Jennifer Doggett reported on the 6th Rural and Remote Health Scientific Symposium held in Canberra from 11 – 12 April, 2018, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. [http://croakey.org](http://croakey.org)
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Some questions for rural and remote health leaders

The new CEO of the National Rural Health Alliance (NRHA), Mark Diamond, had a few questions for health leaders ahead of the 6th Rural and Remote Health Scientific Symposium in Canberra.

Mark Diamond writes:

When leaders in rural and remote health research converge upon Canberra early next month for the 6th Rural and Remote Health Scientific Symposium, I hope they will do three things.

First, I hope they will be able to demonstrate how research has led to some significant health gains for rural and remote communities since the first such symposium was held in Toowoomba in 1992.

Secondly, if research has not led to the health gains that we might have expected, I hope the meeting will give us a sound understanding of why this has happened, and how we can ensure better health returns from research in the future.

I am sure these insights will be of great interest and use to many people across diverse fields, whether in rural and remote health or in the wider health and social sector.
**Tough questions**

Thirdly, I hope that participants in the symposium will ask some tough questions of the National Rural Health Alliance about what we are actually delivering for the health of people living in rural and remote areas.

Since being appointed as CEO of the Alliance last December, this question has been much on my mind.

Our overall remit at the Alliance is to improve health outcomes for people in rural and remote areas. If we’re not achieving that, then we’re not doing our job. We need to justify everything we do in that context.

For Croakey readers who may not know my background, I spent my formative years in central Victoria, and came to my current role with the Alliance with more than 20 years experience in managing health and community services in rural, and regional areas across Victoria, NSW and SA. I have also led community mental health reforms in a metropolitan centre, and worked for the Uniting Church based in Darwin establishing a major new aged care provider.

So I bring diverse professional and lived experience from a range of health and community settings to my new role. I also bring a deep conviction about the importance of access to healthcare as a fundamental determinant of health.

It is good that we increasingly are talking about and seeking to address the wider determinants of health. But that is a challenging and ambitious quest, requiring action from every arm of government, the private sector and multiple stakeholders and agencies.

Actually, I can’t imagine a bigger task – especially given the challenges that we already have in getting a few of the key players talking constructively and acting collaboratively.

**Prioritise access**

Given this reality, I believe that the objective the NRHA can most usefully work towards is improving access to healthcare for people living in remote, rural and regional communities.

Access to timely, appropriate and affordable healthcare is a major determinant of health outcomes. It’s something I think we at the Alliance and our networks can do a lot about.

I am hopeful that the #6rrhss will provide useful knowledge to help us in developing a minimum expectation around service access for country communities.

In doing this work, we need to acknowledge that there is not only a gradient between the health of metropolitan and rural/remote communities, but that there is a gradient within rural and remote areas.

The [National Strategic Framework for Rural and Remote Health](#), endorsed by COAG some years ago, was intended to be used by each jurisdiction in guiding the development and framework of health services.
Every health minister signed off on it at the time. But, so far as I am aware, it has never been properly evaluated, and I think we can rightly ask some hard questions about how useful and effective it’s been.

It’s time that we had a new national rural and remote health strategy. We must ensure that it does actually make a difference.

One way we can achieve this is by maintaining a very strong focus on ensuring greater equity in access to healthcare, recognising that there is also considerable inequity within rural and remote areas.

We want to delineate what service access means for various community settings and contexts – what are the services that need to be available and how should they be provided?

Solutions focus

I believe there are two key ways forward: one is through making better use of technology; and the other is through addressing workforce maldistribution, including through ensuring all health disciplines (not only medicine) have a generalist component.

I’d like to see us doing more to recruit people from rural and remote areas into allied health education, training and placement, for example.

I hope the 6th Rural and Remote Health Scientific Symposium will contribute towards the development of a more extensive evidence base about what models of healthcare work best for different rural and remote locations.

Most of all, I’m hoping that all symposium participants keep their focus on solutions – rather than yet more iteration of the health challenges for rural and remote communities.

We need to make sure we are developing these solutions in partnership with communities, recognising that there is no one-sized solution that will help everyone. We need to tailor make rural and remote health solutions.

I encourage Croakey readers to follow the Symposium discussions on Twitter at #6rrhss and via our Facebook page. And please join the conversation.

• Mark Diamond is CEO of the National Rural Health Alliance.
Jennifer Doggett writes:

The National Rural Health Alliance’s 6th Rural and Remote Health Scientific Symposium brought together established rural health research leaders with political representatives, early career researchers, peak rural health bodies, Indigenous health stakeholders and rural health consumers.

Focussing on the past 20 years of rural and remote health research that informs strategic health policy and service delivery, the aptly named ‘Outback Infront’ event will provide opportunities for both celebration and challenge.

Celebration, firstly, because the Symposium will mark 20 years since the establishment of the first university department of rural health in 1997. This milestone event heralded two decades of innovative rural health research and the creation of an impressive body of knowledge to inform the development of health policies and programs in both rural and urban areas.

The Symposium will also provide an opportunity for celebrating the emergence of rural health leaders who have emerged as strong advocates for evidence-based change and who are now mentoring and guiding a new generation of rural health leaders.
Key research leaders speaking at the event include Professor Tom Calma on the importance of Aboriginal community researchers, Professor Alan Cass on the importance of patient, family and community stories in rural health research, and Emeritus Professor Lesley Barclay, who will lead a panel of experienced researchers to discuss the legacy of 20 years of rural health research.

These speakers will highlight the role that the rural health research movement has had in developing solutions to the health challenges facing all Australian communities, both rural and urban.

**Wider leadership**

While central to the rural health sector, the NRHA and events like the Symposium are also relevant to the challenges faced by those working in urban health care settings.

In fact, whether its collaborating across sectors, dealing with limited resources or working in multi-disciplinary teams (better known in rural areas as ‘just doing your job’), city-based health care policy makers and managers have a lot to learn from how things are done in the bush.

This will be highlighted in the Symposium’s keynote presentations by Dr Judith Katzenellenbogen, Professor Luis Salvador-Carulla and Professor Hugh Taylor. These speakers will focus on the learnings from their research that have broader application outside of their immediate subject area.

For example, Professor Taylor will describe how success to date in improving eye care for Indigenous Australians demonstrates how to effectively link primary care with specialist services in other areas.

A number of sessions will question why the past two decades of high quality rural health research have not resulted in better rural health policies.

**The rural health policy impasse**

Directly addressing the need for increased action on rural health is the Day 1 colloquium session titled: *The rural and remote health policy impasse: why hasn’t research evidence generated policies to improve rural and remote health services?*

This session will include expert speakers Emeritus Professor John Humphreys, Associate Dean John Wakerman, Adjunct Professor Bob Wells, Associate Professor Sue Lenthall and Paul Worley, the National Rural Health Commissioner.

Delegates will have an opportunity to question these speakers on the ‘rural health policy impasse’ and discuss possible solutions to this problem during the colloquium session.

One proposal they might like to consider in this context is the suggestion made at last year’s National Rural Health Conference by leading health administrator and a director of the Royal Flying Doctor Service, Mick Reid who called for a [new national entity to be established](#) to drive collaboration across the rural health sector and the systematic implementation of evidence.

In his keynote address at the conference, Reid said:

> My strong message is we do not collaborate enough. I’ve been around the health system quite a while and there are two characteristics of rural health which really need to be addressed if we are to go forward.
One is, there is very poor collaboration between multiple agencies. The other thing which occurs, which is not specific to rural health, but it is much more obvious in rural health – the application of evidence does not occur to the degree it should.”

Reid went on to describe how such an entity could be modelled upon Clinical Excellence Commissions and located within the National Rural Health Alliance. This proposal was supported by Dr Lesley Russell and others at the conference; it will be interesting to see if it is discussed further at the Symposium.

Timely discussions

An important perspective on rural health policy will be provided in the address from the Minister for Rural Health, Senator the Hon Bridget McKenzie, whose keynote presentation at the start of Day 2 will set the scene for a session on Closing the Gap, clearly the most urgent of our nation’s health challenges.

Hopefully the Minister will provide delegates with an opportunity to ask questions about the Government’s future plans for action on Indigenous and rural health, and will be able to interact with the speakers and attendees and hear at least some of their stories before having to return to her parliamentary responsibilities.

Opportunities to hear about and provide input into specific rural health research projects will be provided by the Rogano Sessions where researchers will present their research and seek feedback from delegates. Topics covered in these sessions include the future for rural generalists, the delivery of health care in rural prisons and over-the-counter codeine dependency in rural Tasmania.

There will also be a series of short Lightning Talk presentations from emerging and active researchers covering a diverse range of topics such as the management of Aboriginal children presenting at rural emergency departments, allied health teletherapy and older people’s roles in rural emergencies.

The final session of the Symposium focuses on resourcing, access and equity in rural health and features keynote addresses from health economist Professor Leonie Segal and Claire Sparke from the Australian Institute of Health and Welfare, as well as a panel discussion featuring: Professor Amanda Kenny; David Hallinan, First Assistant Secretary, Health Workforce Division, Department of Health; Chris Bourke from the Australian Healthcare and Hospital Association; and Australia’s first Indigenous dentist, Rob Curry.

With a Federal Budget around the corner and an election on the horizon, this Symposium will provide rural health advocates with the information, research findings and support they need to make a strong case to governments (and potential governments!) for evidence-driven and community-based changes to improve the health and well-being of rural Australians.
Profiling the diversity of rural and remote health research — and some questions about its impact

The successes and challenges facing rural and remote health research were a trending national topic on Twitter yesterday, thanks to diligent tweeps attending the 6th Rural and Remote Health Scientific Symposium.

As Jennifer Doggett and #6rrhss tweeps report below, one of many big questions up for discussion was this: how to ensure that the commitment of so many in the sector translates into action that benefits communities and their health and wellbeing?

Jennifer Doggett writes:

From food deserts in Tasmania to chiropractic care in the Pilbara, the first day of the 6th Rural and Remote Health Scientific Symposium showcased innovative, diverse and community-focussed rural health research undertaken by established, early career and student researchers all over rural and remote Australia.

Reports of long-term and well-established initiatives, such as research into the so-called ‘leaky pipe’ of eye care service pathways for Indigenous Australians, highlighted the ongoing need for research to inform rural health policies and programs.
As the only developed country in the world still dealing with preventable trachoma-caused blindness, Professor Hugh Taylor from the University of Melbourne reminded delegates that despite a robust body of research in this area, there are still many challenges in translating this research into practice.

He also stressed the learnings from this project around linking primary care to other areas of the health system for addressing broader health challenges in rural communities.

Other smaller scale research projects reported at the Symposium addressed issues such as nutrition, drug and alcohol use, and overweight and obesity in rural communities (see some snapshot tweets below).

A common theme of these presentations was the need to tackle the environmental, practical and cultural barriers to reducing risk behaviours, such as the availability of fresh food in rural and remote areas and the stigma surrounding drug use and addiction.

**Mapping and metrics**

Mapping, measuring and classifying rural health metrics were the focus of several presentations.

Professor Luis Salvador-Carulla, Head of the Centre for Mental Health Research at Australian National University, explained the importance of developing a shared taxonomy for measuring access to health care and service provision to enable comparison across diverse rural and remote communities.

South Australian researcher Dr John Glover described how he uses local level data to map changes in health outcomes and social determinants in communities over a period of time.
His presentation was followed by Rachel Whitsed, who described her research of spatial patterns of disease, including mapping the correlation between health status and topography.

Plenary sessions challenged delegates to ask ‘big questions’ about rural health research and its role in influencing health policies and practices.

**Successes and failures**

Rural Health Commissioner Paul Worley urged attendees to both acknowledge our rural health successes and admit our failures, citing the establishment of multi-disciplinary departments of rural health as a success, particularly in relation to linking research and practice. He identified the ongoing influence of institutional racism within the health system as a failure.

He encouraged the rural health sector to recognise the diversity and uniqueness of rural communities, as well as to identify the commonalities that allow policies and programs to be ‘scaled up’ across wider areas.

A panel of eminent rural health researchers, including professors Lesley Barclay, Lucie Walters, David Lyle, Ross Baillie and Dennis McDermott discussed how far rural health research had come since the establishment of the first rural clinical school in 1997.

They gave some historical context for the initiative and identified some of the major successes, including moving from an optional one or two week rural placement for medical students twenty years ago to the opportunity to undertake an entire medical degree in a rural setting today.

However, Barclay noted that despite these successes, rural health research still only received 1.1 percent of NHMRC funding, citing this recent publication.
Barriers to impact

A panel chaired by senior health policy expert Bob Wells, and including John Humphreys, John Wakeman, Sue Lenthall and Paul Worley, reflected on the influence that rural health has had (or not had) on health policies and programs.

The panellists all acknowledged that rural health research, overall, had not delivered the changes to health policies and programs that had been hoped for by the research community. They cited a number of reasons for this, including ongoing workforce shortages, political apathy and institutional racism.

As indicated by the presentation cited below, questions were also raised about the usefulness of traditional academic metrics.
A question from the floor on whether the rural health sector should advocate for ‘revolutionary change’ in the rural health sector, similar to that achieved by the NDIS, prompted a discussion on research support for more radical changes.

Bob Wells offering his preferred model of health care funding and delivery, involving community-based primary health care organisations with local governance.

The resulting discussion about the political reality and relative benefits of incremental versus systems change sets the scene for the address by Minister for Rural Health, Senator Bridget McKenzie, to open Day 2 of the Symposium.

Further tweet reports

Welcome to country and opening
You can track Croakey’s coverage of the conference here.

Profiling the diversity of rural and remote health research – and some questions about its impact

#6rrhss Matilda House Welcome to Country - Rural Health give Aboriginal people the best you can.

#6rrhss Dr Jenny May is opening the 6th Rural and Remote Scientific Symposium
You can track Croakey’s coverage of the conference here.

Profiling the diversity of rural and remote health research – and some questions about its impact

Paul Worley, National Rural Health Commissioner

Paul Worley national rural health commissioner speaking of the need for rural generalist pathway to be community controlled #6rrhss

Risk of culturally inappropriate care in Rural towns isn’t from Overseas Trained Doctors. It’s from City-based doctors. #6rrhss

Rural Health Commissioner Dr Paul Worley encourages us to be curious, find the commonality to improve rural health. Equity of access to health services is everyone’s right @strokedfn @VSTprogram
You can track Croakey's coverage of the conference here.

Paul Worley on rural health blurring the boundaries between researcher and subject #6rrhss

Prof John Cole OAM @ProfJohnCole · 8h

148% turnover of health care workers on the ground is the dismal reality of the health system in some parts of regional Australia. So how best is it fixed? Rural health Commissioner Worley says Govt must have “confidence” in its ability to succeed #6rrhss

Discussion - how can rural health research influence the policy agenda?

1. Based on what we know from rural health research, what are the major policy initiatives that could be developed to advance the health of rural ad remote residents?
2. Do we need a national rural health research IMPLEMENTATION strategy to inform and monitor outcomes from policies and programs?
3. If so, what process/resources would be needed?

Konrad Kangru @WhitGP · 2h

#Griffith #rockmelon #listeria outbreak a great example of how #ruralhealthresearch so important not just for country people #6rrhss

Western NSW Health Research Network @WesternNSW...

Listening to @PaulWorleySA setting the scene about the value of research in the bush: “Be curious” #6rrhss
Panel discussion

20 years of rural and remote health research

“Giants” of rural health research to kick off the second plenary at #6rhss
A key feature of rural clinical schools is that they were established to have a population health function and locate research and planning within rural health services. #6rrhss

Research snapshots

What makes a successful rural primary health care service? John Wakeman shows delegates at #6rrhss

Why do they work?

- **Essential service requirements:**
  - Governance, management and leadership
  - Infrastructure
  - Linkages
  - Funding
  - Workforce supply

- **Macro-scale environmental enablers:**
  - Supportive policy
  - Federal-state relations
  - Community readiness.
Louise Gates, ABS, calls for input from the rural health sector into including a health question for the next census for the first time. This is an opportunity to obtain valuable localised data on a health issue. See the ABS website for further details.

#6rrhss
You can track Croakey’s coverage of the conference [here](#).

Profiling the diversity of rural and remote health research – and some questions about its impact

One of the first lightning talks for #6rrhss is @drkatherinekent @UTAS_ on (a lack of) access to healthy food in Tasmania.

Lightning talk: Management of Aboriginal children presenting to rural emergency departments - Claire Ronaldson & Swaha Bose #6rrhss @Griffith_Uni
You can track Croakey's coverage of the conference here.

**Profiling the diversity of rural and remote health research – and some questions about its impact**

NRHA

Megan Telford speaks on birthing in the Murrumbidgee @SW_NSW_news @PRIME7Wagga @DailyAdvertiser fabulous young researcher trying to make life better for Riverina health professionals and Riverina mums #6rrhss 6th Rural Remote Health Scientific Symposium - today and tomorrow

NRHA

Student led services on Cape York - paper from Alice Cairns and Lisa McGuire at #6rrhss 6th Rural Remote Health Scientific Symposium - today and tomorrow at Hyatt, Canberra
You can track Croakey’s coverage of the conference here.

Profiling the diversity of rural and remote health research – and some questions about its impact

#6rrhss @WePublicHealth · 7h
Medical students Claire Ronaldson and Swaha Bose answer questions about the presentation of Indigenous children at a hospital ED in Darling Downs NSW
#6rrhss

Lowitja Institute
@LowitjaInstitute
Dr @chrisbourke introducing a presentation by Louise Gates on Aboriginal & Torres Strait Islander smoking trends #6rrhss

Rural Social Worker @silicemunro86 · 12h
Prof Anne Roche sharing findings from recent research coming from @NDARCNEWS about latest trends in opioid use across Australia #6rrhss
Profiling the diversity of rural and remote health research – and some questions about its impact

You can track Croakey’s coverage of the conference here.

So true in many areas of health, especially drug and alcohol use. Ann Roche #6rrhss

What we believe to be the ‘cause’ of problems, shapes our views about potential ‘solutions’.

Personal beliefs and views are often inconsistent with the evidence in this area.

People who travel within three hours to access primary health care. Laura Alston #6rrhss

Illustration: 3 hour drive to PHC

- Populations within (dark green) and outside (grey) a 3 hour drive time from PHC.
You can track Croakey's coverage of the conference here.

Profiling the diversity of rural and remote health research – and some questions about its impact

#6rrhss

Conclusions

- Chiropractic programs are adopting service-learning outreach immersion placements to foster among other attributes, communication and interaction skills, social responsibility and a philosophy of caring.
- This is the first study in Australia that describes the extent to which chiropractic undergraduate students believed a 'country' service-learning clinical immersion placement met these objectives and further, analysed graduate behaviours after finishing studies.
- Results support the utility of rural and remote outreach clinical placements to help meet the educational objectives of the chiropractic undergraduate programme.

Limitations

- No data on ruralACHE.
- Generalizability limited to chiropractic students from the programme.
You can track Croakey’s coverage of the conference here.

Poster display at the #6rrhss #aboriginal #indigenous #oralhealth #health #ClosetheGap #ruralandremotehealth #AboriginalHealth #AboriginalHealthWorkers #communityLed

Results of an education program to prevent dental caries in Aboriginal children

Some of the informative research posters here at #6rrhss @NRHAIIiance #indigenoussheath #ruralhealth
Reflections

@researchjames · 11h
#6rrhss such a shame some of the great research conducted in sexual health is not being presented here- one of the most pressing issues affecting young people in remote areas! I guess next time!

@DoolanNoble · 2h
Community control of health services in rural and remote a key theme at #6rrhss

@drkatherinemknt
Loving the team presentations at #6rrhss highlighting strong collaborations on #ruralhealth projects. Doesn’t happen a lot at other conferences

Social snaps

@OneVisioneers · 8h
@nwqrn is in here element. Long way from Weipa to @cbr for 8 week old baby. @MICRRH_JCU start their education very young! @ACRRM @croakeyblog

@emhprac_central · 14h
Come and say hi to us at #6rrhss. Great information about online mental health resources #headtohealth
For those who hadn’t noticed, John Humphries and Gordon Gregory have a bit in common…

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You can track Croakey’s coverage of the conference here.

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Profiling the diversity of rural and remote health research – and some questions about its impact
Rural and remote health workforce research – complex solutions for challenging issues

The second report from the 6th Rural and Remote Health Scientific Symposium focuses on workforce issues and highlights some of the innovative research being undertaken on how to attract and retain a high quality health workforce that meets the needs of rural and remote communities.

Jennifer Doggett writes:

“It’s the workforce, stupid” was a familiar theme of many of the sessions at the 6th Rural and Remote Health Scientific Symposium, with both speakers and delegates stressing the need to put workforce issues at the forefront of efforts to reduce the rural health deficit.

A number of presenters cited a turnover rate of 148 percent for rural nurses in the Northern Territory to highlight the challenges of running health programs with an inadequate and frequently changing workforce.

It was clear from the many presentations on workforce issues that there is no ‘quick fix’ or generic approach to addressing the health care needs of rural communities. What was provided in these presentations, however, was a nuanced understanding of the varied needs of different groups of rural health professionals, some context-dependent approaches to supporting health care providers working in rural and remote areas and sophisticated models of data collection and analysis to support future workforce initiatives.
Retention strategies

The need to focus on the whole person when developing retention strategies was emphasised by Dr Cath Cosgrave, who reported on her PhD research on allied health and nursing professionals in rural areas.

The resulting ‘whole of person’ retention strategy she developed is based on her research finding that, regardless of background, young early career professionals are not likely to settle down in any one area and that even young professionals local to rural areas were likely to want to leave at this stage in their lives. She argued that therefore a high turnover in this cohort of the health workforce is inevitable and should be accepted and accommodated rather than challenged.

Cosgrave also stated that her findings suggested the need to redefine what is meant by ‘retention’ of rural health professionals and to set realistic goals that take account of health professionals’ life stages.

Other aspects of her work focussed on the importance of creating positive and supportive rural health care teams which provide health professionals with opportunities to progress their careers while remaining integrated in the community.

Clinical placements

The issue of rural clinical placements for medical, nursing and allied health students was discussed by a number of presenters, including Merrilyn Cross, who reported on her research into rural placements in Tasmania.

She described some of the complexities involved in ensuring their success. These included both general issues relating to melding the realities of rural placements with the educational needs of the students and also issues specific to rural Tasmania, such as ensuring student safety when travelling to and from their workplaces in the dark during the short Tasmanian winter days.

A common theme emerging from her consultations with students and providers was the need for longer placements so that students could genuinely integrate into the work of the service and get a feel for the ebbs and flows of rural practice. A comment from the Twitterverse added that as well as ensuring students’ needs are met, it is also important to ask whether rural placements are meeting needs of rural communities.

Rural and remote nurses

As the largest single group of the rural health workforce and, along with Indigenous Health Workers, the entire health workforce in many remote areas, it is clearly important to understand the factors that attract and support nurses in rural and remote areas.

Associate Professor Sue Lenthall reported on consultations she undertook with remote area nurses, which are documented in the Back from the Edge report. She outlined the key findings that nurses working in very remote areas experienced high levels of psychological distress and moderate levels of emotional exhaustion. Despite this, she reported that they also had high levels of engagement and felt strongly committed to their work.

One of the key findings of her research was that many remote nurses found their job demands to be unrealistic and reported that they were operating in an environment with high emotional demands and inadequate resources. The main cause of stress was reported to be the feeling that they could not meet their responsibilities and issues relating to social isolation. Also noted as significant causes of stress were poor relationships with management and safety and violence concerns.
Lenthall noted that one of the challenges in undertaking research on rural health professionals is that their attitudes and honesty about the challenges of their roles can create conflict with managers of the health service in which they work. This occurred in her research when she felt that the clear concerns of the remote nurses she interviewed about their safety were not being acknowledged by management on the basis that the proposed solutions, such as sending drivers to escort nurses on visits, were ‘too expensive’ and unlikely to be funded.

This may be due to a reluctance on the part of managers to admit that there might be problems within a rural health service, as they are worried it may reflect on the public view of rural communities. However, Lenthall was keen to emphasise that when managers fail to acknowledge the attitudes of health care workers they can feel ignored and under-valued.

**Workforce data**

The need for a more sophisticated approach to workforce modelling than crude ‘nurse per head of population’ ratios was suggested by Professor Amanda Kenny. She explained the need to look at community needs and the type of work being done to determine the number and type of nurses needed to fulfil these needs.

In another session, Data Management Project Officer Mr Gary Walker outlined work he is undertaking to develop a single source of linked data on medical graduates called GradTrack. This resource captures data from a range of different sources, cleans and scales the data so it is compatible and stores in a single centralised resource so that the data is accessible to all.

One of the strengths of GradTrack is that it can link data from high school through to post-university career and track where medical graduates come from and go to study and work over time.

**Rural allied health**

SARRAH President Rob Curry articulated the specific challenges facing the allied health workforce in rural and remote areas. He explained that the lack of a funding base to support allied workforce in rural areas made it very difficult to increase workforce numbers.

He advocated for better data on efficacy for allied health professions so that the cost benefit for government was clear. He also made the point that there cannot be a culturally safe health system without Indigenous people being part of the health workforce.

Dr Chris Bourke also explained the importance of workforce issues in closing the gap, arguing that better engagement with the Indigenous health workforce is crucial. One example he gave of unanswered questions in this area is that there are 6,000 Indigenous people registered as nurses, and only one-third of these are employed. Finding out why Indigenous nurses are not finding employment is an important way to address cultural safety and ultimately close the health and life expectancy gap between Indigenous and non-Indigenous Australians.
Tweet reports

You can track Croakey's coverage of the conference here.

Rural and remote health workforce research – complex solutions for challenging issues

#6rrhss
You can track Croakey's coverage of the conference here.

Rural and remote health workforce research – complex solutions for challenging issues

Cath Cosgrave Factors influencing retention change through first 1-2 years #6rrhss

Rural and remote health workforce research – complex solutions for challenging issues

Cath Cosgrave #6rrhss, Retention of nursing and allied health professionals in rural areas in early career

Turnover Intention Theory: Basic social process: Adjusting to change

The Evolution Starts Here
You can track Croakey's coverage of the conference here.

Rural and remote health workforce research – complex solutions for challenging issues

#6rrhss

Cath Cosgrave: “push” factors for rural health workers leaving rural areas are job insecurity and lack of career opportunities #6rrhss

Louella McCarthy @LouellaMcCarthy · Apr 11
It takes a community to keep a health care professional in rural : Dr Cath Cosgrave #6rrhss

Almost all of the health workforce in very remote Australia is made up of nurses and Aboriginal Health Workers: Sue Lenthall #6rrhss
How to achieve a more equitable and efficient health system

Moving to a single fundholding model has many potential benefits for the health of populations, but also comes with some significant challenges, according to Professor Leonie Segal from the University of South Australia.

Segal also highlighted the critical importance of trauma as a public health issue and the need to redistribute mental health funding towards a greater investment in early childhood and families in her recent presentation to the 6th Rural and Remote Health Scientific Symposium.

Jennifer Doggett writes:

Economics is often viewed suspiciously within the health sector as the vehicle used by governments and other funders to justify crude cost-cutting.

However, economics can be a powerful tool for achieving greater equity in health care through demonstrating how maximum value can be obtained for the use of limited resources.
This was the subject of the keynote presentation by **Professor Leonie Segal** at the 6th Rural and Remote Health Scientific Symposium.

Segal, who describes herself as an ‘economist of health and well-being’, started by explaining that, at its core, economics focusses on how to maximise benefit when resources are scarce.

She went on to describe economists as taking a ‘systems approach’ to health care, rather than focussing on one specific component of the health system. This means that they have the ability to look across modalities and identify the best mix of services, from options such as medical care, public health policies and social programs, to achieve a specific outcome.

Segal described three different forms of equity relevant to planning and evaluating health programs: horizontal equity, which delivers equal access for equal needs; vertical equity, which supports greater access to those with greater need; and regional equity which argues that regardless of location, ensure everyone has access to services they need regardless of location.

Arguably Australia falls short in all these areas, as the following examples show:

**Horizontal equity** – people with the same level of need have different levels of access to care (for example **people with mental illnesses** are less likely to get the services they need for physical illnesses than people without mental illnesses);

**Vertical equity** – people with high levels of advantage access more health care than those with the same level of need who are disadvantaged (for example, the **Better Access program**); and

**Regional equity** – people living in rural areas with a similar level of need receive **substantially less health care** than their counterparts living in cities.

**Private health insurance**

Professor Segal made some strong statements about the benefits of a universal funding system for health care and the inefficiency of private health insurance. She said:

“Every time the Government supports private health insurance it costs the community money and diverts resources away from the public sector.

“Economists are absolutely unanimous that universal care promotes equity and efficiency. Every community that has implemented a universal health care program has found that it achieves better outcomes for less money than the alternatives.”

She also reminded delegates that the medical profession was the biggest opponent to the introduction of Medicare, concerned about the impact of a universal funding system on their status and earning capacity.
Segal explained the importance of ‘defining the question’ before undertaking economic research on a health program or issue. If she had a three-year research grant, she would typically spend six months understanding the research question. In particular, she described the type of ‘deep understanding’ of the causal pathways to ill health and disease needed to undertake successful research.

She also explained the importance of taking into account the broad and long-term impact of illness and disability on the community as a whole.

Often research studies assess the outcome of a specific policy or program for its primary target but fail to take into account the impact on families and communities. This does not make sense as health challenges can profoundly affect families and communities, and therefore should be captured in research and evaluations.

**Single fundholding models**

Segal outlined the advantages and disadvantages of a single fundholding model – a model which involving pooling Commonwealth, State/Territory and other funding from other sources across program areas and portfolios. Typically these models operate at regional level with a local governance body overseeing the allocating of funding to meet locally defined priorities.

Segal explained that, in theory, these models should maximise outcomes as they offer the opportunity to shift resources where they deliver most value. They also include a strong focus on obtaining community input into setting priorities, which often place a higher priority on equity than our current system.

The potential for this system to influence service mix is evident from the **Central Australia Aboriginal Congress**, a primary health care service supported by a single pooled fund and run by a community-controlled board, which delivers care for around 9,000 Indigenous people in Alice Spring and surrounding areas.

The programs run by Congress include a strong focus on social and emotional well-being targeting specific groups such as youth, men women and babies and early childhood. Other priorities are public health advocacy and mental health.

Segal also outlined the challenges with a single funding model, which include dealing with vested interests, particularly given the radical changes in clinical service mix that typically result from the implementation of this model.

Another challenge is to persuade Governments to give up the profile-building and media opportunities that come from announcing national programs targeting a specific disease or population group.

Other challenges included allowing regions to set different priorities, dealing with non-health issues that impact upon health and managing financial risks, specifically in a fee-for-service environment. Skilling up the community to participate in priority setting processes is also vital to ensure genuine input that reflects community needs.

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Leonie Segal: Unless we do something about mental illness and childhood trauma we will never close the gap. #6rrhss
Closing the health gap

Professor Segal outlined her work on closing the health gap between marginalised/disadvantaged groups and the mainstream. In implementing her approach of first obtaining a ‘deep understanding’ of the problem, she identified issues of trauma, including inherited trauma, as key influencing factors.

Segal cited research demonstrating that trauma is toxic to brain development and can affect all trajectories of the developing child. She also described how trauma resulting from factors such as dispossession and racism can be passed through generations leading to a cycle of poor parenting, abuse and neglect, resulting in mental and physical illnesses which in turn make parenting difficult etc.

Focusing on children and the early childhood family environment as a priority can help break out of this cycle. However, Segal showed a number of slides that showed that the bulk of funding for mental health goes to treating problems that have already developed rather than on preventing their development in the first place.

Segal also provided an example of how understanding the causes of Type 2 diabetes can inform changes in the primary care service team away from a heavy emphasis on GP services towards more involvement from social workers, psychologists and dietitians.

In conclusion, Segal summarised the important role of economics in promoting a more equitable and efficient health system and stated that her overall aim in her work was to provide policy-driven evidence in order to create evidence-driven policy.

Watch Professor Segal’s presentation
How to achieve a more equitable and efficient health system

You can track Croakey’s coverage of the conference here.

Tweet reports

**USQ cancer research @USQbricc · Apr 11**
Leonie Segal from @UniversitySA says we need to really understand our research questions if we have any hope of finding answers and solutions.

#6rrhss #health

**What to cover in this talk?**
- Burden of disease
- Priority setting – theory / application to lifestyle, diabetes, child maltreatment.
- Economic evaluation – examples, distortion of not including all impacts.
- Health Workforce
- Outcome Measurement metrics
- Defining the research question / the health problem
- Causal pathways into poor health / How to disrupt
- Market failure and how this distorts health service mix / efficiency argument for patient/citizen empowerment
- Case studies
- Developing policy – eg a nutrition strategy

**Louella McCarthy @LouellaMcCarthy · Apr 11**
Leonie Segal and how single fund-holding of populations at a regional level can enable communities to prioritise needs and programs #6rhss

**#6rhss @WePublicHealth · Apr 11**
Leonie Segal: distribution of mental health funding is the reverse of what it should be. More resources into early childhood and families will reduce adult mental health problems #6rrhss

**State ‘mental health’ payments 2012-13**

- In-patient psych services ($2,000m)
- Community adult psych services ($1,200m)
- Youth psych ($646m)
- Residential mental health ($361m)
- Grants to NGOs ($211m)
- Other ($227m)
- Corrections ($9,095m)
- Child protection ($3,823m)

Source: NDIS #6rhss Mental Health Commission Report 2015
Revealing ways forward for better health for Aboriginal and Torres Strait Islander people

Jennifer Doggett writes:

“I would like to be spoken to clearly and in an understandable way by doctors who like Aboriginal people.”

This simple request, made in a consultation process undertaken by Professor Alan Cass and his team at the Menzies School of Health Research, reveals much about the experiences of Aboriginal and Torres Strait Islander people when accessing mainstream health services.

Cass was speaking at the Closing the Gap plenary session at the 6th Rural and Remote Health Scientific Symposium hosted by the National Rural Health Alliance.

The session was opened by the Minister for Rural Health, Senator Bridget McKenzie, who set the tone for the morning by stating that “the health of the First Australians is everyone’s business”.

Professor Tom Calma describes the valuable role of Aboriginal community researchers.

Photo credit: Frank Meaney
She went on to highlight the crucial and integral role of Aboriginal Community-controlled Health Services and Indigenous health leaders in efforts to improve Indigenous health, and also emphasised the importance of “sitting down and listening, hearing what is being said, making the changes needed and investing at the local level”.

These were encouraging messages, as were her comments about the importance of addressing the social determinants of health across all areas of government.

However, many of the delegates, when discussing her speech after the session, commented on the gulf between her seemingly genuine sentiments and the policies supported by the Coalition Government, such as the Northern Territory Intervention.

**Consultation fatigue**

The Minister was followed by Professor Tom Calma AO, Chancellor of the University of Canberra, who focused his presentation on the importance of involving Indigenous people in health-related research and policy making.

He expressed some cynicism about “fly in fly out” policy makers and researchers and – “even worse” – people based in Canberra who make policies for rural and remote Australia.

Calma reported that some communities reported “consultation fatigue”, feeling that they were constantly being consulted without any clear outcomes. This results in communities feeling jaded and then not participating genuinely in consultation process, he said. The mantra “Do it with us, not to us” was suggested as a useful guide to working with Indigenous communities.

The role of Aboriginal community researchers in informing health policies and programs was a key focus of Calma’s talk. He described the work of 250 community researchers working across 100 communities as part of the Ninti One organisation.

Their varied roles include undertaking consultations, co-designing projects with researchers, planning, project management, reporting and evaluation. He also stressed that a crucial role was to provide feedback to community at the end of the projects to ensure they understood what had been achieved.

Professor Alan Cass identified the strengths of these Indigenous health workers, including having an understanding of the language, culture and history of the communities in which they work. He explained that this maximises the impact of the project by avoiding the time and resources wasted when “outside” people first have to get to know the community and gain their trust before attempting similar research.

**Strengths-based focus**

Also presenting was Professor Judith Katzenellenbogen, who discussed her research on cardiovascular disease (CVD) in Indigenous Australians. She stated that CVD contributes 27 percent of fatal burden of disease gap between Indigenous and non-Indigenous Australians. Therefore, reducing the incidence and improving the treatment of people with CVD could go a long way towards closing the gap.

Katzenellenbogen outlined the main features of the BAHWA project, which has successfully reduced the impact of CVD in some Indigenous communities. At the core of the program was a commitment to working with the community to identify and address priorities areas of action.

In reporting research, Professor Katzenellenbogen argued against presenting a deficit model of Indigenous health, as this overlooks the considerable strengths of patients and communities.
She said that while it is important to acknowledge the health challenges facing Indigenous communities, it is also important to recognise their resilience and to include empowering messages when reporting the results of Indigenous health research or programs.

One strategy she suggested to support the translation of research into policy and practice was the development of an “easy reader” stakeholder report. This was done for the BAHHWA project, and involved establishing a stakeholder reference group that influenced both the content and the style of the research.

Professor Alan Cass made a strongly worded plea for the need to address broad determinants of health, such as employment and education. He presented the findings of research he had undertaken on the importance of listening to Aboriginal people’s problems.

He argued that kidney disease is unique in that it requires people to leave communities for treatment over the long term. This has profound impact on both individuals and communities where typically 1 in 40 adults require diabetes.

As an example of the difficulties in accessing fresh food in rural and remote areas, Cass showed a slide of a six-dollar package of browning lettuce, supporting other evidence that a food basket costs 60 percent more in rural settings.

**Deep listening urged**

Cass described participatory action research undertaken by his team, which challenged his assumptions (and those of the medical community generally) about the efficacy of the way they communicate with patients. This research involved filming interactions between health care providers and patients with each group providing feedback from their perspective.

At one regular session, he felt he had communicated very effectively, but when asked afterwards the social worker had received a very different message. For Cass, this highlighted the importance of “deep understanding” and of recognising the unequal balance of power and dominance within the consultation process.

He gave an example of the impact of health professionals’ failure to “listen deeply” to patients—the much lower rate of kidney transplants among Indigenous Australians compared to non-Indigenous Australians.

This was—at least partly—the result of an assumption made by health professionals that Indigenous people did not want transplantation as a treatment option. This view turned out to be false once genuine consultation with Indigenous patients was undertaken and their views sought.

Cass recommended that a “whole of systems approach” be taken to addressing chronic disease within Indigenous communities, and that all care providers listen deeply to what patients say.

While warning that the current rise in obesity could result in the health gap widening instead of closing, he did offer some hope in the form of a new MBS item number for dialysis provided in very remote areas. He said this would address the current financial barrier to the provision of this service in many communities.

**Address institutional racism**

Questions and comments from delegates at the session focussed on the importance of supporting research driven by Indigenous researchers and ensuring that health care services and other organisations involved in Indigenous health are culturally safe and free from institutional racism.
A useful explanation of institutional racism was provided by AHHA’s Chris Bourke who explained that this form of racism did not describe personal behaviour but reflected how institutions operate.

A telling indicator of whether an organisation or system incorporates institutional racism is to examine whether it produces poorer health outcomes for specific groups.

He also discussed the concept of “diversity management” and explained that organisations can actively recruit employees from specific under-represented groups to address imbalances within their staff.

Tweet reports
You can track Croakey’s coverage of the conference here.

Revealing ways forward for better health for Aboriginal and Torres Strait Islander people

Talking about doing policy making and research with community, not to community with Prof. Tom Calma #6rrhss

Proven methodologies delivering better research and community development outcomes

- community engagement
- program evaluation and monitoring
- social and economic systems
- business enterprise development and entrepreneurship
- function and sustainability of remote settlements
- intellectual property management
- natural resource management and land issues
- cultural knowledge and its uses
- governance in remote regions
- remote tourism
- health & well-being
- remote services
- energy and water
- partnerships

An honour to have Tom Calma speaking to us all today about the value of research WITH Indigenous communities not FOR or TO them #CBPR #partnership #ruralhealthresearch #6rrhss

Shared Space approach – the way we work.

Tom Calma - Employing Indigenous researchers helps communities financially, builds capacity, educates the younger community members, creates role models. #6RRHSS @LowitjaInstitut @nhmrc @croakeyblog @ninti_one
You can track Croakey's coverage of the conference here.

Tweets below by Jennifer Doggett for @WePublicHealth

**Focus on Pilbara @WePublicHealth · Apr 11**
Allan Cass describes feedback he received from Indigenous patients on his communication as a doctor. Research showed that health care providers often have no idea when mis-communication is occurring. #6rrhss

John Denny liked
**Focus on Pilbara @WePublicHealth · Apr 11**
Allan Cass: almost all the increased hospitalisation for Indigenous people is for dialysis for kidney disease. We are much better at preventing and managing kidney disease in non-Indigenous populations #6rrhss

RAOR liked
**Focus on Pilbara @WePublicHealth · Apr 11**
Allan Cass: food security and access to affordable fresh food vital. Some success in developing partnerships with community stores to reduce prices of healthy food products. #6rrhss

Revealing ways forward for better health for Aboriginal and Torres Strait Islander people #6rrhss

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Croakey
“Conference News Service”
Revealing ways forward for better health for Aboriginal and Torres Strait Islander people

Watch Professor Tom Calma

Watch Professor Judith Katzenellenbogen

Watch Professor Alan Cass

You can track Croakey's coverage of the conference here.
For rural and remote health research to have impact, what are the key challenges ahead?

Where are the winds blowing for rural and remote health research?

When rural and remote health researchers met in Canberra recently, they were asked to consider why their sector’s work over the past decade or more had not led to the health gains that might have been expected.

Discussions at the 6th Rural and Remote Health Scientific Symposium suggested there are many ways of answering this question.

A presentation by Professor Leonie Segal from the University of South Australia highlighted inbuilt structural inequities in how health funds are spent – with, for example, far too little investment in early childhood and families and in preventing and addressing trauma.

The far-reaching impact of institutional racism was also mentioned repeatedly, including by Rural Health Commissioner Paul Worley – and see more on this in some of the video interviews below.

On a related theme, the challenges of attracting and retaining a high quality health workforce that meets the needs of rural and remote communities were also oft-discussed.
However, the conference also highlighted the sector’s successes and history of innovation, as well as ways forward.

The lessons from Aboriginal and Torres Strait Islander communities – including the importance of taking strengths-based approaches, and listening deeply to the needs and aspirations of patients and communities – resonated more widely.

Below are video interviews conducted by Jennifer Doggett with symposium speakers and participants, followed by some final tweets from the event.

**Room for improvement**

Professor Jenny May, from the Department of Rural Health at the University of Newcastle, said while the rural and remote health sector had been at the forefront of developing team-based and multidisciplinary care, it was embarrassing that health outcomes remained so poor for many people in rural and remote areas. There remained enormous variability in the quality and accessibility of health services in rural and remote Australia. “We still are not delivering that consistent level of quality accessible primary care,” she said. “For that I am sorry.” May said the answer was not calling for rural specific funding, but for mainstream funding that acknowledges different ways of operating and allows us to build careers for rural health clinicians and researchers so that we have a resident population in the areas where it is needed. May stressed the importance of available, accessible “foundational primary healthcare.”
Representative workforce matters

Dr Chris Bourke, Strategic Programs Director, Australian Healthcare and Hospital Association, distinguished between personal and institutional racism, with the latter manifest in services providing poorer outcomes for some groups. Institutional racism was about an organisation’s policies, funding and accountability, and its failure to incorporate Aboriginal people and perspectives in those frameworks. The health workforce should be representative of the workload, or the needs of the population being served, he said.

Listening matters

Professor Alan Cass, Director of the Menzies School of Health Research, spoke powerfully of the need to better serve Aboriginal and Torres Strait Islander patients, families and communities bearing a high burden of kidney disease. People had to move hundreds or thousands of kilometres away from their family and country for dialysis. In the NT, almost one in 40 Aboriginal adults are on dialysis, with more than 800 having haemodialysis three times a week and it is forecast there will be over 1,000 people in a few years. “This is a remarkable burden of illness.” Cass spoke about the importance of better prevention and early intervention as well as more equitable access to kidney transplants. “Research is beginning to clarify that for Aboriginal, as well as non Aboriginal, people there is a survival benefit for transplantation.” He stressed the importance of not making assumptions about what patients understand or want or how they might benefit from a treatment but “that we do the research to give the best evidence to inform those discussions and that we talk with people to ensure their treatment wishes”.

For rural and remote health research to have impact, what are the key challenges ahead?
An appetite for transformational change

Professor John Wakeman, Associate Dean at Flinders NT, said discussions at the conference revealed an appetite for transformational change in rural and remote health. “We have a lot of research evidence to guide us.” He also said the development of rural and remote health infrastructure over the past 20 years, including academic infrastructure, was something to be proud of. “What that has produced is not only workforce but also a whole lot of evidence about how health systems can be improved,” he said.

Final conference tweets

Cost a major barrier to accessing health services, according to a AIHW research study reported by Claire Sparke #6rrhss
You can track Croakey’s coverage of the conference here.

For rural and remote health research to have impact, what are the key challenges ahead?

#6rrhss
You can track Croakey's coverage of the conference here.

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For rural and remote health research to have impact, what are the key challenges ahead?

#6rrhss
You can track Croakey’s coverage of the conference here.

For rural and remote health research to have impact, what are the key challenges ahead?

#6rrhss

Croakey
“Conference News Service”
Warm thanks to all #6rrhss tweeps

The Symplur analytics report that there were 726 participants using the hashtag from 9-23 April, creating 21.8 million Twitter impressions. Read the Twitter transcript here.

Croakey Conference News Service

• Reporting by Jennifer Doggett
• Editing by Melissa Sweet
• Layout and design by Mitchell Ward

For rural and remote health research to have impact, what are the key challenges ahead?