

Panel discussion: Practical workforce reform

Ruth Ballweg, Anne Gardner, Tony Hobbs, Matthew Cane, Lyn Pearson

Robyn Williams: Can we have our panellists now up there. That's Ruth Ballweg, Anne Gardner, Tony Hobbs, Matthew Cane, Lyn Pearson. We're going to have summaries from each of the people on stage and then we'll have a general discussion followed by a summary from each.

Matthew Cane: I'm as nervous as a cat on a hot tin roof at the moment. My name is Matthew Cane. I'm a pharmacy student from the University of Tasmania. I'm here today to represent the National Rural Health Student Network. I'd like to first of all take the opportunity to thank the NRHA for giving us an opportunity and a voice in this panel session.

Just recently we inducted our 29th Rural Health Club, Bond University. It came online with the National Rural Health Student Network. That boosted our number of students that voluntarily join our network to just over 8500 students. 8500 students: approximately 60 per cent are medical students, we have 30 per cent allied health and 10 per cent nursing students. So we have a very multi-d approach to our Student Network. We feel that by having a multi-d approach very early on in our student careers helps to try and break down those barriers for when we basically go into the work field and also to sort of enhance that perspective once the students reach rural experiences and work rurally.

The Student Network aims to increase the amount of students being exposed to the opportunities in rural health areas. It's been proven that students, if they have a positive experience in the rural health area when they go out on prac placements, will have a tendency to go back to those areas once they've finished their training. We would like to try and support that a little bit more through a number of different initiatives and it is through the Student Network we offer opportunities. A national conference which is coming up in Cairns in July gives approximately 300 students the opportunity to get together, meet as a network and discuss and thrash out issues that we feel are important to students, which leads on to when they go into their work careers as well. So I think one of the most important things the Student Network offers is that networking opportunity for students.

We also are trying to create that communication with our professionals as well. We also would like to look at trying to increase our core activities. We attend such events as rural high school visits where students from different groups around Australia go out to rural high schools and speak to high school students about careers in rural health, about the opportunities that they have, about the scholarships that are available to them, what it's like to be at university. It's been shown that by trying to get hold of these students quite early on in their high school years gives them those opportunities to come on board and to look at rural health careers as an opportunity for them as well.

We also take part in a lot of the other activities, such as Vibe Alive and Wakakirri days, Deadly Days, which are the festivals that are held for indigenous children. I was fortunate enough to go to Rockhampton last year. It's a great opportunity of getting out amongst the students and actually letting them know about health careers as well. Basically, one of the other functions that we're looking at through the Student Network is the building of a database for our students. So looking not only at where those students are, but using that database as an alumni and looking at those students as to where they go further on in their career, making sure that the kind of things that we put place for them while they're at university lead them on to having a long or a short-term career within rural health as well. We feel that's a really important thing. We've managed to get some funding for that as well.

The Student Network also has got a few things on our radar that we'd like to see progress, especially when we're talking about practical work for forced reform. One been raised in a couple of the concurrent sessions here at the NRHA Conference and that is looking at cultural awareness not being so much specific but very generic for students and very important for them when they're going out on placements as well. We are also looking at leadership roles and mentoring. A lot of students have been shown, once they become health care professionals, they then wind up taking on a mentoring role for other students as they come through. So we feel that this is probably something that could be built into the curriculum early on so that those students have an opportunity to mentor further students properly.

The aim of the Student Network is to ensure the rural health workforce of the future and that's what we're about at the NHRSN. I'm sorry, it's only a very brief overview, I only have five minutes. I could go on forever. But that's just generally some of the things that we get up to in the Student Network. We're very active, very proactive, and we are very multidisciplinary. Some of the things I hear through conference here is about you're preaching multi-d and trying to incorporate it into your care systems and into rural health or you actually already do that through our network. We're trying to foster that and encourage that further down the field so that when these students do go into rural health as professionals they continue the multi-d approach and know some of the people that they'll be working with and breaking down those barriers that exist at the moment as well. Thank you very much.

Anne Gardner: I'm a professor of nursing with a joint appointment between James Cook University and Townsville Health Service District and I'm talking about nurse practitioners. I've been involved in nurse practitioner authorisation and education and research for over 10 years now. Nurse practitioner roles actually aren't quite so new in Australia as sometimes we seem to think. They were first explored nearly 20 years ago. Planning at state levels, especially in New South Wales and Victoria, began primarily due to the lack of services in rural and remote areas and it culminated in trials for nurse practitioner potential and finally in the year 2000 the first nurse practitioner was authorised in Australia and that nurse practitioner, Ollie Johnston, who many of you will have known was a rural and remote nurse practitioner.

Title protection and authorisation processes were very important in all of this and I was one of four researchers who undertook the research consultancy for the Australian Nursing Council, as it then was, to develop national nurse practitioner competency standards. These are now used by all nurse registration authorities around Australia for nurse practitioners and they will be the basis of the national registration for nurse practitioners that will come in next year. In these competencies we were very careful about the language that we developed and one of the things that I really wanted to point out was that we talk about nurse practitioners being autonomous practitioners and working collaboratively.

We've tried to avoid the terminology of "independent practice" because it's been misused. I know it's really only semantics, but it has been misused in the past to suggest that nurse practitioners work independently and are a bit like loose cannons and aren't going to work with anybody else. In fact, our research showed that core to nurse practitioner practices the collaborative team-based model is really central.

Currently I'm chief investigator in the National Australia Research Council funded study looking at nurse practitioner profile, practice and patient outcomes and I just wanted to spend the rest of my five minutes talking about four key results that came out of the first national census of nurse practitioners that we conducted in late 2007. So four key findings that are really important for rural and remote practice.

There are actually very few nurse practitioners who are currently working in rural and remote Australia despite the fact the model has been around for 10 years now. Well under 20 per cent are employed in rural and remote areas. Most are employed in acute care areas of metropolitan health services and primary health care models are still only a very small fraction. Secondly, we found that over 25 per cent of nurse practitioners who are authorised or endorsed as nurse practitioners are not employed in nurse practitioner positions. The vast majority of these authorised but unemployed nurse practitioners are actively seeking positions. So that's a great underuse of a really important resource.

Thirdly, we found that 75 per cent of employed nurse practitioners cited lack of PBS and MBS provider numbers as one of the extremely limiting factors in their practice and this raised issues for them of inequity for clients and safety and accountability issues. I think, again, this is particularly a problem for the community and primary health care based models that are in rural and remote practice. Fourthly, nurse practitioners identified many unmet educational and continuing professional development needs. Again, I think, a particular problem for rural and remote areas.

There's a lack of support in some areas for release to leave and attend education either to become a nurse practitioner if you are, for example, a RIPEN nurse in Queensland. Also difficulties actually accessing clinical and academic updates as professional development once nurse practitioners are authorised. They also identified a lack of professional development opportunities and there is a newly formed college of nurse practitioners which is actually taking up this challenge.

So I guess I'd like to say in summary that as the National Rural Health Alliance identified several years ago, nurse practitioners are a legitimate framework for safe nursing practice in rural and remote areas, but they're currently very under utilised. I think there are two recommendations which actually feed into some of the recommendations that were mentioned this morning, one particularly about the budget promise of access to PBS and MBS provider numbers and how promising that is, but it needs to be really organised in a way that means that rural and remote nurse practitioners can actually practise to their full scope and be remunerated, and take account of other structural problems like access to dispensing pharmacists. Secondly, I think that nurse practitioners need to be included in incentive initiatives that facilitate best practice in rural areas. I was thinking yesterday about the GP initiative funding that's been suggested for using the electronic record. Thank you very much.

Lyn Pearson: Good morning. I'm Lyn Pearson. I run the Council of Ambulance Authorities which is the peak body of the ambulance industry in Australia and New Zealand. I'd like to just read something that was written after a conference last year. "The issues that led to the introduction of the community paramedic are shifting demographics, shrinking populations, diminishing health human resources, impact of chronic disease survival patterns, overcapacity issues in hospitals and emergency departments and strategies for the health care system necessitated by fiscal and political pressures." You'd think I was talking about an Australian conference but actually that came from a conference in Canada. I just brought that up to identify that this isn't an Australian/New Zealand issue; this is an issue all around the world. The Canadians are doing very well at the integrated programs. If I have time, which I probably won't, I'll list some of those.

So in Australia, really, we developed into the extended care paramedic role on a needs basis. It started in Queensland and you might wonder why particularly in Queensland. The ambulance service is a bit unusual compared with probably most of your industries because the service provision isn't all from professional paramedics. Huge areas of rural and remote Australia are serviced by volunteer ambulance officers and without those volunteer ambulance officers, there would not be a service in some of those areas. They're absolutely essential to the health care of the community in some of those isolated regions. In Queensland there's very few volunteers and most of the rural areas do have a full-time paramedic but, of course, the workload isn't all that high just for the general paramedic work.

The people in the communities found that there was a little bit more time and they all got together and started some informal arrangements, which is a bit scary really because these things really needed to have a more formal process to prepare both community and the people involved. So the graduate certificate of rural and remote paramedic practice was developed in conjunction with the Queensland Ambulance Service and James Cook University. The initial group of students was selected from people who had a passion for what needed to be done in the community and have the opportunity to study some of the areas that particularly related to their community and this has been a very successful program.

There's also other programs in places like New South Wales in rural training and there's another session this morning in the concurrent sessions about one of the rural initiatives that's happening in New South Wales. In South Australia one of the doctors went on leave some years ago and there just wasn't anyone to fill the gap. So between the hospital and the ambulance service and the Health Department and the major hospital in the city they formed an arrangement where the intensive care paramedic worked in that hospital. We worked with the nursing staff and other staff there and linked with the major hospital in the city to provide care during that period of annual leave. That's gone on for a number of years now and is now a much more formalised process, which is very good.

One of the other areas that has been noted to be particularly successful is in the Northern Territory where the nurses go on leave at a certain time of the year and at that time paramedics work with the nurses in the hospitals. Outcomes from that were that both the nursing and paramedics thought this was really good because they learnt from each other and developed their skills that they took back when they weren't working in that environment.

The community paramedic is a fairly new role that is a support structure to those volunteers that I talked about before. It is essential for those volunteers in an ageing population. Some of the volunteers of some years ago are now the patients for the future. The retention of younger people to work as volunteer ambulance officers in those areas is very important. The community paramedic goes out and works with them, helps with the training, deals with some of the major issues, works with people on the road, and that will extend further and further into the extended role.

There's a few other things that are happening in the cities more at the moment but will be valuable and move towards to the rural and remote areas once they've been evaluated, and that's treat and leave. Trying to leave patients at home or treat and refer them to another service to try to avoid blocking up hospital emergency departments and hospitals unnecessarily. This has a number of risks and needs some additional training to do that safely. But for the patient's needs, the patient is much better to be able to stay in their home and the aim is to provide a service that leaves the person in their own home and provides the support structure there to do that. I think this will be an interesting prospect when this moves more into the rural areas, but it's fairly new at the moment.

Just to give you a little bit of an idea on a few of the things overseas, and I think I've nearly run out of time, but there are some fantastic programs that are happening, particularly in Canada, and just to name a few. There are nurse practitioner, paramedic and physician teams. They actually work together not necessarily in the same location but they refer to each other. GPs in the area will refer to one or the other of them. It's a very well accepted process. There is an interesting one in Saskatchewan where a bus with a nurse practitioner and a paramedic is located in certain areas around a town, not a city, a town area and they go to a different place each day and they can actually write prescriptions, they can do wound care, they can do health checks and just provide support to those areas, so people who otherwise would either turn up to the hospital or not get that care.

Paramedics have been identified over there as the ideal person to identify people who are not looking after themselves, who can't care for themselves any more. So they are now working on programs working with the patient and with the other health community to assist those people to get the support they need to live safely in their own home in this combination of health services, immunisation programs and the list just goes on. So the lessons that really are learnt, two major ones I think, is that everyone from overseas that we've talked to and in Australia is consultation with the stakeholders is the key and right at the very beginning of this conference there was discussion on forcing issues on a community just isn't going to work. It has to be a consultation so everyone involved knows what's happening, knows there might be a change in place and understands the benefit and is involved in that.

The final one, I will go back to Joshua Tepper, and I can't quote him because I can't quite remember how he put it, but basically, if you've been to one community, you've been to one community and so one size doesn't fit all. The principles will be the same but the issues or the programs or the projects you undertaken in those areas will have to suit what resources are there and the needs of the community and each one will be different. Thank you.

Ruth Ballweg: I work from the University of Washington and Seattle. I've had a chance to talk about physician assistants in a longer session yesterday, but I want to make some general comments, observations about that as well as about the conference and then end up with a myth to dispel and an overall concern.

So following on from "you've seen one rural community, you've seen another", it's interesting when we talk about interdisciplinary teams or multidisciplinary teams and urban settings and big academic centres, everybody thinks there's like a formula where you need so many physicians and so many nurses and so many physios and so many pharmacists and so many whatever. If you're a rural person, you know that your multidisciplinary team is basically who you've got in the town and that might not just be the formal health care folks, it could be the coach for the athletic teams, it could be the minister, it could be all kinds of people and how do we bring everyone together is what makes rural health exciting. I personally think that social change happens and new innovations happen more in rural communities than they do in urban areas where we get sort of stuck in these formulas.

As we've been talking, I've talked to a lot of people here. Tony and I were talking yesterday about the fact I think we would all agree on and that is part of the issue is in rural communities, or maybe everywhere, health professionals aren't necessarily doing the right things. They're doing things that don't necessarily use their time well. Most people would say—Anne said this earlier—that folks feel that they're under utilised. In the States when we went through this process of decreasing the number of hours that residents could work, so only 80 hours a week, which still seems like too much, the first thing that happened was people went through and they didn't just throw more workers at it, they actually said what are the inefficiencies we need to address. It was amazing to see how you could clean up a lot of things and make sure people really are doing what they should be doing. So that's something to think about.

We also heard about teams and working and Matt's examples of the students working as teams, but to me we all sort of set this up in our faculty roles. A fun thing to me has been to be at James Cook University and see how Anne and her people and the school of nursing know everybody and that's really how things happen across interdisciplinary teams. When we think about PAs again, I want to emphasise that really the real answer and why PAs have a huge amount to contribute as well as other practitioners is the idea of growing your own is really the answer for rural communities. There's many people who, as a second career, paramedics who are older, a variety of different people, the people that come from communities—they hate to be at school, by the way, they can't stand to be at school,

they want to get back to their communities, those are the people that you want and we want because they will stay in those communities forever while everyone else comes and goes. So that's an important issue.

When I talked about PAs I'd left out two groups though that I think are great recruits for rural communities. One is military people, so people that have been trained in the military retire at fairly young ages or leave the military. The broad scope of practice they've had in their various clinical roles makes them wonderful members of rural communities and amazingly many of them are from rural communities as well. Finally, also people that have been involved in international volunteer work, peace corps volunteers, are people that have made good transitions to PAs.

Delegated practice is my next point I want to talk about, a really sort of team practice, an important part of practically all of our roles, but it's not something that's talked about as much as it might be. Originally when PAs and NPs were created in the States there was a lot of training done of physicians by administrators. How were people going to work together? That sort of fell by the wayside. We're now doing it again. But I don't think we can assume that people automatically know how to supervise, to work in teams and whatever. It might be something to think about as a topic for this conference next year. There's a lot of great literature actually, corporate literature and business literature about how people work together as teams that's pretty applicable to clinical settings. So I just wanted to point out that.

The myth I want to dispel is, as I hear about new careers everywhere and this has come up as well, I think we need to be sure that the detractors of these new careers and the people that are frightened about this really want to make the statement that the new careers really are second-class care. That is actually not true and can't be true. The same standards of quality must apply and are designed to apply to the new professions as they evolve regardless of which one it is. So I just want to be sure that we all sort of pay attention to that and call people on that when they say, "Well, so and so are second-class paramedics or physician assistants. They're not as good as you would get from someone else." That's not true. It can't be true.

Last thing, I want to raise a broad concern that isn't about any particular profession and it has to do with the move towards electronic charting, confidentiality, those kinds of things which all go together. The biggest sort of side effect, collateral damage in a big way that's happened to us in the States that's hurt the health profession's pipeline and it's a good thing to call out is that as there's been more concern about confidentiality, the potential for students, younger students, kids at high school and junior high and even college that are exploring health professions, the chances for them to see interactions with providers and patients and clinics has gone away because of the concern that they'll compromise confidentiality.

So the sort of pipeline programs that we always spent time in as younger people have been almost eliminated. So when people say they want to volunteer or shadow or whatever, they're not given the opportunity to do that. I would not want to see that happen, so I just want to raise that issue, that we keep options open and whatever rules are about confidentiality, have some leeway to allow students, maybe with some training, to still have access so we're not cutting people out.

Tony Hobbs: I've been asked to talk about multidisciplinary teams but what I really want to talk about is ICM, integrated coordinated multidisciplinary teams because without the integration and the coordination multidisciplinary teams may not deliver what you want. We have to ask ourselves critically what we do want that team to deliver and I think there are two things; improved health outcomes but also improved patient journey and satisfaction as they go through that journey. Interestingly, when you look at the literature, the literature does support integrated co-ordinated multidisciplinary teams

improving both health outcomes and both patient satisfaction with their journey. Slightly different outcomes, so patients really respond to increased relationship and co-ordination between their health practitioners looking after them, because they don't have to repeat their stories and all that sort of stuff, but also they also respond to empowerment through health literacy in its broader sense.

For health outcomes most of the evidence really is around the integration and co-ordination. Education, for instance, standing alone, by itself does not necessarily improve health outcomes. The other really important thing for the government is that this may come at a cost. We need investment in this model of care to actually improve health outcomes. It is not necessarily about reducing costs and that agenda should not be driven hard. It is about the model of care that's actually going to suit that particular patient sitting in front of you within that community context wherever that may be to improve that person's outcomes. I think that's a really important issue.

The Minister tasked us in the national primary health care strategy to look at multidisciplinary teams, so that was one of the key elements, one of those key 10 elements that we put out and asked for information back. Not surprisingly, there was a lot of discussion about it. Interestingly from my point of view, a lot of the discussion was not just about who should be in the team and how the team should work together, the integration co-ordination, but who should lead the team. I'm just going to leave that question sitting there because I think that's a discussion that we should have.

What are we doing in Cootamundra? I think Sheila is sitting here. Sheila said to me yesterday, "What you've talked about has been very largely about a GP centric model of care". I'm a GP so I take that on the chin and I don't shrink from that. What we need is a team that actually best suits the needs of the local community. What we did in Cootamundra was actually driven by the GPs out of recruitment and retention issues. What we did was to see that if we're really going to be serious about improving a model of care for our community on the south west slopes of New South Wales, that we really needed to start doing our business differently, not just for the GPs, not just for our nurses and allied health, but most importantly for our community and partnership. It's an evolving story. We're certainly not there by any means at the moment.

So collocation, we showed you that left-leaning building, putting a team of people in there, private/public mix. Enabling that team to work together by shared electronic records, remembering confidentiality is important, as our patients want us to share their information so they don't have to retell their story. Looking at that information to see how we're going as a team so that we can feed that information back so we can improve outcomes. We've got a critical friends group that we've invited to come based on the work that Michael Brecher has done and that's a variety of people from across our community, older men, younger men, younger women, older women, people with significant physical disabilities and, more importantly, an Aboriginal elder to make sure that we take on cultural security and safety issues as well. All of those things are important in the mix.

Before we moved into the building, just in the planning phase, we had some work done. We asked Claire Jackson down from Queensland University to help us do some team building stuff. We actually spent a day around how the team was going to use our communication and technology system because we actually morphed from one system to another. So there was a great team building exercise, so we all knew how to use this important enabler.

The funding mechanism drives me to despair, so I think we need to think very critically about how we fund multidisciplinary teams, how we can enable the teams through funding mechanisms, to have more flexibility and each member of that team to work to their full competency and skill base. I think that's a critical issue. Because, again, the thing about teams is to better utilise the members that we have because that's all you may have and also to look at the roles of new cadres of health

professionals coming in, nurse practitioners, practitioner assistants, what is the role of the ambulance paramedic. So I think they're important issues.

The principles for me come back to some really basic issues around team care. So it's inter-professional trust, respect and enabling people really to work as a team respecting what each person brings to the table. I think that's probably about enough.

Robyn Williams: So we've got quite a long time for questions, points made. The microphones are up there. If you're far away from a microphone just wave and I'll stroll towards you.

Daryl Pedler: Daryl Pedler, Monash University, School of Rural Health. I just want to follow on from what Tony just said and also address my comments to Lyn. I was part of a research group about three years ago that looked at the role of the paramedic as an expanded scope of paramedic activity in the community. When we looked at it there was a whole range of things that came out of it, some of which were mentioned this morning and some of which were mentioned yesterday in a presentation. But the paramedic who comes out of an ambulance training base brings a whole range of skills that are not necessarily present in some other members of the team. Some people may have them but others may not.

I'm thinking about interactions with community groups, particularly their ability to be involved in health promotion, health education activities with community groups, their knowledge of emergency care and of the emergency management system, their knowledge of patient transport. I just want to suggest to the group, as we look at other activities like nurse practitioners, like physician assistants, let's put community paramedics there as an equal option because they do bring a considerable role that is of value. As we move into forming new skill groups, let's make sure, as Tony said, that they work together as a team and please let's not have too many more new silos. Thank you.

Lyn Pearson: I have to agree with everything you said there, and thank you for that. I think one thing you did touch on and that is the emergency management and you may or may not have been referring. We've been talking a lot over the last few days about climate change and with climate change, as we know from earlier this year, there comes a lot of disasters and major incidents and I think this year in Australia has really highlighted that. The ambulance paramedic really can be a leader in this area because that's kind of what you do in a small sense everyday as a paramedic and there's a lot of training and a lot of development that has gone on nationally, really Australasian because we include New Zealand, on the development of emergency management programs and working with health centres and hospitals on that sort of situation.

Many years ago when I was working in South Australia we were having a disaster exercise and immediately that sort of thing happens, the ambulance service stops all its transfers and only deals with what the urgent case is. But the hospital, they were saying, well, we're going to move everyone out of our hospital, but the ambulance service wasn't moving anybody out of hospitals. So that just shows how important it is to have these discussions with anything we're doing to make sure—because, in isolation, the hospital thought that would be the way to go, but the ambulance service was thinking in a different way. So with all these emergencies it's highlighted for each one we've learnt more and more and that integrated approach is essential to that success of managing a disaster across Australia.

Robyn Williams: Yes. The news from MIT this morning is that climate change is happening at twice the speed that they thought until quite recently. So it's exactly the kind of thing that you need to be prepared for. Anyone else like to comment on the question from Monash?

Paul Martin: Paul Martin from UNE. I'd like a comment from any of the panel on this particular proposition; that the welfare and retention issues for rural health workforces are significantly common with the issues for other non-health professions and that there are substantial opportunities if we can engage other professions with rural health professions in trying to address those common issues.

Tony Hobbs: Well, I certainly would agree very strongly with that from personal experience. In most country towns all the professions have differently attracting workforce whether you're talking about accountants, it doesn't really matter, teachers, whatever, and there are things that you can do. One of the things that we've done in the Riverina, for instance, is to have a shared system of putting advertisements with our local councils across professions really to start really building a story around attracting people to a region or a set of towns whether it be accountants or health professionals or other people. I think that's a very good thing and I think we can respond really quite positively to it.

Anne Gardner: I'd also agree with that. Certainly in Queensland there are a lot of similar problems for teachers and nurses in rural communities, but they're often dealt with completely separately instead of them being dealt with together. So, yes, I'd agree with that.

Matthew Cane: Strangely enough, as a student, it's one of the things that a lot of the students have trouble with when going into rural areas, they go into those rural areas very young and then they look forward to, once they marry and have children, the education that's important for their children and it's one of the reasons or one of the driving forces as to why a lot of people seem to leave the rural communities to go back into an urban area so that they get that better schooling for their children. So when you're talking about trying to attract the appropriate teachers and trying to give them the appropriate remuneration and support in rural communities, I think that's very important as far as students are concerned as well. It's one of the things they look at as well.

Jeff Fuller: Jeff Fuller, a National Rural Health Alliance councillor and work in UDRH, or University Department of Rural Health in my day job. I'm not sure if the panel's the right set of people to respond to this point, you may be and others in the audience may be, we're talking about team-base models of care and it seems to me that the central driver to team-base models of care will be patient focused or client focused care. I think someone mentioned the word about who should be the leader of the team, we need to put the patient or the client or the consumer as central to the team, not necessarily in a leadership position but certainly in an incredibly influential position. Tony did, I guess, speak to the critical friends group but I wonder if the panel or anyone from the audience has any useful reflections on how we can meaningfully put the patient in as the centre of the team but really in a central powerful position, not in a sense just as sort of there.

Robyn Williams: The patient, yes, Tony.

Tony Hobbs: I think that's a very good point and maybe I didn't address that as well as I should have. I think there are two important levels. One is the individual interface between that practitioner and that particular person and their carer and family. I did say it, but health literacy in its larger role is absolutely important. So it's not just about education. It is about empowerment. So there's a whole range of things around that. It's about education for patients, it's about education for the practitioner so that they can actually do motivational interviewing so they can actually respond more appropriately and be much more comfortable in having an active partnership engagement with that particular person sitting in front of them.

But it's also about community building and community empowerment as well, allowing the community really to own that health centre. It was pointed out this morning that the Aboriginal control community sector do that much better than mainstream health services do and we need to take some of that on

board. There has been some really good work done in the NHS. Michael Greco has led that work. As part of their overall quality outcomes framework, the patient experienced the patient journey and the way that patients perceive that they have been treated in their interaction with the health service is a fundamentally important and reportable outcome for all health services. I think that is a really critical move and we need to take that forward.

Ruth Ballweg: I think sort of following on actually from the previous question as well, I think that in recruiting and interviewing people for a practice in communities it's interesting to me to see that successful communities often involve community members other than the health care clinicians as part of the interview process. I'm not just talking about the community leaders, not the mayor and whatever, but real people that people can connect with. Even the opportunity for somebody coming into a clinic that's thinking about going to a practice, my advice is go and sit in the waiting room for a couple of hours or an hour and see how people are treated. Are they treated respectfully or are they treated like widgets that are moving through? Because it's so important I think for communities—community self-esteem is determined in some ways by—one of the variables is the turnover of the people in the town. So if the community has a reputation for the docs and the nurses and the lawyers and the accountants all coming and going it starts eroding how the community thinks about itself. So involving the community members and the patients in the recruitment, the selection, the feedback, the support of the health environment really makes a big difference I think.

Robyn Williams: Yes, in 1972 we did something which I presume is impossible today for all sorts of protocol reasons. We had a pseudo-patient survey run by Robin Winkler who was then senior lecturer in psychology at the University of New South Wales. We were sent off to GPs as if we were depressed patients and our instruction was simply to give that vague impression but then respond only to questions. There were a bunch of women and a bunch of men and the difference in treatment was startlingly obvious. Most of the guys got interviewed for about 20 to even 30 minutes, given fairly chummy advice about how to join a golf club and how to kind of cope with the naturally understandable problems, because we were supposed to be teachers. The women were given between four and five minutes and a prescription of valium. The contrast was quite interesting. I suspect that would be illegal now, but it was a very interesting survey at the time.

Alison Companti: Alison Companti, south west of Western Australia. I'm a health consumer at this particular conference. Given the average age of GPs and the increase in health professionals in rural areas and their general reluctance to embrace technology, I'm just interested in comments from the panel there about the amount of hoops that you have to jump through to get the funding and the ticks in the right boxes to actually attract the sort of schemes and things that you're talking about up there with your multidisciplinary teams to actually get past all that paperwork stage and get these sort of things on the ground? Have you got any suggestions about how it can be done better than it is at the moment because I know it's quite onerous?

Tony Hobbs: I have two comments. My first comment would be to refute what I think I heard you say, that GPs in rural areas aren't interested in technology.

Alison Companti: No, no, no, I just said there is a reluctance to embrace the technology that they require to actually get the paperwork in that's required to actually attract the funding that gets your teams going.

Tony Hobbs: Okay. Yes. Bureaucracy paid work is the bane of our lives unfortunately and, as I said earlier, it is difficult with current constraints, interest rates and a whole range of other constraints to actually develop the team. It's not impossible, but there are some constraints, but I think we also should look at a journey that we've been taken on. If we just look at the practice nurse items, for and

on behalf of, as they've been very useful in driving some changed behaviour and change in the workforce within general practice because all of a sudden the business case for having a nurse in a private general practice became much more attractive. Yes there are constraints and frustrations around how that funding model sits now that we've moved on a case, and it's time now very much to revisit that, so having a practice-based payment that allows more flexibility. But I think we do need to acknowledge that some of these innovations have actually led to behaviour change even though they've been quite clunky and bureaucratic. So that's my first comment.

The comment about people actually wanting to spend time to fill out pages and all the rest of it, look, I don't know what the answer is except all of us would like to have less paperwork to do. It doesn't matter whether you're re-credentialing for your local hospital, which I'm doing at the moment, and I've worked there for 16 years and I had to get 100 points to show who I am and then I'm filling out the same paperwork that I did three years before and three years before that. All of that sort of stuff is really important of course. So I think we need to have a strategic approach to recruitment and retention of the whole team based on information that says these are the community needs, these are the people we think we need in this place, how are we going to get them there. I think we need that sort of approach.

Alison Comparti: Do you think it detracts from your core business?

Tony Hobbs: Well, I know in my experience what we need is people to do some of that work for me so I don't spend my valuable time as a clinician on bureaucracy and that's why we need people like practice managers, for instance, other people who are actually doing that work for us and on our behalf and, again, very critically, making sure we link in with the community while we're doing that, so actually reflecting the needs of the community because these are dual things. We've got the needs of the community, improved health outcomes, improving their satisfaction with the health service, but critically sitting alongside that we have the needs of the health practitioners who we want to be there to look after that community.

Alison Comparti: I think one of the other issues is that there is actually a safety and quality component to the paperwork so that sometimes what is actually done is increased accountability and those sorts of things. I mean, it's very tiresome often but sometimes it serves its purpose.

Brian Corcoran: Brian Corcoran from the National Rural Health Alliance, although they should bear no blame for this question because it probably comes from the mindset of an ex-federal bureaucrat. In the Health and Hospitals Reform Commission report, buried away in a footnote, was an estimate that if we continue with current systems and current models of service, within 15 years we'll have nearly doubled the percentage of our workforce engaged in health. Now, some would say that might be unsustainable given our need for food production and education and housing and action on climate change and the whole ...

Robyn Williams: Lawyers.

Brian Corcoran: Well, I wasn't going to go near lawyers. So my question to the panel is, what do you see as the approaches—I mean, you've all talked very engagingly about new service models and also new professions, new forms of team work, how do you see those moderating that potential demand so that the health service provision in rural areas is actually provided rather than being not provided because the nation can't afford it?

Anne Gardner: I think that if we end up giving better services at an early level, at a preventative level, then we will actually save money in the long run, but it's very difficult to demonstrate that of course, but I think that's actually a really important issue. I'll just take up Tony's point, I think we also need to

acknowledge that some of these new services are going to come at a cost. It's not going to necessarily be cost neutral, but in the long run hopefully. If you look at smoking cessation programs and those sorts of things, in the long run they are actually going to cut down to some extent in the health costs.

Lyn Pearson: A couple of us have said in our professions—you were talking about the nurse practitioner wasn't fully utilised, the full-time paramedic in a regional area is not fully utilised. The first thing to do is, I guess, use all the resources we have and then hopefully we will provide a better service with the similar sort of resources. I did listen to and I can't remember the detail of a conference a year or so ago when somebody said at the rate we were employing and the rate that health was going we would need 90 per cent of the workforce in 10 years or 20 years to go into the health profession to manage it if we don't make any changes. So I guess the issue is we do have to make some changes. But if we can utilise the skills that are there before we add on to it that should be good.

Tony Hobbs: I mean, that's a huge question. I certainly won't have all the answers, but I think there are several things. Up front investment is really important because we know that well organised primary health care delivery is going to save money. The other thing with an ageing population is we need to keep people as healthy and as active as possible and out of hospital so the end of life problems are compressed. There's really good evidence to show that you save enormous amounts of money in doing that. So front loading the investment is really important in the workforce.

I think there are several key issues. One is we do need to use our current workforce much more efficiently and even though some of the work of nurses, for instance, that Bonnie Sibbald and others have done in the NHS, shows that it may not be cheaper because they spend more time with patients and tend to get patients back more often and maybe even do more investigations, there's an opportunity cost. So if you're working as part of a team, the doctor, for instance, who may be part of that team, can then be freed up to do some other stuff. Now whether that's looking at the more complex or difficult patients where my skills and competency base are more better utilised, whether it's around mentoring and teaching, again that's an up front investment. All of those sorts of things are really important.

But at the moment, look, my experience in general practice is a lot of work I do I firmly am very comfortable with the view that I would very happily delegate that to people with the right competency and skill base working alongside of me collaboratively as part of a team. I think that's got to be part of the future and I'm sure that most people in this room would share that view. It's how you actually operationalise that and enable it to happen and it's about infrastructure, both bricks and mortar. It's about e-health so that you can either do it in a collocated team or a virtual team and, very importantly, it's about how you fund that team and of course, as has already been pointed out, we must not let quality and safety issues fall aside. We must maintain those issues.

John Setchell: John Setchell. I'm the Medical Director for the Flying Doctor Service based in South Australia and the Northern Territory and I have a comment and a question. The comment is to really support Tony's concepts of the integrated collaborative primary care team and say for the 81 years of Flying Doctor history, that's been a very important part of what we do out in the patch that we work in. If we didn't, it wouldn't function. The question is to Lyn, and I think Lyn probably is going to guess what I'm going to ask, but I'm just wondering if you could give us a brief outline of where the current thinking is within the ambulance professions about the question of regulation and registration?

Lyn Pearson: Yes, it came up at a session recently about the question of regulation and registration and it really goes with accreditation as well and in our case it's two separate things and it gets a bit

confused. Accreditation of a program, the accreditation of the training program, I'm sure you've all spent hours and hours preparing for those things and the paramedic programs will be accredited. There's some of provisional accreditation already happened.

The regulation or registration, whichever you like to talk about, is quite a different issue and it's an issue heavily under discussion in the paramedic world. The paramedics themselves generally through their ambulance college, Australian College of Ambulance Professionals, are strongly in favour of paramedic registration. The Board of the CA is made up of all the CEOs and they believe the industry at the moment is highly regulated. In most cases there is one employer in every state and the predominant number of paramedics are employed by those individual employers and they are highly regulated within their state and territory. When we're looking at regulation, it's generally for, "is the patient going to benefit?" and the position at the moment is there doesn't seem to be any evidence the patient will be any safer from that regulation process being introduced at this time. It's something that I think will be under discussion and thinking will change over the next few years.

Lee Martinez: My name is Lee Martinez and I'm the Director for Mental Health and Country Health, South Australia. At the risk of opening up a can of worms my question is in relation to transport of mental health clients. In country South Australia it's possibly one of our biggest issues for consumers when there's a need to transport them to an approved treatment facility as the only approved treatment facilities we have is in the metropolitan area. The issue is that often they're not treated as equitable as other conditions that need to be transported and they end up having to wait a certain amount of time. I guess my question to Lyn is, nationally are there practices in place that we could improve the transport for mental health consumers?

Lyn Pearson: That's another one of those issues that is run separately by the different states and territories. I know over the last few days everyone has been saying, "We all do things differently," and this is one that they all do differently. But, again, there's a lot of discussion, a lot of work has gone on in South Australia, particularly—and I sort of live there so I've got a bit more of an idea of what happens there—and yet it's obviously not a totally successful outcome. It's the processes that are in place for the safety of everybody that seem to hold things up. I don't think there's anything that I can think of immediately that would assist you in improving issues, because I think everybody's issues are the same. The difference in places like Western Australia, South Australia, Northern Territory is the distance. It is just so difficult. There's limited resources, there's rules on when you can fly a patient and what condition they have to be in and what support structures when they're flying, and the same on the road. So I actually can't give you anything exciting, but I do know that in South Australia particularly it is a high priority to continue to try to improve the process. Going back 10 years, it's improved a significant amount.

Lee Martinez: Yes, totally agree. One strategy that we have put in place which you'd be aware of is the patient transport officers to try and alleviate the use of South Australian police in the transport exercise and I believe that's working quite well. Similar I think to the paramedical aid but with a mental health focus. Thank you.

Crystal Cree: I'm Crystal Cree. I'm a general practitioner in the Pilbara. I'm Chair of the GP Division in the Pilbara as well. Look, I've been there a long time, 11 years, and I've seen a lot of people come and go both in allied health and general practice. I want to address rural retention. One of the things of the conference is we want allied health people to have retention incentives, like general practice. Well, I think general practice has got it wrong. All the people I've seen come and go and hang out for that last payment of general practice and then leave. Those incentive payments, they've basically picked up and thrown the bundle into a house somewhere in a capital city. If we want to build health communities, we want people to stay. The one thing that's missed in these incentive payments is

something to make people stay and the biggest thing that I could see is giving them a low-cost loan to buy a house in town as an option to low rental, which often is part of the packages. We lose too much intellectual knowledge.

Now, we're talking about paramedics and other people having multi skills, say, like an OT being the next best person to send to mental health counsellor or take the place of a mental health counsellor who you may not have. So if that person leaves and you replace them with a basic OT two or three years down the track, you've lost that extra skill. We really want these multi-skilled people to stay. We've got to look at better ways of giving them incentives to stay, not just a bundle of money that they can stick into shares or stick into a house somewhere else then leave. Any comments?

Matthew Cane: When you're talking about retention and recruitment of GPs or your GPs into rural areas, from the student perspective, the amount of scholarships that are given to medical students far inundates the amount of scholarships that are actually given to nursing students and allied health students put together. I think that's one of the biggest things that we look at as a student organisation. We would like to see equality across allied health and nursing professions in the student body in trying to encourage other allied health and nurses into those areas because I think they offer such a diversification of roles, like the new nurse practitioners, the paramedic practitioners. By putting students that are interested in those roles and putting them into those areas they will actually stay, whereas some of the students—and it's not detrimental to medical students, it's just the way that the scholarships are set up unfortunately—is that they'll take those scholarships, they'll go into those areas, do their time and then they'll leave. It's something that we've discussed as a network. It's a little unfortunate. The community wants someone to stay. They want someone they can trust.

Crystal Cree: We have medical students coming in under schemes now and the packages that they're given, when they become a medical practitioner, they don't get that sort of money. So they actually end up leaving on the grounds of the retention payment is not as good as what they had when they were student. So don't get it wrong with all the allied health people as well, and I'd love to see the GP stuff change.

Tony Hobbs: Yes, well, I basically agree with what you're saying. As I said yesterday, incentives and relocation grants are a very blunt instrument and I have some concerns about the current package, irrespective of what you said. Look, there's been a lot of work done here that supports what you had said. I know John Wakerman is in the audience somewhere. He's done a lot of work on this, and John Humphreys, about what does attract and retain a medical workforce in rural areas and it's not just about money incentives or other things. It's a whole range of things, including bonding and feeling part of that community, about housing, as you said. It's about spousal employment opportunities or other opportunities. It's about childhood education. It's the whole range of things.

In defence of the government, I think what they've tried to do is to try to address two issues. One is to reward people or encourage people to go to more remote areas and also to look at the timeframe that people have been there. That's that current incentive package. The Minister is going to be here this afternoon and I would suggest you should have a talk to either her or Ruth Kearon and let her know your views.

Bernard Denner: Bernard Denner. I might have a real good story to tell that answers a lot of questions this morning, especially about teams. I work out of the General Practice Network at Alice Springs. I'm in a health team; a dietician, a podiatrist and I'm known as the chronic care educator and we work between Alice Springs and Elliot. We support doctors in each of the locations. We work at Tennant Creek with the Flying Doctor Service and in Tennant Creek with the Anyinginyi Aboriginal Health

Service. In two weeks we will see up to about 120 people, and certainly in the Aboriginal areas we're doing full seven tens in partnership with the doctor and in partnership with the health service.

Listening to some of the comments is the health services we go to are very, very busy in chronic care. There's no health promotion. There's no health education. There's no working out in the community. We go to all the camps and we fill in those gaps. We don't know each other. We come from different parts of Australia into Alice Springs and we rotate every three months. We are not only enjoying it but the client is first, always first, and they are getting to know us and it seems that the General Practice Network Alice Springs have hit on something that works for a whole range of different communities, both indigenous and non-indigenous across an area—and I suppose our biggest, how we feel really is, Utopia. Now, some of you would have heard of Utopia, some of you go, "Holey moley, that's not really true," and the success that we've had there as a team is huge and we're very, very proud of the work there and now we're working towards right up to Elliot.

That's an alternative because here's allied health workers, a dietician and a podiatrist, come from different areas of Melbourne who have said, "I can sustain every three months working for two or four weeks in a rural area," ongoing, not as a visiting nurse, "I've come from three months and then that's a good experience, thanks very much." It's consistency and I'm hoping that we're being funded for another two years where, by the time we leave this area, is not only has there been the clients but also the staff have learnt from our experiences. So there are things out there. The most annoying part is, because the general practice is seen as a division of general practice, is why have they got the money and why are they doing it? It should come directly to the health service.

Let me tell you, I agree with Tony on lots of things and I don't on a lot of other things, but this general practice has structured this program so well, financed it so well, you wouldn't want it going anywhere else. So I say to the audience, there are opportunities and innovative ways to get allied health people into communities for a long time and you don't have to worry about houses.

Robyn Williams: Thank you. We'll take that as a statement.

Tony Smith: This is more of a statement as well, Robyn. My name is Tony Smith. I'm from the University Department of Rural Health in Northern New South Wales at Tamworth. Hearing all these comments this morning and all these wonderful ideas and suggestions reminds me that on 6 to 9 April next year—write this down folks—the All Together Better Health 5 International Interprofessional, Education and Practice Conference will be held in Sydney at the Manly Pacific Hotel and you are all welcome. Abstracts are called for now and are due by 9 November, so there's still plenty of time. Watch this space. Keep an eye on the website and hopefully we'll be able to email you all at some time in the near future. That's the All Together Better Health 5 International Interprofessional Education and Practice Conference in Sydney, 6 to 9 April next year.

Robyn Williams: Thank you for the plug. Wonderful.

Tim: My name is Tim. I'm from Maryborough and I'm a social worker and I manage allied health. You're scaring the crap out of me with the conversations around recruitment and retention. I feel like if I walk into a community, you won't let me go. You might want to, but you won't let me go. I think we've got to be really, really careful about how we approach this whole retention and recruitment thing because I think that we can look at it different ways, that people might come in and out of our community over time and that might be a good thing. People might, near the end of their career, decide to come and work in a rural community or a remote community, people at the start of their career, people in the middle of their career, and we've got to be very careful that we don't think that we need to grab them forever.

I guess most of the conversations that I've overheard about recruitment and retention kind of focus on keeping them forever almost, and that's the underlying sense that I get. As a manager of allied health, I don't want to be there in 20 years with the same people in 20 years. I think that's deathly and that you won't get good practice out of that. I want to see some people that have been there for a long time. I want to see some people that have been there for a medium amount of time and I want to see some new blood in there giving ideas and give everything a push along. I think some people have already done some work on this, but I think it's worthwhile being very careful about retention and what exactly that means for our community, what does that mean for our practice and what does that mean in terms of actually getting people to stay for a bit longer.

Robyn Williams: Tony, could you remember that point and build it into your statement at the end?

Tahlia Heath: I'm Tahlia from the National Rural Health Students Network. My question is regarding the multidisciplinary teams. How important is it for this to be taught at a university level and what do you think the universities need to do to incorporate this into their courses?

Anne Gardner: I think it's absolutely crucial. It needs to be integrated in undergraduate teaching so that undergraduates from all the disciplines actually learn together and do clinical practice together. It's a no brainer I think. It doesn't happen unfortunately in a lot of places.

Matthew Cane: I think I spoke to one of the ladies from a Victorian university and they were talking about their interprofessional education where now they have sort of a common first year amongst their nursing students, their pharmacy students and their medical students. So basically they're all lumped in together, for wanting to say something better. I think that's one way of trying to tackle that issue of interprofessional education. It's also one way of making sure that we continue to push that multidisciplinary approach at the end of their individual training as well. So I think interprofessional education amongst the university is something that really needs to be looked at more than what it is at the moment.

Ruth Ballweg: I think it needs to be a combination of things. Sometimes we think about formal things that are classes together, that's a good thing, and sometimes we think about external fellowships, those kind of things, but I think there also need to be social things. There's nothing like a lot of beer to bring people together and I think sometimes people think it's just formal, but really it's about the social thing sometimes. I also think there need to be some student run things. It could be special projects that just happen for a year so that the students own it as well, really makes a big difference.

Tony Hobbs: Could I quickly add that I agree, undergraduate stuff is critically important but don't forget the ongoing continuing professional development because the way we work in practice is based around relationship often, so being educated in an ongoing way with your cohort of doctors, nurses, pharmacists, allied health, ambulances. It's really important to build those relationships, those referral patterns as well.

Matthew Cane: One of the key focuses that the National Rural Health Student Network looks at is having a combined event which is our National University Rural Health Conference. It's the conference for students. So not only is it a way of disseminating information about what's going on out there in rural health, it's a good way of students actually interacting with one another and actually getting to know one another. We're actually thinking of setting up a dating service, so basically getting students together so that when they go rural they've already got a partner and they actually get two health professionals for the price of one.

Peter Goss: My name is Peter Goss. I'm a paediatrician from Sale in Victoria. In your discussions regarding multidisciplinary teams, child health and paediatricians as in the specialist medical workforce

has not actually come up at any stage and I think that's a significant omission because paediatricians in rural areas actually look after, in a multidisciplinary sense, child disability and involved in child abuse teams and involved in mental health teams and school behavioural issues. I personally have a multidisciplinary clinic. It's probably the only one in rural Australia. We're collocated with a number of allied health staff. Yesterday we presented our results on rural child diabetes and showed that our medical results are better than any metropolitan rural centre. Our patient satisfaction was extremely high with that model of care and the quality of life issues have been totally tipped on their head from the previous disadvantage from rural children. We've got the biggest insulin pump program in Australia and our percentages is beyond any of the metropolitan tertiary centres. So these things are possible and in your discussions regarding this, please include paediatricians in it. Thank you.

Robyn Williams: Thank you very much. Now, final statements. I'd like Tony to go first, then we'll have Lyn and Anne, then, Ruth, we want you to challenge us to the future and finally Matthew. So, Tony, final statements on where we're going.

Tony Hobbs: Just quickly, I think in everything that we do we need to put the individual, the patient, their carers and families in our communities with us in partnership. So the most important person in the team when we're talking about multidisciplinary teams is that person and their carers and families. The second thing is I need to respond to something that was said earlier about the rural retention and recruitment, about the length of time. I think I'm quite agnostic about that. As long as the relationship established between that particular health professional and the community and the people that they're trying to look after is such to enable trust and good health outcomes and a positive experience for that community to develop over time.

Now, whether you do that episodically or over a period time, be it short or long, it doesn't particularly concern me, as long as that's functional. At the end of the day, one of the key drivers around the development and the performance of the teams has to be the funding model that drives that. With the other part of the funding, of course, is accountability, both for patient outcomes, patient experience and efficiencies for the health sector.

Robyn Williams: Lyn, why don't you go next.

Lyn Pearson: Certainly. I think everything that has been said today is that the integrated team, the integrated approach, the multidisciplinary team is the way of the future and it's not only for rural areas. It's happening in urban areas and there's huge benefits for that. I don't think we can provide a health service into the future without it. But if we are looking at a different way of doing things, let's not reinvent the wheel. There's huge amounts of fantastic experiences around Australia and don't just stop at Australia, because what I've seen is amazing things being done through Canada, the US and the UK as well. With the enthusiasm and passion are people like this in the room and our rural workforce we can do more with the resources we have. So just imagine how much better we can do with the additional resources we hope to get shortly. Thanks.

Robyn Williams: Anne.

Anne Gardner: Well, I'd just like to reiterate the fact that we need to use our human resources well and that the structures for who's in the team and who leads the team needs to be flexible, including the funding models. I'd just like to end by saying that, in fact, we talk a lot about the multidisciplinary team but in a lot of really remote areas the team is actually just the community and maybe only one or two health professionals. So in terms of the health professional team, it's actually very small. It may be a team of one person.

Robyn Williams: Ruth, from what you've heard this morning, could you challenge us for the future?

Ruth Ballweg: Challenges for the future, is that my assignment?

Robyn Williams: Yes, why don't you do that. I mean, can you come all this way?

Ruth Ballweg: Well, I'm just looking forward to seeing how this all develops. I've been coming to Australia—I think this is my seventh trip—and I've met a lot of people over time and I've seen a lot of changes during this time. I think Australia has some innovations that we can all learn from and I know that a number of you have been over to the States talking about some of the rural incentives that exist here. So I'm personally looking forward to seeing the development, to see actually even newer innovations arising from Australia because I think the attitude and the point of view and the challenges really are a wonderful environment to make things happen and pretty quickly compared to more traditionally bound places where it's difficult to make change. So I'm excited to see what happens.

Robyn Williams: One or two things strike you, from what you heard this morning, as particularly urgent?

Ruth Ballweg: One of the things that strikes me is the implications of what's going to happen with the budget changes and the new policies that are coming out of that. I also am really struck by the need to create some primary care models, some integrated delivery systems and thinking about how everyone works together. I think Australia is much further ahead on thinking about that than you'll see in other places. As well as the openness of everyone here, it stands out. I feel very welcome. Thank you.

Robyn Williams: Thank you. Matthew, the future.

Matthew Cane: The strength of the Student Network is that we have 8500 members. A lot of those students are made up of mature-age students or students that have different diverse backgrounds. I think it's important that when developing a curriculum and looking at the form and looking at the future as far as we health professionals are concerned, especially in the rural areas, that we should consider what the students actually have to say because they have the vastness of experience and some for the students that are coming out of university have that knowledge as well. When looking at it, don't discount students. It's important to get their voice, to have their input into what's going on in a curriculum, what's going on in the incentives for getting your allied health professionals and medical students into rural areas. I think it's very important to listen to the voice of the future of rural health, assisting them and getting them to assist you, and having already set the standard and the bar very high, trying to take that bar up a notch as well.

Robyn Williams: Thank you very much. Thank you, panel, and indeed, audience. I mean, there's some tremendous interactions there and we have a vision for the future, at least some starting points..