

their communities. When rural Australians of the future ask “Where were you when I needed you?”, the Australian rural health sector needs to be able to respond, “We were there for you.”

At the other end of the demographic spectrum are the elderly in non-metropolitan areas. Providing the infrastructure and services required for comprehensive and effective aged care and other support for the elderly in country areas remains a major challenge for the sector. Conference included a very special session on care for those with dementia in which carers from three States moved their audience with a common determination that people with dementia will not be forgotten.

The rural, regional and remote health sector comprises an extraordinary number of different groupings, professions and organisations. This is both a strength and a weakness. The fragmentation means that sometimes there is some duplication of effort and, at worst, there is out-and-out competition between entities for scarce resources. The sector has come a long way since the biennial National Rural Health Conferences started in 1991 and there is no longer the perception that rural health is unprofessional or “career suicide” for health professionals. Nevertheless the sector must continue to improve itself and, to this end, it is determined to look at its own structures and operation to minimise duplication and internal competition.

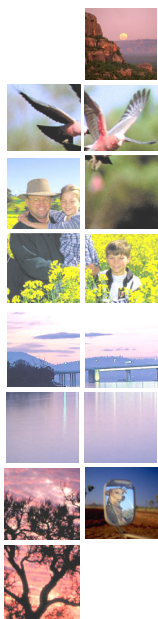
The sector has enthusiastically adopted *Healthy Horizons Outlook 2003–2007*. This is a valuable framework for action in the sector which will encourage collaboration between governments and national bodies, while at the same time allowing each health jurisdiction to respond appropriately in its own domains.

Healthy Horizons promises that there will be “no compromise” on the safety and quality of health services in rural, regional and remote areas.

The sector recognises the importance of social capital to health outcomes. Social capital consists of sometimes unmeasured determinants of health such as the degree of trust experienced by an individual or in a community, and the number of “connections” or memberships an individual has. It is incumbent on the rural health sector to build its own social capital by increasing its connections with other sectors whose work impacts on health status, including education, transport, employment, the arts and the environment. One specific action which will help in this respect, and which will be actively pursued, is to promote *Healthy Horizons Outlook 2003–2007* within the rural health sector and to other sectors and local government. (Conference recognised the benefits for health and community development of facilities such as public swimming pools.)

Mental health is still an area of major unmet need in rural Australia, including because stigma is still alive and well, even in the mental health sector itself.

A number of important gender issues were discussed at the 7th Conference. There were specific presentations on women’s health and men’s health, and gender issues impacting on the rural health workforce are also of significance. The medical workforce is becoming increasingly feminised and this has particular implications for the recruitment, retention and support of rural GPs. The nursing workforce is still predominantly female but the profession needs to acknowledge and recognise its males better than it currently does, as is happening in the UK campaign based on the slogan “Are you man enough to be a nurse?”



There was significant emphasis at the Conference on allied health professions and a sense of anticipation that rural allied health is finally on the agenda and finding its voice. Conference delegates expressed the hope that there will be increasing investment in rural allied health to build on the valuable start being made with the new allied health scholarships.

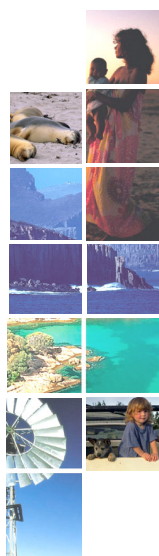
Delegates were critical of the inadequate representation on the Conference program of issues relating to alcohol and other drugs, and oral and dental health, among others. There were also suggestions that the consumer voice could still be better represented.

The Conference is a powerful multi-disciplinary event. Much of its workforce activity is premised on the need for complete health professional teams to be available to rural people. This is not just what rural people need and deserve, but also the only way in which individual health professionals can work safely, effectively and sustainably in the country. Delegates at the Conference therefore continued to support strongly the programs to increase the numbers of individual health professionals working in non-metropolitan areas, but sought a more co-ordinated and collaborative approach to these programs which are currently funded and run separately. There is a need for evaluated outcomes from existing programs so that there can be greater clarity and more focus on what is working well for the rural health team.

There are two pre-eminent areas where Conference delegates believed things are not currently working well for the rural health team. They are student accommodation and the conditions for rural proceduralists. Conference provided strong support for work to improve the availability of accommodation for health trainees on placement in rural, regional and remote areas. Conference supported the existence of a greater number of such placements, but was very concerned that there be adequate supply and equity between various health professions. What is needed is an inventory, a scoping paper and urgent action to provide more accommodation and greater equity.

Rural proceduralists include procedural GPs, anaesthetists, obstetricians, general surgeons and midwives. There is an immediate need for action to ensure that proceduralists currently practising remain and that others are attracted. This will entail urgent action to overcome the professional indemnity needs of such professionals, and work to improve the knowledge and attitude of those who are potential recruits to their ranks.

The 130 papers contributed to the Conference emphasised the relative success of local action where there is energy, leadership and a critical mass of resources. However there was a major concern about whether governments are sufficiently committed to supporting this effective local action. Delegates to the Conference had a sense that very little is happening politically for the rural health sector. Concern was expressed that national resources may be diverted from the health sector to "external threats" and that, if this were to be the case, rural areas might be disproportionately affected. There was also a general concern that rural health must remain up front and centre on the health agenda because of the generally inferior health status in country areas.

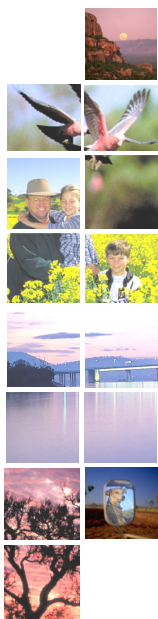


Morale in the sector is currently being sustained by the energy of the relatively small number of committed individuals involved. There is a failure to attract new blood, disillusionment because of a perceived lack of support and reward for those in harness, and the sector is now bracing itself for the trauma following the one-in-one-hundred-years drought and unprecedented water shortages, bushfires and floods. This underpinned Conference's call for immediate re-investment in infrastructure and additional coping services.

Delegates endorsed thirteen Priority Recommendations and also agreed to record all Conference recommendations generated (listed below). Any organisation can identify those suggestions which relate to its area of interest and are within its scope of responsibility. The thirteen Priority Recommendations were selected on the basis of four criteria: their practicability, their urgency, the extent to which they are fundamental to improving rural health outcomes, and the extent to which they reflected the mind of the Conference as expressed in the total set of recommendations received.

THIRTEEN PRIORITY RECOMMENDATIONS FROM THE 7TH NATIONAL RURAL HEALTH CONFERENCE

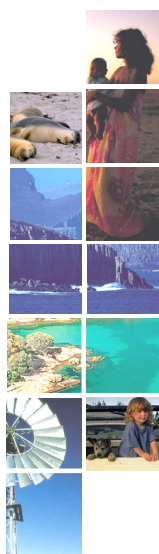
1. In order to improve Indigenous health outcomes, Conference believes that mainstream health services should be required to evaluate their performance against the impact on health outcomes for Indigenous people. (Where mainstream services are currently poor at evaluating outcomes, cf outputs, this will 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:



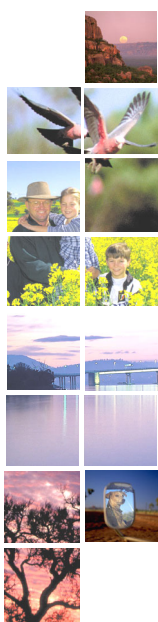
- an inventory of existing accommodation;
 - a scoping study of accommodation needs;
 - consideration of the impact of rural placements on support staff and mentors; and
 - a model for a national approach to this matter, including recommendations relating to funding.
5. Conference recommends as a matter 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.

Note: The remainder of this original recommendation from the Conference has been omitted by request, because it did not reflect the view of parties involved in the RDAA/ACRRM/ARRWAG Symposium on Procedural Rural Medicine held on Saturday 1 March.

6. Conference calls for the existing taxonomies 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 taxonomies and problems associated with their use;
 - a review of other taxonomies 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 taxonomies 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.



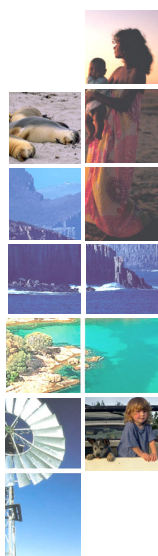
8. Conference calls for the implementation of the 7-Point Action Plan on Nursing in Rural and Remote Areas and makes the point that such a range of incentives would have significant and beneficial impacts on health professionals from other disciplines. The 7-Point plan is listed below in the Recommendations from Concurrent Session Papers under the heading *Nursing Workforce*. (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.



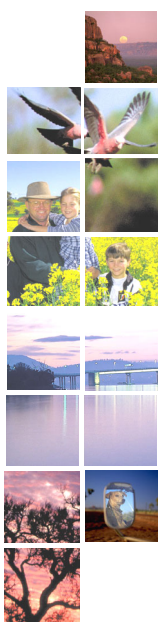
RECOMMENDATIONS FROM SESSIONS

Note: This is a list of the recommendations generated through the agreed processes at the 7th National Rural Health Conference. They have not all been prioritised but some of them are reflected in the 13 priority recommendations above. The ones in the second section below (pp 18–28) were written in to the Concurrent Session papers and have been organised by subject. The recommendations will be considered by the NRHA and other interested parties with a view to their possible adoption and action.

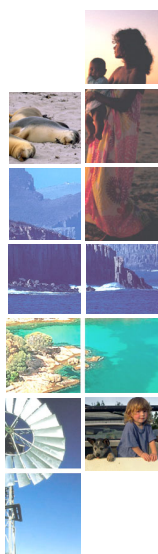
- The range of issues that impact on family caregivers highlights the cross-portfolio nature of the caring role and the need to develop a whole-of-Government approach to family carer policies within a central framework. This framework needs to include carers in acute situations (example palliative care). 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; current research shows that carers rarely use their respite for rest and relaxation
 - adequate financial compensation/income support for caring by family members.
- 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 to cope in their adolescent years.
- That there be greater consumer focus and acknowledgment within the Conference and greater consumer contributions to papers within the program. Less policy-type papers and more clinical "grass roots" papers to encourage greater consumer involvement.
- That the role of the carers be acknowledged and there be recognition that carers required emotional and financial support, education, training, domiciliary and respite services.



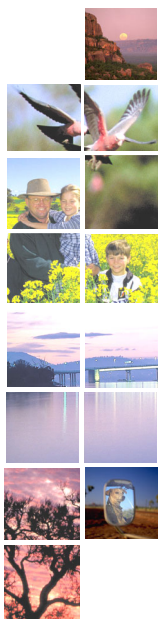
- This Conference calls on governments at all levels to invest urgently in additional resources for infrastructure and services which will enable communities affected by the drought to rebuild and for their families to cope with the financial, social and spiritual stresses it has caused.
- Primary health services for rural areas should be provided by community-based organisations not Government departments
- That the NRHA urgently produce a “thoughtful paper” acknowledging the continuing nature of flood, drought and fire, outlining problems and solutions.
- This 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, community arts, transport
 - provide interim reports on progress against Healthy Horizon yearly in addition to the major progress report scheduled for 2005.
- Seeding funds should be made available for small group programs for the socially excluded in rural and remote areas.
- Swimming pools should be constructed in rural and remote areas for the social and health benefits they bring to the community.
- 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.
- Aboriginal rural and remote health strategy should be national, not just New South Wales.
- Targeted funding to provide health information on diabetes for Indigenous children using culturally appropriate touch screen technology.
- State and Territory governments to give priority to training for Aboriginal Health Workers on diabetes prevention and management.
- Strategies to be developed to promote the incorporation of Chronic Disease Self Management into the organisational planning of health programs and practices (recognising that this will increase costs).
- Time for diabetes care management to be explicitly funded in order to improve diabetes-related outcomes.
- Rural health services to promote diabetes information and education support groups in rural and remote communities.
- Diabetes remain a health priority area with ongoing attention from health practitioners and health service funders.



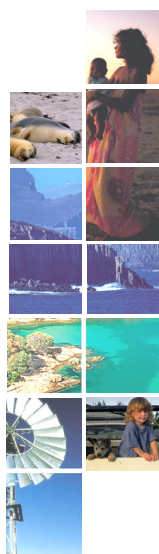
- That State and Commonwealth Governments commit to the development and maintenance of rural nurse “education and training in after hours triage”. This education and training program should be developed in consultation with local GPs and communities.
- Recommend the promotion of innovative programs (such 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.
- Children and youth health need their own co-ordinator/advocate/manager in health services and their own strategic plan and child/youth-dedicated services.
- That service providers be encouraged to develop dementia-specific day centres with secure areas in rural community centres.
- That a common assessment tool and case management model be developed to avoid over assessment and improve service co-ordination.
- That an ongoing education campaign 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
 - essential funding to support more rural dementia services and research into Alzheimer’s origin and prevention.
- It is recommended that:
 - the National Rural Health Alliance recognise the importance of visual health to the communities it represents, and seeks greater emphasis on visual health awareness from its members, communities and governments
 - public health campaigns 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 consider the role of partnerships in successful health promotion.
- 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.



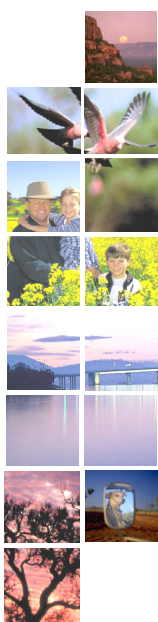
- That there be substantive action to ensure equity across the States and Territories in regard to access to mammograms and resources available to Indigenous and non-Indigenous women, particularly in remote communities.
- Comparable service for treatment of mental health across all regions that involves recruitment of well supported multi-disciplinary teams, across sectors (health, education, housing, etc) that have ready access to relevant professional development.
- That nurse registering bodies not reaccredit curricula if Aboriginal and Torres Strait Islander history, culture and health issues are not separately and visibly included.
- Provide “mapping or navigation” information for local communities and health providers to find out about professional associations and organisations that can assist a local community recruiting staff.
- GAP [Graduate Assistance and Partnership Program] identified – losing students from undergraduate to postgraduate procedural practice.
- This Conference supports the Australian Local Government Association’s call for a national inquiry into the rural health workforce. It asks the NRHA and other relevant organisations to advocate for such an inquiry and to provide input into it.
- In support of Mike Montgomery’s comments regarding workforce planning:
 - The health sector needs an integrated, timely, sound and consistent basis for developing good data sets of available supply of medical/health workforce and anticipated demand/need to enable good planning to be done. Instead of various groups (eg AMWAC, Divisions of GPs, Schools of Nursing, GP Training, AHWAC, Rural Workforce Agencies, State and Cwlth Depts, AIHW, ABS, etc) competing/ disagreeing and replicating work wouldn’t it be better to consolidate efforts in one independent body.
 - 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.
 - That the three models for measuring access to and isolation from health services at this session be advanced and supported as tools for assessing health workforce needs in rural and remote Australia.
 - This Conference calls on the NRHA to begin work on a co-ordinated national approach to accommodation and facilities for students of all disciplines undertaking placements in rural, regional and remote communities. This work will include:
 - an inventory of existing accommodation
 - a scoping study of accommodation needs
 - a model for national approach to this matter, including recommendations relating to funding.



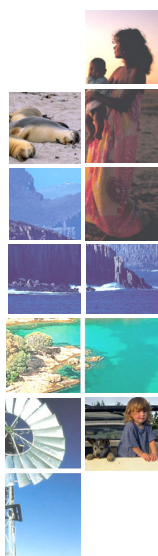
- That priority be given to development of better tools to support co-operational planning and action to build local health workforce capacity.
- Re-establishing comprehensive models of maternity care (including birthing services) in rural and remote areas that do not necessarily have on-site surgical facilities.
- Continuity of midwifery care should be available to all women in Australia.
- All midwifery service providers look at adopting models of care that are family centred with the midwife as the primary care provider.
- That the Commonwealth Government follow the state lead and remove the barriers to the development of nurse practitioner models, eg
 - provider numbers for payment of services
 - resolution of professional indemnity issues.
- That all high school health careers programs target Indigenous young people in late primary and early high school years.
- That a central website is developed to advise students of potential sources of funding for undergraduate health students, eg Commonwealth, State, Territory (AHMAC?).
- (private scholarships can also be posted on the site).
- That rural high school students with an interest in a health career from the area around the Conference (ie Alice Springs in 2005) are invited to participate in the Conference (eg 20 students per day – no dinner, cocktail party, etc)
- That oral/dental health 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 become a member of the NRHA.
- This is a recommendation to establish a new university (not a satellite or a campus of an urban university) in a rural or remote setting (central Australia!!) to provide an educational environment for students with a commitment to rural and remote Australia. The setting for their education (eg rural, Indigenous friendly etc) would support and strengthen their interest in rural/remote lifestyles, culture and improve the chance of them working in such communities after graduation.
- IPE should be included in all undergraduate health courses, including:
 - explicit and discrete focus
 - formal assessment and recognition
 - community-based component
 - elective (or not).



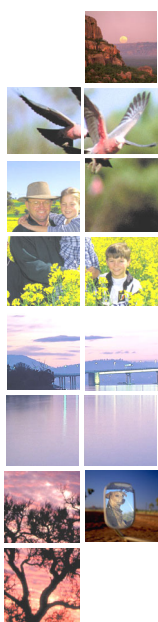
- Government, university and other co-ordinating bodies collaborate to conduct research, develop and maintain a pool of advice, exemplars and other resources to assist those undertaking community-based learning activities in the health disciplines.
- That a reference for “101 ways for community engagement” be developed/collated/researched.
- The NRHA, general practice and rural women’s organisations to lobby the Minister for Health and Ageing to approve, release and fund the GPPAC rural female general practitioners’ recommendations.
- That projects to produce and disseminate further culturally sensitive palliative care information to Aboriginal Medical Services be undertaken.
- That more national research in Aboriginal health is 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 Australia wherever 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.
- That COAG and other bodies representing the three tiers of white government in Australia commit themselves to understanding and using respectfully elements of the Indigenous languages of their regions as agreed by the Indigenous speakers of those regions.
- That Commonwealth and State governments acknowledge financially that Aboriginal community controlled health services are the principal – and often the only – source of primary health care for Aborigines and are not merely “complementary” to white mainstream services which have failed dismally to sustain healthy Aboriginal nations over the past 200 years.
- Education and recruitment strategies 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, 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 protocols for effectively making a safer workplace. They could also encourage rural practice issues being addressed in the curriculum.
- Research on “self care” (WACRRM) needs to be extended across all rural and remote health professions.
- Consideration about going across professions for help (eg GP to psychologist).



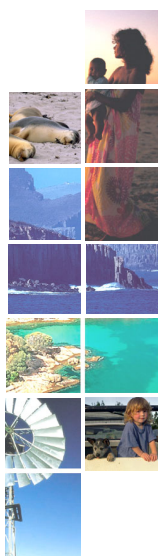
- Education for rural managers on how to build and support their workplace to:
 - enhance well-being at work
 - reduce staff turnover.
- Support rural managers to have that education and support them overall – and it will go down the line.
- There is NO data on rural and remote health workforce apart from in medicine to enable planning. This must be remedied.
- NRHA Conference lacks specific focus on remote (ie 3-4 hours beyond Alice Springs).
- That the NRHA continues to target oral health and that the role of oral health practitioners be acknowledged in the primary health care model. Further, that the NRHA encourage a collaborative approach from Federal and State governments to implement oral health education for doctors, nurses and allied health professionals.
- We have 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.
- Work with schools to inform students of options and to encourage their success in mainstream education.
- Encourage more flexible funding mechanisms for allied health staff participating in Enhanced Primary Care (EPC) processes. (NB: currently GPs and pharmacists are funded for this work via MBS, but allied health and private providers are not.)
- Very valuable contributions are being made to rural health by carers and volunteers who provide services that would otherwise need to be provided by government.
- Recommendation:
 - recognise and resource community volunteers
 - expand information and training input for volunteers.
- That the Government continue to support the Rural and Remote Pharmacy Workforce Development Package, as it has shown positive results for rural communities in recruiting and retaining pharmacists in rural areas.
- That if collaborative programs such as Chronic Disease Self-Management and EPC are to be successful, government must examine opportunities for reimbursement of allied health and pharmacists' time in such initiatives.



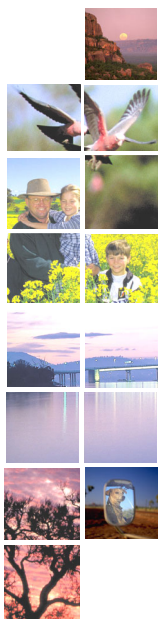
- That the Pharmaceutical Benefits Scheme (PBS) should not be seen as a cost to Government but rather an investment in health, particularly considering there is less PBS “investment” in rural areas compared to metro areas. The Government should support and work with pharmacy, medical, consumers and allied health to implement greater access to PBS and pharmacist care in rural areas.
- 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.
- That funds be set aside for a secondary student (preferably Year 12) to attend the Conference (registration, travel and accommodation).
- That the National Rural Health Alliance lobby appropriate body(s):
 - to 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;
 - to 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;
 - to fund the organisation of a national representative forum or 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 NRHA Conference); and
 - to lobby OATSHI (through its Indigenous workforce strategy framework) to implement its recommendations regarding improving the level of Aboriginal and Torres Strait Islander participation in Australia’s allied health workforce.
- General agreement and understanding is to include the volunteer workforce especially ambulance officers.
- That research will focus on the practical aspects and understandings of rural health and social capital.
- Communities accept responsibility that they have power to implement change.



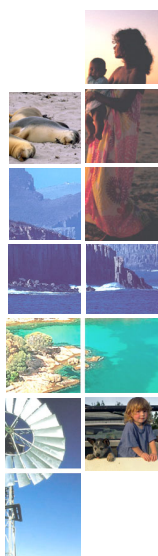
- That work continue by NRRAHAS and the allied health professional associations to develop and promote the working definition of allied health as applicable to rural and remote Australia.
- Employers of rural and remote AHPs should:
 - aggregate the local demands for AHP education, co-ordinate a combined 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; and
 - use technology to facilitate efficient delivery of education and support that would otherwise be unavailable.
- That rural allied health professionals require a centrally co-ordinated CPE program – of equivalent standard across all disciplines and state and territory boundaries.
- Rural allied health practitioners are recognised as instrumental members of the rural health team and are involved in the development of policy and planning at the State and Commonwealth level.
- That jurisdictions endorse and support collaboration between providers of AHP education, training and support – so that jurisdictions can develop appropriate and cost effective models utilising existing proven frameworks and resources.
- 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
 - have a mechanism for accountability back to the community.
- 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.
- That service providers be encouraged to develop dementia specific day care centres with secure areas in rural community centres.
- That a common assessment tool and case management model be developed to avoid over assessment and improve service co-ordination.



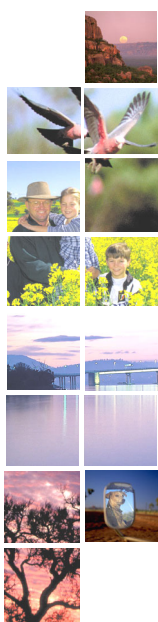
- That the role of carers be acknowledged and recognition that carers require emotional and financial support, education, training, domiciliary, respite services. Funded packages of care for the unpaid carer to establish and implement their “Plan of Caring” by the provider. This interfaces with the care planning for the dementia client ensuring a sustainable holistic care approach.
- That advocacy services do 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 the client.
- In dementia there is a continuum of care in particular from the comprehensive early intervention assessment through to permanent care placement. There is a mobile “package of caring” for the client that moves seamlessly across a range of settings including acute, community and residential with linked funding.
- Nurse Practitioner model for early assessment with timely management for simple medical issues that can have a profound effect on the dementia client, ie UTIs etc. This could be provided in both the residential and community setting.
- The National Rural Health Conference recommends 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.
- 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.
- That Alliance members and governments commit to build the capacity of rural communities for active engagement in workforce and service markets.
- That therapeutic touch be introduced to rural areas for:
 - dementia and palliative care
 - care for the caregiver
 - support for allied health staff.
- Consumer groups to advocate for the introduction of the Laughter Therapy Program into rural and remote communities.
- 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 UDRHs 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.



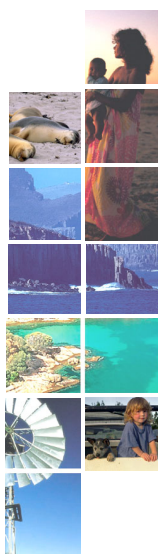
- Advocate for increasing the opportunities available to undergraduate nursing students to participate in meaningful and financially supported, adequately mentored rural and remote placements.
- That the NRHA ask that the Commonwealth Government not consider “trading away” the Pharmaceutical Benefits Scheme in the negotiations for the Australian–United States Free Trade Agreement.
- 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.
- Larger research studies are required in rural aged care organisations to determine:
 - attitudes to and use of evidence-based practice
 - education and training programs to implement use of evidence in daily practice.
- That scholarship and other support structures criteria for secondary and tertiary students planning to undertake a career in any health profession be broadened to include those from:
 - metropolitan and metropolitan fringe backgrounds/origins who demonstrate an interest in rural/remote practice
 - mature age groups.
- In rural areas as elsewhere, reproductive and sexual health projects 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.
- Looking at health in the broader social and community context it would be a good move to have a recycling bin for unwanted paper (most gets thrown out in hotel rooms and is not recycled!) and a less wasteful final lunch. I (we) found the wastage quite distressing particularly in the context of learning about inequalities in Kenya.
- To promote the Conference to grade 12 students who are interested in a career in rural medicine.
- Future Rural Health Conferences include sessions with specific focus on social determinants and public health.
- That Regional Health Service programs and other government funded programs recognise social models of program planning, implementation and evaluation.
- Develop partnerships across governmental and non-government organisations to address social determinants of health.



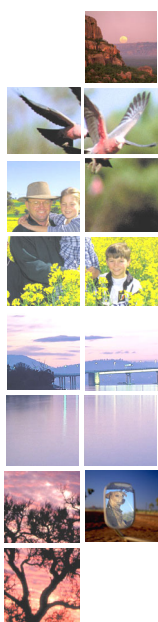
- Pooling of available funds to ensure that programs can be flexible and community-driven.
- We recommend that laughter therapy, therapeutic touch, and manutention for agricultural workers be adopted to improve health in rural and remote Australia.
- That the next National Rural Health Conference provide more opportunities for discussion and sharing of ideas and views.
- Students gain an enormous amount from these Conferences. It's a pity the registration isn't significantly cheaper to allow more students to attend. Thanks for a great conference.
- That the National Rural Health Alliance issue a strongly worded statement condemning the Federal Government's support of the US and UK's proposed military action against IRAQ. Such military action would further deplete resources and funds needed to improve health care services in rural and remote areas. It would also increase Australia's profile as a terrorist target.
- National continuity of care funding strategy supporting improved shared patient information services and hand held computerised devices with centralised patient/client records and privacy arrangements for PHC teams.
- That the NRHA, nurse leaders, 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 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 next NRHA Conference include papers and speakers on the theme of inter-professional and inter-institutional communication.
- 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
- It is impossible to list.... Recommendation from the study... (*paper torn*)
- Encourage the use of qualitative research in rural and remote health.
- Support Network for Human Services Providers in rural and remote communities that crosses disciplines. There are a lot of good services for professional groups but little or no cross communications between these groups.
- There is a need for community base strategies that can provide assistance to all relocators – not just professionals. This community base strategy needs to assist in co-ordinating social support services for relocators and identifying new relocators to guide them to find assistance.
- A strategy or mechanism whereby regional universities involved in undergraduate health discipline education, but not formally involved with a clinical school or University Department of Rural Health, formally work together.
- That the Australian Longitudinal Study on Women's Health continue to be funded by the Commonwealth Department of Health and Ageing in recognition of its role in identifying issues for rural women, and that consideration be given to a parallel study of men's health.
- (Include an arm that looks specifically at Indigenous men's health in remote areas.)
- ARHEN Symposium recommendations:
 - A co-ordinated strategic approach to promoting health professional careers in rural and remote areas to high school students, including Indigenous students, is needed.
 - A funded national 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.
 - All tertiary health professional courses should include a serious, examinable rural health stream, and mandatory time spent in rural and remote areas.
 - 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.
 - A close working relationship needs to be developed between University Departments of Rural Health and Rural Clinical Schools.



- 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.
- That the Alliance lobby the Minister for the establishment of a National Rural Female GP Network as a matter of urgency, and that such a Network be established and closely linked with the Divisions of General Practice to establish both grassroots support and national input.
- Larger research studies are required in rural aged care organisations to determine:
 - attitudes to and use of evidence-based practice
 - education and training programs to implement use of evidence in daily practice.
- 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 MBS 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.
- That 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, be investigated at the national level.
- That NRHA examine ways by which a participatory (rather than representative) body can own rural health and its associated conferences.

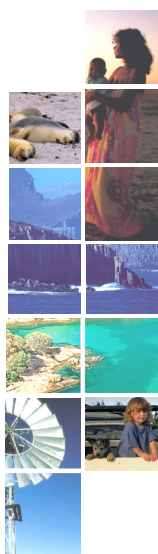


RECOMMENDATIONS FROM CONCURRENT SESSION PAPERS

Note: These have been ordered into arbitrary groups and listed alphabetically.

Aged care (including dementia)

- When a person is unable to sign an ACAT assessment, an advocate should be there to ensure that clients' best interests are looked after both in terms of Power of Attorney and also in view of the aged care placement.
- Someone should speak on behalf of the client and no guardianship order should be given by the Civil Administrative Tribunal unless they personally have met or spoken to the person for whom the guardianship order is being taken out.
- Elderly people should have access to advocates in rural and metropolitan areas and that advocacy services should be increased to cover not just disability but incorporate elderly people as well.
- Service providers should be encouraged to develop dementia-specific day centres with secure areas in rural community centres.
- A common aged care assessment tool and case management model should be developed to avoid over assessment and to improve service co-ordination.
- A broad and ongoing education campaign should be undertaken to raise public awareness of dementia, increase understanding for workers and help to remove the stigma.



Allied health

- Recent research has identified key areas impacting on the recruitment and retention of allied health professionals in rural and remote areas. The theoretical studies have now been validated by the development of some new services. Services wishing to recruit should take note of the evidence with respect to management and support of allied health professionals.
- The development of new services requires new infrastructure, recruitment and orientation of staff, and establishment of a sub-management structure to support the development and implementation of innovative components of the service.
- Re the AHPEP program:
 - seek recurrent funding to ensure that appropriate resources are available
 - develop guidelines to ensure consistent state-wide co-ordination of the program
 - redirect the promotion of AHPEP to professional groups not making optimal use of the program
 - review and refine the evaluation tools
 - use evaluation data to continuously improve the responsiveness of the program.



- The development and delivery of programs that work to enhance service delivery and increase the number of allied health practitioners in rural areas need to be led by rural allied health practitioners.
- Resource pooling options to be considered to expand the number of allied health publications available to practitioners through their local health service library.

Cancer

- A centre should be established to study models of service for oncology to rural Australia. This follows the recommendation of the “Cancer in the Bush” seminar (Canberra 2000) and would allow a centre such as the Royal Adelaide to construct surveys of consumer and health profession satisfaction, as well as carefully measuring outcomes statistics including the utilisation rate of treatment in regional areas as well as in-patient days, morbidity and mortality. This is along the lines of the designated National Breast Care Centres. Many of the efficiencies developed will be applicable across a number of other areas of specialised medicine.

Carers (see also aged care)

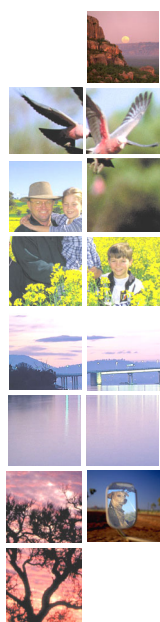
- A caregiver representative should be included on any future state or national government policy or program development in this area.
- The specific problems identified regarding income security payments should be made known to Centrelink, with recommendations for changes to eligibility requirements for Carer Payment.
- That the role of carers be acknowledged and there be recognition that carers require emotional and financial support, education, training, domiciliary and respite services.

Diabetes

- We recommend that time spent by health care professionals for diabetes case management is explicitly funded in order to improve diabetes related outcomes.

Disability

- Health professionals should extend their viewpoint about disability beyond the “disease-centred” medical model and expand their knowledge by paying attention to disability from a person-centred perspective.
- Annual checkups with general practitioner should be used as a means to refer those living with disability to a multi-disciplinary team in order to address each person’s needs with as much breadth and depth as possible.



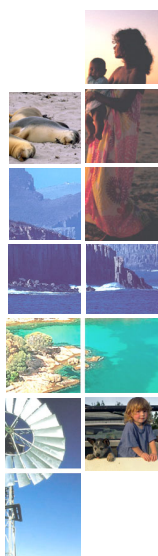
- Health professionals should turn their attention to identifying ways of preventing further health risks associated with disability by discussing future scenarios.

Emergency services

- It is recommended that a patient-centred, cost-effective and comprehensive aeromedical service be maintained and further developed for the health and well-being of Australians living in rural and remote communities.

Evidence-based practice

- Multi-disciplinary evidence-based practice is a concept which has had limited consideration to date. While significant time and resourcing has been allocated to increasing the uptake of EBP for disciplines such as medicine and physiotherapy, the notion of evidence to inform practice remains new to many health disciplines, particularly in remote locations. Work needs to be undertaken to redress this balance, especially given the pivotal role played by multi-disciplinary practitioners in rural and remote Australia.
- Current health policy development in relation to EBP assumes health disciplines are at comparable stages in understanding and uptake of EBP. While there is policy rhetoric around EBP and multi-disciplinary approaches to health care, no framework exists to build and implement uptake by multi-disciplinary teams operating in rural and remote environments. Policy initiatives need to reflect the diverse needs of different disciplines in adoption of EBP.
- Rural environments impact significantly on practitioner capacity to adopt EBP therefore policy and funding targets need to address issues of access, professional development and contextual relevance for all discipline areas, to encourage expansion in uptake levels.
- Evidence-based approaches to health care may not be readily transferable from metropolitan settings to rural and regional settings. The National Rural Health Alliance should inquire into and prepare a position paper on the applicability of, and factors affecting, the uptake of evidence-based health care in rural areas.
- Existing explanatory models about the uptake of evidence-based health care in rural areas have been dominated by micro-level perspectives. Future projects should also be informed by consideration of broader power relationships within the health system, and the development of effective strategies to reconcile potentially competing views and interests. One such strategy may be the introduction of multi-disciplinary undergraduate training and ongoing professional development in evidence-based health care for all rural health care practitioners.

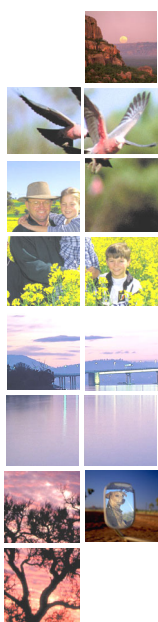


Eye health

- The “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. The authors recommend that:
 - the National Rural Health Alliance recognise the importance of visual health to the communities it represents, and seeks greater emphasis on visual health awareness from its members, communities and governments
 - public health campaigns 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 consider the role of partnerships in successful health promotion.

Health and “social capital”

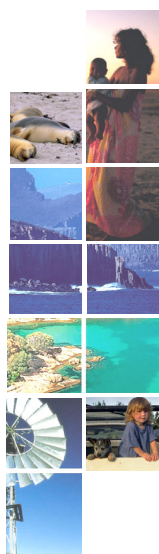
- The role of local government in supporting civil society must be formally recognised and appropriately financed so it can maintain its important advocacy role in supporting civil society for both all community residents.
- The emotional well-being of rural women is essential to the continuation of rural life in Australia. This paper recommends that investigation by Women’s Health Australia into factors influencing rural women’s ability to cope should continue to be funded.
- Government rural initiatives should be supported and extended. For example, strategies to increase the number of GPs who stay in rural areas for longer periods and better access to specialist mental health services. Support services for people experiencing adverse events such as bereavement, divorce, cancer diagnosis and treatment and caring for chronically ill relatives should be available when needed.
- Initiatives to improve the health of rural people should take a broad social approach to the concept of health, recognising the importance of leisure time and choice in promoting positive well-being.
- There are many examples of responsiveness, improvement and innovation in rural and remote areas. These show that although rural and remote areas face particular challenges, they also benefit from strong community support and from being forced to think outside the square. However, while innovation may emerge from the isolated efforts of individuals or communities, government may play a role in nurturing innovation. This may be through means such as:
 - wider dissemination of information about initiatives, the rationale for them, their successes and failures



- the development of effective outcome indicators to guide communities and service providers in the evolution of aged services appropriate to their local needs.
- Socially inclusive activities should be available for those not able or willing to access mainstream services. These activities should be collaborations between workers from Community Health, HACC, Mental Health, Aboriginal Health, ATODS, Aboriginal Health, Public Health, Healthy Ageing, Area Healthy Ageing and the hospital.
- Community programs in small country towns and regional centres should include activities for the most socially excluded members of our community. These activities should be client driven and the groups small. HACC funding should remain available for such projects and Aboriginal Health sections of the State Departments invited to participate.
- Funding needs to be dedicated to support capacity building.
- Increase access to educational resources such as video-conferencing by providing training and ensuring access by all practitioners.

Health consumers

- It is recommended that a further study be undertaken to investigate what knowledge rural residents from different size rural and remote communities have about the role and function of the Health Services Commissioner (HSC), and how they feel about using its services and in what circumstances. In particular, the study should focus on how the HSC might assist to maintain and improve access to and quality of rural health care services with a view to bringing about improved health status and outcomes for non-metropolitan Victorians.
- Do not underestimate the power of the consumer voice. It will resonate much more deeply than others for those who are diagnosed with a similar condition. Find at least one passionate consumer who is willing to devote ongoing time and energy to local support groups.
- Develop collaborative arrangements between local health professionals and consumers in all rural areas to facilitate group start-up, and ongoing functioning.
- Getting new members is a task for local health professionals, such as specialist nurses and GPs, and consumers.
- Enlist community support for the group. Communities must be prepared to provide some financial support for groups to be viable.
- Involve consumers at the planning stage for all health services. This can be as members of planning committees and working parties, who have their designated tasks like other members.

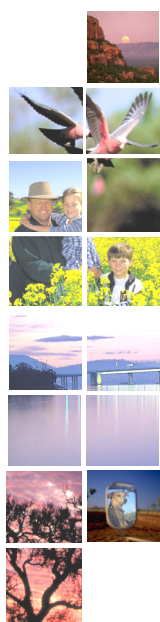


Index of Health Care Access

- That the Conference support development of a National Index of Health Care Access that will:
 - maximise the health and well-being for people in particular areas, regardless of where
 - apply to the range of primary, secondary and tertiary services
 - support resource allocation
 - be used for reporting purposes.
- That the Conference support the proposal to seek government funding to conduct a scoping study on the development of a National Index of Health Care Access that will:
 - examine similar indexes in Australia and overseas and identify key findings and work undertaken on health access in or indicators in Australia
 - consult and gain stakeholder input on the framework and parameters
 - develop an agreed project definition document that will outline the proposed framework and parameters for the National Index of Health Care Access
 - develop a data definition document that would address the technical data issues
 - prepare a final proposal and recommendations including costing options for the construction of the Index and the trialing of the Index.

Nursing workforce

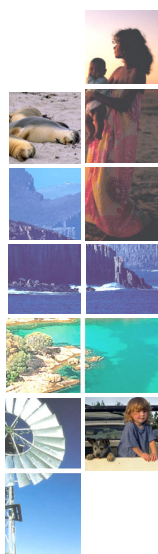
- Support for recommendations 1-7 from the Action on Nursing in Rural and Remote Areas Project (2002) (reprinted below).
- The positive aspects of practice in rural and remote Australia deserve more attention. Problem resolution can be approached both from the perspective of decreasing negative factors and increasing positive factors.
- It is recommended that:
 - Rural and Remote health care organisations evaluate current management development strategies with a view to addressing rural health workers' need for greater management support. Management is a complex and ever more demanding job, requiring managers to engage in ongoing development. It may be that a relatively minor adjustment in focus of some development activities could produce marked gains in rural health.
 - Health care organisations achieve greater transparency in resourcing issues, benchmarking resourcing strategies against performance indicators.



- Resourcing, and perceived inequities in resourcing, are identified as problems across many industries and locations. Transparency does not increase the total resource pool but does promote the distributive justice important to job satisfaction. Benchmarking provides data to guide resourcing strategies and verify perceptions about relative levels of resourcing.
- Health care organisations provide for equity in access to continuing professional development (CPD) for rural and remote health practitioners across all disciplines.

This provision must recognise not only the additional cost of accessing CPD from rural and remote locations but also the logistics of scheduling and in many cases, the provision of relief workers to permit release to attend.

- With regard to the positive factors, the primary recommendation from this paper is:
 - Develop and implement strategies to highlight and support the positive aspects of working in rural and remote areas. Accurate promotion of the positive aspects of working in rural and remote health would contribute to both recruitment and retention, attracting workers who value the positive factors identified in this needs assessment and assisting established staff to remember, on the bad days, why they came. However, balancing attention to include the positive aspects must be more than hollow words, there must be organisational support for these assets. The pleasing factors identified provide guidance for management regarding facets of rural health work strategically important to protect from inadvertent undermining and to actively support.



Recommendations 1-7 from the Nursing Project ("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/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

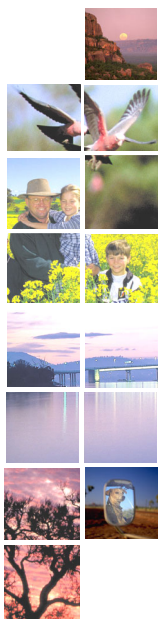
Action to ensure that health service providers in rural and remote areas provide workplace environments with adequate levels of human, financial and material resources (including adequate facilities and equipment), flexible employment models, reliable relief systems and professional support mechanisms.

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.



Palliative care

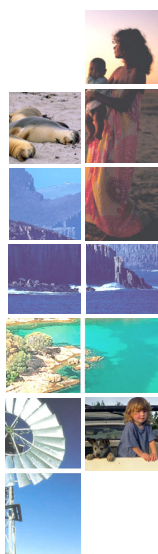
- Projects are needed to produce and disseminate further culturally sensitive palliative care information to Aboriginal Medical Services.

Quality improvement

- The clinical practice improvement methodology is a potentially useful tool for improving the processes and outcomes of care, and success has been demonstrated in rural health services. Subject to a management commitment to identify and commit resources to train and support clinical leaders, it should be considered for use in the quality improvement program of smaller hospitals and health services.

Recruitment and retention

- Governments and other funding agencies commit to a nationally co-ordinated, adequately funded, long-term research and evaluation program to determine the effectiveness of rural workforce recruitment and retention strategies.
- Agencies working in recruitment and retention explore opportunities for collaborating with parties who have an interest and mandate for addressing issues that face other professional groups and the general community. It is essential that the administration of resources be flexible. Policy makers and service providers need to remain open to the range of alternatives available to address the specific issue of recruitment and retention of GPs in rural areas and at the same time the more general issues associated with disadvantage and rural communities which bear a critical relationship to the success of rural retention strategies.
- The experiences of welfare workers highlight many of the issues reported in the literature about rural practice. They underline the need to manage confidentiality, personal and family safety, workplace issues and living and working in the same community and the implications for individuals of lack of anonymity.
- There needs to be allowance for other major issues by professional bodies and unions, including the impact of workplace harassment and violence. There need to be funding for replacement staff during periods of recreation and other leave. Further training and staff development should not have to be completed at the participants' own time and cost.
- Education, training, recruitment and retention strategies need to consider not only individual attributes such as ability to be resilient, mature and independent, but organisational factors such as resourcing, supervision and debriefing, and funding for replacement staff during periods of leave. Educational institutions should include appropriate training for the complex personal and professional issues arising from rural practice. The relevant unions and professional bodies such as the Australian Association of Social Workers (AASW) and the Australian Institute for Welfare and Community Workers (AIWCW) must become involved in advocating for better workplace



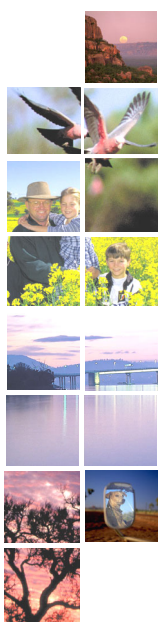
conditions and protection of rural social welfare workers. Strategies such as allocating funding at a rate that allows for replacement of staff during recreational or sick leave, improvement in pay scales for rural welfare practice in acknowledgment of the high level of complexity, and protocols for effectively managing the real and vicarious trauma experienced by workers and their families when undertaking these important roles for the community must be developed.

Rehabilitation

- Extensive comprehensive pulmonary rehabilitation programs can be provided in the majority of sites within a rural area health service.
- Consideration of the local barriers to provision of pulmonary rehabilitation services is necessary for development and implementation of a flexible area wide model.
- Improved patient access to pulmonary rehabilitation, through the addition of intermittent programs offered in smaller rural communities, can significantly increase patient recruitment.
- “Generalist” rural health professionals, with local training and support, can provide effective comprehensive pulmonary rehabilitation programs.
- The provision of pulmonary rehabilitation programs can positively impact on individual staff attitudes and their understanding of chronic respiratory disease.
- Bringing the multi-disciplinary team in contact with patients attending pulmonary rehabilitation groups can positively impact on sustainable re-orientation of service provision across all disciplines.
- For people who are involved in injury prevention, rehabilitation and return to work programs, to retain credibility and respect from their farming clients it is imperative that they understand the industry and have intimate knowledge of the tasks performed, the skills needed to perform those tasks, and current work practices.

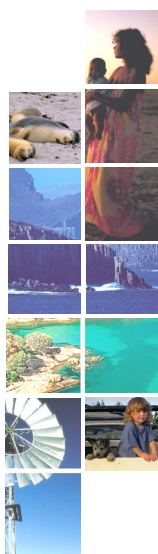
Reproductive health

- In rural areas as elsewhere, reproductive and sexual health projects 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.



Rural general practice

- In order to ensure the provision of viable health care services to rural and remote Australians and the sustainability of their communities, governments need to factor differences relating to the nature and complexity of rural and remote general practice activities into differential measures designed to support and remunerate rural doctors.
- Ensure that all research, policy, programs and initiatives for rural general practitioners take into account the interests of women and women must be represented on all decision-making bodies. Furthermore, ensure that female friendly structures are available in organised medicine to enable women's equal participation in leadership.
- There should be an immediate and substantial increase in undergraduate medical student numbers across Australia, with a selection process to target likelihood of working in remote and Indigenous settings (eg origin in rural area closely correlated with working in rural area).
- Medicare rebates in remote and rural areas should be weighted either directly or through the Blended/PIP payments in recognition of extraordinary cost of service delivery (Commonwealth Grants Commission recognises a 2-times loading for remote area work).
- The RRMA 1 and 2 classifications should be reviewed to bring them in line with ARIA classifications regarding access to GP rural incentives and a reassessment of the capital city weighting in relationship to Darwin.
- All remote GP benefits should be extended to all Aboriginal Community Controlled Health Centres eg Remote Area Grants available to all identified ACCHO or similar positions.
- The Federal Government should create 50 Indigenous bonded medical scholarships.
- There should be a sliding scale grant payments to GPs working in areas of need in return for a commitment to bulk billing.
- There should be trials of alternative models of General Practice in targeted areas of need which provide quality and access as key components of service delivery, utilising current and additional targeted population-based financing in a mix of alternative General Practice financing and workforce arrangements.



Telehealth

- The quality of the technical and clinical component of telehealth activities must be addressed at an enterprise wide level, not by individual clinics or projects.
- The variable costs associated with the 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.
- Inclusion of a wider range of telehealth services on the Medicare Benefits Schedule must occur to improve the equity of service delivery to rural and remote locations.
- The option of funding telehealth supplied by private sector providers on a cost and volume agreement basis be investigated at the national level.
- Registration boards should develop a position on cross-border clinical practice and telehealth.

Therapeutic touch

- The long-term goal is to train local Therapeutic Touch Teachers so that health care workers and their clients can more easily access the benefits of Therapeutic Touch. Such an ambition requires both formal and informal networking. Funding be provided to introduce Therapeutic Touch more extensively to rural communities.

Undergraduate education

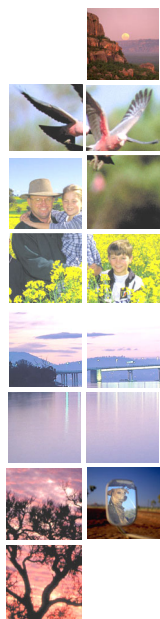
- All undergraduate courses in the health disciplines should include at least one formally assessed elective unit that explicitly focuses on inter-professional education and involves at least one community-based activity.
- Government, universities and other co-ordinating bodies should collaborate to develop and maintain a pool of advice, exemplars and other resources to assist those undertaking community-based learning activities in the health disciplines.
- All secondary and tertiary students studying Agriculture, be it at College, University or as an apprentice, should have Manutention skills training. This will ensure all graduates have the knowledge and automatic human movement patterns to reduce the risk of developing “a bad back” and other musculo-skeletal injuries.

Violence

- The feasibility should be investigated of providing domestic abuse counselling services by people who do not live in the towns that they service.

Women's health

- Because there are multiple causes for women’s psychological distress in midlife, we need to ensure there are multiple strategies available to help them – pharmacological, welfare services, respite for carers, counselling from a range of therapists. There are many people who by their cultural or personality attributes will not benefit by self-disclosure and talking therapy and they should be accommodated.



- The effects on women's mental health as a consequence of the downturn in the economy of the Australian farming sector and associated rural towns should be monitored in future surveys by WHA (?) and SMHWB (?).
- Providers of Midwifery services should review their models of care and consider introducing a CMP (?) model similar to that developed by Northeast Health Wangaratta to allow pregnant women the option of a family-centred stream of care.
- The Commonwealth Government should follow the lead of State Governments and remove the barriers to the development of Nurse/Midwife Practitioner models in Australia. The area in need of most urgent reform is that involving the allocation of Medicare Provider numbers to Nurse/Midwife Practitioners who are formally endorsed by the state Nurses Board for advanced practice.
- There should be a greater emphasis on developing local cancer support groups to help meet the psychological needs of women with breast cancer.

Youth health

- The Y-FAT (available as a NSW State Health Publication) has broad applicability to other health services, particularly those in rural locations. It is recommended for health service use as a key initiative in improving service access and hence health outcomes for young people.
- The Federal and State Governments should recognise the value of early intervention programs that value young people as an asset in their community. Policies should provide opportunities for young people to contribute in their community and to their own well-being through involvement in connectiveness with each other. The community, in partnership with Health Services and Schools, could be funded or encouraged through resources and best practice models, to develop opportunities for youth to reduce their health risks and increase their socialising opportunities.
- State Governments should expand Secondary School Nurse programs to areas not currently serviced by the program by supporting a Community Health Partnership between Health Services and Schools to deliver a Community Health School Link Worker in partnership with the local/regional Secondary School Nurse Cluster.
- Rural youth are the future of rural communities. We need to encourage, support and value them as adolescents.

