

Robyn Williams: And now for our third keynote; it comes from Louise Lawler, who works in Dubbo for the University of Sydney and has been involved, for many years, with schooling for Aboriginal youngsters as a means of enhancing their connectiveness and their health and wellbeing. This is actually Louise's eighth National Rural Health Conference and she has connections with the Torres Strait, which makes her well equipped to comment on the progress that's been made in rural and remote health and the contribution to this biennial event. So would you please welcome Louise Lawler?

Are we there yet? Lessons for today from nine conferences

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I need the specs on first. Okay. Good evening, everyone. Initially, I would like to acknowledge the traditional owners of the land on which we are gathered and pay my respects to the elders of the Kimoi, Wilaburra, and Yidinji tribes.

Are we there yet? Every journey has a beginning and a destination, and most of us would agree that our sector's destination is equivalent health for the people of rural and remote Australia as soon as possible. The purpose of this paper is to look at what progress we've made towards that destination. Are we there yet? Well, clearly, we're not. The time has not yet arrived that we attend this biennial event just to celebrate our successes, and there have been many notable successes and some of them will be celebrated here in Cairns. But there are still barriers and blockages. The evidence shows that people in rural and remote areas have poorer health status, higher rates of health risk factors, and less access to needed health services. Are we there yet? No, we're not there yet.

So how are we travelling and what progress has been made? One thing we cannot change is the place from which we started. It is often said that if we were devising the perfect health system, including for rural and remote Australia, we would not start with what we've got; a complicated Federal system with three levels of government involved in health, arbitrary jurisdictional boundaries, divides between primary care, acute care, and aged care, strong professional barriers and area or regional health services whose structures can change once, twice, or three times a decade. We can't change these starting point parameters but we can critically appraise the destination we have in mind.

Every long journey starts with small steps and it helps if those are in the right direction. Are we headed in the right direction? Is equal or equivalent health for rural and remote people the right end point? What is achievable and what's practicable, and what have we learned so far, along the journey, about the best way to proceed? Which barriers can we overcome and which do we need to walk around? Should we move more quickly by reforming the system radically, or should we move incrementally, step by step? To what extent do we, in the rural and remote health sector, need to travel alone rather than in concert with health interests of the capital cities and the tertiary institutions?

It is clear that our effects to continually improve the health and wellbeing of rural and remote Australians will continue to morph and change through a range of topics and stages. Steve Clark and Angelita Martini first demonstrated this in the synthesis of the outcomes of the first four National Rural Health Conferences from 1991 to 1997 and Steve reassured us in 2007 in Albury that the trend persisted.

So first, let us refresh ourselves with those past findings and then have a look at what has happened in the two years since the 2007 conference in Albury in which time we've acquired a new Federal government, a new Prime Minister, and a new President in Barack Obama, whose influence we can feel already. Yes, we can.

Steve and Angelita analysed the early conference recommendations via thematic groupings and, because these don't seem to have changed much in the last 20 years, we're going to follow suit. The early studies identified some frustration as, year after year, the same topics continued to appear in programs and recommendations. At face value, it looked like progress was not being made, however, when they examined those more closely, Steve and Angelita found that there were stages of progress that were readily identifiable and that topics were progressing through them, albeit somewhat slowly for some. The four stages of progress were identification, development, implementation, and funding.

At the eighth conference in Canberra, Ralph McLean compelled us to accept the mantle of professional maturity and to add review to those stages. Ralph talked about the bundling and un-bundling of recommendations and topics. For example, Aboriginal health recurs in every program, and every recommendation set is littered with calls for improvement in this realm. If we look at a micro level at just one aspect of that huge topic, say health worker training, we have moved from calls for professional health worker training through accreditation at TAFE, to accreditation in university, to equity and professional recognition, to training in specialist areas, such as cancer and mental health. It's taken 20 years but there is that identifiable and continuing path of improvement. And past and present participants of this conference and the recommendation process have achieved that in concert with the frontline workers and the communities bringing these to our attention. So the topics, which were broad and encompassed so much work in the early years, are gradually being broken down into more specific issues as problems are solved, lessons are learned, progress is made, and new aspects that require our attention are identified.

The themes identified in the 1997 Synthesis of Conference Outcomes remain immediately recognisable today. Workforce, local management, service delivery, research, public, and Aboriginal health; all familiar and all completely incorporated in the program of this conference. They're all here, as they have been now for 10 conferences. When we break these themes into topic areas, we are still on familiar ground. Education, training and curriculum, undergraduate and postgraduate issues, technology, recruitment and retention, but, here again, there's evidence of progress. Rural health training units—remember those—replaced by university departments of rural health and rural and remote clinical schools as the key educational units under discussion. And of these, there are more of them, they're more widely spread, they undertake more work, they're better funded than their predecessors—all improvements. These are all indicators of continuing improvement and expansion and the success of your work and that of the recommendations progressed from the conference.

The theme of local management breaks into topics such as primary health care, employment, providers, community control, and community participation—again, all still with us today. But hospital boards have been replaced in some states by area health services and broader governance, for better or for worse. We do seem to be losing that battle for local government and control on that front.

Service delivery topics include multi-purpose services, funding, transport, aged care, gender-specific services, and medico-legal issues. In recommendations set post 1997, these have been joined by women's health, men's health, dental, and mental health. Again, we can see that unbundling at work, with services breaking into specific areas of need as they're identified and dealt with. Research, as a key theme, has experienced this same unbundling process. Aboriginal health and policy remain a top priority but perhaps this is one theme that is just so huge, and that has so many aspects to deal with and such complicated underpinnings, that it will take longer to make progress in, but I'm convinced that we are making it and you are all vital to the continued progress on that front.

When Steve Clark revisited the Evaluation of Conference Recommendations in 2007, he re-examined the themes and topics, and found all those early ones that he and Angelita had identified, still there—no surprises there. So he then looked at matching those topics with budget papers from the periods of '97 to

2007. With many of these topics incorporated into the national rural health strategy, Healthy Horizons, he concluded that funding, more often than not, was following the priority recommendations,

In the '96/'97 budget, despite a three billion cut to health expenditure, there was an extra \$150 million made available for rural health. Steve credited the work of all of you, including the conference recommendations, for that achievement. In 1997/98 the health workforce crisis was specifically acknowledged by the federal government in its budget papers—unprecedented. There was also funding for structural and strategic reform that was a recommendation in 1997. Again, Steve acknowledged you were part of the reason that this happened. He also found that, across all conferences, a strategic approach to setting and driving a national rural and remote health research agenda has been recommended. Funding started in '97/98 and continues to be available. Workforce, services and education, have also been big winners from the budgets. 1998/99 saw the multipurpose services get substantial funding. Steve says, "You asked for those." Training for remote nurses, rural doctors, retention payments, and bush crisis line were funded, but allied health, dental health, pharmacy, and health managers still were not.

The real watershed was the 2000/2001 budget, which gave us "More doctors, better services", with \$560 million over four years. The title was, of course, significant with the main emphasis on rural general practice, with a little nursing and allied health added to the mix. Departments of rural health and rural clinical schools received a boost and were expected to be multidisciplinary. Pharmacy got a guernsey for the first time; aged care and bush nursing also got a piece of the pie.


In 2001/02, Health Horizons was implemented and the focus was on disease, treating the worst first, with asthma, diabetes, and cancer receiving funds. Mental health, Indigenous access to primary health care, and nursing scholarships were funded. 2003/04 aged care and a focus on prevention were targets. 2004/05 aged care again, medical research, and some selected access to allied health under the MBS through the GPs were won. Consumer and community involvement in influencing health decisions were also rewarded.

These are the regurgitated findings from Steve, but it's succinct and it shows the progress and how your impact has been exerted over the time, and the impact of the recommendations process.

2005/06 Healthy Horizons continued to focus on disease. Service delivery got a boost; for example, pap smears delivered by practice nurses, along with more practice nurses. Rural and remote health training was supported, allied health scholarships were introduced, and Aboriginal health was funded over a range of initiatives. 2006/07 medical research and programs to align services to small rural communities received funding, additional medical, nursing, and Aboriginal health worker education places were allocated, along with supportive scholarships. That's truly a lot of change.

So now we come to the last two years and the recommendations from the Albury conference. The key recommendations from the last conference attest to the progress through the themes and topics we've been dealing with now for 20 years. The old themes are there, although we can see the emergence of new ones; for example, climate change, which has made earlier appearances at conferences, but this year is a whole new theme, signalling its potential for major impact on so many other topics. Aboriginal health, of course, is right there at the top, as highlighted in the key conference theme of Closing the Gap. This was recommendation number 4 from the Albury conference.

While the topic headings stay the same, the content under each has developed. For example, early conference recommendations included the implementation of programs to encourage students to rural placements. Now we're looking at evidence that shows these have been identified, implemented, evaluated, and proven, and the 2007 recommendation was that they be expanded.



Broad topics are being unbundled into more specific ones, with public health, service delivery, and research showing huge emphasis on mental, dental, men and women's health, obesity, and aged care. Chronic disease and cancer are also massive topics. Ralph's bundling can be seen through recurring calls for inter-disciplinary, inter-professional curriculum, and inter-sectorial and inter-governmental—lots of inters—agency collaboration on such things as housing, obesity, nutrition, and service delivery. Early intervention and working on the social and economic determinants of health are also identifiable. There were 19 references to working in and with schools alone in the last conference recommendations.

The recommendations from Albury charged the Alliance itself with seven specific tasks, such as promoting the need for the national rural health strategy to follow on from Healthy Horizons. For this, we will need the support of all of you good federal, state, and territory public servants. Another thing for us to take on board is the repeated request for successful programs to be re-funded and ongoing, instead of having them constantly fall by the wayside under a new set of pilot programs.

Since 2007, there has also been the allied health clinical placement scholarship scheme to support allied and oral health students undertake a clinical placement in rural and remote Australian communities during their degree. There are now some more postgraduate scholarships for allied health professionals living and working in rural and remote Australia to undertake continuing professional development activities.

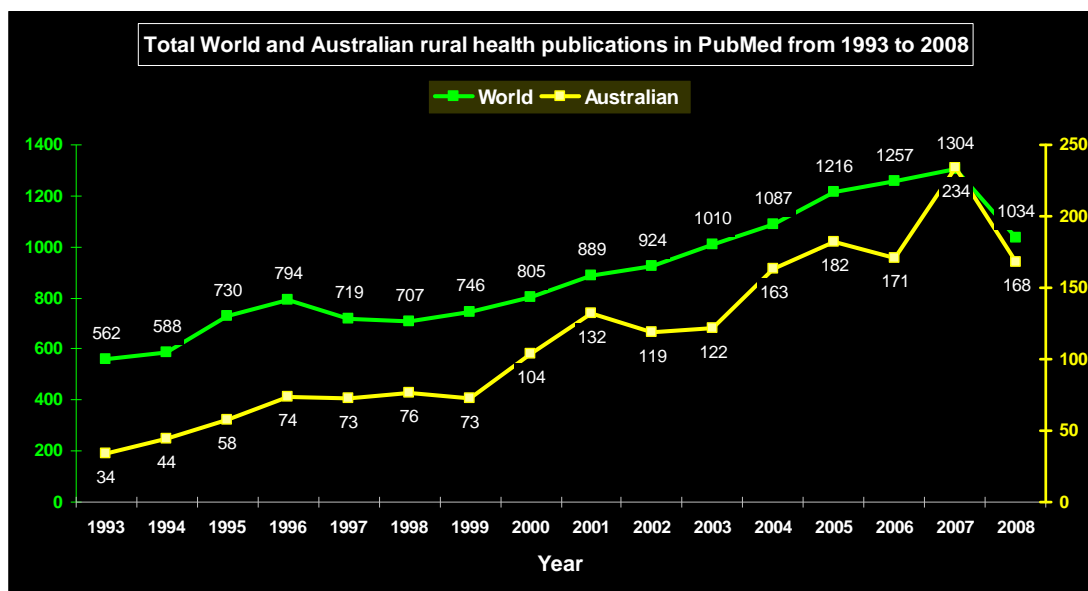
The Rural Health Workforce Audit report led to a review of the targeted rural health programs by the Office of Rural Health and to another review of the rural, remote, and metropolitan areas classification, RRMA, which has not been updated since 1993. Last week's budget has seen augmentation of the incentive scheme for rural and remote general practice through the establishment of a new GP locum scheme and a relocation incentive scheme. Both of these new elements, plus existing GP incentive programs, will now be subject to scaling, meaning that financial incentives and return of service obligations will be varied or weighted so as to encourage people to go to more remote areas. These schemes will be based on the new remoteness area classifications, with communities and doctors serving inner regional areas, class 2, eligible, as well as those in classes 3, 4, and 5. This emphasis on recruitment and retention for more remote areas is something that conference recommendations have been advocating for some time.

This last week's budget also announced some investments in rural maternity services and in specialised cancer centres. But perhaps the most encouraging, was the announcement that nurse practitioners and selected midwives working in health care teams, would be able to bill the MBS and the PBS. In February, the NHHRC interim report proposed equivalence payments, which would see funding equivalent to national average medical benefits and primary health care services appropriately adjusted for remote nursing health status. This would be made available for local service provision where populations are otherwise under-served.

Now, in the rural and the remote health sector, we are constantly worried about where we stand in the political agenda of the day. Are we on the radar? Are we being ignored? Are the politicians, the media, and the public hearing our messages or not? One way we could test such questions would be to count the column inches of coverage of our issues in newspapers, the minutes of coverage on television news, and on regional radio. The Alliance and its member bodies report that, using such criteria, health policy, including rural health policy, was high on the agenda during the last federal election and up until we became very distracted by the global financial crisis. One proxy for this sort of public exposure is the volume of stories in peer-reviewed journals that relate to rural and remote health sector. PubMed is the freely accessible online database of bi-medical journal citations and abstracts, created by the US National Library of Medicine. Approximately 5200 journals published in more than 80 other countries have contributed to the nearly 18 million articles. We first looked at rural and remote health publications indexed in PubMed from 1993 to 2008 from all countries in the world and compared that to Australia to see the general trend. There is a steady increase in publications from '98 to 2005. However, in 2006/07, there's a

decrease in the rate. The marked dip in the 2008 publications is an artefact due to the timing of the analysis.

Figure 1 Total world rural and remote publications in PubMed publication compared to the Australian publications from 1993–2008



This next graph shows us what the Australian contribution has been in that same time period. This indicates a steady increase in the percentage of Australian publications from 6 per cent in 1993 to almost 18 per cent in 2009—a trebling of publications in 17 years.

The percentage contribution of Australian rural and remote health publications in the Australian Journal of Rural Health is depicted in this next graph. The Journal of Rural Health has maintained around 50 per cent of total publications, achieving the highest percentage of 71.4 per cent in 1997 and then dipping to the lowest in 2007 at 32.8 per cent. Australian journals have increased their share of the total rural health publications in PubMed, while the relative contribution to the Australian Journal of Rural Health falling as other journals from Australia, notably the Journal of Remote and Rural Health, have increased publications in a relatively short time.

Figure 2 The percentage of Australian rural and remote health publications in relation to the total world rural health in PubMed from 1993–2008

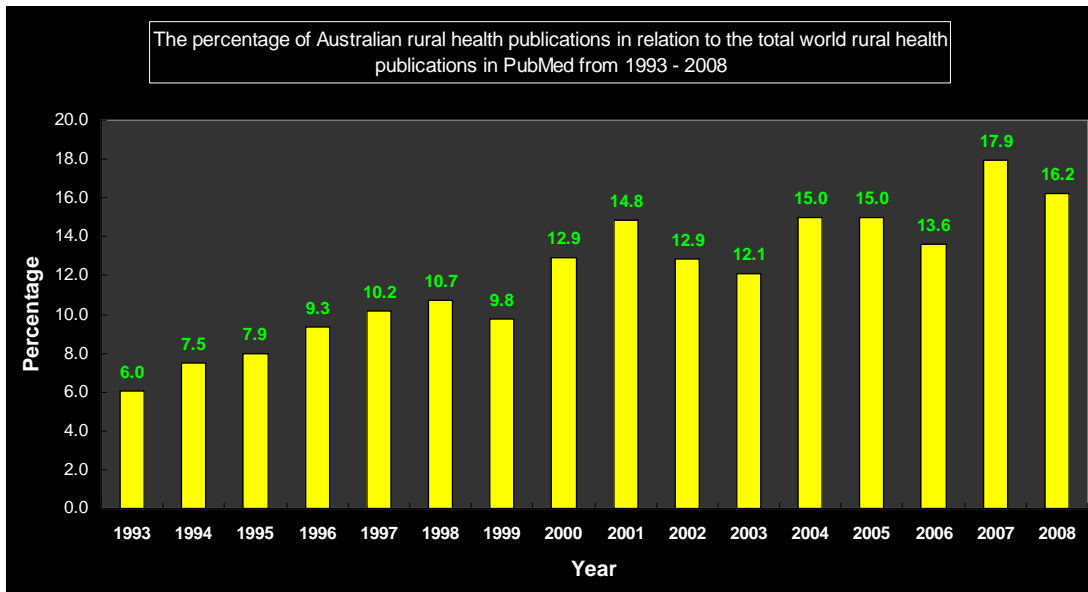
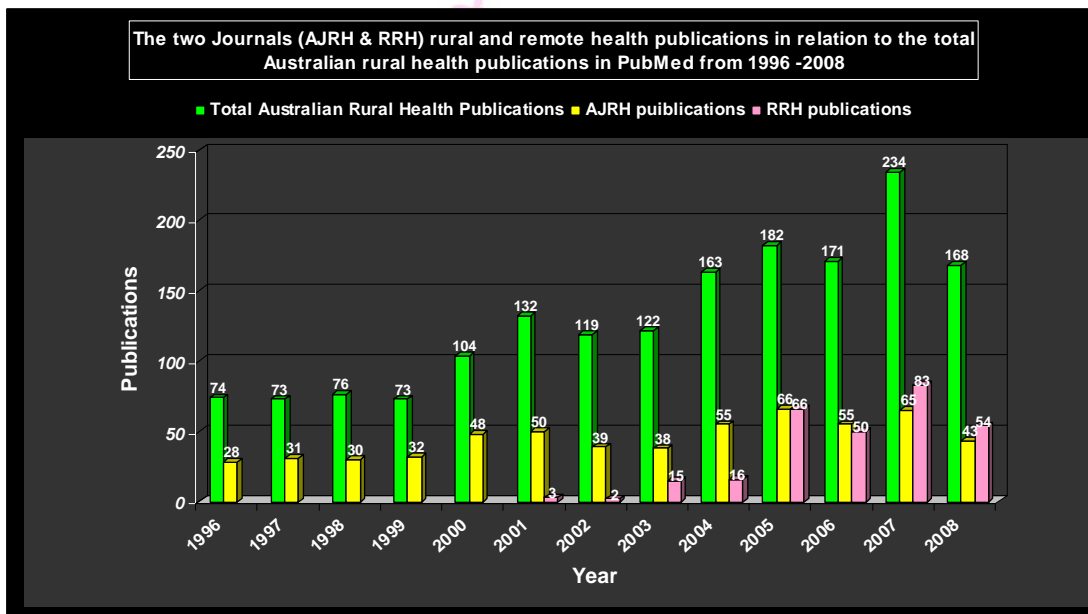


Figure 3 The two Journals (AJRH & RRH) rural and remote health publications in relation to the total Australian rural health publications in PubMed from 1996 -2008



Complex timing issues mean that no correlation is visible on these graphs between the biennial conference and the volume of Australian publications on rural and remote health, but what is obvious is that this biennial event promotes and provides a major surge in interest among the media, the service providers, and researchers, and that this surge every two years in reports and recommendations and networking has a major impact on policy development.

When we're on the agenda and we report on good ideas that work, the record shows that policymakers will and do listen. This conference helps pull together the threads and gives us a surge in energy, attention, and profile. We can pat ourselves on the back as a sector for the progress made, and we can acknowledge the contributions of those who work for governments who have supported and enabled

progress. We can acknowledge and thank those in the sector who have contributed and those who have led, especially the unsung heroes, most of whom are never able to attend these conferences. We can be confident that, had it not been for the work of the sector—your work—things would be much worse than they are.

We need still closer connections between good health research and the policy process. Health is a complex issue and we need to be informed by researches from many disciplines. We need stronger evidence of what works and why, especially for remote Australia. So after 20 years of living it, studying it, and discussing it, we're all pretty qualified. We know the problems and the challenges, but this conference and the recommendation process means more than that. This is our chance to help to solve the problems, change the policy directions that are not working and implement new ones. We have proved that we're a big part of the progress and that we have access to the steering wheel, so we need to use it.

So, over the next few days, I would urge you to concentrate on actions and solutions, rather than on just reiterating the problems. Use the process offered by the conference, the recommendation process; use it intelligently and considerately, but use it. Are we there yet? No, we're not. We've got plenty of work to do, but we know we have and can continue to make things better in the bush. Yes, we can.

Presenter

Louise Lawler is an academic nurse who for the past 30 years has worked to improve Indigenous health, education and welfare. Her most recent work is conducted in secondary schools where she and a group of dedicated professionals attempt to retain, motivate and engage disaffected students. She believes that through education and access to a sustainable future the health disparities of rural, remote and Indigenous Australia can be overcome.

