practice issues being addressed in the curriculum.
- Where rural and remote communities clearly lack basic medical and health services and the standard ways of working have failed, all stakeholders—Commonwealth, State, NGOs, local government, community and private service providers must:
  - come together with the common purpose of improving situation;
  - commit to removing their own barriers;
  - be prepared to commit resources and take risks; and

- have a mechanism for accountability back to the community.

- The National Rural Female GP Report and GPPAC Working Party have recommended and supported the establishment of a National Female Rural GP Network. This recommendation is currently in the Minister’s Office.
- The Alliance must lobby the Minister for the establishment of a National Rural Female GP Network as a matter of urgency. When it is established this Network must be closely linked with the Divisions of General Practice to establish both grass-roots support and national input.

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### **Educating the community**

In some circumstances professional groups may be able to provide people with skills or information which may be desirable but which may have to be promoted.

Manutention is a training program for reducing the risk of manual handling activities. It treats manual handling as a skill. It covers: body awareness, co-ordination, body movement patterns, flexibility, using one’s body as it was designed by using and strengthening the muscles of the thighs and buttocks and those muscles that stabilise the lumbar spine. It has been successfully applied to agricultural work. (Taylor, Anne)

Optometrists in rural Victoria want to do more health promotion. The Optometrists Association of Victoria is developing a kit and providing training with partner organisations to enable optometrists to do this. This “See to the Future” project demonstrated some clear lessons applicable to public health delivery in regional Victoria. Many of these lessons are likely to have wider utility across rural, regional and remote Australia. Further, the project demonstrated a specific need for eye health education in regional Victoria. (Harris, Ben)

Actively involving the community can improve the definition, delivery and acceptance of more complex and sensitive health related information.

Three projects covering aspects of the sexual health of women, men and children were planned and executed with input from the community and community involvement in delivery to encourage ownership. Reproductive

and sexual health projects in rural areas should incorporate community input, knowledge and know-how. In both planning and implementation phases the process should be transparent, the outcomes documented and widely disseminated to all stakeholder groups involved. (Read, Christine)

Community consultation helps educators to provide students with access to information they want and can use. Women from rural Victoria were asked for their health information priorities. Rural women 40 to 60 years old have identified the following health needs: information on menopause; hormone therapy; natural therapies; weight management; sexuality; depression and stress management. The Jean Hailes Foundation then developed an education program to meet the needs of health professionals and women living in the bush. It includes a professional's resource kit and a CD to meet the needs of isolated women. (Hardy, Sarah)

#### *Participants' recommendations*

- The National Rural Health Alliance has to recognise the importance of visual health to the communities it represents, and seek greater emphasis on visual health awareness from its members, communities and governments.
- Public health campaigns have to be planned to take fullest advantage of local knowledge and local services.
- All health care workers, community advocates and other friends of the National Rural Health Alliance must consider the role of partnerships in successful health promotion.

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## **Drought**

At an open forum on the social and environmental impacts of the current drought delegates told their personal stories of the impact of the current drought on their own family or area.

The Commonwealth has provided additional counselling services to rural and remote communities as a result of the drought. (Cartledge, Matthew; Humphries, Peter)

#### *Participants' recommendations*

- That the NRHA urgently produce a "thoughtful paper" acknowledging the

continuing nature of flood, drought and fire, outlining problems and solutions.

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## **Providing services people want to use**

There are clearly opportunities to ensure that the most appropriate health services are available to rural communities. Enabling these services to be developed and delivered in ways which make them attractive and easy to use must be an active process which involves users, providers and community stakeholders.

Australian rural communities must actively engage in the market for medical services if they are to attract the service they want because practitioners and facilities will no longer come to them. To attract practitioners and services a community must: accept its problem; accept responsibility to act; establish leadership through community action; mobilise the community for action; inform itself of the elements and workings of the medical workforce system; plan systematically to develop a plan tailored to the community needs to address the problem; then act decisively to address the problem and strive to improve upon the gains and advantages achieved. (Lennox, Denis)

The Towards Unity for Health Partnership Pentagon approach involving health policy makers, health providers, communities, health service organisations and academics has led to a large increase in the number of doctors and services to patients in the Walgett region in NW NSW. The structure could be used for combined primary health care, acute health care and population health initiatives. (Cameron, Ian)

Community action to establish better health services will require people throughout the community to take on new and different roles and expand their existing skills or develop new ones.

Community development projects have shown impressive achievements in terms of strengthening social networks, fostering the skills of residents in dealing with health issues and opening up the channels of communication between professionals and residents. Experience with practical implementation of the community development approach during the last 4 years in 14 communities in rural and remote regions of Queensland has resulted in learning covering: local level processes; practitioner skill and knowledge development; organisational change and whole of government policy. There must be

a national whole of government strategy to support community capacity development. (Dower, Jo; King, Mary; Sorensen, Sue)

Health service planners should use a variety of methods to obtain community inputs which quickly lead to a widely accepted and understood plan. Discussion with key stakeholders during set up, including local providers and community members, helps to identify the best methods for obtaining community input. This example included the use of a volunteer steering committee, community meetings (ineffective in this case) and easily returned questionnaires widely distributed by mail and media to households and the community. A key outcome was the emergence of local leadership in both the steering committee and in local champions to communicate about primary health care with their communities. (Hodgson, Meredith)

The Victorian Government wants communities to have the central role in defining, delivering and managing strategies, structures and processes to improve the contribution of rural and regional health services to community sustainability. To enable effective participation by community members the Rural and Regional Health Services Branch of the Department of Human Services is planning a three-year training program to improve the skills of local boards of management. (Pollerd, Ian; Pulvirenti, Mariastella)

South Australia has instituted a program to improve the sustainability of health and human services in rural communities based on collaboration between government and non-government agencies to establish locally responsive sustainable models being trialed in Millicent. (Beisiegel, Rachel)

#### *Participants' recommendations*

- A reference for “101 ways for community engagement” must be developed, collated and researched.
- Through the consumer representatives on the National Rural Health Alliance and other consumer groups and individuals, an infrastructure has to be developed to grow and strengthen the consumer presence at the 8th National Rural Health Conference, aimed at delivering a consumer representation strategy encompassing formal and informal networks.
- There have to be more consumer papers and greater consumer contributions within the Conference program. There have to be fewer policy-type papers and more clinical “grass roots” papers to encourage greater consumer involvement.
- Alliance members and governments have to encourage and assist rural communities to a radical change of stance in health workforce and health service markets from passive to active engagement.
- Alliance members and governments have to commit to build the capacity of rural communities for active engagement in workforce and service markets.
- Primary health services for rural areas should be provided by community-based organisations not Government departments.

#### **Communities in action**

Community representatives reported on a number of examples where community initiatives resulted in needed services being retained or more viable services delivering a wider range of functions than those previously available being established.

In Tasmania the West Coast Health & Community Service provides a wide range of social and health services through multiple service providers. While the multiplicity of providers created barriers, service delivery gaps and duplication, the resolution of a recent crisis and more funding is leading to better integration. (Vause, Lee)

Despite an apparently dysfunctional community the Kentish, NW Tasmania, health centre has been able to quickly set up a comprehensive health service by identifying and nurturing opportunities for providing services by community members and by co-operating with existing providers and involving critics. (Stemm, Mark; Hill, Coralanne)

Despite the predicted increase in dementia sufferers Tasmania has not yet implemented the Tasmania Dementia Health Care Plan. Current services are poorly resourced and co-ordinated and lacking in rural areas. The Westbury Community Centre could be a model for other services. It provides a twice-weekly day respite service which is well accepted by its rurally based participants. (Campbell-Smith, Mollie)

The Gippsland Helicopter ambulance, now known as HELIMED, began in the 1970s. During the 1990s the State Government wanted to close it down. The service survived because a loose coalition comprised of staff and community supporters, service clubs and industry groups and the regional media undertook an effective media campaign and political lobbying. The survival of health services in rural communities depends on active community support. (O'Meara, Peter; Houge, Terry)

#### *Participants' recommendations*

- The role of the carers has to be acknowledged and there has to be recognition that carers require emotional and financial support, education, training, domiciliary and respite services.
- Service providers have to be encouraged to develop dementia-specific day centres with secure areas in rural community centres.
- A common assessment tool and case management model has to be developed to avoid over assessment and improve service co-ordination.
- An ongoing education campaign has to be undertaken to raise public awareness of dementia, increase understanding for workers and help remove the stigma.
- There need to be:
  - practical changes to service delivery;
  - more dementia specific rural health centres;
  - more selected and trained dementia staff, co-ordinators and volunteers;
  - community education; and
  - essential funding to support more rural dementia services and research into Alzheimer's origin and prevention.
- Providers have to fund packages of care for the unpaid carer to establish and implement their "Plan of Caring". This interfaces with the care planning for the dementia client ensuring a sustainable holistic care approach.

#### **Operating a service**

Recent research has identified new ways of delivering human services in rural and remote

areas, which avoids common problems with delivering evidence-based policy. Success requires openness, trust and commitment between all stakeholders during policy development, service delivery and evaluation. The necessary dynamic linking of service establishment, delivery activities, improvement of outcomes and evaluation of the policy's effects is achieved by establishing reflective (feedback) processes where all involved (including policy makers) can learn from their experiences as the services are delivered and used and, as a result, continuously do better. (Stehlik, Daniela; Chenoweth, Lesley)

More specific experiences with the delivery of a variety of services were also reported.

Communities in rural and remote Australia are providing quality aged care to their seniors and working hard to deliver individual solutions to their particular situations and needs. Identified success factors were:

- Governance and management: strong visionary local governance; effective business management practices; open communication; significant involvement of consumers and community stakeholders;
- Client centred quality: a client centred service; an accessible service; quality in all aspects of service; and
- Organisational dynamics: major emphasis on staff and their development; effective managers working with strong teams.

Rural and remote areas do face challenges but they also benefit from strong community support and being forced to be innovative. Government can play a role in nurturing such innovation by disseminating information and developing indicators so providers and communities can evaluate their success. (Beatty, Dianne)

From January 2002 the North West Queensland Allied Health Service (NWQAHS) provided primary health care: early intervention, primary and secondary prevention to 11 communities. Staff recruitment and retention strategies are evaluated together with the challenges faced by the Service. (Ashworth, Elaine; Batty, Kristine)

Southern Agcare provides an independent, free mobile counselling service operating within the central and Lower Great Southern in Western Australia supported by a mixture Commonwealth, State and local government

funds, in kind donations and client donations. It supports two financial counsellors who provide budgeting and advocacy for people in financial crisis, and four family counsellors to provide personal, couple and family counselling or mediation. The services are in demand and growing at about 30% a year. Clients respond favourably to services they receive. (Byles-Drage, Helen)

A client focused, social model of health is used to deliver a co-ordinated sexual assault service offering confidential medical and forensic examinations, counselling, information, court support and community education through 10 hospitals in the Mt Isa Health District. (Byrnes, Kaye)

#### *Participants' recommendations*

- That policy makers need to recognise the barriers to enacting policy and implementing it at community level and consider reflective and evaluative measures to ensure these are supported and enabled.

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## **Planning and developing services**

### **Information for planning**

The Australian Institute of Health and Welfare is shortly to publish four reports to provide consistent regional, rural and remote health information at a national scale. These reports will cover: a framework for rural health information; an analysis of mortality of people living outside major cities together with a summary report; a report in which measures of health status, health determinants and health system performance are reported against the framework mentioned previously and a geographic concordance which demystifies and translates between the three measures of remoteness ie the Rural, Remote and Metropolitan Areas Classification (RRMA), the Accessibility/Remoteness Index of Australia (ARIA) and the Australian Bureau of Statistics (ABS). (Phillips, Andrew)

However, in some situations the current geographically based indexes of remoteness are inadequate for assigning health delivery priorities on a national or state-wide basis. The work of the Rural Workforce Agency Victoria using more sensitive indicators could provide a basis for developing a National Index of Primary Health Care Access. A government funded scoping study would be a first step toward the development of such an index. (Kosmina, Sharon)

Currently, Queensland Health uses a standardised model to determine the expected level of need for general practitioner services in rural and remote Queensland. This model is used to manage the State's medical workforce eg to determine areas where overseas trained doctors can be registered, help communities to recruit and retain doctors or help postgraduates assess the viability of a medical practice. (Lennox, Denis)

At a regional scale the Mid Western Area Health Service (MWAHS) of NSW has developed a model for service distribution taking population base, equity of access and distance from other services. This model is based on weighting formulas taking account of age distribution, Aboriginality, population density and post secondary education. Staff are allocated to sites based on current average provider to population ratios. (Lea, Anne)

#### *Participants' recommendations*

- Tools that measure access to and isolation from health care services should reflect the time taken for travel associated with vast distances in some areas.
- The three models for measuring access to and isolation from health services have to be advanced and supported as tools for assessing health workforce needs in rural and remote Australia.
- Priority has to be given to development of better tools to support co-operational planning and action to build local health workforce capacity.

### **Including stakeholders' views**

Nationalism and cultural values and myths influence media presentations and public perceptions of rural and remote health practitioners. Particular lobby groups and professions have been able to advance their values and interests using these processes. Some of these have been successfully transplanted from the media to political policies and program structures. (Fitzpatrick, Lesley)

A National Rural and Remote Allied Health Advisory Service (NRRAHAS) has been established in Canberra with funding from the Commonwealth's Office of Rural Health. This required the two peak national bodies representing rural and remote allied health professionals (Services for Australian Rural and Remote Allied Health (SARRAH) and Australian

Rural and Remote Allied Health Taskforce of the Health Professions Council of Australia (ARRAHT)) to articulate allied health issues as well as the ability to advocate the community's needs. The new organisation should allow rural health policy to better incorporate improvement in the capacity for the allied health workforce and the provision of allied health services. (Adams, Robyn; Lowe, Shelagh)

The General Practice Partnership Advisory Council (GPPAC) advises the Federal Minister for Health and Ageing. It assesses current issues impacting on contemporary general practice; and proposes policy options and advising on program development to meet the needs of Australian consumers for accessible, viable and quality general practice. Its current activity covers chronic diseases, access and integration of GP services in the short, medium and longer term. (Maxwell, Jill)

#### *Participants' recommendations*

- That work continues by NRRHAS and the allied health professionals Associations to develop and promote the working definition of allied health as applicable to rural and remote Australia.
- Employers of rural and remote allied health professionals should:
  - aggregate the local demands for allied health professional education and co-ordinate a combined response that will reduce duplication and achieve economies of scale in education provision;
  - re-allocate and amalgamate existing expenditure on training and education to facilitate larger scale, efficient and sustainable models of education and support provision;
  - use technology to facilitate efficient delivery of education and support that would otherwise be unavailable.
- Rural and allied health professionals require a centrally co-ordinated continuing professional education program—of equivalent standard across all disciplines and State and Territory boundaries.
- Rural allied health practitioners have to be recognised as instrumental members of the rural health team and have to be involved in

the development of policy and planning at the State and Commonwealth level.

- Jurisdictions have to endorse and support collaboration between providers of allied health practitioner education, training and support—so that jurisdictions can develop appropriate and cost effective models utilising existing proven frameworks and resources.
- The NRHA, General Practice and Rural Women's organisations have to lobby the Minister for Health and Ageing to approve, release and fund the GPPAC rural female general practitioners' recommendations.

### **Possibilities for improving services**

#### ***Women's health***

Women's Health Australia is a large-scale 20-year longitudinal survey which began in 1996. It covers 3 cohorts of women: young (18–23); mid-age (45–50) and older (70–75). Older women have the best mental health and younger women the worst. Rural and city women have equivalent levels of mental health even though rural women have poorer access to services. Older rural women report high levels of neighbourhood satisfaction and access to social and practical support, but the mid-age and younger women are in the same situation as urban women. The data suggest that strategies to support and maintain a sense of community in rural areas are essential to maintaining good emotional health among women in the bush. (Lee, Christina)

Rural women in midlife who are seeking help for psychological distress consult a variety of health practitioners, with GPs being the most frequent. GPs could provide a service which did not automatically stigmatise mental health problems. But improvements are needed in the attitudes, knowledge and communication skills of individual GPs. Further, the lack of GPs in rural areas means poor access to their services. Some of the women's problems are difficult to address because of perceived stigma of psychological distress and lack of privacy. More medical and non-medical support services are required, together with a wider choice of helping strategies and continuing monitoring of rural women's mental health. (Outram, Sue)

Rural women who experience domestic abuse tend to be isolated. They are more likely to be threatened with a firearm. They were inhibited from seeking help by isolation, distance, and

fears about confidentiality, social relationships between the abuser and help providers, poor rapport with doctors, previous adverse responses and fear of disbelief. They were more likely to seek help when help providers could engender trust and were non-judgmental, and confidentiality and anonymity was assured. No health worker had breached confidences but police or court contact lead to community awareness. The women found the resulting community gossip distressing. (Loxton, Deborah; Hussain, Rafat; Schofield, Margot)

#### *Participants' recommendations*

- The Australian Longitudinal Study on Women's Health has to continue to be funded by the Commonwealth Department of Health and Ageing in recognition of its role in identifying issues for rural women. Consideration has to be given to a parallel study of men's health which has to include a component that looks specifically at Indigenous men's health in remote areas.

#### **Information technology**

Queensland Health is progressing a State-wide approach to the deployment of telehealth infrastructure and applications. The approach integrates telehealth technologies into existing services to enhance the delivery of health care to rural and remote communities by using telehealth for direct client care. The funding model will encourage funding to follow activity and resource use. Queensland's success could form the basis for a national model of sustainable funding for telehealth to achieve equitable access to health services in rural and remote activities. (Parkinson, Cathy; Hudson, Lisa; Hornsby, Danielle; Madl, Romana; Collins, Nikki)

Rural patients find it difficult to get information and have their cancers tested. Visiting medical specialist clinics in country centres in SA, NSW and NT were set up and telemedicine used for case discussion between the visits. In Darwin these services were upgraded to the point where patients did not need to go to Adelaide for pre-radio-therapy planning, local health practitioners were trained to carry out ongoing treatment and follow-up locally. This was made possible by linking Darwin's CT scanners with the Royal Adelaide Hospital Oncology Department. There are two models for establishing a radiation oncology unit in Darwin, either a subsidised private centre or a "hub and spoke" model where the NT becomes part of an established advanced cancer centre. A centre should be established to study models of service for

oncology to rural Australia. (Penniment, Michael; Katsilis, Angelo)

#### *Participants' recommendations*

- National continuity of care funding strategy has to support improved shared patient information services and hand held computerised devices with centralised patient/client records and privacy arrangements for primary health care teams.
- The quality of the technical infrastructure and clinical processes of telehealth activities must be addressed at an enterprise-wide level, not by individual clinics or projects.
- The variable costs associated with telehealth activities must be funded in a standardised way across an entire health service.
- The classification of telehealth activities according to casemix must be driven at a national level, as has occurred for casemix research performed to date.
- Where evidence exists, the Medicare benefits schedule should include item numbers that reimburse service providers for telehealth consultations, in order to redress the inequity of access to services in rural, remote and regional Australia.
- Registration boards and relevant professional bodies need to develop a national position on cross-border clinical practice in the context of telehealth.
- The option of funding telehealth, supplied by private providers on a cost and volume agreement basis, needs to be investigated at the national level

#### **Rural dental services**

Tasmanians have poorer access to dental care than do inhabitants of other States. To pilot improved approaches new clinical teams of dentists and dental therapists have been established. They have an extended role working with new programs covering oral health promotion, prevention and timely interceptive dental care in targeted communities. The pilots will be analysed to assess risks, quality, costs and accessibility as evidence for further dental workforce development. (Cane, Rosemary)

#### *Participants' recommendations*

- Oral/dental health has to remain on the national health agenda as a high priority.

Assistance is needed from organisations such as NRHA to support and encourage the dental nurses/dental hygienists and rural/remote dentists to participate in forming a special interest group, which could sit at the NRHA Council as a Member Body.

### ***Health promotion by rural pharmacists***

Pharmacists and pharmacy organisations generally take a narrow interpretation of health promotion, essentially equating health education with health promotion. Pharmacists can have a wide role but are restricted by their location in a pharmacy and generally narrow understanding of the possibilities of health promotion. The introduction of automated prescribing could threaten the profession and health promotion based on community respect for pharmacists. Co-operation with other health professionals and community participation could provide other ways toward future viability and professional satisfaction. (Howarth, Helen)

#### *Participants' recommendations*

- The Government has to continue to support the Rural Pharmacy Package, as it has shown positive results for rural communities in recruiting and retaining pharmacists in rural areas.
- If collaborative programs such as Chronic Disease Self-Management and Enhanced Primary Care are to be successful, government must examine opportunities for re-imburement of allied health and pharmacists' time in such initiatives.
- The Pharmaceutical Benefits Scheme (PBS) should not be seen as a cost to Government but rather an investment in health, particularly considering there is less pharmaceutical benefits scheme "investment" in rural areas compared to metropolitan areas. The Government should support and work with pharmacy, medical, consumers and allied health to implement greater access to PBS and pharmacist care in rural areas.

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## **Planning and development of the workforce**

### **Educating health workers for rural and remote Australia**

The James Cook University School of Medicine course began in 2000 with the mission of training doctors for practice in northern Australia emphasising rural, remote, Indigenous and topical health. Early evaluations suggest students are developing sound understandings of these fields with many considering careers in them. Long-term evaluation will be needed to gauge the effectiveness of the current strategies. (Sen Gupta, Tarun)

Flinders University's Parallel Rural Community Curriculum (PRCC) was developed in 1997 so senior medical students could undertake an entire clinical year based in rural general practice in the South Australian Riverland. Despite the PRCC's success it is not clear if the success has been due to the distinctive characteristics of the Riverland. To further establish the Program's likely success in other areas of Australia, a second and similar program has been developed for the Greater Green Triangle Region and initially evaluated. (Walters, Lucie)

### **Helping students move to their professional life**

There are a number of programs to help students begin their life in rural and remote health services. The graduate assistance and partnerships program (GAP Program) supports all graduates as they make the transition from student to health professional. It will take the form of "alumni membership" of a communication network with supporting infrastructure to facilitate discussion, peer-support and access to information about discipline-specific and cross discipline resources for new graduates, including mentoring and professional support programs and professional associations. (Bryg, Christopher)

The Rural Australian Medical Undergraduate Scholarship Scheme (RAMUS) requires scholars to select a practising GP as mentor. This Rural Doctor Mentor Program is designed to complement and develop the scholar's rural life experience. It requires regular contact between the mentor and the scholar together with a mutually developed learning plan to guide their rural health experiences and mentor contact. The scholar and the mentor must report on their resulting experiences. Evidence to date shows

that the mentoring relationship is helpful but the results depend on the amount of effort both participants put into it. (Brophy, Carmel)

### **Attracting health professionals to rural and remote Australia**

Some papers at the conference emphasised the issues associated with retaining general practitioners in rural and remote areas. Other professions are likely to confront similar issues.

A needs assessment is the first stage of a project which aims to address the high rates of rural and remote health staff turnover through a postgraduate workplace psychology course. Work in rural health potentially offers some factors important to high levels of worker motivation and satisfaction and hence low turnover. Intervention to reduce workers' negative perceptions of management, resourcing deficits, career development and rural disadvantage are likely to reduce turnover. It appears that the turnover problem is not inevitable given the positive aspects of work in rural health, but rather that urgent action must be taken to address the factors identified as dissatisfying. (Kennedy, Barbara)

Successful retention of GPs in rural and remote situations requires giving the GPs a greater sense that they are being actively supported, making their access to support visible and uncomplicated, paying more attention to developing their professional and social networks, preparing both families and practitioners for rural life, and support organisations which recognise and help struggling GPs. Retaining a GP in a rural or remote situation is a process which requires continuous attention. Relocation by the GP to another rural area cannot be considered to be retention. These issues are likely to be common to most rural health professionals. (Veitch, Craig)

The Commonwealth makes an additional payment to GPs practising in rural and remote areas to encourage them to stay there. Those in the most remote areas get the most. There are administrative arrangements to even out differing work regimes such as fee-for-service versus salaried general practice. There have been some administrative difficulties but these have largely been resolved. There is anecdotal evidence that the payments have helped retain doctors. There will be a demand to extend the scheme to other health care workers but there is no obvious payments agency or mechanism for these groups. (Seward, Mike)

Doctors who practice in rural and remote areas are more likely to be regularly engaged in critical emergency treatments employing an expanded skill base. This likelihood increases as the remoteness and isolation of the practice increases. Programs designed to support and remunerate doctors need to take account of the variations in costs of practising and the availability of professional support for rural doctors. Rural GPs play a key role in ensuring that their communities have equitable access to medical services. Communities highly value this local service provision. Effective retention strategies must take account of the nature and complexity of rural general practice. (Mildenhall, David)

Visiting Medical Practitioners (VMPs) at Kalgoorlie are concerned that frequent changes in the hospital workforce reduce their efficiency and effectiveness. Reduced availability of allied health staff reduces the quality of service at Kalgoorlie Regional Hospital and affects the quality of medical service. From interim analysis the reasons for high staff turnover included "moving on", maternity leave, financial reasons and working relations with the VMPs. (Reid, Philip)

### *Participants' recommendations*

- Rural managers have to be educated on how to build and support their workplace to enhance well-being at work and reduce staff turnover. If rural managers are supported to have that education and supported overall it will go down the line.
- There is no data on rural and remote health workforce apart from in medicine to enable planning. This must be remedied.
- In order to ensure the provision of viable health and medical services to rural and remote Australians and the sustainability of their communities, governments should factor differences relating to the nature and complexity of rural and remote practice activities into differential measures designed to support and remunerate rural doctors.

### **Recruiting the workforce**

Success in recruiting people for health careers in rural areas must be broadly based on strategies founded on sound appreciation of the factors which make these careers attractive to the largest possible pool of recruits.

Queensland's Health Careers in the Bush (HCB) program, founded in July 2001, has established a State-wide, co-ordinated program to recruit year 10 and 12 Indigenous and non-Indigenous students to health careers. HCB has replaced previously *ad hoc* efforts by rural health organisations. Post 1998 evaluations indicate that workshops for year 10 and 12 students held since 1995 have been successful in encouraging students to choose careers in the health sector. (Hindmarsh, Natalie)

The evidence for selectively promoting rural health careers to secondary students is not strong. Given Australia's population structure the recruitment of rural students to health care is probably close to its limit and including urban students will increase the availability of willing recruits. Recruitment programs should first ensure equity of access for rural students and then seek to maximise rural health recruitment potential by promotion which includes rural, fringe urban and metropolitan areas. (Kelly, Heather; Chesters, Janice)

Support for rural and remote clinical placements for nursing students currently favour students with rural and remote backgrounds because it is assumed they are more likely to return to and remain in these areas. Students from urban backgrounds are overlooked. Experience shows that many city people find country life appealing and spend years working and living in rural Australia. Properly supported and encouraged nursing students from urban backgrounds could form a resource for future rural workforces. (Taylor, Kerry Anne; Neill, Jane)

The range and availability of health services in rural areas has declined and current approaches to recruitment and retention do not work. There are examples from the School of Clinical Sciences Charles Sturt University, Wagga Wagga, of partnerships between education providers, rural communities, local government and health employers that can make rural practice more attractive to students. (Francis, Karen)

Twenty-two Australian reports evaluated the outcome of program and services aimed at improving recruitment and retention of rural GPs. The nine initiatives considered in the reports were: medical course admission criteria favouring rural students; rural student placements; student scholarships; financial incentives; continuing medical education; university linked rural practices; case management; overseas trained doctors and

community capacity building. Overall, there is not yet strong empirical evidence for the efficacy of any particular initiative in Australia and the available evaluations have significant deficiencies. A nationally co-ordinated, adequately funded, long-term research and evaluation program is needed to determine the effectiveness of rural workforce recruitment and retention strategies. (McDonald, John)

Little research has been done on the factors which influence urban background doctors (in Australia 50 per cent of rural doctors) to enter rural practice. Rural background students are more likely to prefer a rural career because they are familiar with the environment whereas urban background students are more likely to have altruistic motive or to be seeking adventures. Both males and females emphasise the importance of lifestyles, with women giving priority to family, while men see location as following their career choice. Students highly motivated by altruism tend to prefer salaried positions to private practice although all see corporate practice negatively. Strategies such as community placements, locations, work structures and fixed-term rural work could make work in rural areas more attractive. (Tolhurst, Helen)

#### *Participants' recommendations*

- Any high school health careers programs have to target Indigenous young people in late primary and early high school years.
- Scholarship and other support structures criteria for secondary and tertiary students planning to undertake a career in any health profession have to be broadened to include students from metropolitan and metropolitan fringe backgrounds/origins who demonstrate an interest in rural/remote practice and mature age groups.
- The National Review of Nursing Education recommends targeted assistance for the development of nursing research. As the majority of rural nursing schools are not represented by University Departments of Rural Health or Rural Clinical Schools, it is recommended that at least one-third of rural health research dollars be quarantined for rural nursing research. A committee of senior rural nurse academics from regional universities should oversee the development of this program.

- A gap has been identified whereby students are not making a transition from undergraduate to postgraduate procedural practice.
- That the NRHA, heads of nursing, nursing policy branches, leaders of nursing education, peak nursing bodies, local government and community leaders, lobby and support the Commonwealth and State Governments to develop 20 Rural Regional Nursing Clinical Schools (RRNCS) across Australia.
  - The RRNCS model must facilitate the development of flexible collaborative models between universities and health services across regions in rural Australia.
  - Each RRNCS should be adequately resourced to provide undergraduate, postgraduate and research programs all aimed at developing a skilled sustainable rural nursing workforce including clinical, educational and management components.
  - Over a 3-year plan each RRNCS receive 100 additional HECS funded undergraduate nursing places. RRNCS should be linked to each other and Departments of Rural Health.
  - Over time, each RRNCS should move towards an interdisciplinary based clinical school bringing on board allied health streams as funds become available.
- That the Commonwealth Government/GPET review the effectiveness of compulsory rural and outer metropolitan terms in GP training, with respect to the quality and quantity of workforce, and long-term retention.

### Supporting professional development

Interdisciplinary learning and distance learning using modern technology are both being used in professional development programs. But participation in and access to professional development programs is variable and depends on the institutional framework of the workplace.

The Rural Inter-professional Education project aims to develop a generic inter-professional learning curriculum model for health

professionals. Volunteer medical, nursing, pharmacy and physiotherapy students have undertaken projects and placements in a community-based primary health care context. Qualitative and quantitative evaluations have indicated mutual benefits for all participants and enhanced student learning about inter-professional practice through experiential learning. (Stone, Nick)

Because the professional development and continuing education of allied health practitioners is relatively neglected a two-year multi-disciplinary continuing professional education project for both public and private practitioners is being undertaken in Victoria. After extensive consultation to identify needs, information technology (internet, email and video conferencing) is being used to establish networks, deliver training and provide information. Workshops and well-resourced libraries and links to local clinicians have also been developed. Programs need to be led by rural health practitioners through local health services or associations. (O'Reilly, Clare)

The Allied Health Professional Enhancement Program (AHPEP) provides professional development and support opportunities for fourteen allied health professions (audiologists, dietitians/nutritionists, occupational therapists, orthotists and prosthetists, orthoptists, pharmacists, physiotherapists, podiatrists, psychologists, radiographers, social workers and speech pathologists) employed by Queensland Health in remote, rural, provincial and metropolitan areas. A structured application process helps participants identify their goals and locate opportunities throughout the State. In its first year this program had helped participants feel less isolated, network more efficiently, have peers validate their work and understand the rewards of working in remote and rural areas. (Abernathy, LuJuana)

Every second Tuesday evening the Rural Health Education Foundation broadcasts an educational program to 550 hospital-based sites in the Rural Health Satellite Network. The audience can interact with the expert panel providing the broadcast material. The Foundation archives all programs on its website. (Perlgut, Don)

General Practice Education and Training aims to have in place, by 2007, regionally proved, high quality, innovative, responsive general practice education and training programs which meet the needs of communities, individuals and general

practitioners across Australia by enabling practitioners to meet the standards set by the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM). (Coote, Bill)

The Australian National Council on Drugs (ANCD) has identified that alcohol and other drug workers based in rural and regional centres are less well supported and have fewer training and development opportunities than urban colleagues. Better relationships and processes are required for co-morbid clients. ANCD has held workshops to address these issues and the outcomes have included recommendations covering general practitioner training, national standards and clinical guidelines. (Price, Karen)

#### *Participants' recommendations*

- Rural Inter-professional Education should be included in all undergraduate health courses. It should include: an explicit and discrete focus; formal assessment and recognition and a community-based component. It may or may not be elective.
- Government, university and other co-ordinating bodies have to collaborate to conduct research, develop and maintain a pool of advice, exemplars and other resources to assist those undertaking community-based learning activities in the health disciplines.
- Access to educational resources such as video-conferencing has to be increased by providing training and ensuring access by all practitioners.

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## **Improving treatments and developing skills**

Papers in this section largely describe practical experiences with the provision of health services to patients or with upgrading skills. Many papers underline the importance of co-ordinated team approaches to the delivery of care together with the active involvement of patients and their relatives and friends in achieving successful management and treatment of their conditions.

### **Mental Health**

There will be a continuing increase in the demand for mental health services in rural Australia. Despite recent increases in resources and improvements in the structure of Australian mental health services this demand will have to be met by the mental health sector forming

partnerships with other organisations such as welfare organisations. (Groom, Grace)

The NSW Central West Division of General Practice now operates 5 different approaches to delivering psychology services—a travelling psychologist, using locally available private resources, using a clinical psychology registrar, operation of diagnosis specific groups and telepsychology. (Wylie, Karen; Vines, Robyn)

#### *Participants' recommendations*

- There has to be comparable service for treatment of mental health across all regions that involves recruitment of well supported multi-disciplinary teams, across sectors (health, education, housing, etc) that have ready access to relevant professional development.

### **Diabetes detection and management**

There are six essential elements for an effective local case management model: greater knowledge and use of local services; improved access to proactive monitoring; named and helpful care co-ordinators; promotion of client autonomy and self sufficiency; protected time for care co-ordination and excellence in communication. Health workers and people with diabetes do not yet clearly understand the diabetes case management system. The systems must allow for the beliefs in the importance of medical or diabetes educator roles. Case management can be a safety net for sufferers who are progressing toward autonomy. Case management must be adequately funded if health workers are to dedicate adequate time to it. (Artridge, Judith)

#### *Participants' recommendations*

- It is time for diabetes care management to be explicitly funded in order to improve diabetes-related outcomes.
- Rural health services have to promote diabetes information and education support groups in rural and remote communities.
- Diabetes has to remain a health priority area with ongoing attention from health practitioners and those funding health services.

### **Cancer**

A consumer driven process has resulted in setting up more effective community cancer support groups in country areas involving

service providers and consumers. (O'Connor, Lera; Shepherdson, Judy)

The availability of a specific case manager for prostate and bowel cancer patients in the Western District Health Services area has greatly improved the integrated delivery of services to patients and hence patient care and outcomes. (Willder, Stuart)

#### *Participants' recommendations*

- There has to be substantive action to ensure equity across the States and Territories in regard to access to mammograms and resources available to Indigenous and non-Indigenous women, particularly in remote communities.

### **Chronic diseases**

In all patients with asthma, allergy triggering is possible. Diagnosis can be helped by understanding the pattern of asthma, recognising that allergic reaction may play a part in the disease and listening to patients' views on the possibility of allergies causing their asthma. Health providers should guide patients through the process of deciding if their asthma is being caused by allergies and lead discussion of management options. (Luttrell, Christopher)

The delivery and effectiveness of pulmonary rehabilitation programs in the Northern Rivers Area of NSW has been significantly improved. A specifically funded program has improved patient access better information on the availability and benefits of rehabilitation, delivery in regional, local and home settings, employment of skilled staff to train and support providers in local settings, provision of best practice guidelines to deliverers, providing the necessary equipment on loan and funding to deliver each program. Patients and their partners report improved quality of life and disease management skills, most notably in the domestic setting. (Barrack, Cecily)

#### *Participants' recommendations*

Strategies have to be developed to promote the incorporation of chronic disease self-management into the organisational planning of health programs and practices even though this will increase costs.

There has to be education for rural and remote GPs re simple testing for allergies and new management options for asthma and allergies, leading to planned treatment self-management programs for patients/parents/carers/schools.

### **Emergency**

Improved training of nurses in South Australian rural hospitals to provide after hours triage will improve their ability to provide support for the local rural GPs. This should lessen the load on GPs. (Fleming, Jenny; Sumner, Karen)

A "1800" dedicated telephone line provided by the North West Regional Hospital in rural Tasmania gives general practitioners direct access to the senior emergency medical doctor for advice on stabilising and transferring seriously unwell patients. This service has developed into an emergency medical network with a continuum of teaching, advice and assistance for a broad range of adult and paediatric problems. (Arvier, Peter)

In Victoria the rural emergency skills training (REST) program has successfully piloted two day courses for training Overseas Trained Doctors (OTDs) in rural practice in key emergency procedures using specially trained experienced rural GPs. In future these courses will be held 4 times a year for all rural practitioners. (Campbell, David; Uppal, Veeraja)

#### *Participants' recommendations*

- Governments have to commit to the development and maintenance of rural nurse education and training in after-hours triage. This education and training program should be developed in consultation with local GPs and communities.

### **Pregnancy and childbirth**

At Wangaratta Base Hospital, Victoria, a program staffed by 5 annually credentialed midwives cares for 120 families a year. Each woman who enters the program is assigned a primary care midwife who is responsible for managing all aspects of care, including ordering pregnancy related diagnostic tests and routine medical assessment after the 18 week ultrasound until 6 weeks post partum. The qualitative and quantitative success of the program is well documented. (Giles, Chris)

Current Australian policies of centralising obstetric services in a medical context in regional centres are unpopular with many women because their social needs are disregarded as well as posing additional medical risks. Experience both internationally and nationally strongly suggests that providing obstetric services in rural and remote settings leads to better and less expensive outcomes. Providing locally based comprehensive maternity care will

require providers to recognise the existing demands of consumers along with appropriate support, resources and education for service providers. (Kildea, Sue)

#### *Participants' recommendations*

- Comprehensive models of maternity care (including birthing services) in rural and remote areas that do not necessarily have on-site surgical facilities have to be re-established.
- Continuity of midwifery care should be available to all women in Australia.
- The Commonwealth Government has to follow the State lead and remove the barriers to the development of nurse practitioner models, by for example allocating provider numbers for payment of services and resolving professional indemnity issues.

#### **Dementia**

HACC funding has enabled the Albany Integrated Health Service in Western Australia to employ a dementia services co-ordinator to give sufferers and carers better access to the wide range of services which are available to them. (Pearson, Lesley)

A 92-year-old woman was wrongly diagnosed as cognitively impaired by a city service and placed in a rural aged care unit in Warrnambool, Victoria. It took 15 months and 14 different rural health and legal professionals to reverse this bad decision and return her to her Melbourne home. It takes a very long time to reverse a bad decision. (Brumby, Susan)

#### *Participants' recommendations*

- In dementia there has to be a continuum of care in particular from the comprehensive early intervention assessment through to permanent care placement. There has to be a mobile "package of caring" for the client that moves seamlessly across a range of settings including acute, community and residential care with linked funding.
- Because Nurse Practitioner model for early assessment with timely management for simple medical issues can have a profound effect on the dementia client it should be provided in both the residential and community setting.
- Advocacy services must not just cover disability but also elderly people and this

access should be readily available in both rural and metropolitan areas. These services need to be independent, external services that are easily accessible to their clients.

#### **Palliative care**

The National Palliative Care Strategy established palliative care as an integral part of health care across Australia, routinely available within local communities to those people who need it. The Griffith Area Palliative Care Service (GAPS), within the Griffith LGA and Carrathool Shire areas of NSW, is a two year pilot study to provide strategies for successfully delivering a palliative care service through a truly integrated approach to providing care for patients, their carers and families in rural/remote areas. (Hatton, Ian)

#### **Evidence-based practice**

Significant time and resources have been allocated to increasing evidence-based practice (EBP) in disciplines like medicine and physiotherapy but using evidence to inform practice is new to many health disciplines, particularly in remote locations. Currently policy approaches assume disciplines are at comparable stages in understanding and adopting EBP but no framework exists to build and implement uptake by multi-disciplinary teams operating in rural and remote situations. Rural environments make it difficult for practitioners to adopt EBP so policy and funding need to improve access, professional development, practical relevance and encourage uptake. (Murphy, Angela)

High quality, locally adapted evidence-based guidelines for the management of back pain in a rural community in Victoria had not been taken up because of questions of power and politics. Reasons included; failure to engage GPs, concerns about GP autonomy, GPs' preference for medical rather than multi-disciplinary treatments, its impact on the availability of hospital funding, patients wanting to avoid a mental illness stigma and resources for patient education being directed toward acute health. In rural and remote areas successful implementation of evidence-based practice will have to recognise and overcome these problems. (McDonald, John)

In two South Australian rural aged care facilities the best available treatments for, or management of, specified common clinical problems were identified. Nurses and carers interpret this evidence and translate it into practice. The staff's

knowledge and awareness of evidence base practice have increased. An ongoing education and follow-up is in place for clinical staff. (Blue, Ian; Taylor, Judy; Walker-Jeffreys, May)

#### *Participants' recommendations*

- Larger research studies are required in rural aged care organisations to determine attitudes to and use of evidence-based practice and education and training programs to implement use of evidence in daily practice.

### **Using electronic communications technology**

The Midwest Health Service of Western Australia has established a pilot program applying videoconferencing technology to clinical and non-clinical programs in April 2001. The paper covers examples, key success factors and failures in the establishing a network throughout multiple, small scattered communities. (van Ast, Penny; Hall, Maeva; McDonald, Sue)

Health services managers are often solely responsible for ensuring the viability of day-to-day services while simultaneously managing radical service change. Participants in the Electronic Advanced Learning Set (EALS) pilot project in Western Australia have used a range of electronic technology (with limited face to face meetings) to form action learning project teams and collaborate in a change management process within and across geographical regions. The paper presents an evaluation of the practicalities of using electronic media and action learning/reflective practice to develop and support learning communities in rural health services. (Roche, Val)

In the Midwest of Western Australia therapists get to a community once a month. Videoconferencing has become an important option in the Midwest by enabling therapists and Integrated Therapy Assistants (ITAs) to work together to model roles for a therapy program, to allow therapists to supervise ITA sessions with clients, to allow ITA to watch therapists assess a client and the ITA to watch a treatment session by a therapists for training purposes. (Hall, Maeva)

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## **Recognising the whole person**

### **Helping people cope with changes in their lives**

Current socio-political developments are marginalising pastoralists in SW Queensland. A framework informed by grief and loss theory could help service providers to work effectively with them in relationship and family counselling, health promotion or policy development. (Darracott, Rosalyn)

When people are disabled their life changes. Medically treating just their disability will probably not help disabled people to achieve their optimum health results. Health care professionals can help people work out their priorities, maintain relationships, advocate rights and help people to cope with physical and social adversity. They need knowledge and attitudes to allow them to do this and to recognise that a disability is a continuing journey rather than a final destination. (van Erp, Ansmarie)

#### *Participants' recommendations*

- Treatment and support practice has to:
  - expand viewpoint beyond disease-centred to person-centred
  - extend health care to other health professionals
  - explore scenarios to enable people to remain in their own home if that is their wish.
- The use of qualitative research in rural and remote health has to be encouraged.

### **Therapies**

Laughter therapy is cheap to administer, needs minimal equipment, has many documented benefits and can be delivered equally well in an urban or rural location. This Tasmanian project has shown that it is a valid treatment option for people with chronic health problems, those who are socially isolated and people who are emotionally challenged. (Bishop, Robyn)

A multi-disciplinary exercise group, the self-expression, gentle exercise and music (SEGEM) group, provides physical activity to Orange, New South Wales, hospital residents in a popular form through a structured exercise program. (Brigden, Rosemary; Crossman, Tara)

The therapeutic touch practitioner uses intentionally directed processes of energy exchange to help the body relax and increase its own natural healing. Therapeutic touch helps people to experience a sense of physical, emotional, mental and spiritual wholeness and well-being despite illness, injury or imminent death. In a rural New South Wales pilot trial both recipients and practitioners found therapeutic touch helpful. It is a useful addition to rural health care, benefiting both patients and those providing the service and enabling the women involved to be change agents in their community. It can be taught to families and others for home use. (Gregory, Sue; Graham, Marg)

#### *Participants' recommendations*

- This session recommends the promotion of innovative programs (such as Self-Expression, Gentle Exercise, and Music) across many sectors and health disciplines; inclusive targeting of falls risk prevention programs with funding package opportunities not exclusively retained within Aged Care.

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## **Improved access to health services**

### **Pharmacy**

There is a rural pharmacy package which aims to overcome difficulties providing pharmaceutical services in rural and remote Australia. The Rural and Remote Pharmacy Workforce Development Program (RRPWDP), managed by the Pharmacy Guild under an agreement with the Commonwealth Government, is part of this package. It was established in 1999 to strengthen and support the rural and remote pharmacy workforce. It includes: an emergency locum service; a continuing professional education development scholarship scheme; an undergraduate scholarship scheme; a rural placement (internship) scholarship scheme for students; an Aboriginal and Torres Strait Islander undergraduate scholarship scheme; a rural and remote pharmacy infrastructure grant scheme; the placement of rural pharmacist academics at university Departments of Rural Health; a rural pharmacy newsletter; and a rural pharmacy promotion campaign. There have been fewer closures of rural pharmacies and rural pharmacy practice has become more attractive. (Thornberry, Fiona; Emerson, Lance)

Because pharmacists are relatively scarce in rural areas locums may not be available at short

notice, hence pharmacies are forced to temporarily close if the resident pharmacist is ill. This is a disincentive to rural practice and compromises the health of rural communities. As part of its Rural and Remote Pharmacy Workforce Development Program (RRPWDP) the Pharmacy Guild of Australia has established, with funding from the Department of Health and Aging, the emergency locum service. This service gives rural and remote pharmacists direct access to locums in emergency situations. (Anderson, Neil; Thornberry Fiona; Emerson, Lance)

Two pharmacies have successfully established a high quality pharmacy clinical service to aged care facilities and private homes in the Wagga, New South Wales, area from a facility established for that purpose. (Cooper, Mandy; Cooper, Carl)

### **Transport services**

The New South Wales Government Transport for Health program is intended to provide a better service for rural community members who need non-emergency health related transport to reach the health services they require. It aims to better co-ordinate public and community transport services available to rural people. (Olsen, Simon)

This year is the 75th anniversary of the aerial medical service of the Royal Flying Doctor Service (RFDS). The RFDS has grown to cover gaps in the services of other providers. It now provides nursing services, 3000 medical chests, outback medical clinics and a locum service and a mental health service. It will be there to serve the needs of people living in the outback as long as it is needed. (MacDonald, Gerry)

There is a continuing need for aero-medical evacuation services so the RFDS retrieval services have expanded greatly over the last 8 years. The RFDS still faces challenges in delivering patient-centred and cost effective services. (Grant, Duncan; Markwell, Susan)

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## Measuring performance

### Evaluating health service performance

An analysis of complaints to the Victorian Health Services Commissioner (HSC) over the period 1988–2001 has shown that rural Victorians complain slightly less frequently than urban Victorians. While this may indicate differences in the way services are provided, it could also mean that rural people are less aware of, or have difficulty accessing, the HSC's services. (Wilson, Beth)

The New England Area Health Service (NEAHS) of New South Wales has developed the Youth Friendly Assessment Tool (YFAT), including a staff self assessment tool to enable it to assess and improve the youth friendliness of its facilities, services and staff so it can plan for making youth health a greater priority including through earlier intervention. The tool may be useful to others. (Bartik, Warren)

In New South Wales the Mid Western Area Health Service (MWAHS) Primary Health Care Program (PHCP) needed to develop an overall system for measuring the quality of their service delivery so they could encourage benchmarking and evaluate effective and affective service provision to consumers. Performance indicators use the domains of: appropriateness; effectiveness; access; efficiency; safety; and consumer participation for both acute care and community-based services. All indicators are clearly defined and sourced so they are easy to use. Data collection has begun recently with analysis available soon. (Wade, Sue)

The Hepburn Health Service, Victoria, has developed and implemented a risk management program for its four campuses, which includes relevant clinical indicators, a review committee and a database for systematically reviewing clinical and occupational risks. (Latter, Stephen)

The successful use of Clinical Practice Improvement (CPI) methodology for improving the processes and outcomes of care involves the identification and diagnosis of a problem, the identification and implementation of interventions and their re-measurement to ascertain whether interventions have been effective. Projects in the New South Wales Southern Area Health Service successfully overcame barriers to implementing CPI. CPI is an effective tool to improve the quality of care in rural hospitals, despite relatively low resource levels and service volumes. (Mortimer, Jon)

### Evaluating program performance

Different States use differing approaches to delivering the Strengthening Support for Women with Breast Cancer program. Because of this complexity the national evaluation focused on the delivery structures in use (process) rather than measurable outcomes (impact). The assessment used consultations to identify common thematic outcomes and encouraged local evaluations to describe how strategies worked at that level. Future policy should address the needs of developing sustainable health initiatives that meet the local concerns of rural health professionals and consumers. (Campbell, Danielle)

This project attempted to evaluate the functioning of novel types of psychiatric services using outcome measurement tools and to assess the attitude of mental health professionals to outcome measurement. Shortage of staff, lack of adequate IT support on-site and technical difficulties limited participation. Staff need reasons and incentives to incorporate outcome measurement into routine practice, in addition to continuing training and support in time and resources from management. (Aoun, Samar)

Program evaluation is undervalued and neglected as a basis for academic research and learning. Primary health and service delivery are not easily susceptible to study through randomised controlled trials but evidence collected through more carefully designed and better funded program evaluations could form a basis for greater understanding of the effects of systems and policies. The methodology could help overcome the current credibility gap between research and evaluation. (Orpin, Peter)

# The symposiums

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## Healthy Horizons: Outlook 2003–2007

The main features of the Healthy Horizons Framework are outlined at Keynote 13—Policy know-how.

Healthy Horizons provides those involved with rural health with a way of expressing and sharing their aspirations and galvanising their efforts in an organised and professional way.

It has established an effective, working Framework, collaboration between governments and peak national rural health bodies, accountability for commitments made and a process to measure progress towards its goals and vision.

Everyone with an interest in rural health should use it at every opportunity, promote it with their colleagues and contribute to its development and implementation wherever there is an opportunity. (Snowball, Kim and members of the Rural Sub-committee of AHMAC)

### *Symposium recommendations*

- This Conference supports the seven goals and eight principles of Healthy Horizons Outlook 2003–2007. It calls on Health Departments and the NRHA to:
  1. Promote Healthy Horizons at all levels in the health sector, eg Area Health Services, health workers in the community
  2. Promote Healthy Horizons to organisations in other sectors, eg housing, employment, local government, environment, transport, etc
  3. Provide interim reports on progress against Healthy Horizon yearly in addition to the major progress report scheduled for 2005.

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## Sunday Symposium A~Unveiling the secrets of the allied health workforce

The National Rural and Remote Allied Health Advisory Service (NRRAHAS) reported on a comprehensive overview of the state of the allied health workforce developed using 2001 census data.

There are five major issues affecting this workforce:

1. In contrast to medicine and nursing there is no comprehensive workforce data collection for allied health professions. Effective planning and policy development for the allied health sector will not be possible until such data are available.
2. People living in regional and remote regions have poorer access to allied health professionals.
3. Throughout Australia half of those who have a professional qualification in allied health are actually employed in their discipline. Thus there is a significant pool of qualified professionals potentially available.
4. The number of Indigenous allied health professionals is startlingly low. This is a significant impediment to providing culturally appropriate allied health services to Indigenous people.
5. Less than half the workforce is directly employed through government agencies or departments. This is major issue for workforce planning and may significantly affect disadvantaged people's access to services. (O'Kane, Ann; Curry, Rob)

### *Symposium recommendations*

- That the National Rural Health Alliance lobby appropriate bodies to:
  1. Take responsibility and fund the collection and analysis of appropriate, accurate and comprehensive allied health professional workforce data for State and national levels, for the purposes of workforce planning and monitoring

2. Develop and fund a scoping project to investigate why allied health professionals remain in or leave their profession. Further, in the light of rural and remote workforce shortages, this project should develop recommendations to encourage rural and remote allied health professionals to keep working within their profession.
3. Fund the organisation of a national representative forum of rural and remote allied health leaders and other key stakeholders to investigate recruitment and retention issues and put forward recommendations to address them (this is in line with a similar recommendation from the 6th NRH Conference).
4. Lobby the Office of Aboriginal and Torres Straits Islander Health (OATSHI) (through the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework) to implement its recommendations regarding improving the level of Aboriginal and Torres Strait Islander participation in Australia's allied health workforce.

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## Sunday Symposium B~Sustaining rural and remote area nursing

This symposium reviewed the progress with the review of the rural and remote nursing workforce which had been undertaken since 2001 by the profession as a whole. The symposium refined and endorsed the "7-Point Action Plan" developed at the National Rural and Remote Area Nursing Forum, Canberra, 18 October 2002. (Lindsay, David)

### *Symposium recommendations*

- Recommendations 1–7 from the Action on Nursing in Rural and Remote Areas Project (2002), reprinted below, are supported.

#### *The 7-Point Plan*

#### **Recommendation 1**

There should be pilot projects to establish national locum relief and mentoring programs, and additional incentives for rural and remote nurses and midwives in areas that have difficulty attracting and retaining

staff. These additional incentives should include:

- reimbursement of relocation costs;
- an accommodation allowance;
- appropriate housing;
- financial recognition of qualifications and/or years of experience in remote settings;
- annual airfares to nearest capital city for nurses and midwives and their families;
- study allowances, including leave to access courses and financial support to attend;
- salary loading to reflect the degree of remoteness or isolation;
- education on local cultural issues; and
- regular isolation leave.

#### **Recommendation 2**

Encouragement to health service providers to meet their duty of care obligations to nurses and midwives by adopting risk management strategies covering the provision by the employer of comprehensive preparation for practice relevant to the specific health setting of practice including in relation to context-relevant clinical skills, occupational health and safety, violence, cultural safety, and personal safety and coping skills

#### **Recommendation 3**

A collaborative effort involving governments, nursing organisations, non-government organisations and the media, to market to the public and all other relevant stakeholders a positive image of nursing in rural and remote areas. This collaborative effort should involve the Association for Australian Rural Nurses, the Australian Nursing Federation, the Council of Remote Area Nurses of Australia, Commonwealth, State and Territory Governments, the media and rural and remote area communities. The image should be positive, enthusiastic and contemporary, highlighting that nurses are valued and necessary for the continued health care of these communities. The work should start from the premise that there are

opportunities in crisis and that nurses are brave and caring people.

#### **Recommendation 4**

Insistence that Schools of Nursing, including in the vocational education sector, provide nursing courses that prepare graduates for the realities of rural and remote areas, including through curriculum content, placements and the needs of marginalised groups.

To this end, all Schools of Nursing must ensure that:

- their courses contain elements that cover all contexts in which nursing care is provided, including rural and remote areas;
- Indigenous health and cultural safety education is incorporated as part of their core curriculum;
- access to clinical placements in rural and remote areas is facilitated;
- they establish regionally based learning centres to support locally based undergraduate nursing students;
- funding for nurse education programs in rural and remote areas is appropriate to the unique circumstances applying, such as high travel and accommodation costs; and
- negotiations are undertaken between the Universities, rural and remote nursing organisations, and the Federal Government on the funding formulae for nursing education to achieve adequate financial support for both the administrative costs of clinical placements and the costs incurred by students.

#### **Recommendation 5**

Action to ensure that health service providers in rural and remote areas provide workplace environments with adequate levels of human, financial and material resources (including adequate facilities and equipment), flexible employment models, reliable relief systems and professional support mechanisms.

#### **Recommendation 6**

Action to lobby for the provision to nurses and midwives in rural and remote areas of regular access to reliable and relevant information technology, including telephones and the internet, and training and support for its use.

#### **Recommendation 7**

The funding of postgraduate advanced practice training programs for rural and remote area nurses that include context-specific advanced clinical nursing skills, public health, clinical supervision and co-ordination of trainee support and placements.

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### **Sunday Symposium C~Road safety: the rural dimension**

There is a National Action Plan for Road Safety in Australia that goes up to 2010. Its goal is to reduce the population death rate from road accidents by 40% by 2010.

Road crash was the sixth leading cause of death in Australia in 2001. Road crashes make up a little over 2% of deaths by number but they account for 7% of years of statistical life lost through all causes. Worldwide, road crashes are expected to be the third largest public health issue by 2020. Road safety is a function of driver attitudes and behaviour.

Thirty-eight per cent of rural crashes result in injuries, twice the rate of city crashes. The rural death rate is over 10 times higher than the city death rate. About three out of four of people who die in rural crashes live in rural areas.

Factors which contribute to rural accidents include high speeds, lack of safer types of transport, bad driving habits, greater travel distances, poorer road quality, greater size and mass differences between vehicles involved in accidents and less effective enforcement. But the most important factors are alcohol, speed, not wearing seat belts and fatigue.

US studies show that rural victims are 7 times more likely to die if they have to wait more than half an hour for emergency attention from paramedics. In Australia a rural accident victim has a higher chance of dying before medical attention arrives than does a city victim.

Road design and improvement can have a major impact on safety. Major road upgrades are very expensive but remedial safety treatments can have significant benefits. For example upgrading roads, principally with roundabouts and shoulder sealing at accident black spots, has an average overall benefit cost ratio (BCR) of 14, with regional projects having have a BCR of 11.

Rural and Indigenous road safety issues are a major action area in the National Action Plan over the current biennium, with speed and alcohol as other priorities. (Motha, Joe)

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### **Sunday Symposium D~The Australian Indigenous Health/InfoNet—a model of knowledge sharing for the health sector**

Indigenous HealthInfoNet (<http://www.healthinonet.ecu.edu.au>) was established in 1997 to make relevant, high quality knowledge and information about Indigenous health easily accessible via the Internet. Despite development of a better evidence base for health care little attention is being paid to active knowledge sharing. HealthInfoNet provides a model for the more widespread sharing of knowledge within the health sector.

It provides the best possible information on a specific topic to all those who are likely to use that information to provide information to others or to make decisions. Users could include community health workers, policy officers, students and politicians.

The information on the HealthInfoNet website must be accurate and reliable. To ensure this, materials are subject to quality control checks before they are added to the site, a full peer review process for all substantial reviews, overviews and summaries is being developed and HealthInfoNet is negotiating with some specialist agencies for them to be responsible for parts of the sites where they have relevant expertise.

HealthInfoNet also works directly with Indigenous people so they can develop the skills they need to access Internet-based knowledge and information. It also helps Indigenous and other relevant agencies to develop their own Internet sites so their own information becomes more accessible. (Thompson, Neil)

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### **Sunday Symposium E~The art of healthy community: a Tasmanian retrospective**

Through a series of 96 images this symposium showcased a diversity of Tasmanian arts-based projects initiated by government and non-government sector organisations. This survey showed how the value of working in different and creative ways to enhance the health and well-being of communities has captured the imagination of communities, workers and services. The symposium also provided an overview of funding sources and partnerships. (Moss, Sue)

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### **University Departments of Rural Health symposium~Addressing rural and remote health workforce issues: what role for University Departments of Rural Health**

Departments and Schools of Rural Health are located in regional settings in every State and Territory. The eleven now in place have significantly increased the resources and infrastructure directed toward providing education and training for medical, nursing and allied health professionals who work in rural and remote areas and to enable students to practise their skills in that environment. They also conduct research and development on rural health and workforce issues.

Education and training programs affect recruitment and retention of the rural health workforce by making it easier for rural residents to enter medical and health science courses, making tertiary education more accessible to rural students, providing targeted training to prepare health professionals for rural practice and promoting rural health practice to students.

While research can provide accurate information on the workforce and health needs and can assess how well the workforce meets these needs, there are still significant information gaps about the best models of care for rural and remote Australia. Research can also evaluate the effectiveness of innovative solutions. Further effects arise from encouraging the development of better models of health care and service delivery, providing enhanced career development opportunities, attracting resources and identifying and promoting research opportunities.

There have been major difficulties in attracting and retaining medical and allied health professionals into the Aboriginal Medical Services or to work in Aboriginal and Torres Strait Islander communities. These difficulties relate to lack of professional support in remote areas, inadequate remuneration, lack of appropriate housing, lack of family support and lack of cultural knowledge. There is a need to address these issues by improving the training of the non-Indigenous workforce in cultural matters, to ensure mainstream services better respond to Indigenous health needs and to increase the numbers of Indigenous health professionals. Indigenous health must be a priority in primary health care, education and training.

University Departments and non-Indigenous staff need to recognise and speak for their own culture, not for anyone else's. Indigenous people have the knowledge and expertise to speak for themselves.

To develop the health workforce in rural and remote communities University Departments of Rural Health provide multi-disciplinary and vertically and horizontally integrated professional support programs. The needs of communities, their health workforces and the formation of partnerships with key external organisations have expanded the range of programs to cover medicine, population health, Indigenous health, nursing, allied health, and pharmacy.

The outcomes of the work of University Departments of Rural Health program are to be regularly evaluated by the Commonwealth Office of Rural Health and by their own organisations. (Walker, Judi; Lyle, David; Beard, John; Drysdale, Marlene; Mifsud, Jason; Pashen, Dennis)

#### *Symposium recommendations*

- The Symposium recommended:
  1. A co-ordinated strategic approach to promoting health professional careers in rural and remote areas to high school students, including Indigenous students, is needed.
  2. A funded strategic approach to rural and remote health research is needed, building on the existing infrastructure of academic units in these areas. This approach would include Centres of

Excellence for health research in rural and remote areas.

3. All tertiary health professional courses should include a serious, examinable rural health stream, and mandatory time spent in rural and remote areas.
4. Serious efforts are needed to increase the numbers of Indigenous students accessing tertiary health professional education and training. As part of this, every University needs an Indigenous employment strategy.
5. A close working relationship needs to be developed between University Departments of Rural Health and Rural Clinical Schools.

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## **Monday Symposium A~Tasmania Together**

Tasmania Together is a long-term social, environmental and economic plan for Tasmania's development over the next 20 years. It is an overarching framework for planning, budgeting and policy priorities for government and non-government sectors.

It was developed through an extensive community consultation process involving forums, public meetings, postcards and the Internet which established the six themes which most concerned Tasmanians as a whole. The six themes are community well-being, employment and economy, sustainable development, natural environment, arts, culture and heritage, and open and inclusive governments. These themes were used to establish 24 goals. Progress toward these is measured using 212 measurable benchmarks.

A statutory authority, the Tasmania Together Progress Board, promotes, monitors, advises and reports on progress towards the goals of the strategy. The Board is developing a transparent process to ensure that the strategy can be modified so it remains relevant by responding to change.

The Board reports annually to Parliament on progress toward the goals as measured by changes to the benchmarks. The annual report tells the community, business and government where Tasmania is doing well, where it is doing badly and consequently where current activity levels and directions are satisfactory or where

changes are required to overcome poor performance. It provides a basis for long-term planning as well as establishing priorities for action and encouraging responses by all sectors. The development and implementation of the strategy has evoked significant domestic and international interest. (McAlpine, James; Bennett, Jane; Prince, Lee; Walker, Judith)

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## Monday Symposium B~Sustainable communities and health inequalities

The goal of the Sustainable Communities Network is to seek effective interventions that address health inequalities in rural, remote and Indigenous communities through sustainable development and supporting sustainable communities. Australian and international research has shown that people who experience social and economic disadvantages tend to be sicker and die younger than others who do not. The Network works in four areas: the effects of policy; community capacity; environmental justice, risk and experience; and cross-sectoral and participatory approaches.

The symposium considered three topics which give rise to possible policy interventions:

- For community capacity building to impact on health inequalities, assessment must be driven within the matrix of regional development to ensure things like income inequality are addressed.
- There is a need to implement Health Impact Assessment in Australia in such a way that the impact on inequalities (for specific groups and the overall population) is an integral part of all policy formulation and decision making.
- Policy interventions from the natural resource management sector need to be explicitly influenced by the health sector and evaluated for their health effects.

These statements require further refinement and debate. To participate visit the Sustainable Communities Network website at <http://www.scn.ecu.edu.au> or contact [meredith.green@ecu.edu.au](mailto:meredith.green@ecu.edu.au). (Horwitz, Pierre; Drew, Neil; Thompson; Neil; Green, Meredith)

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## Monday Symposium C~Community participation—a mouthful at a time

Community members' participation can occur either formally or informally. Formal models involve organisations which have a governance policy which actively seeks and supports consumer participation. They enlist the services of community members who are active, attend regular meetings and present an informed contribution to the topics being considered. More prevalent and potentially more powerful, simply on the basis of numbers, is the informal consumer network. This is often made up of those whose participation arises from a particular adverse experience and who are not continuously involved for extended periods.

Both groups need support to improve their effectiveness. To maximise their effectiveness those participating in formal organisations need training to provide them with relevant skills and to be selected and appointed in a way which validates their role as representatives and community leaders. Informal participation would benefit from information networks which enable them to learn from the experience of others and to learn how to present their arguments effectively. (Mills, Irene; Lawrence, John; Archer, Elisa; Lennox, Dennis)

### *Symposium recommendations*

1. That through the consumer representatives on the National Rural Health Alliance and other consumer groups and individuals, an infrastructure be developed to grow and strengthen the consumer presence at the 8th National Rural Health Conference, aimed at delivering a consumer representation strategy encompassing formal and informal networks.
2. That Alliance members and governments encourage and assist rural communities to a radical change of stance in health workforce and health service markets from passive to active engagement.
3. That Alliance members and governments commit to build the capacity of rural communities for active engagement in workforce and service markets.

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## **Monday Symposium D~Agriculture and rural health—Agriculture Fisheries and Forestry – Australia perspective**

The agricultural sector makes a major contribution to the prosperity and health of rural Australia. This symposium provided information on some of the products and services provided by the Commonwealth Department of Agriculture Fisheries and Forestry – Australia (AFFA) and explored some of the social aspects of Australian agriculture, especially in relation to drought and its effects on rural communities, families and individuals. Information was presented on AFFA's "Social Atlas", small town water supply issues, current social research, and the empowerment of local communities through program such as the Natural Heritage Trust and the National Action Plan for Salinity and Water Quality. (Fisher, Melanie; Curtis, Allan; Hostetler, Stephen; Cullen, Ron)

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## **Monday Symposium E~The art of healthy community—strengthening rural communities**

Healthier communities can be achieved through: creative self expression; engagement of hearts, minds and imagination; communication; participation; skills development; confidence building and empowerment.

The *See Saw* project involved 4 Indigenous and 4 non-Indigenous women from Ceduna making 18 sculptures which used the image of a see saw to explore the complex community issues involved in cross cultural reconciliation. Because people can directly see, touch and experience the constructions based on a see saw the project enables them to physically and mentally explore concepts such as harmony, movement and potential shifts of position needed for cross cultural reconciliation. This engages them with basic questions related to the general community's psychological, emotional and physical health.

The *Dirt Roads and Desert Roses* project engaged 23 women living in remote and isolated parts of South Australia writing fiction, autobiography and poetry and the subsequent editing, design and printing of full colour book which sold 700 copies in two months. This project, based on creative writing and visual arts/photography, was developed after directly consulting the women. The project participants grew in confidence; developed skills for communicating

with each other, drew comfort and support from their sharing of perspectives and situations and developed a strong link with the outside world. Members of the group have formed an Outback Women's Writing group and plan to keep writing and publishing.

Community cultural development (ccd) is an ongoing process in which a community creatively determines and expresses who it is and where it wants to go. Outcomes can include social or political change for the community, as well as personal development for individual participants.

A new approach to engaging communities in their own cultural development is encouraging the creation of "meshworks". These are self-generating networks which are largely self-supporting. They are not imposed from the top down but are started and maintained by people who are actively engaged and working in areas of shared interest. The Community Arts Network South Australia is attempting to create such a meshwork through a national website project [ccd.net](http://ccd.net). The website was launched in March 2002. At the moment it contains the following information: [ccd.net](http://ccd.net) content and functions; a national project register and an online forum. (Murphy, Catherine; Philip-Harbutt, Lisa)

# The Conference's major recommendations

The Conference plenary session came up with thirteen priority recommendations

1. In order to improve Indigenous health outcomes, Conference believes that mainstream health services should be required to evaluate their performance against the impact on health outcomes for Indigenous people. (Where mainstream services are currently poor at evaluating outcomes, *of* outputs, this will necessitate them re-organising their operations.) Also, additional effort should be urgently allocated to Indigenous health through the community-controlled sector.
2. Conference calls for a national inquiry into the rural, regional and remote area health workforce to collate information on workforce shortages in all professions and to lay the basis for better rural health workforce planning. The rural health sector needs an integrated, timely and consistent basis for developing useful data sets of the available supply and anticipated demand in its health workforce.
3. Conference calls for the establishment of a single body to progress rural and remote health workforce planning. It would replace the groups based on specific disciplines which currently exist and would cover all health professions. The body will be a key player in charting a course for effective rural, regional and remote health workforce planning. (Note: the work of this body will complement action required to enable and support those directly involved in health outcomes who are not health professionals.)
4. Conference calls on the NRHA to begin work on how Australia could develop a sustainable, high-quality placement system for students and short-term professional health staff in rural, regional and remote communities. The work will deal with the total costs to students and communities of placements, including accommodation and facilities for students of all disciplines, and the costs of transport and supervision. This work will include:
  - an inventory of existing accommodation;
  - a scoping study of accommodation needs;
  - consideration of the impact of rural placements on support staff and mentors; and
  - a model for a national approach to this matter, including recommendations relating to funding.
5. Conference recommends as a matter of urgency that the Commonwealth and State Governments work together to ensure that rural and remote communities have access to a range of procedural services including obstetrics, anaesthetics and general surgery. In ensuring that such services continue to be available in rural communities, Conference calls for urgent action to resolve issues related to professional indemnity.
6. Conference calls for the existing classification systems used in rural and remote health (ARIA, RRMA and ASGC) on which funding allocation and incentive programs are based, to be reassessed as to their appropriateness as planning and allocation tools. (For instance the classification of Darwin as a capital city is not appropriate as a basis for allocating health resources.) This review should prepare a proposal and recommendations which incorporate:
  - stakeholder feedback on the current classification systems and problems associated with their use;
  - a review of other classification systems used in rural and remote health service planning in Australia and overseas and of technical issues associated with definitions of data and their use; and

- recommendations for the development and use of more appropriate classification systems that will see the level of funding increased to areas of need.
7. Conference supports the seven goals and eight principles of *Healthy Horizons Outlook 2003–2007*. It calls on Health Departments and the NRHA to:
    - promote *Healthy Horizons* at all levels in the health sector, eg Area Health Services, health workers in the community;
    - promote *Healthy Horizons* to organisations in other sectors, eg housing, employment, local government, environment, transport, community arts; and
    - provide interim reports on progress against *Healthy Horizons* yearly, in addition to the major progress report scheduled for 2005.
  8. Conference calls for the implementation of the 7-Point Action Plan on Nursing in Rural and Remote Areas and makes the point that such a range of incentives would have significant and beneficial impacts on health professionals from other disciplines. (As far as allied health is concerned, Conference notes and supports the proposal from Adelaide 2003 to convene a summit on issues affecting rural and remote allied health professionals.)
  9. Conference calls on the NRHA to produce a background paper detailing the post-trauma crises likely to be associated with flood, drought and fire and acknowledging and outlining the subsequent problems and the possible solutions.
  10. Conference calls on governments at all levels to invest urgently in additional resources for infrastructure and services that will enable communities affected by the current drought and other disasters to rebuild, and for their families to cope with the financial, social and spiritual stresses it has caused. It calls on the relevant Government jurisdiction(s):
    - to address matters related to income security and disaster relief;
    - to address issues related to housing, transport, education and physical infrastructure; and
    - the Australian Local Government Association to work with its members to develop programs and specific solutions that can be implemented at a local level, including programs which are valuable in building social networks and a sense of community such as arts-in-health.
  11. Conference calls for a funded national strategic approach to rural and remote health research, building on the existing infrastructure located in rural, regional and remote areas. The approach should encompass all institutions in which research and evaluation is undertaken including academic bodies and service providers. The research should include participatory and action research as well as more theoretical inquiry.
  12. In recognition of its importance as a fundamental determinant of health, Conference calls for a significant increase in national effort on early intervention in child and adolescent health.
  13. Conference calls for increased national effort, including through the National Strategy for an Ageing Australia, to develop a comprehensive system of aged care and other services for the elderly in rural and remote areas, giving particular attention to the needs of those with dementia and their carers.

# Acting on the Conference's major recommendations

On the day immediately after the Conference, about 65 representatives of national bodies and grass roots health workers met in a workshop to begin to refine the recommendations, and seek agreement on action to implement them. As a result of that work, eleven revised priority recommendations were agreed. These help set the agenda for rural and remote health for the next two years, including the Alliance itself.

The actions required to progress the priority recommendations are:

1. improving the status of Indigenous health, including through evaluations of the performance of “mainstream health services” by community controlled Indigenous health services, greater use of joint planning forums, the employment of greater numbers of Indigenous people in health professions, Indigenous content in curriculums, and staff exchanges between the community controlled and mainstream health sectors;
2. an integrated plan for improving the rural and remote health workforce, and clear lines of responsibility for delivering on it;
3. work to develop a sustainable, equitable and high-quality placement system for students and short-term health staff in rural, regional and remote communities;
4. a rescue package for procedural medical services, based on collaboration between local, State and Commonwealth Governments, academia, the professional Colleges, and hospitals;
5. reassessment of the systems of classification used for funding and resource allocation in rural and remote health (RRMA, ARIA and ASGC);
6. endorsement of Conference's support for the seven goals and eight principles of *Healthy Horizons Outlook 2003–2007*;
7. implementation of the 7-Point Action Plan on Nursing in Rural and Remote Areas, and a recommendation that issues for nurse practitioners, including remuneration, be referred to the project committee responsible for that 7-Point Action Plan.  
  
(Note: The Workshop also noted that the range of incentives outlined in that 7-Point Plan would have significant and beneficial impacts on health professionals from other disciplines. In particular, those at the Workshop recognised that there are similar issues for allied health professionals. Accordingly, they re-endorsed the recommendation made at the 6th National Rural Health Conference (Canberra, 2001) that the NRHA should convene a Summit (or its equivalent) to discuss issues affecting allied health professionals in rural, regional and remote areas of Australia.)
8. a call for more work on the post-trauma crises associated with flood, drought and fire, and for additional investment in infrastructure and services enabling communities to rebuild;
9. a funded strategic approach to rural and remote health research, building on the existing infrastructure in rural, regional and remote areas, and driven by the agenda in rural areas so that the research is closely related to real health improvements;
10. the need for major rural, regional and remote investment in early intervention in child and adolescent health; and
11. a call for increased commitment to a comprehensive system of aged care and other services for the elderly in rural and remote areas.

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# Appendix A      Saturday Symposium 1: Aboriginal and Torres Strait Islander health symposium

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## Hobart Health symposium and showcasing a big success<sup>1</sup>

NACCHO's 3rd Aboriginal Community Controlled Health Symposium in Hobart in March—as a precursor to the large National Rural Health Conference—was regarded as a great success.

In fact such was the unexpectedly large attendance for almost all sessions that it was a case of borrowing chairs and tables from everyone to accommodate participants.

Broken into four distinct components, those components featured wide-ranging presentations.

For example, the symposium's opening session, on Workforce Issues chaired by NACCHO Director and Kambu Aboriginal Health Service CEO, Florence Williams, featured detailed presentations from a diverse range of presenters.

The first, entitled *Aboriginal Health Workers and Training* was delivered by the Queensland Aboriginal and Islander Health Forum's Workforce Issues Project Officer, Ms Mary Martin.

Ms Martin backgrounded the audience on the QAIHF's history since its establishment in 1990 with a mandate to provide a forum in which Aboriginal community controlled health services in Queensland could share information to assist in progressing the individual and collective development on Aboriginal health, while also promoting an Aboriginal philosophy and approach. QAIHF also works to promote the Aboriginal community controlled model for the provision of health care services and, in concert with NACCHO, to increase the prevalence of community controlled health services; and progress and monitor the implementation of the

National Aboriginal Health Strategy in Queensland.

Outlining the external members of the alliance, such as the Royal College of General Practitioners, the AMA, Rural Doctor's Association, the Department of Health and Ageing and many others, Ms Martin added that all members of the alliance had signed an MOU in 1999 to participate collaboratively to improve Aboriginal health outcomes within a framework of principles that included self-determination, community empowerment and that health services must be culturally acceptable, readily accessible and affordable.

Ms Martin said as its resources had been expanded, so too had QAIHF's capacity to achieve better health outcomes for Aboriginal people.

Dr Sally Goold's presentation, in contrast, went under the catchy title of *Getting' Em n Keepin' Em*.

It was a detailed and comprehensive PowerPoint presentation on the work, role and outcomes achieved by the National Indigenous Nursing Education Working Group of which Dr Goold is the Chairperson.

Why, asked Dr Goold, in the year 2003 was Australian Indigenous health still at third world standards? Dr Goold's answer was that unlike in Canada, New Zealand and America where improved health outcomes for Indigenous people had been achieved, in Australia more had to be done to:

- involve Indigenous people in education programs;
- to implement culturally appropriate retention, recruitment and support strategies;
- employ Indigenous health professionals; and
- implement cross-cultural training for mainstream health professionals.

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<sup>1</sup> Extract from NACCHO News, May 2003, Number 13, pages 5 to 8.

Dr Goold said the Indigenous Nurses Education Working Group had enacted a wide-ranging group of core principles to underpin its framework agreements and had also surveyed all universities and adopted policies to actively encourage recruitment of Aboriginal Australians, increase support for retention programs and to develop an Indigenous friendly environment and culturally aware staff and students.

The Working Group had also settled on a wide-ranging group of some 32 separate recommendations specifying what approach should be taken on a wide-ranging list of Aboriginal health issues. The presentation was particularly well received.

### Shocking shortfall

So, too, was the presentation *Doctors Working in Aboriginal and Torres Straits Islander Health* by Dr Ngaire Brown, CEO of Australian Indigenous Doctors' Association. The presentation broke down, in detail, current medical workforce numbers.

For example, Dr Brown pointed out that Australia had over 69 000 medical practitioners, but that the total number of Aboriginal and Torres Strait Islander people in the health workforce numbered just 3493.

“But the minimum, yes minimum, figure should be at least 6700,” Dr Brown added. Of course those figures spoke for themselves, for example a near 50 per cent shortfall in workforce numbers. When broken down into component parts it showed:

	Current Numbers	Min Required	Min Increase
AHWorkers	1 105	1 856	750
Admin & Support	889	860	
Allied Health	90	348	258
Medical Officers	52	696	644
Nurses	424	1 780	1 356
Others	923	1 160	237

Dr Brown said the size of the total workforce (ie black and white combined) in Aboriginal and Islander settings numbered 8728 when the nominal requirement was 12 618, in other words a shortfall of 3890—or a massive 44.6 per cent.

Dr Brown's presentation also outlined some of the important objectives and work being done by the Indigenous Doctors' Association.

The final presentation was from the University Department of Rural Health, the presenters being Juanita Sherwood, Indigenous Research Fellow, Centre for Remote Health and Juli Coffin, Lecturer, Aboriginal Health, Combined Universities Centre for Rural Health.

Again it was a most detailed presentation, outlining how in 1996 the Government had funded a strategy that enabled the establishment of health academic units in rural and remote areas of Australia. They had the overarching objective to promote recruitment and retention of health professionals in rural and remote Australia through education, training and professional support. The key emphasis, however, was to reduce differentials between rural and non-rural communities and between Indigenous and non-Indigenous peoples.

Participants were told that 11 such centres had been established. Each of the centres had Indigenous staff (with the exception of Lismore and Tamworth) employed in the areas of administration, research and education.

As Juanita Sherwood said, the real intent was to see the expertise on Indigenous people recognised and acknowledged in the areas of health and education and real capacity put into developing a research agenda that does have real outcomes for Aboriginal people in relation to the employment of Aboriginal people in partnership with research groups rather than simply to make the process look safe because it utilised an Aboriginal person.

Too often the expertise being used was the expertise of non-Indigenous rather than Indigenous Australians.

### Emotional and social well-being

This session was chaired by Director Cheryl Mundy from Tasmania, who also presented an overview of social and emotional well-being

Other speakers included Sam Crane who presented the findings of a research study he had conducted for the Enmaraleek Cooperative in Victoria to examine the post Stolen Generation side effects leading to a lack of reactionary thinking abilities, physical activity and literacy skills among the community's adolescent population.

Mr Crane said the objectives of his fieldwork in the community was to acknowledge the issues concerned and to provide new programs to stem

the onslaught of health risk behaviours heading towards a more holistic wellness for future adult Indigenous people.

Clearly the study had noted that the holistic health, ie psychological, physiological, mental, cultural and societal for the Indigenous community was in a declining mode.

It noted the need for a whole range of program/activity led initiatives that would have a significant impact on the overall well-being of young Indigenous Australians.

These included access to such settings as re-claimed properties such as that at Lake Condah (Gunditmarra Tribe) where in a rural setting, built cabins, self-contained cultural meeting rooms and historical tribal stepping stone pathways programs were held that helped young people to not only reacquaint with cultural values but to have the benefits of such values in their lives reinforced.

Such a setting also promoted a traditional healthy lifestyle while generally Governments also needed to look at helping Aboriginal communities to have access to proper sporting and recreational programs with new emphasis necessary to encourage more young Aboriginal women to participate in healthy physical activity. Holistically, greater emphasis was also needed to learn one's cultural dance and language, art and music.

"The very nature of these type of programs, one may state as being able to provide Indigenous adolescents with the necessary tools to survive within the broader community, and being aware of the apparent health risk behaviours of an "inherited" white Australia culture yet embracing their own unique and definable culture," the study states.

### **The Canberra Region**

The next presentation, from George Wilson and Len Barrett of Canberra's Winnunga Nimmityjah Health Service explored the social and emotional well-being of Aboriginal Australians in an urban environment. It pointed out that Winnunga's service area was not just the ACT, but also Queanbeyan and Yass while also noting that a considerable number of clients came from all over Australia as Canberra has a significant transient Indigenous community.

The presenters also stated that Winnunga had an active MOU with ACT Mental Health, a

partnership that provided two male and two female stolen generation counsellors, two substance misuse workers and a midwife with a psychiatrist employed on a fee-for-service basis three days per week with ACT Mental Health also employing a drug and alcohol and mental health workers.

This spread of staff was designed to achieve outcomes such as increased access to mainstream services, cross cultural awareness and the identification of gaps and issues for Aboriginal people within the ACT health system.

The presenters said clients included those who were suffering from grief and loss, family issues, depression, bipolar, schizophrenia, dual diagnosis, psychosis and trauma and the effects of the stolen generation policies.

The presenters pointed out that in taking a holistic approach to care, the service offered a range of programs such as men's and women's groups, men's and women's camps, youth sporting programs (touch, football and basketball) and men's and women's art for therapy programs as well as other preventative activities such as parenting programs for all age groups and anger management courses in partnership with Relationships Australia.

Winnunga also operated an intensive staff development program but despite its strategic approach to social and emotional well-being issues barriers still existed to maximising its ability to help clients. These said the presenters, included inadequacies of the current Winnunga building, and lack of professional recognition.

Next came an enlightening presentation from the Kimberley Aboriginal Medical Service, which was entitled *Youth Suicide Prevention in the Kimberley*.

It was presented by Chris (Chips) Bin Kali (KAMS Chairperson), Louise McKenna, the KAMS health promotion officer and research assistance, Cormalie Manolis.

The presentation outlined the KAMS history, the fact that it was a regional resource service that covered Broome, Derby, Fitzroy Crossing, Halls Creek and Kununurra and a number of smaller Aboriginal communities as well.

It was overseen by a Council comprised of representatives from all the areas it serviced. The presenters explained that KAMS had conducted a Kimberley-wide survey of 367 young people

who were surveyed as to their potential suicide risk. Done by way of a specific and targeted set of questions, it had found that:

- 15% of those surveyed were low risk
- 17% were classified as of moderate risk
- 18% were high risk, and 10% had made a previous suicide attempt.

There was also a direct correlation between traumatic life events, post traumatic stress disorder symptoms and suicide ideation. As a result of these findings, KAMS had developed and operated a number of programs to assist young people throughout the Kimberley.

They included playback theatre, cultural counselling, and programs for family violence, suicide, sexual abuse, stolen generations, substance misuse, empowerment and even programs to help youngsters deal with bullying.

Additionally, there had also been programs aimed at the more remote communities under a title of Bush Women's meetings whereby contact had been made with 80 women and issues such as focusing on child sexual abuse, prevention, detection, and care and the formation of a specific Peninsula Women's Group had occurred.

Other major initiatives include wide-ranging programs for men, the introduction of a Help Card for youth at risk and extensive promotion of the card throughout the Kimberley as well as the development of Young Men's Camps.

These brought young men and Aboriginal elders together and involved story telling, presentations, the workshopping of a whole range of issues, cultural activities and sport.

The final presentation in the Social and Emotional Well-being Section was a presentation on the Community Life Project by NACCHO's community life project officer, Elaine Lomas.

### **Final Session**

NACCHO director and CEO of the Goondir Aboriginal and Torres Strait Islander Corporation for Health Services in Dalby, Queensland, Mr Brian Riddiford, chaired the final session, which was entitled *Programs and Alliances in Aboriginal Health*.

It began with a review of the Section 100 program by NACCHO's Deputy CEO, Glenda Humes and was followed by a presentation by

Joan Smith, of the Bidjerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service in Rockhampton. Ms Smith, the Service's nutrition health worker, presented the findings from a major exercise on nutrition she had conducted at Woorabinda, a remote Queensland community.

Ms Smith emphasised that in Bidjerdii's service area the high incidence of diabetes had had a major impact on renal health. To combat this, and other health issues, what had been designed was a healthy lifestyle program for Indigenous adults. But it was done differently—very deliberately so that it would attract those who had apparently been disinterested in, and untouched by, previous campaigns.

And who was it aimed at? None other than the Woorabinda Wadja Warriors Rugby League team whereby Ms Smith emphasised just how healthy eating could improve not just one's weight but also stamina and would actually cost less.

Areas covered with the players included the types of foods to eat (and what not to eat) and how best to prepare them, how to lock in place a lifestyle of good nutrition and physical activity and also to show the players how best they could effect changes in their eating habits and lifestyle.

For example, workshop topics included cooking demonstrations (based on a low budget) while also covering such issues as food safety and hygiene and how to shop better (and at lower cost) not just for themselves—but also for the whole family. And when Ms Smith asked all the men in the audience to put their hands up who had had eggs and bacon for breakfast (and got a sizeable response), she then really made the point when showing them how much better it would have been had they had scrambled eggs rather than poached eggs or beans instead of bacon.

Joan said she had also worked with the Woorabinda community to produce a healthy lifestyle video, facilitated the introduction of Healthy Weight Programs and various physical activity programs as well as using her other skills as a registered applied suicide intervention skills trainer.

"I worked with the whole community," she said. "What worked well with the men, particularly the footballers, was encouraging them to participate in cooking at home, then have knowledge of good eating and cooking so they

could share that knowledge, to make them see the benefits of changes to their lifestyle and eating habits—particularly proving to them how many healthy types of meals they could cook reasonable easily.”

And an evaluation at the end of the work with the football team showed remarkable results in weight loss and better eating habits—and maybe even fitness levels, for that season Woorabinda won the grand final for the first time in some years.

Space prevents précis on the final two presentations, *Issues of Partnerships for Aboriginal Controlled Organisations* by WAACCHO CEO Darryl Kickett and *Developing Alliances* by QAIHF CEO, Mick Adams. Again, however, the presentations were well received and appreciated by the audience.

# Saturday Symposium 2: Cross Sectoral Symposium—Procedural Rural Medicine: Clinical, Consumer and Community Issues

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### Rural communities to benefit from national approach to sustain procedural medicine<sup>2</sup>

An exciting and constructive symposium on procedural rural medicine has come up with a raft of recommendations to stem the decline in obstetric, anaesthetic and surgical services to rural communities,

Around 160 rural doctors, nurses, midwives, researchers, local, State and Commonwealth officials, and community and consumer representatives gathered for the symposium at the start of the 7<sup>th</sup> National Rural Health Conference in Hobart on the weekend. Discussion and case studies explored issues such as rural obstetric care, professional collaboration, education and training, social and financial issues, infrastructure for rural health care teams and skills maintenance.

The symposium clearly demonstrated that rural communities want to retain and expand service in their areas. Participants discussed solutions in the context of the changing medical workforce and the overall rural environment. They developed a number of specific recommendations that form the basis of a national strategic framework, which will include signposts to mark progress towards more obstetric, anaesthetic and surgical services for rural communities. Recommendations come under the broad areas of:

- developing and maintaining procedural skills
- encouraging new graduates in procedural practice
- evaluating the impact of recruitment strategies

- strengthening the facilities and role of Regional Health Authorities
- enhancing collaboration between all levels of government

The symposium provided considerable evidence of the effectiveness and safety of procedural services, with examples of better outcomes than city-based services. It also highlighted the value of having the full range of medical services to the social, economic and general well-being of towns and regions.

Discussions reinforced the emphasis on the team approach and the need to consider recruitment and retention of all groups within the health workforce. Displaying the usual rural approach and “can do” attitude, participants expressed their desire to get on with solutions to the problem and not wait for detailed policy and planning development.

The recent announcement by the NSW Government to establish a procedural training program in that State was identified as an example of a good initiative—but the symposium stressed the need for a co-ordinated national strategic framework.

The recommendations of the Symposium will be used to inform and influence the Australian Health Ministers in their deliberations as they try to find solutions to the problem of declining procedural medical services in rural and remote Australia.

The Rural Doctors Association of Australia, the Australian College of Rural and Remote Medicine, and the Australian Rural and Remote Workforce Agencies Group organised the symposium.

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<sup>2</sup> Media release dated 3 March 2003.

## Appendix C      Special Presentations

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### **Des Murray Scholarship**

The Des Murray Scholarship is awarded in memory of a great friend to the rural and remote health community. One or more young people have all costs paid to attend and participate in the Conference. It was presented by Mary Murray to Brett Gibson from Emerald, Queensland and to Monica Walley from Port Lincoln, South Australia.

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### **Louis Ariotti Award**

Louis Ariotti Research Award of \$1000 is sponsored by the Toowoomba Hospital Foundation to recognise and encourage excellence and innovation in rural and remote health. It recognises those who have made a significant contribution to rural and remote health in Australia. The award is made every second year. Marie Pietsch presented the award to Professor Roger Strasser.

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### **Infront Outback Research Grants for Rural and Remote Health**

The Toowoomba Hospital Foundation sponsors the Infront Outback Research Grants Program to promote and support health-related research relevant to rural and remote health. Two \$5000 awards can be made every two years. On this occasion there were no successful nominations for the Infront Outback Research Grants.