



8th National Rural Health Conference

Conference Recommendations

Note

This is a full list of the 8th Conference recommendations. Apart from ten, they were not subject to review or prioritised at the Conference. Therefore there can be no implication that all Conference delegates support any particular recommendation in this full list, or that the NRHA or any other organisation associated with the Conference does so. Conference delegates endorsed a set of ten priority recommendations, published by the NRHA and others with the Communiqué.

All organisations and individuals are encouraged to use this full list as a source of or as support for ideas that will improve the health of people in remote and rural Australia. For its part, the NRHA will engage in 'due process' with its 24 Member Bodies to prioritise the proposals in this full list, as well as the ten key recommendations, in order to inform its work.

The recommendations have been collated from papers presented to the Conference, from concurrent sessions and from the workshops. They have been edited for consistency of style and presentation. For ease of access, some of them have been grouped into sets by topic.

They are arranged below in six categories:

1. **'governance of health'**, ranging from high level governmental issues (characterised as 'health reform'), to issues concerning the way consumers interact with, and are treated by, local and regional health services;
2. **intersectoral determinants** of health status;
3. **lessening the 'Indigenous health differential'**;
4. developing and supporting an appropriate **health workforce** for rural and remote areas;
5. health service models and approaches to health **service delivery**; and
6. **other topics**.

1. Governance of health

The restructuring of health services should be underpinned by the principles of community participation, equity, sustainability and quality. Communities must be centrally involved in decision making about the type and mechanism of health service delivery that will best meet local need and priorities. Communities should be supported in this involvement by medical, nursing and allied health agencies.

To promote more efficient, effective and sustainable models of health service delivery in rural and remote areas, the artificial boundaries created by separate state and federal health funding must be removed. For example the desired reform would see Medicare reformed to remunerate hospital nurses to triage and support private general practitioners in the provision of after-hours care in rural and remote areas. We need to go further in having specific item

numbers under Medicare to cover the work of non-medical professionals who support and extend the role of the general practitioner.

There must be a 'whole community' approach across Australia to 'Health' and this has to be initiated from the government down to each community/local government body/area. 'Health' needs to be recognized as a whole Government responsibility and not just something that happens in hospital settings and there have to be workable policy and sustainable funding for community initiatives to suit each community, whether it be rural or remote, Indigenous or not.

This conference has brought into sharp focus the great differences between remote and rural areas, especially in health. There are differences of geography, access, demographics, levels of poverty, Indigenous population etc. Unfortunately, 'remote' is still often subsumed into 'rural', so 'remote' gets lost. It is proposed that the NRHA should become the National Remote and Rural Health Alliance to reflect more accurately who we are, where we live and what we do.

It is proposed that we accept and promote a full definition of remote health is an emerging discipline with distinct sociological, historical and practice differences.

Sustainability strategies must be built in to one-off funded projects subject to evaluation and service priorities.

There need to be systems in place for people to have increased awareness and self-management in relation to their own mental health.

The current funding model obstructs the provision of services by the 'health team' eg there is no basis for declaration of service provision. (?)

It is important for older people to be given the opportunity to continue their adopted lifestyle. Older people need to keep meaningful community connections such as school groups to maintain a sense of belonging, reduce loneliness, break down generational barriers and improve general health and well-being.

The States, Territories and Commonwealth should make greater efforts to ensure that projects and programs receive a minimum of three years funding or service agreements. There remain many examples of month-by-month and annual funding arrangements which disadvantage remote and rural communities.

The past 40 years has seen the breakdown of social capital in remote communities. To rebuild it will take financial capital, employment and training and a vision of direction that is in tune with local needs. It is important to consult with local people who should be given the trust, encouragement and support to determine and implement the answers. Employment, training, education and a sense of direction can all be achieved through an approach based on gaining economic strength through social development - building a healthy community through building social capital.

In many parts of remote and rural Australia, challenges like pressing demographic issues, poorer health outcomes for particular population groups, poor infrastructure and financial

concerns, demand a widespread system change. The new health service paradigm is one in which priorities and processes are geared towards a co-ordinated population health approach.

The Medicare Schedule should be adjusted to allow a Rural Equity and Access Loading (REAL). This fee would be additional to the Schedule fee and be a similar percentage as the Practice Incentive Payment rurality loadings and linked to RRMA classifications. One half of the loading should be based on location and half on whether the practitioner provides more complex consultations (which has been shown to be linked to Hospital Admission Rights and provision of A&E services -- a review mechanism would be necessary to ensure inclusion of practitioners who provide those complex services but do not have a local hospital).

Governments should support partnership approaches, such as that between the Carers' Association and Council of Aboriginal elders, so that mainstream organisations and Indigenous groups can work together – in this case, to develop meaningful services for Aboriginal carers. These partnerships require steadfastness to the agreed approach and task, time, development of trust and respect, and a willingness to work through key elements vital to making effective partnerships (eg respect Elder's role, establish ethical practices, nurture close relationships, mutual respect, community involvement, working protocols).

Private health providers must be encouraged to play their part in rural and remote health service provision. (Over 50% of elective surgery in metropolitan areas is private.) We need to develop and strengthen regional centres as preferred referral centres.

Given the dearth of private sector investment in rural health, remote and rural health professionals could create our own 'private sector' investment fund. The NRHA – or another body, if more appropriate – could co-ordinate an investigation into the viability of a National Rural Health Co-operative, which would provide a focus for investment and provide a central body for development of rural health infrastructure.

Australia needs to develop and use appropriate health data sets that capture the impact of primary health care services and can measure individual and community 'wellness'.

We should look to 'the public' to provide direction and impetus to change the current funding model. The community is an important and often untapped resource for supporting the delivery of health services. It is therefore important to develop tools to assist health services to engage their communities and to establish community-based services eg. through volunteers.

The sector must continue to work on a whole-of-government approach to health, which should include practical projects that ensure partnerships with Indigenous people.

Because cultural affiliation is essential to successful health care, the culture of peoples must be accepted as inherent in service provision and projects.

2. Intersectoral determinants of health

There should be greater collaboration between the health sector and other sectors in order to improve health outcomes. For instance, as demonstrated by a conference paper, collaboration can occur between farming families, their industry associations, a rural health service and a university.

The debate over telecommunications needs to take account of the need for improved mobile phone coverage, as mobile phones provide reassurance for carers should they need to leave their care recipients 'home alone' for a short while.

Rural health programs which seek to change behaviour must be undertaken in full collaboration with people and the specific industries in these places. They should be people-centred, knowledge-based, built on strong evidence and intersectoral.

To protect the safety of those using life support equipment, power authorities should be required to provide adequate warning of planned electricity blackouts.

Particular consideration in policy and planning, and in the analysis of issues associated with spatial distribution of inequality, should be given to older women who move from a rural to a more urbanised area.

Strategies need to be put in place to redress the increasing problems of access to bulk billing and increased out-of-pocket costs for younger women in remote and rural Australia.

There needs to be a greater focus on a population health approach to the potential for good nutrition to manage and prevent disease, including for towns and communities to create supportive environments for healthy eating. This would include programs relating to food access and security and to the health and nutrition of the 0-5 year age group. Such an approach would reduce the incidence of diabetes, renal disease and obesity.

To have healthy outcomes we need to concentrate on all related matters. It seems that housing has been left out [of the Conference's considerations]. Healthy housing is essential.

We must continue to advocate to all relevant organisations about the impact and implementation of 'mainstream' and 'urban' policies and decisions on rural and remote, including Indigenous, health.

In line with the Ottawa Charter that recognizes the strong link between 'country' and health, natural resource management projects need to be recognised and financially supported as opportunities for innovative health promotion.

3. Lessening the 'Indigenous health differential'

To address Indigenous health needs, Australia needs a comprehensive primary health care approach. For most existing services and staff (both clinical and managerial) this will require a paradigm shift, and many of them will find this to be daunting. Sustainable health service reorientation requires changes to attitudes as well as clinical practice, and needs to begin in training institutions.

We must invigorate the debate on Aboriginal health and education, and examine options that would help change the way in which Aboriginal health is developed and delivered. This will require workplaces to re-examine their own staff development strategies and higher education must become the benchmark for the training of Indigenous health workers. In this we need to examine pre-conceptions, standard responses and entrenched models of thinking.

Indigenous health workers need to evaluate their roles as community workers and leaders. They need access to and understanding of the clinical, social, political and cultural issues that are at work.

More scholarships should be available to encourage the participation of Aboriginal and Torres Strait Islander people in relevant mental health tertiary studies.

As much training in the old *ngangkari* ways as possible should be given to the young people to keep the old powers and skills alive. Mainstream health must support this concept by continuing to incorporate *ngangkari* practices with western medicine. This means funding bodies recognising that *ngangkari* may not possess Australian Business Numbers, Tax File Numbers or even bank accounts into which financial support can be paid.

Mainstream responses to Indigenous health care could be improved. For example policy makers, funding bodies and legislative practices could give stronger support to mainstream services to provide culturally appropriate care to Aboriginal people, eg through *ngankari*. The Age Care Act could be amended to enable four or more traditional people in a room as that is their preference.

The Council of Australian Government (COAG) trials provide further evidence of the need in Indigenous health for partnerships across Departments, with local Indigenous people and their community controlled organisations. There has to be 'shared responsibility' between government, organisations, families and individuals.

The NRHA, in partnership with the Aboriginal community controlled health organisations, should lobby the Federal Government to maintain and increase funding to the Primary Health Care Access Program (PHCAP). PHCAP is a health financing model based on need. Through the full implementation of the PHCAP, Aboriginal and Torres Strait Islander peoples will be able to access quality, comprehensive primary health care at home where they live. PHCAP is a community development model which enables local communities to organize and be in a position to make their own decisions about their health. The full implementation of PHCAP provides an appropriate approach which has the power to improve the health status of Aboriginal and Torres Strait Island peoples.

There needs to be more Aboriginal representation on Regional Boards and committees involved in the health system. It would be useful for Aboriginal health to be a standing item on the agendas of all regional health committees.

Greater use should be made of peer education in Indigenous health, for example bringing together groups of Aboriginal women in various communities who have an interest in furthering their knowledge of maternal and infant health issues. This will enable the individuals concerned to encourage, advise and support others in their community to gain access to the services about which they have learnt. Trained Peer Educators, whilst not professionals, can be identified in their communities as knowledgeable women who can influence the thinking and behaviour of their family, friends and community members in relation to aspects of health and lifestyle. They can, if they so choose, assist their community in formal or informal ways, or they can use their TAFE qualification as a stepping-stone to continue their own education and improve their employment prospects.

It is recommended that there be structured support and funding for early interventions for Indigenous young people in remote communities with mental health issues.

All agencies should support and encourage creative approaches to comprehensive primary care initiatives for health promotion in Indigenous communities.

All of those involved in Aboriginal health must understand, acknowledge and include their law, culture and governance.

Conference should support and advocate for genuine community control for Indigenous health organisations, including adequate funding recognition.

Adequate resources are urgently required for the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Well-being, 2004-2009, to operationalise the areas identified for action.

The Conference should endorse and pursue the three points raised in Ted Egan's address:

- \$100 for each dog;
- 'suitable' housing; and
- one free nutritious meal a day.

Government and health managers must recognise the critical importance of place to the overall health of Indigenous peoples and Indigenous communities, and ensure that this recognition is embodied in programs.

Attracting and appropriately qualifying Indigenous health workers should be a national priority, as a means of facilitating health care delivery in Indigenous populations.

The model outlined in the conference paper for Aboriginal mental health workers in remote and rural areas should be endorsed. It requires recurrent funding to sustain it. There should be revision of salary award and clinical recognition at completion of the program. This is part of what is required for adequate wages and employment environments for Indigenous health workers.

There needs to be increased scholarship support for people undertaking Aboriginal and Torres Strait Islander Studies.

Funding needs to be secured in order to continue the *Indigenous Health – Working Both Ways* program (currently through the Top End Division of General Practice). The current program needs to be maintained and strengthened. It should be possible to partner with other providers and agencies to expand the program into new communities.

4. Health workforce

Carers

More public debate and understanding on carers and caring is required. This would provide valuable information on the mix of formal community care and informal care; how people without primary carers manage; how we accurately estimate unmet need and establish appropriate levels of service, which are then reflected in benchmarks, planning ratios and resourcing; the extent to which public funding should be used to provide formal care; and

how the private sector responds to demand. The remote and rural health care sector would then be better placed to develop sustainable models of care.

Carers need improved access to allied health services for provision of care in the home and improved access to counselling services for themselves and their care recipients. There is also a need for bereavement counselling as carers often feel neglected after the death of their care recipients. More respite care is required, particularly at night and at weekends.

Carers and caring need added support, including through:

- policy developments in taxation, social security and income/pension benefit;
- more carer-friendly workplaces with flexible employment arrangements;
- evaluation of services to ensure closer links between policy and practice;
- promotion of the social value of caring;
- addressing carers' barriers to seeking support;
- education for carers and health professionals;
- multi-disciplinary research leading to evidence-based practice approaches; and
- partnerships between government, service providers, families and researchers.

If care is to be sustained in the home environment, the role and work of carers has to be better recognised and supported by governments, service providers and the wider family.

To improve services to Indigenous carers, partnership approaches need to be supported so that mainstream organisations and Indigenous groups can work together. For example there is the successful partnership between the Carers Association and Council of Aboriginal Elders.

Relationships between health professionals and carers need to insure that carers have information and education about an ill relative's condition and its implications, the treatment options, managing medication, and recognising and reporting changes in health and functional status of the patient. They need increased knowledge about available services and how to access individual and family counselling services and physical support, such as appropriate respite care and domestic help.

There needs to be better co-ordination of the local availability of equipment for the recipients of care: commodes, shower curtains, mattresses, syringe drivers, mobility aids, etc. Without appropriate equipment and training, the patient may be at increased risk of injury and pressure ulcers and carers may also be at risk of injury from inappropriate lifting.

Health care teams

The recruitment and retention of multidisciplinary health teams (inclusive of nurses and allied health professionals) to remote and rural areas can be supported by line management by a health professional; access to professional development and cross-cultural training; remuneration packages that include financial reward relevant to complexity and responsibility of isolated practice; accommodation subsidy; relocation expenses; annual repatriation to the person's designated 'home'; and professional mentoring.

For successful approaches to health care delivery to be replicated from one place to another, there must be dedicated and skilled health workers available locally.

Public resources would go further with reconfiguring of recruitment, retention and remuneration packages through salary packaging and tax-based incentives and rebates that

may include childcare, provision of motor vehicles and accommodation options and offsetting liabilities such as HECs.

Better ways must be developed of defining and quantifying all of those in the rural and remote health workforce. A national definition of the non-medical health workforce should be developed and endorsed by all organisations.

The focus of health workforce considerations should expand to encompass volunteers.

We must promote careers in remote health care at all levels - from students to near-retirees - and explore different models of work in rural and remote health away from permanent, full-time, long-term health practitioners, and consider expanded models of team-approach to workforce needs in recruitment and retention. We must be supported professionally and in advocacy by our professional organisations to government and the community for recognition of our work.

The Australian Rural Health Education Network (ARHEN) and Federation of Rural Australian Medical Educations (FRAME) should encourage and fund research into reasons why students are and are not interested in rural health careers, focusing on key areas such as [Tolhurst & Heading] the physical, social and cultural environment, and accessibility; and looking for factors which promote a flexible attitude (eg. urban students towards rural, rural students towards remote). (Note: a study along these lines is planned at the Universities of Melbourne and Monash.) This recommendation is applicable to other disciplines as well as Medicine.

All remote health professionals should have access to accreditation, and the availability of education and accreditation programs for remote area nurses should be accelerated.

New clinical systems based on non-doctors should be developed and supported by the range of rural health organisations. The Nursing Colleges, universities and CRANA all have a continuing role. For physician assistants and clinical associates there are educational curricula in existence that could be further developed by University Departments of Rural Health and Medical Schools and in vocational training. Rural Workforce Agencies and Divisions could both have a role in continuing education and in workforce development. Governments would need to be involved in changing regulation and legislation to allow delegation, both financial and clinical.

Sharing staff resources between towns helps to address short-term staffing difficulties and offers staff the option of gaining extra experience without being disadvantaged.

The education and health sectors need to establish a national, consistent approach and equity in the funding of and support for all members of the health professional workforce – allied health, nursing and medical. This approach should extend to undergraduate and graduate education and training and employment incentives.

Local townspeople become disillusioned if they are unable to benefit from the specialised training they support for health professionals (eg for continence sisters) who leave because of job availability elsewhere for their partner. For this reason special training and education eg for work in continence, nurse education, asthma and diabetes advice, lifestyle, health worker training, etc, should be funded federally or by the State on a needs basis as often as it arises.

The NRHA should maintain a list of all rural health workforce databases that can be accessed by researchers and policy makers.

Universities and other health education and training providers must be responsive to service needs in remote and rural communities.

We need to improve the way in which health care workers are prepared and trained for future work in Primary Health Care models. There needs to be greater attention to:

- the ability to collaborate within a multidisciplinary team and with other community and Indigenous groups;
- the use of evidence-based practice; and
- working within a model focusing on prevention and early detection rather than an acute care, biomedical model.

Governments should provide support for rural health professionals, including nurses and allied health professionals, to gain accident qualifications.

Agencies in Australia should develop, in co-operation, a program to teach neonatal skills to practitioners in remote and rural Australia, and to expand that program to ‘train the trainers’. These programs should be able to be transferred to countries overseas.

Health professional training (ie. its curriculum) needs to reflect the health needs of community, incorporating a strong focus on issues such as mental health which are a significant component of the health burden.

In the recruitment of health professionals, the concepts of sharing and collaboration should apply, rather than competition.

Attempts to improve the integration of multidisciplinary undergraduate health education should include increased resources and support for non-medical students. (A number of medical students were funded to attend this conference.)

Working committees should be established to discuss and draw together a proposal to address key issues for the future health workforce, ie:

- new models of care for rural and remote areas;
- new approaches to the workforce;
- new funding and remuneration structures; and
- one level of government.

Such committees would deal with one each of the above requirements and be interdisciplinary, inter-organisational and interstate in balance. They would work towards the production of a united remote and rural policy document to form the basis of a campaign to government for fundamental and sweeping change to rural and remote health care.

The conference is aware of the looming health care work force crisis due to the ageing and changing profile of the Australian population. This crisis is likely to impact most significantly in rural and remote areas. It is therefore recommended that alternative workforce structures and models of healthcare delivery in rural and remote areas are urgently developed, implemented and evaluated for the health outcomes of the population.

A national sustainable approach be taken to the training and support of Indigenous health service managers in both the community controlled and public sectors.

That a team-based approach to program development and funding be adopted in which the health care team rather than the medical officer is the health workforce focus.

Inter Professional Education

There needs to be a greater commitment to Inter Professional Education (IPE) in Australia from both government and educators, and educational assumptions and norms that prevent collaboration must be challenged. IPE and inter-professionalism should be included as core curriculum to better prepare health care students for rural work.

In order to break down the uni-disciplinary silos and help to create a more effective workforce, we need to unite to argue for a policy commitment to inter-professional health care teams.

State and Federal Ministers for Health and Higher Education should immediately inform the higher education institutions and the health professional bodies that undergraduate health professional curricula must be changed to incorporate and/or address the need for interprofessional education and future clinical practice.

The Alliance should support interprofessional education – both theoretical and practice-based – for all undergraduate health science students prior to registration.

The professions

It is proposed that a modified Stage 3 of the [RDAA's] Viable Models Project be funded to allow implementation of the Viable Models Framework at the practice level in all rural practices.

It is proposed that Infrastructure Practice Support mechanisms be enhanced to allow establishment of sustainable health clinics to meet the needs of rural communities. Such mechanisms include improved funding for the Department of Transport and Regional Service Medical Practice Infrastructure Support Program and establishment of a Rural Medical Infrastructure Support Fund which would guarantee a 10% return on capital investment in rural medical practices.

To extend the care provided by general practitioners, Australia must speed up the development and adoption of alternative practitioner models, such as physician assistants, nurse practitioners and other new roles. This requires resources to develop curriculum and pilot programs, and the introduction of legislation to describe the role and responsibility of the profession. This needs to include examination of role delineation and territorial prescriptions around care delivery – eg midwifery development and support.

Professional structures, from national funding and accreditation to local practice management, should be systematically designed to maximize flexibility and encourage diversity in rural general practice. The future trend is for an increasing proportion of female rural doctors. There needs to be flexible professional and practice structures to facilitate work-life balance.

The complexity of doctors' lives and practice must be recognised by national and state government and Medical Colleges and built into models of funding, training and support for rural practice.

Viable alternative models to traditional general practice need to be promoted to enable the GP to focus on patient care rather than worrying about business management. An example is the model developed by the Divisions in north-western NSW which also provides a centre for training GPs, allied health, nursing, and medical receptionists; and helps GPs to practise high quality health care in the general practice setting.

If rural and remote Australia wants to recruit and retain more Overseas Trained Doctors, it must recognise that they are not afraid to move when they recognise better opportunities. We therefore need to provide more support for the work of OTDs and more acknowledgement of their importance and impact in rural health.

The supports needed by OTDs include:

- orientation to rural practice and the Australian medical system;
- training and upskilling; and
- support for study skills, communication, English, cultural sensitivities.

The Australian, State and Territory Governments, as well as other key stakeholders, should adopt a common national assessment tool to apply to all OTDs, permanent and temporary, and the medical registration boards should consider establishing nationally consistent criteria and processes for granting area of need registration. This will ensure that all OTDs granted area of need registration have the skills and experience required for rural general practice in Australia.

All permanent and temporary resident OTDs should receive more adequate and effective information and orientation programs to the Australian medical system and for work in Australia.

Overseas Trained Doctors should be eligible for family and professional support, realistic advice on prospective incomes and access to employment, individual case management services, orientation and welcome, an initial practice grant to support start-up costs, and assistance for exam preparation.

Rural Workforce Agencies should be resourced to establish a network of trained GP mentors within their states/territory who are then provided with funded communication and meeting opportunities to provide mentoring support to OTDs who require and/or desire it.

Physician assistant roles should be developed for Overseas Trained Doctors who do not have recognised Australian qualifications. This would be a pathway of support and supervision to assist an OTD gain experience and training towards achievement of recognised Australian qualifications.

To develop and strengthen the role of Indigenous health workers, it is recommended that their training be professionalised and recognised and delivered in an authentic cultural context.

When specialist services are recruited (whether in metropolitan or regional areas), a condition of employment should be the requirement to visit or service more isolated areas.

The Australian Government should institute a national approach to the management of allied health professional workforce data by funding Services for Australian Rural and Remote Allied Health (SARRAH) to develop, in conjunction with the AIHW, an annual review of datasets available from the States and from professional bodies.

The Australian Government should fund a national project to benchmark appropriate allied health staffing levels and develop guidelines to support rural and remote allied health professional practice.

The Australian Government should provide the funding to enable a national approach to the collection and analysis of consistent, current and quality remote and rural allied health workforce data, including supply and demand, recruitment and retention, education and training.

State and Territory Health services should ensure that adequate and appropriate management and leadership is in place to ensure that allied health professionals working in remote areas are supported to provide effective and appropriate services in a sustainable way, to ensure that the resources in place are most effective in impacting on the health of communities.

National vocational training and education options for Indigenous people to work in allied health should be extended (or reviewed) to offer options other than ‘Allied Health Assistant’ competencies. In remote communities Indigenous workers have the skills and knowledge required for collaborative practice in allied health.

More consideration needs to be given to placing Nurse Practitioners in rural and remote areas, especially when female GPs cannot be recruited to look after women’s health issues i.e. pap smears, health education, domestic violence, family planning.

In support of the move from a medical to a health model, we should call for exploration and facilitation of the uptake of community Nurse Practitioners. The work should encompass independent nurse practitioners; the credentialing of nurse practitioners; and a funding model/paradigm change for Nurse Practitioner development akin to Medicare perhaps.

Nurse Practitioners can do the Family Planning course which nurses have been doing for years which enables them to do PAP Smears, breast examinations, cervical swabs etc.

High quality preceptor preparation and support should be available on a national basis to rural pharmacists, and should provide equivalent opportunity for professional development to that available for metropolitan counterparts.

5. Service delivery

Cancer services

The recommendations from the 2001 Cancer in the Bush report were endorsed, with particular emphasis on transport assistance for rural and remote patients.

Existing cancer units need to review their efficiency as a means of minimizing the impact of workforce shortages while acknowledging that care needs to be delivered with compassion.

Cancer care providers need to define realistic levels of service that can be sustained in each health area. These service levels need to be advocated both to governments and the community to promote realistic expectations of service provision in particular health areas.

Recognising that rural and remote service provision is vulnerable to workforce shortages because of low staffing levels, the highest priority must be given to workforce planning for those areas.

High priority needs to be given to the provision of low cost accommodation close to treatment centres for rural and remote cancer patients and their families to ensure minimal disruption to their normal lifestyle in both symptom control and terminal care.

The shared care of cancer patients will be improved by closer collaboration between regional and remote GPs and specialists located in central treatment facilities. The encouragement of these links and better regional networking should be given greater priority.

Greater efficiency could be promoted by the co-ordination of chemotherapy treatment protocols and their publication on the Internet.

Palliative care

More conversations about palliative care with rural communities are imperative.

Carers need assistance with the costs related to medications, equipment hire and co-payments for community services. Health care and social welfare (eg Centrelink) forms need to be more user-friendly and appropriate to palliative care recipients. More flexible carer's benefit schemes are required to meet the unique needs of the recipients of palliative care (eg. increased amounts for shorter periods of time). Employers should be encouraged to provide flexible employment arrangements for carers in the workplace, to enable carers to balance work and care.

We must resist the 'medicalisation' of the dying process.

Palliative care should form a part of the undergraduate curriculum for all health professionals, including medical students.

Staff development programs should incorporate training in palliative care for all health professionals.

Health services need to adopt a coordinated and transparent approach to delivering palliative care services.

Funding should be directed at full-time services, rather than part-time staffing positions.

More funding for research in rural palliative care is essential.

Palliative care for Aboriginal communities is wanting.

Palliative care education for all rural nurses should be embedded in continuing education.

Rural and remote areas require more palliative care workers who can support each other and provide cover to clients they know when their co-worker is on-leave.

Mental health services

There needs to be a mental health training and learning culture within Aboriginal services which promotes and enhances the skills and knowledge of Aboriginal workers, achieves equitable training outcomes, and therefore provides leadership and direction in culturally appropriate learning.

Mental health first aid should be promoted in the same way as medical health first aid, including to teachers in schools.

Approaches to mental health should be based to a greater extent on partnerships with communities, services and in program delivery, eg methadone prescribing. Potential partners include:

- child and youth mental health services;
- drug and alcohol services;
- non-government organisations;
- GPs and other clinical workers; and
- Aboriginal social and well-being teams.

Telephone counselling services, such as Lifeline, should be promoted more widely in remote and rural areas.

The mental health role of remote and rural generalist nurses should be acknowledged in policy nationally and at state/territory level. The resulting policy changes should be implemented through role recognition, training and accreditation.

Strategies should be developed to formalise the in-patient management of mental health clients in district hospitals.

Mental health service reform should include the capacity to be respectful of people's cultures.

Birthing services

In response to the decreasing workforce in the maternity field and to address the needs of women in rural areas, the NRHA should promote policies to support a midwifery-focused model of service delivery (similar to that in the Southern NSW District Health Service).

The NRHA is asked to endorse and support independent midwife deliveries as an important part of the solution to birthing services in the next 20 years.

The NRHA and the Commonwealth should convene a working group to support sustainable models of remote, rural and regional birthing services.

Oral and dental health

It was disappointing that the 8th Conference did recognise oral health as an integral part of health care. The NRHA should develop a comprehensive oral health policy to take forward the rural oral health agenda, with a view to addressing the critical state of oral health care in remote and rural Australia.

The poor state of oral health is a major national issue warranting a significantly higher level of consideration. Oral health needs in rural, remote and regional Australia are a priority and a primary oral healthcare approach should be adopted, emphasizing oral health promotion and the prevention of oral health disease.

Conference should recognize and support the full implementation of Australia's National Oral Health Plan 2004-2013.

Federal, State/Territory and local governments should be held accountable for improved recruitment and retention of a quality integrated oral health workforce in rural, regional and remote communities through:

- an increased number of undergraduate places;
- dedicated places for students from rural and remote backgrounds;
- rural scholarships;
- funded rural and remote placements for students, possibly in Rural Clinical Schools;
- professional support available through local Continuing Professional Development, rural rotation and rural incentives for the workforce;
- facilitated immigration, assessment, registration and support for overseas trained dentists; and
- integration with community-based education of the dental workforce.

Conference emphasises the need for oral health to be incorporated into national health policy and reform, including models of affordable oral health care.

Conference calls for fluoridation in rural, regional and remote communities.

State and Territory Governments are encouraged to review Dental Acts, Regulations and Codes of Practice to identify and remove barriers to the full use of the whole dental team (general and specialist dentists, dental therapists, dental hygienists, oral health therapists, dental assistants, dental technicians and prosthetists) in the provision of high quality, accessible and affordable dental care for Australians living in regional, rural and remote areas.

Oral health should be integrated within comprehensive primary health care services for Aboriginal and Torres Strait Islander peoples.

Conference seeks the strengthening of Medicare Enhanced Primary Care initiatives that address medically necessary oral health care in Indigenous communities particularly in relation to:

- the epidemic of early tooth loss associated with poorly controlled type 2 diabetes in Indigenous communities;
- oral health and its relationship to rheumatic heart disease; and
- oral health and its relationship to renal disease.

Services to travellers ('The Grey Nomads')

A forgotten (and growing) sector of our rural and remote population is the one comprised of our perennial travellers or itinerants - those choosing to travel Australia by road. Frequently their caravan is their only home. They have no fixed community GP or health centre. They are often extremely 'under-diagnosed'. More community education and advertising is needed on the management of themselves, their vehicles and equipment. Our continent is

unforgiving if preparations for travel have not been adequate. ‘Grey Nomads’, just like stoic farmers, are not accessing health centres as they “feel OK”.

They should be encouraged to carry health records which all health professionals could add to at any encounter: RN, GP, hospital etc. Health improvement would be easier if health professionals could inform these persons or note in records for them when they should seek follow-up.

Our Grey Nomads need particular information:

- on medications – knowledge of medications used – extra prescriptions/extra repeat prescriptions/regular doctor and pharmacist contact for more scripts during their travel. Correct storage of medications and insufficient supplies while away from large towns where chemists are available. Carry Webster packs (pre-packaged daily medications required to avoid confusion of times when medications should be taken). Doctor’s letter of current health status, treatments, vaccines (ADT), allergies, relevant past medical history and family support and background.
- transport – know the vehicle – is it appropriate for the region – are the travellers physically and mentally prepared for the vast distances and rugged terrain.
- destination planning, current maps and appropriate equipment to repair a vehicle eg. fanbelts, oil, coolant, water, tow ropes, spare tyres are fully inflated etc. Staying with the vehicle if they break-down.
- appropriate communications – radio/EPIRB (Emergency Position Indicating Radio Beacon) to be fitted at front of vehicle in order to use in an emergency when satellite phone is unavailable. Know how to use it! ‘EBURP’(its maritime equivalent) has saved many lives at sea by the persons using it being found early, before vessels have “not arrived home/acknowledged as missing”. It is cheap and very effective emergency device works everywhere. Satellite phones are not cheap. Mobile phones reach very little of our outback and phone batteries may be flat.
- appropriate stops/camping grounds/fuel stops, fatigue issues.
- maintenance of vehicles regularly, spare tools/equipment/camping available if they break down. Plenty of food and water.

Services – other

There needs to be a review of reimbursement schemes for travel and accommodation (PATS, IPTAAS) with a view to national consistency in eligibility criteria and reimbursement rates appropriate to the cost of living in the city concerned.

It is recommended that the four principles emphasised by Professor Hollows in the provision of effective specialist services to remote communities in Australia be adopted to bring psychiatric services to remote areas. These are:

- the need for credible and competent services providers;.
- regular services;
- good liaison and communication with the local community; and.
- empowering local health care professionals so that they are better able to advocate for and manage their patients.

There needs to be clear determination of the total cost of obtaining healthcare in remote and rural areas, including the associated expenses (eg. transport, accommodation). This determination would also establish the level of staff turnover among health professionals in areas of different type.

The More Allied Health Services program should be augmented. Evidence from the Kimberley and other regions shows that dietetic services, funded under the MAHS, can help meet the needs related to primary and secondary prevention of diet-related conditions, and the dietary management of established conditions such as diabetes, obesity, renal impairment and failure, hyperlipidaemia and cardiac conditions.

The health funds should be required to develop private rural health insurance packages incorporating travel assistance to nearest private hospital. The assistance could be capped or substituted for other benefits. (?)

Rural young women, especially young mothers, require better access to mental health counselling, to bulk-billing GPs (in particular female GPs), and we need policies that integrate a gendered approach that takes these into consideration.

Middle-aged women need health care that is directed towards helping them with the 'carer' role as these women tend to be looking after both elderly and young people in the home. This means that financial and mental issues need to be addressed, particularly the costs of access to health care and help with stress management.

Medical services in rural and remote areas would benefit from more attention to:

- developing overseas partnerships;
- bonding medical students;
- regional recruitment strategies;
- local council and community 'buy-in'; and
- Colleges' recognition of rural placements.

Rates of retention will be higher for those whose comfort zone extends to country places. Recruitment and retention programs should therefore identify and allow for this characteristic.

That a toolkit for remote and rural practitioners be evolved for remote and rural practitioners. Both the NRHA and NHMRC could be involved. Such a toolkit would address issues relating to the sensitivity of approach in Indigenous communities.

That the Government recognise the need to support chronic illness management through the funding of relevant infrastructure.

The National Rural Health Alliance should acknowledge the significant deficiencies of our health promotion capacities in the bush, and work with others on clear strategies to fill the gaps.

For health services, evaluation methods that are not driven by indicators have much to offer. This would involve different means of assessing client satisfaction. Retrospective techniques can be a powerful tool if baselines do not exist. Methods of contribution analysis – as opposed to attribution analysis – may be appropriate.

The establishment of the Trek as a compassionate, mutually supportive program has potential to promote both positive and lasting impact amongst individuals upon their return to work. It is recommended that this program be offered as part of a worker support program

(particularly in rural areas) and the concept be widely supported as part of an ongoing bereavement service for all health services in the future.

6. Other

Foetal Alcohol Syndrome

International evidence suggests that Foetal Alcohol Syndrome (FAS) is under-estimated, under-diagnosed and under-managed in Australia. There are pockets of activity around the country. These include efforts of researchers, community-based workers and community groups. These groups and individuals have made a commitment to work together and request the NRHA to facilitate the linking up of these groups, with the aim of a national conference on FAS which would involve researchers, practitioners, policymakers and overseas experts in order to develop a nationally co-ordinated strategy for the improved diagnosis, management and prevention of FAS.

Foetal alcohol syndrome should be seen as an important preventable cause of growth failure and developmental/behavioural problems, but should be recognised as only one of many contributors.

The NHMRC should promulgate the evidence, strength of evidence and rationale for its statements on foetal alcohol.

Research and data

There need to be more resources quarantined to remote and rural health research, which remains the poor cousin of mainstream health research and continues to be characterised by small-scale, local, non-cumulative, descriptive or evaluative studies. The new funds allocated need to support programmatic research which is the antithesis of localised, opportunistic, or highly personal research interests involving isolated projects undertaken either by a sole researcher or with one or two colleagues.

Research should be performed in a manner that is respectful and appropriate to Indigenous people.

Indigenous people are integral to research involving their communities including planning, participation and implementation, analysis, reporting and follow-up. This has a two-way benefit for the research, and for the Indigenous people involved, eg upskilling and ownership.

Research and practice initiative outcomes need to be more broadly disseminated to limit “re-inventing the wheel”.

Government and industry research is dominated by randomised control trials, and where rural research does occur there is little translation into policy and practice. What is required is a rural health research agenda focused on applied research. A new study of research (through the NHMRC) and evaluation of Commonwealth and State programs for common threads should provide the foundation of this new agenda.

Funding for rural health research should encourage gender competence in developing the research question, analysis of data and development of policy outcomes.

It is appropriate to continue to expect knowledge transfer in [rural and remote health] research but it requires adequate funding and time expectations. Consideration of a researcher's track record should include their approach to and history in knowledge transfer. Peer review of knowledge transfer should be established. ('Knowledge transfer' is the processing, interpreting and disseminating of information from research in an appropriate format and style).

There needs to be a clearinghouse for rural health research and evaluation of service models. It would link relevant websites.

The funding allocated to clinical research targeting rural, remote and Indigenous projects is only about 3% of all major sources of grants. We need to reduce the barriers and introduce incentives for programmatic clinical research targeting rural, remote and Indigenous research, including incentives to assist allied health and nursing to win clinical research dollars.

Competent gender analysis should be built in to all research, analysis and policies relating to the rural medical workforce.

It should be made a condition of health research grants that an effective gender analysis and proportional numbers of women and men be included in the research.

The NRHA should negotiate with Australian Indigenous HealthInfoNet to have a rural catalogue of resources gathered from the Conference participants.

Greater efforts should be made to provide epidemiological and health trend data to rural communities and their representatives, and to empower them to advocate for a better deal.

Arts-in-health

There is a great deal of anecdotal evidence regarding the use of Arts-in-health. It is recommended that we start to collect evidence to put Arts-in-health on the evidence-based map. There is a centre for research on Arts-in-Health in England which we could tap into.

TORCH project provides an excellent model of Arts-in-health collaboration which would be a powerful tool in all health sectors. The model follows the sequence:

- permission;
- gathering stories; and
- celebration / song and dance / gathering people.

Other

The National Rural Health Alliance should recognize that the health of young people (12-25) is critical to the future of rural communities. A greater focus on these issues at the next National Rural Health Conference would contribute to building capacity in rural or remote communities over the long term.

The NRHA should call for the long-term detention of refugees to be stopped.

Refugees could be accommodated by rural and remote communities across Australia, both to improve the skills of these communities and to provide safe sanctuary for refugees.

The Commonwealth and States should make a considered approach [?] to minimum infrastructure in remote and rural communities of less than 200 people.

There needs to be PoC technology for all remote and rural areas that don't have a full-time GP. In order to sustain programs like this [Denner re diabetes] program staff need to be trained in how to market or value-add to the program. The health message and awareness of the program's value will not get out unless you establish and 'work' the audience.

Commonwealth, State, Territory and local governments should continue to invest in the implementation of chronic disease programs.

We should acknowledge the impact of remote and rural practice on metropolitan practice. (This arose in the context of mental health but relates also to other policy areas.)

We must recognise that people in the city can still be powerful in visiting communities over many years, for instance by acknowledging the role of fly-in/fly-out practitioners.

The NRHA should encourage Conference participants to share resources, including through post-Conference email.

Injury is one of the highest causes of mortality and morbidity – the highest in Rural/Remote and even higher for Aboriginal and Torres Strait Islander Peoples (who refer to 'safety promotion' not injury prevention). The importance of Injury Prevention and Safety Promotion should be acknowledged.