Melissa Sweet reported on the 14th National Rural Health Conference held in Cairns from 26 – 29 April, 2017, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. http://croakey.org

We acknowledge contributions to our coverage from Associate Professor Lesley Russell and Ms Kristy McGregor.
## Contents

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preview of the National Rural Health Conference in Cairns</td>
<td>3</td>
</tr>
<tr>
<td>Investing in rural health brings dollar returns to local economies (and improves health)</td>
<td>8</td>
</tr>
<tr>
<td>A World of Rural Health in Australia: Snaps and selfies from the National Rural Health Conference</td>
<td>12</td>
</tr>
<tr>
<td>Rural health sector urged to get its evidence together</td>
<td>23</td>
</tr>
<tr>
<td>Today is tomorrow’s history – be brave, so we can envisage Australia in 2037 like this</td>
<td>33</td>
</tr>
<tr>
<td>Calling for “all hands on deck” to transform preconception care</td>
<td>46</td>
</tr>
<tr>
<td>The future is fast approaching, but are we ready? A LongRead on what AI might hold for rural health</td>
<td>53</td>
</tr>
<tr>
<td>Antibiotic resistance: a health hazard for rural and remote communities</td>
<td>60</td>
</tr>
<tr>
<td>The National Rural Health Conference: a feast of song, dance and other creative experiences</td>
<td>65</td>
</tr>
<tr>
<td>Shouldn’t rural doctors be on the call sheet in serious local accidents &amp; emergencies?</td>
<td>79</td>
</tr>
<tr>
<td>Stories from Primary Health Networks – small fish in poorly mapped, choppy seas</td>
<td>84</td>
</tr>
<tr>
<td>What are the identified priorities for rural health? (And what’s missing?)</td>
<td>91</td>
</tr>
</tbody>
</table>
Preview of the National Rural Health Conference in Cairns

The National Rural Health Conference is well known for profiling the diversity, creativity, innovation and resilience of rural and remote communities – as well as highlighting the health gap with metropolitan Australia.

This year the conference – bringing together arts and cultural performances alongside clinical, policy and public health discussions – was held as part of ‘A World of Rural Health’ that also includes the 14th World Rural Health Conference.

The conference was timely in view of rural health concerns about the abolition of 457 visas, and the article below previews the #ruralhealthconf.

Putting a focus on healthy economies

Melissa Sweet writes:

Policy makers must work to ensure that economic growth is more inclusive and its gains are shared more widely, using such policy levers as progressive taxation, and investments in skills, lifelong learning and high quality education.

They must also work towards mitigating and adapting to climate change, and supporting labor market adjustments to the major structural transformations now underway globally, partly due to technological change.

This advice comes not from the world’s leaders in public health (although it easily could), but from the International Monetary Fund (IMF) in its latest publication, *World Economic Outlook, April 2017: Gaining Momentum?*
This IMF publication was timely, coming ahead of the 14th National Rural Health Conference, being held on the country of the Traditional Owners and Elders of Cairns, the Gimuy Walubara Yidinji and Yirrganydji peoples.

The economics of rural and remote communities was the theme for the first plenary session addressed by Professor Allan Fels AO, Chair of the National Mental Health Commission; Mick Reid, Deputy Chair of the Royal Flying Doctor Service, and Adjunct Associate Professor Lesley Russell, of the Menzies Centre for Health Policy at the University of Sydney.

This theme reflects that the economic agenda is the first of five key advocacy priorities for the National Rural Health Alliance, which published a position statement earlier this year urging government to “commit to unlocking the economic and social value of the 7 million people living in regional and remote Australia by reducing the gap in health and wellbeing outcomes compared with people living in cities”.

This would “dramatically improve participation and productivity, and increase Australia’s economic growth,” it said.

The statement, published in The Australian Journal of Rural Health, states that while agriculture will continue to be the mainstay of the regional and remote economy, finding ways to diversify and expand local economies is vital.

The statement highlights the importance of retaining young adults and older people in local communities and says “the interests of both groups would be served by growing workforce and facilities to support older people, and people in need of community based services, locally”.

“With the ageing of Australia and an increased need for services to support mental health, ageing and disability care, there are growing opportunities in regional and remote communities to generate new jobs to support these changing needs,” it states.

The CEO of the Alliance, David Butt, believes rural health advocates can make a powerful case for policy advances by focusing on the economic toll of health inequalities. He told Croakey:

The case for social disadvantage and for the higher burden of disease in terms of chronic complex illness has been made pretty well in relation to rural and remote Australia.

Where there could be a stronger argument for change and new policy directions is in relation to economic burden, as well as social burden.

As you move away from metropolitan centres, your access to services gets poorer, and your health gets poorer – which impacts on your ability to participate in employment, and in turn on economic growth.

We are interested in looking to the economic benefits that could flow to Australia by improving the health outcomes in rural and remote communities.”
Butt argues that improving health outcomes in rural areas, through more effective health promotion, addressing the social determinants of health, and primary healthcare, has the potential to have significant economic benefits, in addition to saved healthcare costs.

Equitable access to the internet is another factor vital for the health and development of rural economies and communities, he says.

“To create jobs, to be innovative, you are going to need good access to fast internet,” he says, adding that this is also vital for health service delivery and development.

(Access to the internet was also profiled at the 2013 and 2015 conferences as a critical rural health concern – see these stories, What will it take to improve rural health? and The NBN is vital...)

**Mental health**

Meanwhile, conference delegates will hear a strong economic argument for mental health reform from Fels, Chair of the National Mental Health Commission.

“The economic gains from mental health reform dwarf the gains that would be made from most of the conventional microeconomic reforms that are being talked about at the moment, such as tax reform and efficiency gains in a whole lot of sectors of the economy,” he told Croakey.

Efforts to improve mental health through prevention and early intervention, stepped care, better integration of mental and physical healthcare, and attention to critical determinants such as housing and employment had the potential to increase GDP by one per cent, he said.

Rural and remote communities have potentially the most to gain from mental health reform because they are often so poorly served at present, he said.

Fels said there was an urgent need for the current national debates around housing affordability to focus more on the needs of people with mental illness.

“There could be much more done on mental illness and housing,” he said. “The mental health sector and service providers and government all need to take an interest in this. We feel policy is a bit thin in this area so we are trying to get it developed.”

Governments needed to work more closely and effectively with the finance and super funds to stimulate investment in affordable housing, in particular for people with mental illness, he said.

**National policy gaps**

David Butt hopes the conference will also spotlight the need for a national rural health plan, to help promote a more concerted focus at the national policy level.

He says there is currently no area within the Federal Health Department that is responsible for rural health, and that the National Rural Health Framework that was released in 2011 “has just died”.

“There seems to be a view in a lot of ways that solutions that apply in metro areas will suffice for rural and remote areas,” he says.

The Alliance is also advocating for the Rural Health Commissioner to have a broader remit than its current focus on rural generalist pathways and to extend beyond June 2020.
Watch this interview

Added on 26 May, this interview from the conference with Professor Alan Fels examines the maldistribution of the mental health workforce, and calls for greater use of e-health services.

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

Preview of the National Rural Health Conference in Cairns

#ruralhealthconf

Croakey
“Conference News Service”
Investing in rural health brings dollar returns to local economies (and improves health)

How can investing in rural health boost economies?

Dr Lesley Russell makes the case in this curtain raiser piece, published at The Conversation ahead of her keynote address at the National Rural Health Conference.

Russell argues that rural health is not just an issue about equitable access to health care services but also an economic issue that impacts on national, community and family budgets and life’s opportunities.

But, she says, Australia has to date shown little interest in evidence, for example, from the United States that shows that every US$1 invested in community health centres generates an estimated US$11 in total economic activity.

See her preview here.
Dr Lesley Russell writes

When we talk about rural health, it’s easy to focus on health inequalities between the roughly 10% of Australians who live in rural and remote areas and those who live in our cities.

Statistics show the further Australians live from the major cities, the less their life expectancy and the poorer their health.

But rural health is not just an issue about equitable access to health care services; it’s an economic issue that impacts on national, community and family budgets and life’s opportunities.

The government isn’t investing enough in rural and remote health because of its failure to recognise the comprehensive impact of health care funding as a driver for local economic development.

The federal government’s development plan for Northern Australia doesn’t appear to mention health and health care services at all.

This is despite international research showing investing a dollar in rural health care can generate more than a ten-fold economic return.

How can investing in rural health boost economies?

The best example of health care centres as anchors for economic growth and investment comes from the US. Here, community health centres run primary health care clinics (patients’ initial point of contact with the health system) in rural and medically under-served areas.

Data collected over their nearly 50-year history show these centres not only provide quality and culturally safe health care and related social services to vulnerable populations, they stimulate the economies of their local communities.

There’s a multiplier effect that extends beyond the employment of health care professionals and ancillary staff and beyond the walls of the clinics; the centres buy goods and services from local businesses and the improved health of the local population means increased employment and household spending.

For every US$1 invested in these health centres, an estimated US$11 is generated in total economic activity.

Could this happen in Australia?

Australia has shown little interest in these sorts of analyses and economic justifications for changes in health policy to better service rural areas.

For example, we have no idea what economic impact, if any, GP Super Clinics have had in their communities. These are meant to bring together GPs, practice nurses, allied health professionals, visiting medical specialists and other health care providers to address the health care needs and priorities of their local communities.

And data is limited for the economic impact of Aboriginal Community Controlled Health Organisations, which are similar to the community health centres in the US. Although we know such organisations are the largest private employer for Aboriginal and Torres Strait Islander people, I have seen no economic data beyond this.
What we do know is on the basis of health care costs alone, spending more money more wisely on rural and remote health could result in some significant savings.

For instance, an Australian study showed investing A$1 in medium-level primary care (2-11 visits per year) for people with diabetes in remote Indigenous communities could save A$12.90 in hospitalisation costs.

**How best to care for the health of rural Australians?**

If we accept there are economic benefits to investing in rural health care, what should our rural health care system or systems look like?

Work from the now-defunded Centre for Excellence for Accessible and Equitable Primary Health Care Service Provision in Rural and Remote Australia gives us some clues.

Researchers said we should agree on a core set of primary health care services to be available to Australians living in rural and remote areas and the necessary support functions to ensure these are sustainable.

Knowing what services are needed allows communities, health professionals and policy makers to ensure they can be delivered in a way that is “fit for (local) purpose” and there are no gaps. It is clear we need something beyond general practice.

They highlighted necessary services including: emergency care, obstetrics (pregnancy and birth-related services), mental health and counselling, dental health, rehabilitation, and services for substance abuse, disability and aged care. And of course, there is a range of necessary support functions. These include on-demand specialist back-up, telehealth and video conferencing, and the ability to promptly evacuate seriously ill patients.

Researchers have also looked at the features of effective and sustainable models of primary health care in rural and remote Australia. Key issues were supportive health policy, productive relations between federal and state/territory governments and a receptive community; essential services like good governance, management and leadership; as well as adequate funding, infrastructure and workforce supply.

**Who will staff primary health care in the bush?**

So, how do we recruit, structure and retain the primary health care team needed to deliver these services? Again, we know quite a lot about health care professionals who are more likely to be attracted to the challenges of rural and remote medicine.

Those who love their work in country areas talk about high levels of professional satisfaction, the challenging variety of the work, close relationships with other health professionals, and the sense of satisfaction from their patients.

But the isolation, the struggle with work-life balance, career advancement, schooling for children, jobs for spouses and difficulty finding locums (for instance to back-fill when they are sick, want to take a holiday or need extra training) are causes of dissatisfaction. Future policies need to address these issues.
Looking to the future

Providing sustainable health care services in the bush is possible. But finding the evaluations and anecdotes about what works is not easy.

For instance, it’s now impossible to know from publicly available documents how much federal money is spent on rural health initiatives, let alone their outcomes.

However, websites like Community Commons, which allow people to share their experiences, data and resources about providing health care to local communities, can help.

Expenditure on rural and remote health is a wise use of government resources because it focuses on what private markets are unable to do. It also delivers on outcomes that can be measured in dollar benefits, as well as the social justice currency of a fair go for all Australians.

Yet, there are also concerns that federal government attention to rural health is waning. So, many hopes are pinned on the proposed Rural Health Commissioner to champion the strategic, consistent, long-term and varied health needs of rural and remote communities.

Dr Lesley Russell is Adjunct Associate Professor, Menzies Centre for Health Policy at the University of Sydney. She spoke during the opening plenary of the conference on: The economics of delivering primary health care in rural and underserved areas—what works?
A World of Rural Health in Australia: Snaps and selfies from the National Rural Health Conference

“If you’ve seen one rural community you have seen just one community!”

The theme of the 14th National Rural Health Conference was A World of Rural Health in Australia...to reflect the diversity of health care settings and challenges in rural, regional and remote Australia.

This post aims to capture some of the diversity at the conference, which brought more than 1200 people to Cairns, with happy snaps, tweets and a “Wall of Selfies”.

http://bit.ly/2qYk3lv
Welcome to country

Marita Cowie @MaritaCowie · Apr 25
Smoking Ceremony to welcome A World of Rural Health to #Cairns
#ruralhealthconf #ruralWONCA #ACRRM

CWA of Australia @CWAofA · Apr 25
Smoking ceremony respecting traditional owners to start the #ruralhealthconf

Anthea Gellie @AntheaGellie · 11m
Images from the opening of the #ruralhealthconf in Cairns 2017, the smoking ceremony. I felt privileged to be a part. #firsttimer #lovedit
You can track Croakey’s coverage of the conference here.

A World of Rural Health in Australia: Snaps and selfies from the National Rural Health Conference

#ruralhealthconf
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Conference dinner

Croakey "Conference News Service"
Arts and health

NRHA @NRHAlliance 7h
#artsandhealth at the #ruralhealthconf
You can track Croakey's coverage of the conference here.

A World of Rural Health in Australia: Snaps and selfies from the National Rural Health Conference

#ruralhealthconf

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A World of Rural Health in Australia: Snaps and selfies from the National Rural Health Conference

#ruralhealthconf

Croakey
“Conference News Service”
Rural health sector urged to get its evidence together

Leading Australian health administrator **Mick Reid** has laid down a challenge to the rural health sector, recommending it establish and self-fund a new entity to address a critical failure in our system to adequately translate evidence into policy and practice.

Journalist Melissa Sweet reports below on his presentation and other highlights from the National Rural Health Conference which she is covering for the Croakey Conference News Service.

You can also watch her interviews with Reid and fellow keynote speaker Dr Lesley Russell below, and view some tweets from the conference.

**Melissa Sweet writes:**

Progress in rural health is held back by a lack of collaboration across the sector, as well as harmful delays in implementing evidence, according to one of the country’s most senior health administrators.

At the 14th National Rural Health Conference in Cairns, **Mick Reid** called for a new national entity to be established to drive collaboration across the rural health sector and the systematic implementation of evidence.
“My strong message is we do not collaborate enough,” he said.

Reid, Deputy Chair of the Royal Flying Doctor Service, suggested that such an entity could be modelled upon Clinical Excellence Commissions and located within the National Rural Health Alliance.

“I’ve been around the health system quite a while,” he said. “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.”

Failures to translate evidence on the ground

Reid cited several examples of failures to translate clinical and public health evidence into practice and policies that could have saved lives and improved the health of people living in rural and remote areas.

One example was the lack of systematic national implementation of an initiative proven to be successful in reducing deaths among people admitted to rural hospitals after a heart attack in South Australia.

According to a 2014 report in the Medical Journal of Australia, an Integrated Cardiovascular Clinical Network was implemented from 2001 in rural South Australia to address disparities in outcomes for heart attack patients admitted to rural hospitals compared with those treated in metropolitan hospitals.

The network supported enhanced local risk assessment, standardised evidence-based treatment protocols, rapid access to an on-call cardiologist, and the urgent transfer of higher risk patients to metropolitan hospitals, as well as patient education. By 2008, this service was available to all 66 rural hospitals in SA.

This integrated approach led not only to a reduction in mortality for rural patients, but also to a decrease in the overall length of stay for rural patients, “suggesting efficiency gains combined with outcome benefits”.

The authors concluded that these “interventions closed the gap in mortality between rural and metropolitan patients in South Australia”, and suggested the approach could be useful in other “geographically challenged regions of Australia”.

Reid questioned why this approach was then not immediately implemented across Australia, and said the proposed new Rural Health Excellence Network could drive the translation and implementation of such evidence.

Invest in the evidence, and community control

But rather than asking for government seed funding for the new entity, he said the rural health sector should invest in its establishment, given the importance of community control for sustainability of such initiatives.

“We’ve had a history of things seed funded by the government,” he said. “The funding doesn’t continue and the innovation dies.”
“If we try to make this an initiative of the communities of interest who work in rural Australia, I suspect it would have far greater benefits and longevity.”

Reid said many organisations operated in silos, pursuing their own agendas and resisting collaboration, contributing to fragmentation, waste and duplication. He included his own organisation, the RFDS, in this critique. He told the conference:

> “Every serious health leader here knows we can do more with less.”

Reid also urged the rural health sector to do a better job of communicating to politicians, providing simple messages with clear calls to action. “I don’t think we’ve made it easy for governments to hear our voice,” he said.

Dr Lesley Russell, an Adjunct Associate Professor at the Menzies Centre for Health Policy at the University of Sydney and another keynote speaker at the conference, said she was a “big supporter” of the proposal because “we do not make the best use of the evidence that we already have”. She said:

> “The basement of the Department of Health must be full of reports, evaluations, commissioned studies that people have forgotten about.”

> “That means there is a lot of data, a lot of wisdom, a lot of learnings about what works and perhaps more particularly about what doesn’t work that we could be utilising every day to make rural and remote health better, and get better bang for the buck.”

The proposed entity could make the evidence accessible to a range of stakeholders beyond healthcare groups, including schools, local governments and community organisations, she suggested.

Russell also called for analysis of the economic impacts of spending on community health services, suggesting that Australian governments did not appreciate the multiplier effect of investing in healthcare for local economies.

Spending on rural and remote health was a wise use of government resources because it focused on what the market was unable to do, she said.
Watch these Croakey interviews with Mick Reid and Lesley Russell

Responses on Twitter

Krispin Hajkowicz @Krispy76 · 12h
Way to go Mick! #ruralhealthconf

TT Mobile AU @TTMobile_au
Mick Reid is now trending in Australia, ranking 2

Skye Kinder @skye_kinder · 14h
Mick Reid: For bang for buck in rural health, need to combine evidence with collaboration #ruralhealthconf

Jackie Kelly @jackiek90996315 · 14h
Create a body gather and disseminate evidence implement findings across Rural Australia Mick Reid #ruralhealthconf
You can track Croakey's coverage of the conference here.

Rural health sector urged to get its evidence together

#ruralhealthconf
Rural health sector urged to get its evidence together

From the plenary and other sessions

**Jenny May** @drworkforcereg · 13h
Uber health disruptions will bypass current health models / are we ready?
#ruralhealthconf

**Melissa Sweet** @croakeyblog · 13h
Strong theme from #ruralhealthconf plenary this morning about the importance of community ownership of RRR health services

**Bshep** @bshep · 13h
‘Hit government where it hurts’ calling for economic development data to drive rural health agenda #ruralhealthconf

**Jackie Kelly** @JackieK0995315 · 13h
Communities do need to understand that appropriate healthcare in small rural areas are not just bricks and mortar #ruralhealthconf

**Outbush Medicine** @Outbushmedicine · 13h
A healthy population, that is what our vision is. Much $ spent on hospitals and not enough on prevention #ruralhealthconf

**Heidi Drenkhahn** @DietitianHeidi · 13h
Rural areas need to tell their policies they don’t want bricks & mortar, they want primary health care services #ruralhealthconf #prevention

**Daniel Manahan** @dmanahan · 13h
Lesley Russell: rural sector littered by rural projects that just “ended”. Some good projects died early. Resource wasted #ruralhealthconf

**Danielle Kennedy** @dmkennedySP · 13h
Continuity of care is essential as patient is the only constant in healthcare!
#ruralhealthconf

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

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

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

#ruralhealthconf

Launches and interviews

@DavidButtFive
@LRussellWolpe
Research in remote Aboriginal communities

Anthea Gellie @AntheaGellie · 10h
Presentation on conducting research together with Aboriginal communities in the Kimberley #ruralhealthconf

Anthea Gellie @AntheaGellie · 10h
Great recommendation from Session A #ruralhealthconf based on qual data from interviewing Aboriginal leaders in the Kimberley collaboration

Recommendation 3
Research protocols and ethical guidelines for research with remote Aboriginal communities should be:
- Require funding bodies to be more flexible in their timelines allowing for unexpected cultural obligations.
Loss of maternity services

In her presentation, **Professor Lesley Barclay** from Sydney University’s Centre for Rural Health looked at what have we learned from the Australian Rural Birth Index study. You can also listen to a *Radio National interview* with her on her concerns.

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**Additional findings**

- Poor clinical governance of many rural and remote health services.
- E.g. regional hospitals with staff specialists & registrars not supporting small towns only 100 kms or so away
- Abdicated responsibility for local GP proceduralists
- No planning for practitioners leaving & modest an absence of support or clinical governance for procedural GPs
- The absence or poor quality of networking, e.g. non-qualified nurses trying to lead midwives or maternity services
- Poor and outdated models of care not using skills of midwives well
Deadly Sport initiative

Gippsland PHN @gippslandphn · 5h
Congratulations David Roberts presenting @DeadlySport at the #ruralhealthconf & celebrating results for 715 health checks @gippslandphn

Bshep @sbshep · 6h
@DeadlySport great example of a local social marketing strategy to engage Aboriginal communities in their health #ruralhealthconf

Trending nationally

Australia Trends · Change
#afidonspies
#nriroostersdragons
#ACL2017
Jamie Young forced off field following nasty injury
#ruralhealthconf
@MrOTJames, @gammacrawford and 3 more are Tweeting about this
Yassmin Abdel-Maged
6,742 Tweets
Jonathan Demme
Director Jonathan Demme dies at 73
#SmallizeSurgery
Family First
8,811 Tweets
Jeff Goldblum
Jeff Goldblum handed out free sausages in Sydney
Mark Ellis
One Nation candidate Mark Ellis withdraws from state election
Today is tomorrow’s history – be brave, so we can envisage Australia in 2037 like this

“Great speech by Janine Mohamed CEO of CATSiNAM on her vision for Indigenous health in 2037 - inspiring for a better future” – David Butt, Chief Executive Officer of the National Rural Health Alliance on Twitter (@DavidButtFive)

It’s 2037 and Janine Mohamed’s grandchildren are learning about the tremendous achievements of Australia’s first Indigenous Prime Minister, Mr Adam Goodes....

Twenty years from now it’s a country that has closed the gap in health outcomes for Aboriginal and Torres Strait Islander people and non-Indigenous Australians, where cultural safety doesn’t begin in the health system but in our homes and schools and public discourse, and where recognition of the urgency of climate change has prompted a profound sea change around the world in the way we live and do business.

It’s no wonder this speech from Mohamed – CEO of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSiNAM) – sparked such a big response at the National Rural Health Conference in Cairns.

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

She imagined a strong, positive future for Australia 20 years from now – and what it might take to get us there.

You can read her speech in full below, or watch it via the video link at the bottom of the post. See below too for some of the Twitter responses to her call for action for us to be brave and to make some great history.

Thanks to Janine Mohamed and CATSINaM for making her speech and slides available for this post.

Janine Mohamed: speech to the National Rural Health Conference

Good morning ladies and gentlemen, Elders, dignitaries and colleagues.

I would like to begin by paying my respects to the Traditional Custodians of this land, the Yirrganydji Gimyayg Yidinji people, and to Elders past and present, and future generations.

Thank you for your very warm welcome and for the invitation to talk to you today.

About two years ago I had the privilege of meeting Professor Moana Jackson, from Aotearoa. He is truly an inspirational Maori leader, who challenged us at CATSINaM to ‘see beyond the mountain’, to vision our future at all costs, and to be brave because that is the way of our people.

He also reminded us that we are storytellers – Moana has inspired me to share our hopes for the future with you today.

So….hang on to your seats – we are going to be doing some time travel together!

Becoming advocates and agents of change

When I was a young girl I realised I wanted to become a nurse, after seeing my family members suffer traumatic experiences at the hands of the health system.

While I have worked in many different roles across the health system – clinically, in program development and delivery, academia and in policy – I am now very pleased to be leading the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, or CATSINaM since 2013.

I am proud to be an advocate for the unique and powerful roles that Aboriginal and Torres Strait Islander nurses have in the health system and their communities, as agents of change.
I like to begin my speeches by acknowledging May Yarrowick, who trained as an obstetric nurse in Sydney in 1903. She may well be our first Indigenous nurse qualified in Western nursing.

Let's take a few moments to reflect upon the challenges that May must have overcome to train and work as a nurse in those times. Remember, this was just a few years after the new federation of Australia passed the Immigration Restriction Act of 1901.

This legislation enshrined the White Australia policy, embedding dominant culture worldviews and priorities into the very birth of the federation, and of course the exclusion of us from Australia’s birth certificate.

Some might say that to this day Australia has not yet grown up, or out of those views.

Too often, the limitations of these dominant culture worldviews stop non-Indigenous people from recognising the incredible strengths of our Aboriginal and Torres Strait Islander peoples and cultures.

**Imagine this is now 2037….**

Now, I'd like to invite you to cast your minds forward.

Imagine that we have travelled forward in time from May Yarrowick and 1903, all the way to 2037 – 20 years in the future from the time of this conference here in beautiful Cairns.

How old are you in 2037?

I am 62. – I think I look like I belong on the set of the Golden Girls – the Black Betty White. But I am not yet retired. Now that we all are living longer, the retirement age is now 70.
I am happy to still be working. In fact, I am happy to still be alive and in relatively good health.

When I think back to 2017, I remember that I was not at all sure this would be the case. In my early 40s I developed a chronic disease and worried about what it might mean for my future health. But my worries proved unfounded. As I grew older, I remained strong and well.

When I think back over the last few decades, I realise that what helped to keep me feeling good was the strength of my identity, my connection to community and country, and my mentors.

The health literacy that I developed through my nursing career also helped – just one of many ways that developing an Aboriginal and Torres Strait Islander health workforce helps to improve the health of our people.

At 62, I must admit that I am feeling pretty good about myself. My life has had – and continues to have – purpose and meaning, thanks to my passion for improving the health of my people.

So much of my work has been about re-writing national narratives that were once so detrimental to our well-being but are now a source of pride and strength in our identities as members of the world’s oldest living cultures.

One of the reasons I’m so happy is that I am now watching my grandchildren thrive.

I am seeing that their experiences at school and university are so different from my days and even from those of my children – their parents.

My grandchildren are reading histories and textbooks that have been written by Aboriginal and Torres Strait Islander people.

My grannies are learning from Indigenous teachers and lecturers and television presenters. And they are proud and strong in their identities because of how and what they are learning.

It is such a far cry from when I was at school and university. Then our romanticised and exotic histories were being told by non-Indigenous people, who too often saw us through the overlapping lenses of deficit, unconscious bias and racism.

My grandchildren are learning about the tremendous achievements of our first Indigenous Prime Minister, Mr Adam Goodes.

From their classrooms, they scan in to hear the discussions from the First Nations Parliament.

Self-determination is not an aspiration or even a dream for my great grandchildren. It is their daily reality.
They grow up conscious of whose country they are on

In school, they learn about our many Indigenous health heroes — about people like Professor Tom Calma, Aunty Pat Anderson and Aunty Gracelyn Smallwood……

It is not only my grandchildren who are learning about the strengths and proud history of Aboriginal and Torres Strait Islander peoples – so are their non-Indigenous classmates. Together, they are learning a shared, true history of this place we call Australia.

My grandchildren and their non-Indigenous friends share in learning local language and they learn together about the importance of respecting and caring for country. They grow up knowing about whose country they were born on – because this is written on their birth certificates and is part of their identities from the day they are born.

They grow up knowing to always be conscious of whose country they are on – the signs, GPS reminders and names on our maps and roads also remind them of this.

Thanks to the many outcomes of the Truth and Reconciliation Commission, when they go on fun school excursions, they visit fun exhibitions that are informed by our Indigenous knowledges and cultures.

They visit memorials that honour our First Nations people, including our brave Warriors and protectors of country such as Pemulway.

When they go on school excursions, the signage on the streets and highways is not only in English, but also honours the language and naming of the local First Nations peoples.

They grow up with intergenerational hope, not trauma

My grandchildren are growing up in a society that values them and their heritage. They are growing up with intergenerational hope, rather than intergenerational trauma.

They are relative strangers to the experiences of racism that were part of the daily experience of their ancestors over so many generations — including for me, my parents and my children.

The health professionals of the future are learning, from their earliest days, when they first set step into early childhood learning and development centres, about cultural safety. Not that they call it that any more.

Cultural safety has become so embedded into all systems that it has become the norm – rather than something exceptional that people have to learn when they start training to be a nurse or a doctor.
In 2037, cultural safety doesn’t begin in the health system; it begins in our homes and schools. It is evident in our private conversations, and our public debate and discourse.

In 2037, there is no longer a disconnect between public and political discourse – and the language used in the education and training of health professionals.

Politicians of ALL persuasions now understand – just as well as do ALL health professionals – that racism is an attack on people’s health and well-being, and our capacity to live productive, self-determining lives.

In 2037, cultural safety has become a societal norm. The cultures, knowledges and practices of Aboriginal and Torres Strait Islander people are central to the national narrative; they are valued and respected.

We have fixed the “racism problem”. Embedding cultural safety into all aspects of society has helped us to transform Eurocentric systems and worldviews.

In 2037, I no longer feel the need to put on my heavy “armour” when I venture outside of my home. It’s a far cry from 20 years ago, when this armour was part of my defence system against the everyday insults of unconscious bias born of racism. Experiences such as deflecting or swallowing hard when I hear:

- ‘You’ve done well for yourself’
- ‘Aboriginal people get so much given to them’
- ‘You’re too pretty to be Aboriginal’
- ‘Yes, but you’re not like the rest of them, you’re different’
- ‘You’re not a real Aboriginal, you’re a half caste’
- or being asked to see my receipt at Woolworths self-serve because ‘they’ve had problems with my sort of people’.

In 2037, I know that when non-Indigenous people see me in the street or at work, their first reaction will not be of prejudice or fear, but of gratitude and pride.

This reflects their understanding of the profound value that Aboriginal and Torres Strait Islander peoples and cultures bring to Australian society.

We have closed the gap in health outcomes

In 2037, when my grandchildren get sick or need to go to the hospital, I no longer even think to worry about whether their care and treatment will be respectful.

No longer do my people leave seeing a doctor or visiting a hospital to the last possible moment because of the fear of being humiliated or traumatised.
The real-time reporting of national safety and quality healthcare data shows that cultural safety is now so embedded across all health systems that Aboriginal and Torres Strait Islander patients are as likely as any other Australians to have proper access to respectful and appropriate care.

The Health Barometer – which was established some years ago to measure our health outcomes, race relations and the cultural safety of health services, programs and policies – has become redundant.

The dual governance boards which Local Area Health Networks established to eradicate racism at the organisational and direct service delivery level are also no longer needed.

There is no longer a gap between the safety and quality of healthcare provided to Aboriginal and Torres Strait Islander people and that provided to other Australians. Our health status is now comparable with other Australians.

The health sector has long ago acknowledged its role in colonisation and such traumatic practices as removal of children and the medical incarceration of Aboriginal and Torres Strait Islander people. Nursing and midwifery now learn this history at the same time as learning about our founders, for example Florence Nightingale.

Health professions and systems have apologised and provided reparation and justice for harmful practices.

Over the past 20 years the sector learnt how to be part of healing, rather than causing harm.

The persistence, hard work and brilliance of our Indigenous health leaders paved the way for a sea change that became evident around the time this century celebrated its 21st birthday.

**Climate change prompted a global sea change**

I must admit that things were looking pretty grim in the years leading up to 2021. We were still dealing with the aftermath of President Trump, fake news, climate deniers, and the rise of nationalistic, xenophobic movements.

But as the impacts of climate change started to hit – earlier and harder than expected – there was a profound sea change around the world.

People realised the limitations of the usual Western ways of doing business. Globally, Indigenous knowledges were not only legitimised, but valued and centred in responses to such complex problems as climate change; social and economic inequality; and the protection and management of land and water resources.

As new social and economic structures emerged in response to these challenges and in response to what was then called the Fourth Industrial Revolution, the voices of Indigenous peoples were heard – not only in Australia but also globally.
Our ways of doing business – informed by practices of respect, reciprocity, caring for country, and relationship-based ways of working – are now centred.

Power no longer rested in self-interested hierarchies but became de-centralised. People and organisations were valued for what they could do for the well-being of the community and the planet.

Just imagine what a wonderful difference this has made for rural and remote people and communities!

At the same time as these wider shifts were occurring in society, some fundamental shifts were occurring in health systems.

The health system changed its way of doing business

It wasn’t just that the Aboriginal and Torres Strait Islander health plan was fully resourced and implemented – and that this became remembered as one of the landmark achievements of Minister Ken Wyatt, along with establishment of the National Aboriginal and Torres Strait Islander Health Authority.

It wasn’t just that the Rural Health Commissioner’s role was reformed – after some sustained, behind-the-scenes lobbying – to ensure that the Commissioner had a more wide-ranging and meaningful remit.

It wasn’t just that in the wake of the abolition of the Indigenous Advancement Strategy, the Goodes Government set up a Productivity Commission for Indigenous Health. This quarantined money so that we were able to self-determine the way we invested in our health. And what a difference that made!

It wasn’t just that insurance laws were changed and health systems were reformed to enable women, both Aboriginal and non-Indigenous women, to birth on country.

It wasn’t any one of these changes alone that led to us closing the gap in life expectancy and health outcomes – years earlier than we had hoped for in our wildest dreams.

It was these things, but it was more than this.

When I look back now, it seems incredible that most of our health dollars and efforts were once spent on centralised, institutional systems of care that contributed relatively little to health outcomes for the large investment they incurred.
It now seems unbelievable that we once invested so little effort and money into providing the conditions that empowered people and their families and communities to have to healthy, contributing lives.

Such a fundamental shift occurred. As Indigenous knowledges and practices were centred in wider systems, so too did the health system change its way of doing business.

The mainstream health system learnt from the successes of the Aboriginal community controlled health sector. The mainstream re-oriented itself around our ways of doing business – to focus on primary health care, communities, prevention, social justice, and the social and cultural determinants of health.

Health services moved towards providing long-term contracts and seamless services addressing peoples’ needs for inclusion, housing, transport and integrated care.

For our members at CATSINaM, the changes have brought profound transformations to the way they work and how they are valued.

Our members now work at their full scope of practice. They are involved in diagnosing and managing dental caries, for example, while dentists are incorporating population health strategies into their daily work. Their work has been funded for many years now by ….the sugar tax (dare I say this in Queensland?).

It is so thrilling too to see that the mainstream politic has learnt from the ingenuity of Aboriginal and Torres Strait Islander peoples. Creativity and innovation are not only valued — but properly funded and rewarded.

After its unpromising early years, visionary leadership transformed the NBN to provide equitable access to connectivity right across the country.

Aboriginal and Torres Strait Islander people capitalised on this opportunity, supporting our creativity, entrepreneurialism and innovation. We used the NBN to drive innovation in healthcare and health promotion, as well as to contribute to a better future for all.

**We are all making history right now**

As I stand before you in 2037, I am not only happy, but I am proud.

One of the highlights of my career has been working to use the virtual world – cyberspace – to embed cultural safety, not only into the training and education of all who work in the health system – but also into wider societal systems. Along with my newly released cookbook, written in conjunction with the CWA of course.

As we contemplate this potential future together now from our present reality in 2017, let us remember that history is not something that happens in the past.

It is happening right now. We are all making history right now.
Over the next few years, as we move to embedding cultural safety into our systems and services, supported by the forthcoming Version 2 of the National Safety and Quality Health Service Standards and CATSiNaM’s current campaign to have Cultural Safety embedded into our Health Practitioners legislation, let us ensure that this brings meaningful improvement to rural and remote health services.

Let us remember that cultural safety is a philosophy of practice that is about how a health professional does something, not simply what they do. Its focus is on systemic and structural issues and on the social determinants of health.

Cultural safety is as important to quality care as clinical safety. It includes regard for the physical, mental, social, spiritual and cultural components of the patient and the community.

Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples’ unique needs – and to be regardful of difference.

For Aboriginal and Torres Strait Islander health, cultural safety provides a decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege.

These actions are a means to challenge racism at personal and institutional levels, and to establish trust in health care encounters.

Culturally safe and respectful practice therefore is not about learning about Aboriginal and Torres Strait Islander peoples – in fact you can never know this.

Cultural safety requires having knowledge of how one’s own culture, values, attitudes, assumptions and beliefs – influence interactions with patients or clients, their families and the community. Being aware of our racial orator.

As we contemplate a culturally safe future from our current vantage point, let us reflect upon how each and every one of us can contribute to making this future that I’ve shared with you today a reality.

I’d like to conclude this presentation by inviting you to journey with me into the future. I ask each and every one of you to think deeply about how you might contribute to creating this future.
How can YOU help to make history?

Here are some suggestions:

• Embed cultural safety in your organisation’s strategic plan, and Reconciliation Action Plan.

• Make anti-racism practice part of your everyday – whether you are at home or at work – and whether anyone is looking or not. Enact zero tolerance for racism.

• Ensure your governance structures reflect the communities who you are serving. Privilege the voices and the wisdom of Aboriginal and Torres Strait Islander people and organisations.

• Inform yourself about 18C and Constitutional Recognition.

• Inform yourself about climate change and the actions you can take – and try to put aside non-Indigenous lenses when doing this. Learn from us about caring for country.

• Practise trust, respect and reciprocity. Build and value your relationships with us.

In 2037, let us look back on this conference – and this moment – as a time when we stood together, determined to make history and to create a better future.

Because today is tomorrow’s history – be brave.

Thank you.

Watch the full plenary session
You can track Croakey’s coverage of the conference here.

Today is tomorrow’s history – be brave, so we can envisage Australia in 2037 like this.

#ruralhealthconf

What delegates said on Twitter

Emily Saurman @esaurman · 4h
Best plenary-Janine Mohamed. A positive outlook and hopeful vision! Thank you. #ruralhealthconf

NATSIIHWA @NATSIIHWA · 4h
Janine Mohamed - 2037 *Strength in my identity*” “Aboriginal language being taught in school” *Self determination is reality* #ruralhealthconf

Kylie Stothers @KylieStothers · 4h
@JanineMiera thank you for taking us on a journey to 2037 #ruralhealthconf @CATSiNaM

Martin @dadability · 4h
“Make anti-racism part of your everyday” - Janine Mohamed - quote of the conference so far 😊 #ruralhealthconf

Janette Milera liked
Karen Ingram @kanoolah65 · 4h
#qanda needs Janine Mohamed @CATSiNaM on the panel pronto! #ruralhealthconf
You can track Croakey’s coverage of the conference here.

Today is tomorrow’s history – be brave, so we can envisage Australia in 2037 like this.
A fundamental re-think of preconception health, education and care is required, according to a visiting expert from Scotland, Dr Jonathan Sher.

In a presentation to the 14th National Rural Health Conference in Cairns, Sher highlighted initiatives in the United States and Scotland aimed at improving outcomes for new and future generations.

But his main message was that everyone – as individuals, professionals and organisations – must embed a focus on preconception into their lives and work.

Melissa Sweet writes:

“What’s the difference between Las Vegas and early childhood?”

The answer, according to Dr Jonathan Sher, is that “what happens in Vegas stays in Vegas, but what happens in early childhood never stays in early childhood.”

Sher, a preconception consultant in Scotland, asked the question at the start of his presentation to the recent National Rural Health Conference in Cairns to make a point about the need to transform thinking around preconception care.
“It’s not a question they’ve ever been asked before,” he later told Croakey. “It’s a way of reminding people … that those early experiences, that sometimes which we don’t even consciously recall, are the ones that shape us for the rest of our lives, and sometimes unfortunately mis-shape us.”

Sher, who has worked in the United States, Australia and in Scotland in early childhood education and rural health, called for transformation in thinking about preconception care, instead of focusing on just the period just before pregnancy.

“We need to radically redefine the meaning of ‘early’ when we think about early childhood or early intervention,” he said.

“The beginning of parent education is how we are ourselves parented. That creates the template; that creates the default setting in our brains about what parenting is like.

“If it’s good, we tend to emulate it; if it was bad, we will become fiercely determined to not repeat the harsh experiences we’ve had.

“Preconception health education and care should be envisaged as taking place across the life course, starting with our own birth, continuing in childhood and adolescence; it’s not just about a few months before becoming pregnant.”

**Primary prevention**

Such a focus had potential to shift the policy focus on “closing gaps” that now dominate in Australia, the United States and the United Kingdom in education attainment, health status, income and wellbeing.

But in addition to closing the gap, the focus should also be on stopping those gaps from ever opening in the first place through primary prevention, he said.

> **My message to you is, preconception is where primary prevention truly starts. It’s also the time where it succeeds most easily, most cheaply and most successfully.**

> **We know it’s never too late to do something good for another person, but if we wait to help only once a child goes to preschool or has reached school age, then there are some important boats that have already sailed.**

> **Preconception truly begins at our beginning, rather than solely in the months just before pregnancy; this has profound implications for policy, practice and our own understanding. If the gap never opens, you don’t have to spend your time, energy and money closing it.**

Sher said that the roots of much inequality and social injustice began well before pregnancy.

“Remember that pregnancy and birth outcomes and the life trajectories that follow can be predicted with some accuracy, maybe depressing accuracy in some cases, at the outset of any pregnancy,” he said.

“Women who are relatively healthy, reasonably educated, unstressed and supported at the time of conception are more likely, but not guaranteed, to have safe pregnancies and to deliver healthy babies.

“By contrast, women who are unhealthy, who have substance abuse problems, who are deprived in various ways and who are living stressful, chaotic lives when they conceive are notably more likely, but not doomed, to have much riskier pregnancies and to deliver more vulnerable babies.”
Making rural and remote Australians and their communities more wealthy, more empowered and fairer, as well as less marginalised and less deprived, would significantly improve pregnancy and overall birth outcomes, he said.

Inadequate or missing preconception health, education and care is both a cause and a consequence of poverty, discrimination, racism, substance abuse, poor physical and mental health and the other problems bedevilling too much of rural and remote Australia, he said.

The lack of attention to preconception care was exemplified in the common description of women “falling” pregnant, he said.

“It reflects a passivity and a ce sera attitudes that underlies preconception. No one falls into a profession or buying a home; we plan for these significant life events and yet we fall into pregnancy and parenthood, arguably the most significant life events that most people will ever experience.”

**Programs in action**

Sher outlined programs in Scotland and the United States that are developing a new focus on preconception care.

To be effective, it was crucial that such programs created a sense of agency and empowerment relating to health decisions, especially about fundamental questions around parenting.

**Mellow programs**

A Scottish initiative, the Mellow Parenting program was designed to help vulnerable young mothers better relate to their children. Recognising the need for earlier intervention, Mellow programs were then developed to target toddlers, babies and then “bumps and dads-to-be”.

Now, Sher said, the Mellow approach is being piloted with young people leaving care who are dramatically more likely to become early parents and to have children who end up in care. The program is designed to break this cycle.

**Earlier intervention for depression**

Recognising that most women who develop post natal depression have had undiagnosed and untreated depression antenatally, the Church of Scotland is developing programs for women with depression, addiction or obesity who are pregnant, and for before they become pregnant.

**Early childhood**

Sher suggests that parenting programs are occurring in preschool when young children are being encouraged – but not commanded – to wash their hands, brush their teeth, eat more healthy foods and get plenty of outdoor exercise, developing healthy habits that can last a life time.

“Most importantly, doing this with preschool children in the right way, in an empowering way, is the foundation of a sense of agency, the understanding that their knowledge and decisions really matter in staying healthy,” Sher said.

“This is a crucial precursor to making more complex choices about their own wellbeing as they get older, including about pregnancy, parenthood and relationships; this work of developing agency and sense of optimism.”
One Key Question

Sher also described a “brilliant” program developed in Oregon and since rolled out in 22 US states, based on the “deceptively simple idea” of GPs regularly asking all women of child bearing age, no matter why they are coming to the doctor, about whether they want to become pregnant in the next year.

Those who say no are offered contraception, and the others are offered preconception health, education and care.

The One Key Question program was developed to provide preconception health, education and care, knowing that about 50 per cent of pregnancies – and more in rural, remote and marginalised communities – are unplanned.

While no randomised controlled trials have been conducted, evaluations have been “very encouraging”.

“This was created by women, for women, for the most part – and women appreciate being asked, for the most part,” he said.

“How it is done and the quality of the follow up is what makes or breaks its effectiveness.”

All hands on deck

However, Sher said his main message was that Australia should not look to adapt overseas programs or establish Ministries or Departments of preconception health.

“I have very intentionally chosen examples that are not reliant on new legislation or millions of new dollars or years of revamped education or training,” he said.

“What I am looking for is an ‘all hands on deck’ effort,” he said. “It’s not a spectator sport.

“The magic is to see what you are already doing; to see what you are already good at in light of how they can be applied to preconception health, education and care across the life course.

“This is about people working in their own backyards and their own organisations and professions and with the others around them to each do what they can.

“The crucial slogan is that nobody can do everything, but everybody can do something to make sure that the next generation of mothers and fathers are better prepared, better supported.”

“We can and must do better with and for the next generation.”

See further by Dr Jonathan Sher:

A primer on preconception health, education and care

Prepared for pregnancy? Preconception health, education and care in Scotland

Scotland is tying one hand behind its – and children’s – backs by waiting too late to address gaps
Dr Sher is currently Director of Sher Consultancy. Previous positions include Scotland Director of WAVE Trust; Director of Research, Policy and Programmes, Children in Scotland; CEO of the North Carolina Child Advocacy Institute; Lead Consultant, Annenberg Rural Challenge; Co-founder of Rural Entrepreneurship through Action Learning; CEO of the Rural Education and Development Inc.

Croakey readers may also be interested to explore the work of First 1000 Days Australia, being led by Professor Kerry Arabena.

Watch this interview with Dr Johnathan Sher

You can also watch the full plenary session in which he presented, published online by the National Rural Health Alliance (Dr Sher is introduced at the 35:00 minute mark).
What delegates said on Twitter

Loddon Campaspe CLC @lcclc · Apr 27
...we have to dedicate ourselves to supporting parents - particularly in the rural context #ruralhealthconf

Sabina Knight @nwqran · Apr 27
Genetics, epigenetics together with family behaviours really matter to child and adult health outcomes @Jonathan Sher #ruralhealthconf

David Butt @DavidButtFive · Apr 27
Jonathon Sher again - preconception is where primary prevention really starts. Couldn’t agree more #ruralhealthconf
And a bit of explanation needed for these – sparked as Dr Sher stripped to his Friend of the National Rural Health Alliance shirt during presentation. He is a long-time member.
The future is fast approaching, but are we ready? A LongRead on what AI might hold for rural health

The rapidly advancing field of Artificial Intelligence (AI) is set to shake up the health and healthcare of rural communities, the National Rural Health Conference was told.

The prediction and its accompanying warning – from a leading rural doctor and medical educator, Dr Jenny May – is underscored by a scan of recent medical publications, reports Melissa Sweet below.

Melissa Sweet writes:

Not so long ago, a worrying realisation crept up on Dr Jenny May, Director of the University of Newcastle Department of Rural Health.

Perhaps she was failing in her day job – training the doctors, nurses and allied health professionals of the future.

May began questioning whether she and her colleagues were preparing the next generation of health and medical professionals for models of care and service delivery that might not exist in the future.
She subsequently began a journey investigating the burgeoning field of artificial intelligence (AI) and its implications for the future of healthcare. It was somewhat out of her comfort zone, as May describes herself as anything but “a geek”.

May recently presented her findings to the 14th National Rural Health Conference in Cairns, warning that the rural health sector needs to prepare for seismic changes in how it does business (and her caution no doubt applies more broadly as well).

She painted a picture of a future where intelligent machines have replaced pathologists, oncologists and many other health professionals, and where autonomous vehicles have made large sections of the rural workforce redundant.

It is also quite likely that in this future, she warned, the transformational changes brought by AI and the Fourth Industrial Revolution will exacerbate social, economic and health inequalities.

May’s concerns are underscored by a World Economic Forum assessment of the wide-ranging impacts of the Fourth Industrial Revolution, which is described as “a fusion of technologies that is blurring the lines between the physical, digital, and biological spheres”.

Klaus Schwab, Founder of the World Economic Forum, has foreshadowed an exponential pace of technological change in coming years, writing:

“The possibilities of billions of people connected by mobile devices, with unprecedented processing power, storage capacity, and access to knowledge, are unlimited.

“And these possibilities will be multiplied by emerging technology breakthroughs in fields such as artificial intelligence, robotics, the Internet of Things, autonomous vehicles, 3-D printing, nanotechnology, biotechnology, materials science, energy storage, and quantum computing.”

Schwab says that to date those who have gained the most from such changes have been consumers able to afford and access the digital world, and that there are concerns of the potential for greater inequality to result from disrupted labour markets.

“The largest beneficiaries of innovation tend to be the providers of intellectual and physical capital—the innovators, shareholders, and investors—which explains the rising gap in wealth between those dependent on capital versus labor,” Schwab says.

He adds:

“Technology is therefore one of the main reasons why incomes have stagnated, or even decreased, for a majority of the population in high-income countries: the demand for highly skilled workers has increased while the demand for workers with less education and lower skills has decreased.

“The result is a job market with a strong demand at the high and low ends, but a hollowing out of the middle.”

Advancing AI

“Artificial intelligence” is not a new concept, with a recent review of AI in medicine noting that the term was first coined in 1955 to describe “the science and engineering of making intelligent machines”.

However, the review described an increasing application of AI across healthcare in recent years.
It cited wide-ranging examples, including sophisticated robots providing care to frail elderly in Japan, emotionally sensitive avatars helping people with paranoid hallucinations learn to moderate their behaviour, and the use of algorithms and knowledge management to boost discoveries in genetics and molecular medicine.

Meanwhile, doctors from New York City reported a small study last month in the journal Stroke, showing that a smartphone app using AI was effective in helping stroke survivors to use anticoagulation medication appropriately.

The randomised controlled trial of 28 patients reported that 100 per cent of the group using the app took their medication as directed, compared with 50 per cent of the control group.

The study was sponsored by a US-based company, AiCure. Its app visually identifies individual patients and confirms their ingestion of medication.

The publication follows a growth in the number of start-ups exploring the use of AI in healthcare, with one industry analyst predicting that by 2025 “AI systems could be involved in everything from population health management, to digital avatars capable of answering specific patient queries.”

Meanwhile, researchers from Imperial College London in England and the Massachusetts Institute of Technology in the US recently cautioned that while AI could identify patterns and trends in routinely captured clinical data that yielded useful clinical insights, it also risked leading to over-diagnosis and unnecessary interventions.

Commenting on a study about AI being used to identify patterns in the clinical data of patients with atrial fibrillation and atrial flutter, the authors said AI brought the risk of generating “a variety of signals with little to no clinical relevance”.

Their article, published this month in the journal, Critical Care Medicine, defined overdiagnosis as the detection of disease that, if it had remained undetected, would not have affected a person’s life.

The downsides of overdiagnosis included patient anxiety, harm from further testing and unnecessary treatment, and the opportunity cost of wasted time on the part of both patient and provider, and healthcare resources that could be better used to treat or prevent genuine illness. The researchers said:

“The use of AI may well contribute to this problem by discovering patterns undetected by the human mind that are not actually causing problems and never will.”

“Clinically meaningful advances in this field will be an iterative process, where new algorithms are developed and systematically tested in real clinical settings for relevance against hard clinical endpoints. Only those that demonstrate value should be refined and improved before consideration for systematic bedside implementation.”
These authors also noted that despite several decades of research and hype, the AI field had failed to deliver on its promises of automated and improved disease detection, more effective monitoring and efficiency boosts in workflow – a caution also echoed by a CSIRO scientist in [this article](#) in *The Conversation* late last year.

However, algorithmic advances have started to trickle into areas such as radiology and pathology, the researchers said.

**Future fast approaching**

May predicts that the use of AI in healthcare is set to advance rapidly in coming years, with smart phones being used for X-rays, pathology tests and genomic profiling.

“If you are a pathologist, I think you need to be having some career counselling about now, because many of the things that you would have considered bread and butter are probably yesterday,” she told Croakey.

“I think there will be very few things that in the future that computers with the use of AI can’t do.

“I was very surprised to find just how much technology using AI is already out there, and is already part of many other peoples’ daily clinical work flow.”

Examples cited by May included the use of sensors in the homes of elderly people to assess gait length and alert health professionals when this was noted to shorten, which is predictive of the likelihood of falls.

She also said that IBM’s [Watson for Oncology](#), which can crunch lab tests, read doctors’ notes and provide highly validated treatment recommendations, raises questions about the future of oncologists, as well as other health professionals.

May also described another IBM algorithm called [Medical Sieve](#), which aims to build a next generation “cognitive assistant” with analytical, reasoning capabilities and a wide range of clinical knowledge, to help clinical decision making in radiology and cardiology.

Last year, [Atomwise](#), which uses supercomputers that root out therapies from a database of molecular structures, launched a virtual search for safe, existing medicines that could be redesigned to treat the Ebola virus, May said.

They found two drugs predicted by the company’s AI technology that may significantly reduce Ebola infectivity. This analysis, which typically would have taken months or years, was completed in less than one day, according to May.

Developments in AI outside of healthcare also will have significant implications for health.
The advent of autonomous vehicles – which the recent World Congress of Public Health in Melbourne was told had the potential to bring public health gains by reducing traffic accidents – could add to rural unemployment, May said.

She noted that a significant proportion of rural workers are employed driving cars, buses, trucks and harvesters, for example.

“We are going to lose a swathe of these jobs,” she said. “That’s of great concern; we need to be preparing for this sort of structural reform. This is a whole-of-community revolution.”

May said the potential for AI to reduce the number of health professionals needed in rural communities also could contribute to wider job and population losses.

“In some of our smaller communities, the health service is the major employer,” she said.

She also warned that the AI revolution had the potential to exacerbate health inequalities because it was likely to be unevenly available in an environment where developers were likely to focus on profits rather than providing equitable service to communities.

“Similar to the institution of other market-based approaches, it may be of benefit to individuals but not to communities as a whole,” she said.

May is also concerned about inability of current structures to adequately regulate AI developments, especially as it is likely that vast amounts of personal health data will be held offshore.

**NBN failings**

But one of the major barriers to equitable access was the uneven access to high quality NBN, she said.

May has recently returned from a year working in rural British Columbia in Canada where a town of 6,000 people had unlimited high speed broadband.

“The Canadian Government had invested significant amounts in high speed broadband, which made all these technologies possible,” she said.

> **“Ubiquitous high speed broadband is a necessity. I’m not interested in an answer that it’s too expensive or we can’t do it.”**

As just one example of how uneven NBN access is already affecting healthcare, May said she finds it almost impossible to place students on even short-term clinical placement in rural areas without good broadband access. They just won’t go there.

At the moment, she says broadband is patchy in northwest NSW and through to the coast, although some towns have excellent access via the NBN.
“For anybody who would like to see regional rural and remote communities go ahead with the potential that they have, I believe that we need the highest possible speed broadband,” she said.

Contrary to some suggestions that rural people do not need quite the same bandwidth or speed as city people, the reverse was true, May said.

“If we look at agriculture or health or education, I would have thought the need was on steroids.”

By the time the next national rural health conference is held, in Hobart in 2019, May hopes that rural communities and the health sector have progressed much further in their understanding of the likely impacts of AI and the Fourth Industrial Revolution.

“The question is,” she said, “is there a way we can adequately prepare for it?”

Watch Croakey’s interview with Dr Jenny May

Further reading

The Fourth Industrial Revolution: what it means, how to respond

https://www.weforum.org/agenda/2016/01/the-fourth-industrial-revolution-what-it-means-and-how-to-respond


Autonomous vehicles


See also background on the inquiry by the Standing Committee on Industry, Innovation, Science and Resources on the social issues relating to land-based driverless vehicles in Australia, which is currently holding public hearings.
Antibiotic resistance: a health hazard for rural and remote communities

The World Health Organization is mounting a global campaign to tackle antibiotic resistance through wider uptake of handwashing.

In Australia, concerted efforts are needed to tackle antibiotic resistance in rural and remote communities, the recent National Rural Health Conference was told.

Melissa Sweet writes:

The global scourge of antibiotic resistance – which a recent British report estimated may cause 10 million deaths annually by 2050 if not addressed effectively – is of particular concern for rural, remote and regional communities in Australia.

Speaking at the recent National Rural Health Conference in Cairns, infectious diseases physician Dr Krispin Hajkowicz said non-metropolitan communities faced a triple whammy.

They were often at increased risk of infections, as well as being at increased risk of developing antibiotic resistance due to the high level of antibiotic usage in many rural areas.

Exacerbating these concerns was the lack of a specialist medical and pharmacist workforce to tackle antibiotic resistance in rural and remote areas, he said.
In Queensland, there were no infectious diseases physicians outside of Brisbane, Rockhampton, Mackay, Townsville and Cairns, said Hajkowicz, who is director of the Queensland Statewide Antimicrobial Stewardship Program and a senior staff specialist in infectious diseases at Royal Brisbane and Women’s Hospital, as well as a senior lecturer in the School of Medicine at the University of Queensland.

“The whole concept of antimicrobial stewardship has become central to controlling the threat of resistance in Australia,” he said.

“Mandatory anti-stewardship programs have been implemented in Australia since 2014 but it’s very important to have specialist knowledge from infectious diseases physicians and from pharmacists to run these programs and achieve really good results.

“Where programs have been rolled out in Australia, there have been substantial reduction in the usage of antibiotics… but it takes expertise and knowledge that isn’t currently available in rural and remote Australia.”

In parts of Queensland, 50 per cent of Staphylococcus aureus infections were now resistant to treatment with methicillin, he said, meaning that frontline antibiotics would not work for many patients.

Instead, alternative antibiotics had to be used, which were potentially less effective and more toxic, adding to the complexity and burden of treatment, he said.

Numerous reports have shown that Australia’s use of antibiotics in human health is relatively high, being well above the OECD average.

A national survey cited in *Australia’s First National Antimicrobial Resistance Strategy 2015–2019* found that, overall, 30 per cent of antibiotic prescriptions were deemed to be inappropriate, and this was mainly related to unnecessary use of broad spectrum antimicrobials and incorrect duration of treatment.

As well as contributing to increasing antimicrobial resistance, unnecessary and inappropriate use is also causing harm to individual patients, Hajkowicz said.

“There is individual patient harm every time a patient receives an inappropriate antibiotic,” he said.

“Every time you take an antibiotic … the bacteria in your gut are also affected and over time you will personally develop antibiotic resistant bacteria in your gut.

“If you then become really, really unwell with severe infection, pneumonia or a blood stream infection and need an antibiotic, it may not work at the critical moment in your life … and it may lead to a really poor outcome.”

**Standards needed for community based care**

The National Safety and Quality Health Service Standards have driven improvements in antimicrobial stewardship in hospitals and acute care settings, but Hajkowicz said similar standards were also needed for community-based healthcare.
There are no overarching community healthcare standards for antimicrobial use at the moment: that is something we would like to see progress down the track.

I think GPs and primary care clinics are doing their absolute best under the circumstances but with all the competing needs they have, there is a potential gap there, and programmatic support, auditing and surveillance are going to help primary health care practitioners achieve better antibiotic use without a large investment in time.

We would like to see hospitals, community primary care, and public health networks all aligned and working together on this problem with a clearly defined research agenda with excellent education, and a program of restriction, audit and surveillance of antibiotic use throughout the country.”

Hajkowicz said a big focus on consumer engagement and public education was also needed.

“At the end of the day, consumers drive health care and we know they definitely drive requests for antibiotic scripts,” he said.

“For them, understanding the risks associated with taking antibiotics for viral infections would be key.”

In five years time, he’d like to see patients arriving at GP clinics without an expectation of getting an antibiotic.

Instead, they would come with the idea of being reviewed to make sure they are not critically unwell, understand how long they need to take off school or work, and have a discussion about treatment but without expectation this would lead to a script.

Further reading:


Watch this Croakey interview with Dr Krispin Hajkowicz
More on the Queensland Statewide Antimicrobial Stewardship Program

Hajkowicz and his colleague Dr Minyon Avent, an Antimicrobial Stewardship pharmacist, promoted the Queensland Statewide Antimicrobial Stewardship Program at the conference: see these tweets below and also the program website.
10 recommendations from the 2016 UK Review on antimicrobial resistance:

1. Undertake a global public awareness campaign
2. Improve sanitation and prevent the spread of infection
3. Reduce unnecessary use of antimicrobials in agriculture and their dissemination into the environment
4. Improve global surveillance of drug resistance and antimicrobial consumption in humans and animals
5. Promote new, rapid diagnostics to reduce unnecessary use of antimicrobials
6. Promote development and use of vaccines and alternatives
7. Improve the number, pay and recognition of people working in infectious disease
8. Establish a global innovation fund for early stage and non-commercial R&D
9. Introduce better incentives to promote investment for new drugs and improving existing ones
10. Build a global coalition for real action – via the G20 and the UN.
The National Rural Health Conference: a feast of song, dance and other creative experiences

After the National Rural Health Conference in 2015, Croakey’s Jennifer Doggett wrote a thoughtful article reflecting on the importance of arts and cultural performances in the conference program.

Shared cultural and creative experiences helped to create a sense of community, make spaces for reflection and rejuvenation, link delegates to the environment, and to share and celebrate the many talents of rural communities, she wrote.

Likewise, the diverse creative talents on display at the 2017 National Rural Health Conference in Cairns provided many memorable experiences for conference participants, as well as insights into related therapeutic benefits.
One conference highlight came courtesy of Professor Gracelyn Smallwood who, during a plenary session on cultural competence, ended her presentation with a rendition of “Crazy”, accompanied by Dr Mark Wenitong on guitar.

Below, Kristy McGregor, a young rural change maker who now works in New Zealand, shares some of her conference journey through the arts, as well as vignettes from the Channel Country Ladies’ Day, which she helped establish in 2012.

Other creative highlights from #ruralhealthconf are featured beneath her article.

Kristy McGregor writes:

Through the arts and health stream at the National Rural Health Conference, we were taken on a journey.

It was a journey into the lives of people in communities across rural and remote Australia, and a journey to understand the impact of the arts on health and wellbeing.

In Whyalla, South Australia, the power of stand up comedy is creating mental health awareness and reducing stigma. Stand Up for Mental Health was held in 2016, a program supported by a number of health organisations and featuring Canada based counselor and stand-up comic, David Granirer.

Seven comics from Whyalla, Port Augusta and Port Lincoln were trained over 12 weeks. The team on the Eyre Peninsula harnessed the use of digital technology to overcome isolation, with David skyping in before flying over for the final series of workshops and the ultimate conclusion – the performance, where the whole community was invited along.
For Granirer, comedy helps to build self esteem and reduce public stigma around mental illness: “Laughing in the face of pain makes people go from despair to hope, and hope is crucial to anyone struggling with a mental illness”. (Read more in the Whyalla News).

Power of song

At the conference in tropical north Queensland, we heard directly from a group of choir singers: “When you sing as a group, you start to feel you matter”. Another said: “Singing for me is like medicine, I use it everyday to shift moods”. Powerful stuff indeed.

**Arts Nexus** was established in 1996 and has been working with artists and communities, giving people a voice. Linking with local festivals and events scattered across north Queensland, local communities are supported to grow and thrive.

Down south, in Bundaberg, every weekend people gather in hotels and pubs around the region for the **Pub Rock Choir**. It’s a fun, social opportunity for people to come together and sing songs that they know and enjoy – and no formal training is necessary. It’s accessible, promotes wellbeing, and is just one of the experiences that Creative Regions has developed, in response to the needs of rural communities.

The team at **Creative Regions** works with government agencies and industry to understand the big issues affecting communities, and leads arts responses to those issues. And they are passionate about it – they live and breathe their community.

On a summer’s night in January, community members in Bundaberg gathered in front of a makeshift stage of scaffolding, to hear a piece of theatre that has been pulled together by the community over the past year.

**Elephant in the Room** is a play that highlights common troubles youth face, with challenges of anxiety, social media and relationships woven in. Teenagers, mental health workers, school chaplains, youth at risk and teenagers all helped to bring together the production.
In the Channel Country

And in the Channel Country, it’s the poetic words that speak as 200 women gather at the racetrack of remote Betoota (the smallest gazetted town in Australia).

“On a concrete floor/just before midnight/we dance”.

“Cars parked in the desert/ tents greet women/ secrets are shared”.

As reported for ABC Open, through poetry with artist Emilie Zoey Baker, the women ponder their experience of coming together in the outback for the Channel Country Ladies’ Day.

I was invited to attend the National Rural Conference in my capacity as co-founder of this event, which has become a staple on the western Queensland calendar.

It draws together women from across western Queensland, northern South Australia, and north-west New South Wales. Acknowledging the Indigenous people on the land where we gather, local female elders and female Aboriginal artists are celebrated through the arts program.

When we started Ladies Day in 2012, we thought it was a fun weekend in a tin shed – the hangar on a remote station. And that’s all it was – with a sex toy consultant, a tarot card reader, a visiting author, and a singer, we were all there to have some fun.

Fun we did but the weekend gave so much more. It touched the lives of the women who had travelled hundreds of kilometres to get there.

I recall a moment that weekend when a young woman came up and said to me that it had made her question what she was doing with her life. And it seemed then that this was more than just an opportunity to dress up; this was giving women a place to explore.

The event, now a “fixture on the outback calendar”, is valuable because it is the one opportunity that women in the remote corners of the three states have to make time for themselves. In dresses, heels and some still in their work boots, we all gather at the racetrack for a weekend for us.

Left at home are identities as mothers, wives, cooks, plumbers, teachers, cleaners, ringers, contractors; for one weekend women have the chance to tap into and rediscover what makes them them.

Pushed out of their comfort zone as they stand on stage to enact a newly prepared comedy routine, as they share a part of themselves with the actors who will play out their lives in playback theatre in the dry creek bed, or as their naked body is painted by the international body painter.
This is a chance for women to act as a quiet observer or active participant in new experiences that will challenge how they think about themselves.

Through participation in the performing arts, experiences are shared, stories are told and we all connect, young, old, mothers and daughters, neighbours and friends. At playback, two women shared how working in a dinosaur museum on the bones had got them through depression during the drought. Stories like this connect us all and are raw, honest and real.

Ladies Day doesn’t glorify life in the outback but it celebrates women and allows a place for expression.

I’ve witnessed some beautiful things at Ladies Day. One that sticks prominently in my mind is my friend Bernie cradling her baby on the dance floor at midnight.

As Bernie dances, her baby feeds. It’s a weekend for herself after weeks on end of being at home on the property on her own, with four children in tow, including one who she has been told has special needs, and running the property while teaching her small children.

She’s only afforded the opportunity because we line up to get her there and for her mother-in-law to mind the children. It takes some quiet words with her husband.

Addressing mental health

Another woman, a young mother, shared that it was the connections she had made at Ladies Day that had gotten her through depression, at a time when she was struggling.

The Channel Country Ladies Day doesn’t do mental health in a way that is explicit. But we offer opportunities for women to talk with mental health professionals in a quiet and confidential manner over the weekend, to be connected with follow up support from professionals, to be able to have an appointment with the female GP so that under the guise of constant headaches or aches and pains, social and emotional wellbeing can be raised. And for some, just being with other women is all that they need.

We weave women’s health into the program too – so that among silversmithing and circus, health professionals build rapport with local women, so they know who to call when they need to see a physio, or want some nutrition advice for their children.

The women’s health nurse attends each year to provide a valuable service – the dreaded Pap smear – so that there is no excuse even for women who live 450 kilometres from the nearest hospital.

As dreaded as is the thought of having a Pap smear in a grader drivers’ mobile camp (yes that’s right), when you’re called up a week later to say you’ve got precancerous cells of the cervix, and shipped off for tests and surgery – as I was after my Pap smear at Ladies Day – then you’re reminded of how important these services are. Suddenly the transformation of a grader camp into a consulting room seems so incredibly ingenious.

The Channel Country Ladies’ Day isn’t like any other event that I’ve heard of or come across. It’s not just women getting together just for a nice lunch, it’s not the same as the rural women’s gatherings that happen once a year in regional centres.
It’s about high quality arts and offerings in the desert. It’s about bringing all these things – guest speakers, beauty treatments, a live band, burlesque – whether by car or by charter flight, to women in the outback.

It’s bringing a catering team 1400 kilometres and with their canapés in tow because we want to provide women with gourmet menu that for the first time in a month they haven’t had to cook themselves. It’s created by women in the Channel Country for women in the Channel Country; and so all the finishing touches are there because we know what women are looking for.

When I see the smiles on women’s faces, when I hear the laughter, and when I feel the sense of togetherness that being together with 200 other women on the edge of the desert brings, I know this is a worthy, valuable thing.

Arts for health

With all this in mind, what did I take out of listening to the experiences and stories of arts projects happening across Australia at the National Rural Health Conference?

A total faith that community driven arts projects and events are absolutely necessary for our rural communities to thrive.

And a strong sense that anyone who can see opportunities for change has the ability to make that change. No matter what hat we wear, no matter what status we have, change comes with the tools you have, inspired by the best asset you have – local people.

One of the priority recommendations from the conference was that arts intrinsically improves health through connecting people, opening conversations and delivering physical and psychological benefits, and that a whole of community approach should be central to the strategy.
This isn’t just about creating a new role for an arts worker or artist within a health organisation, but means looking holistically at how arts and health can be interlinked – and how the arts can be used to understand, interpret and deliver critical health messages.

Since the conference, I’ve headed home to New Zealand with new ideas as to how we can link the arts and health in the Channel Country Ladies’ Day, so that link is as strong as ever, and the wellbeing and women’s health outcomes even more pronounced.

And I’m heading home to see how we can use the arts to address some of the issues facing the rural and remote communities with whom I’m working.

If we all could believe in the power we have to make a difference through the arts, then we’d make for a prouder, more colourful and vibrant rural Australia, where people feel connected and as though they belong.

Kristy McGregor is a young rural change maker, passionate about building vibrant rural communities through the arts and community driven events. Kristy spent a number of years living on a cattle station on the remote Queensland-SA border, and in other remote towns in western Queensland. It was in western Queensland that she was involved in co-ordinating a number of arts projects connecting local artists with women across the west, and established the Channel Country Ladies Day in 2012, a project she continues to be involved in and build.

Kristy works in local government and resource management policy, as a Regional Policy Advisor with Federated Farmers of New Zealand, an advocacy organisation for agriculture and rural communities. When not forging new contacts on either side of the Tasman, Kristy is studying for her Masters in AgriScience, with an interest in rural sociology and community development, at Massey University. Most recently, she has co-founded a festival to link community with their local food producers. Despite being based across the Tasman, she still remains closely involved with and committed to remote Australia.
Healing songs and more

Melissa Sweet writes:

“Music is a healer, a provider of hope, a means of expression, a mode of storytelling, a way to build bridges, a way to make and preserve memories, and so much more.”

So states the CD cover for “Songs of Murray Street”, which arose out of a healing project for the children and community around Murray Street in Cairns, following a tragedy that took eight children’s lives in 2014.

Conference participants were privileged to witness the children in action, together with artist Roz Pappalardo. Their songs were written and recorded at the Manoora Community Centre.
You can track Croakey's coverage of the conference here.

The National Rural Health Conference: a feast of song, dance and other creative experiences

#ruralhealthconf

Croakey
“Conference News Service”
The Soldiers Wife project also conveyed the power of songs to share stories and enable healing. The project’s songwriters talked to almost 100 women, aged from 25 to 104, to tell the stories of women whose partners had served in conflict over the past 60 years.

Listen below.
One personal favourite was a listening meditation courtesy of Natalia Mann and her harp, which provided a sensory feast as she played before a backdrop of a giant underwater scene. Bliss!

Sample some of the session below.
Conference participants also learnt about **Kid’s Thrive**, a Victorian arts and community development organisation committed to child-led social change. The organisation seeks to foster positive outcomes for children and their communities by developing innovative arts and social justice programs in collaboration with specialists in children’s education, health, welfare and cultural diversity.

Kid’s Thrive uses the arts to tackle issues that children experience arising from trauma, disadvantage and cultural conflict, and to expand children’s creativity, communication and social skills.

Warm thanks to Aunty Rhonda Brim and other cultural practitioners from Wuchopperen Health Service for sharing some of their knowledge around weaving as part of the conference.

It’s a privilege to hold knowledge that has been passed down for thousands of years, she says in the interview below. Weaving, an important cultural practice, is relaxing and good for wellbeing, she says.
I joined some other early risers for an enjoyable session of Dance Games with Owen Allen (photo courtesy of Leanne Coleman).

Allen is a physiotherapist who uses dance and physical theatre to encourage middle and older age people into movement (watch the interview below to find out more about his work).
Biddigal Performing Arts shared stories through dance and culture.

Cairns also provided many opportunities for enjoying public arts.

• For more photos and reports from the conference arts program, see our “Snaps and Selfies” post on page 12.

• Read more about the conference art’s program here.
Shouldn’t rural doctors be on the call sheet in serious local accidents & emergencies?

Improving outcomes from Rural Trauma

A proposed National Rural Emergency Responders Network

Victims of serious accidents and disasters in rural Australia may be missing out on critical immediate care because local doctors are being excluded from emergency responses.

The recent National Rural Health Conference in Cairns heard a call for the establishment of a national network of rural doctors with the appropriate skills and support to respond to emergencies.

Rural GP Dr John Hall, one of the doctors leading the call, said that local ambulance officers and other first responders are sometimes explicitly prohibited in state emergency protocols from informing local doctors.

Hall, who is vice president of the Rural Doctors Association of Australia, told of a personal example where a major road crash occurred just five minutes away, but his rooms only found out 40 minutes later via Facebook.

Melissa Sweet writes:

June 2017 marks the 10-year anniversary of an horrific train crash near Kerang in northern Victoria. Eleven people died and many more were injured when a truck crashed into a V-line passenger train at a level crossing.

For some rural doctors, the anniversary on 5 June will have a particular significance, as the Kerang crash has come to symbolise a flashpoint in their campaign for an overhaul of emergency responses in rural areas.
Dr John Hall, a rural GP from Oakey in Queensland and vice president of the Rural Doctors Association of Australia, says the Kerang disaster is one of the most high-profile examples of rural doctors being locked out of emergency responses in their areas.

But RDAA members have raised concerns about many other such cases where the exclusion of local clinicians could be compromising patient outcomes, he told Croakey during an interview at the recent National Rural Health Conference in Cairns.

“Over the years, many of our members with the RDAA have come to us with concerns about not being informed about major disasters happening on their doorstep and not being brought into the mix when the response is centrally coordinated by emergency services,” he said.

Together with Dr Tim Leeuwenburg, Hall has been advocating for a national rollout of a network of rural doctors with the skills to respond to serious emergencies.

In a study published in Emergency Medicine Australasia in 2015 (see abstract), the pair argued the case for the development of such a network to respond to emergencies requiring pre-hospital care, ranging from vehicle crashes to farming and mining accidents.

They cite evidence that road fatalities and other major traumas are disproportionately more common in rural areas, and that mortality rates from trauma in rural areas are reported to be four times those in major cities.

**South Australia’s scheme could show the way**

Hall and Leeuwenburg want to see a national roll out of a system used in South Australia, where rural doctors opt in to be part of such a network.

There, rural doctor members of the Rural Emergency Responder Network (RERN) scheme can be tasked to rural incidents via the South Australian Ambulance Emergency Operations Centre, and commit to maintaining relevant emergency skills via regular training focussed on the prehospital environment.

“It’s an opt-in system,” says Hall. “But it also comes with a lot of support; they get extra training in the prehospital space, they get to work alongside their emergency service colleagues with orientation and training.

“They get kitted up with the right gear, they get an emergency bag stocked and funded by the State Government, and they get given pagers so they are linked into the emergency response.

“This process gives emergency services confidence and certainty that the people they are calling to assist have the appropriate skills and equipment.”

By contrast, in his home state of Queensland, Hall knows what it is like to find out there has been a major local incident without being notified by emergency services.

He describes finding out there had been a major bus and car crash just five minutes away from his rooms. “We found out about it about 40 minutes after it happened via Facebook,” he said.
“At the time I was the doctor in charge of the hospital; there was no mechanism for the communications system to notify the hospital. We had three or four highly skilled doctors who would have been a massive value-add if we’d been notified earlier.”

Hall says the centralisation of emergency services has contributed to the exclusion of rural doctors, as local ambulance officers and other first responders are sometimes explicitly prohibited in state emergency protocols from informing local doctors of emergencies.

“Over time, rural GPs have just been marginalised in this space, probably inadvertently, not necessarily in a way that is intended, but it’s potentially leading to significantly bad outcomes for rural communities.”

Hall says this move may reflect the emergency services experiences with GPs who did not have the appropriate skills to contribute to prehospital care.

“We think it stems from bad experiences in metropolitan areas where a doctor has rocked up to a scene and not been helpful, so there’s been some form of conflict,” he says.

“You can understand why, if it’s an office-based GP who has never done critical care and doesn’t understand the context, it makes sense that they may potentially not be a value-add.

“Understandably, emergency services need to know that if they are relying on a health care professional that they are credentialed in that space.”

However, many rural GPs had done anaesthetic training and were skilled in complex airways management, he said, “and they would be a huge value-add in a lot of critical care and difficult situations”.

Hall said: “The truth is the retrieval services are calling rural doctors to the scene in an ad hoc way when the chopper or plane physically can’t get there.”

Ensure local GPS are equipped for major traumas and disasters

A recent joint position paper from RDAA and the Australian College of Rural and Remote Medicine called for a nationwide Rural Emergency Responders’ Network to be developed to identify rural doctors with advanced emergency response and retrieval skills, and to ensure they were appropriately equipped and supported to deal with major traumas and disasters.

The paper urged state-wide retrieval services and other organisations responsible for emergency response and disaster management planning to formally recognise local rural doctor and hospital facilities and staff as important and integral components of the pre-hospital and disaster response team.

However, the paper said most States did not have policies and clinical management frameworks formalising the role of the rural GP in the pre-hospital emergency or disaster response. In some cases, the protocols instigated by centralised State government retrieval agencies may not permit local doctors to respond to disasters in their own towns.

This created the potential for the rural GP to be bypassed in communication regarding local emergencies and the paper said:
“This lack of involvement in formal coordination and communication networks can cause significant delays and fails to make the most effective use of valuable local knowledge and resources.”

“In countries such as New Zealand, Scotland, the UK and Canada there are formal rural responder networks which incorporate the rural GP in their centralised emergency response protocols.

“It seems counter-intuitive that these countries, where rural areas are generally less isolated and have potentially faster turnaround times for city-based retrieval, respect and coordinate the role of local medical staff, yet this does not happen in Australia where there are vast distances, vagaries of weather and often significant delays in retrieval time.”

Need to address our ‘tyranny of distance’

Leeuwenburg, whose paper to the National Rural Health Conference was delivered by Hall, told Croakey that developing such a network was important as the tyranny of distance in Australia means specialist help may take hours to arrive.

“In rural areas the responders may be ambulance volunteers, therefore scope for appropriately trained rural docs to help fill the gap by delivering meaningful interventions – to value-add where there’s a patient need, not to detract or play in another’s sandpit,” he said.

“The fact that the UK and NZ have such a system, despite small geography and proximity of major hospitals, yet Australia does not, is puzzling and speaks more to politics and turf than delivering quality care.”

Despite the growing momentum for change from the rural medical lobby, Hall said it had been difficult to get widespread traction on the issue due to the number of state-based ambulance and other emergency services agencies involved.

The plan now was to first focus on getting action in Queensland, where there was some high level support among some of the emergency services for developing such a network.

“The tyranny of distance and retrieval time is so important in the bush because the average retrieval response time in rural Queensland is four hours,” he said.

“So that’s a massive gap of time where lives would be saved by having skilled doctors supporting their paramedic colleagues in the bush to keep people alive in that time frame.”

Croakey readers interested in finding out more can contact Hall and Leeuwenburg on Twitter:

@JHRural
@KangarooBeach
Watch this interview with Dr John Hall from the National Rural Health Conference.

Via Twitter

Shouldn’t rural doctors be on the call sheet in serious local accidents & emergencies?

#ruralhealthconf
Stories from Primary Health Networks – small fish in poorly mapped, choppy seas

Some of the big challenges facing the country’s 31 primary health networks (PHNs), established in July 2015 by the Coalition Government to replace the 61 Medicare Locals created under the previous Labor Government, were highlighted at the recent National Rural Health Conference in Cairns.

Adjunct Associate Professor Trent Twomey, who chairs the Northern Queensland Primary Health Network, gave a presentation exploring how wider governance structures impede action on the social determinants of health (SDOH).

While his analysis was focused on Queensland, it is likely to be relevant for many other places.

Meanwhile, Phil Edmonson, CEO of Primary Health Tasmania, shared some telling glimpses into the tensions that PHNs face as “little fish” doing big tasks – as commissioners of services and agents of disruption.

In the #LongRead below, Melissa Sweet reports and you can also watch interviews with both Twomey and Edmonson below.

Melissa Sweet writes:

Mapping some barriers to action on the SDOH

Insights into the immensity of the task facing the Northern Queensland Primary Health Network (NQPHN) can be found in its inaugural Health Needs Assessment, published almost a year ago.

This PHN covers a vast area – twice the land size of the United Kingdom – but is home to only 730,000 people, who are mostly in the regional centres of Cairns, Townsville and Mackay, although populations with the greatest need for health services are often in remote areas.
The needs analysis graphically illustrates the link between social and economic disadvantage and poor health outcomes, as well as the big health inequities evident within the PHN’s boundaries (see more details in the images at the end of this article). Areas with the worst health outcomes tend to have worse social and economic indicators and greatest difficulty accessing health services.

Just under 50 percent of the PHN’s population fall in the two most disadvantaged quintiles, while for the Torres Strait and Cape regions, 73 percent of the population are within the most disadvantaged quintile, as are one-third of people in the Cairns Hinterland region.

About 11 percent of the total Australian population of Indigenous people live within the NQPHN region, with Aboriginal and Torres Strait Islander people being the majority in 13 of the 31 local government areas falling within the PHN.

The needs analysis also reported that one in five people in the PHN said they waited longer than acceptable for an appointment with a GP in the last year, while more than one in four said they could not see their preferred GP at any time in the past year, and one in ten delayed or did not get prescription medicine in the past year due to cost.

The needs analysis also highlights an “overwhelming need” for more mental health services across the PHN, especially for the Torres Strait and Cape regions, where people “have no access to acute mental health beds and poor access to mental health professionals”.

The needs assessment makes it clear that efforts to improve health in northern Queensland must tackle the social determinants of health (SDOH), as well as ensuring better and more equitable access to more appropriate health services, especially in the community.

**Messy governance**

However, the PHN’s chair, Adjunct Associate Professor Trent Twomey, presented a series of maps at the National Rural Health Conference that powerfully illustrated a lack of convergence in governance between the various domains relevant to SDOH action.

These included non-aligned boundaries for the governance of education and training, police, local government and health services.

In addition to the many boundaries of federal and state agencies, he said there were 31 local government areas with 31 mayors. Addressing the SDOHs required the PHN to develop relationships with federal and state politicians as well as local governments and mayors.

He suggested the need for governance based on “communities of interest”, and said:

- **We think we are the most over-governed part of Australia.**
- **We have these multiple layers of governance that don’t align. In northern Queensland, we have an innate distrust for government. Brisbane is an awful long way away and Canberra is even further.**
- **How can we create a better system of local governance, not only in primary health care, but in those other areas that will address the social determinants of health?**
- **It is extremely difficult for regional Queenslanders to have control over their destiny if the boundaries of all the different state and federal agencies don’t line up.**
- **We have a plan to align all the boundaries. We want to have conversations about communities of interest.”**
This concept, which recognised the profound differences between communities, would help to advance changes in primary healthcare, preventative health and the social determinants of health, he said.

“There is no such thing as Northern Queensland,” he said. “We are a variety of smaller communities of interest.”

“If we want to have any meaningful results in closing the gap in Indigenous health, or improving the indicators in the generic health needs analysis, we need to have an underlying focus on addressing the social determinants of health.”

This meant reform of governance at all levels so that local communities felt empowered “to take control of our destinies in a planning process,” he said.

“The system of government, whether state or federal, is basically designed against us.”

Twomey called on the rural health sector to advocate for the Queensland Premier to address the governance structures of state departments to ensure that they enable empowerment for people in the regions.

“This needs to be something the Premier takes the leadership in, that Premier and Cabinet takes responsibility for,” he said.

“That way in Cairns we can have a conversation with the local director of education, the local director of the police service, the local director of the hospital and healthcare service, or the Department of (Transport and) Main Roads.”

This would contribute to a more streamlined system that empowered people in the region to take control of their destinies, and for local communities to be able to prioritise their needs and direct resources accordingly, he said.

Details from the PHN needs analysis
Illustrating diversity within the PHN...
You can track Croakey’s coverage of the conference here.

Illustrating inequities within the PHN and the State...

![Bar chart showing life expectancy at birth by area and gender](chart)

Concerns identified by the health workforce across the PHN...

**15.2 Workforce feedback on consumer needs**

- **Torres and Cape HHS**
  - Workforce feedback indicated need for transport and access for Northern Peninsula Area and Torres Strait.
  - Equitable access to fresh fruit and vegetables for rural, remote and metropolitan areas.

- **Cairns HHS**
  - Patient transport services raised as significant issue.
  - Identified need for direct referral of HHS patients (seeking outpatient specialists) to primary allied health professionals within the community.
  - More Indigenous Australian education for engaging patients in their own health management.
  - Increasing ED attendance raised as an issue that needs to be addressed.
  - Communication between HHS and primary health needs improvement.

- **Townsville HHS**
  - Transport was flagged as a huge issue for the region—for clients travelling from rural areas to regional centres for medical reasons, and also for clients travelling between rural areas (both for medical reasons and to visit family in care).
  - Family support and social determinants of health raised as important.
  - Service mapping raised as important for identifying health access.
  - Telehealth identified as important, especially for elderly and children in remote areas.
  - Lack of counselling and mental health services for men who are perpetrators of domestic violence.
  - The local nursing home has issues with attracting/recruiting staff, mainly registered nurses, and currently relies on employing overseas nurses (457 visa).
  - Equitable access to fresh fruit and vegetables for rural, remote and metropolitan areas.

- **Mackay HHS**
  - Patient transport services raised as significant issue.
  - Improve and increase mental health services to the area.
  - Very little acute care provision.

**Mapping governance**

Twomey presented a number of maps showing poor alignment in governance.

![Maps showing governance](maps)
You can track Croakey’s coverage of the conference here.

Stories from Primary Health Networks – small fish in poorly mapped, choppy seas

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

Stories from Primary Health Networks – small fish in poorly mapped, choppy seas

Mapping a vision for the future...

Future vision of governance in northern Australia

- Establishment of Healthy Communities strategy
- Creation of Health Action Coordinator positions
- To sit within Regional Organisation of Councils (ROCs)

The tweet, below, of Twomey’s presentation is from Dr Tim Kelly, a rural GP and immediate past Chair of the National Rural Health Alliance (while tweeting the conference for @WePublicHealth).

Vision of North QLD PHN - Empowerment. I’d like to see that! #ruralhealthconf

A vision for the greater good

- Our vision is for a society where people are empowered
- Without any new Government money

Watch an interview with Trent Twomey
Lessons from a small fish making waves

While PHNs are small fish in a huge ocean of health funding, they must be capable of creating seriously disruptive waves while also facing off dangerous sharks.

He didn’t quite use those exact words, but that is the image that sprang to mind when listening to Phil Edmondson, CEO of Primary Health Tasmania, describe the challenging roles of PHNs since they replaced and succeeded the former Labor Government’s Medicare Locals.

Edmondson who has worked in primary care organisations since the days of Divisions of General Practice, which came before Medicare Locals, sees PHNs as the third and most advanced iteration of organised primary care in Australia.

However, his experience – of coming under public fire from journalists, politicians and others – is a reminder of the complex environment in which these organisations work.

Next to the “behemoth” of the wider Australian healthcare system, PHNs are “little fish” that must create change through partnership, leverage and influence, he said.

“We don’t have the capacity to actually buy change in the same way that major government can when they make large scale investment,” Edmondson said.

Nonetheless, the PHNs’ role as commissioners of mental health and other specific services provided an opportunity for disruption, so that services better meet the needs of communities.

However, this inevitably created angst. Edmondson said:

- **We've had a very provider- and a funding-centric thinking to our system for a long period of time.**

- **This is about trying to get that shift so that we get a partnership between providers and patients in ensuring that the right services get to the right people and they get the right outcomes for those people.**

- **That's ultimately what our disruptive role is; it's asking those questions and it's being prepared to make some of the tough decisions about where the best bang for the buck can be achieved and where the needs are most demanding of the limited resources that we have.”**

This approach has resulted in some uncomfortable moments for Edmondson and his organisation, including public attacks, as the tough questions they are raising “immediately sends shivers of concern through the funded sector”.

“Things don’t always go to plan,” he told the conference. “Unfortunately squeaky wheels and the media have a very unpleasant cohabitation habit.”

Edmondson said such experiences had reinforced the need to take multiple stakeholders, including communities and providers, on the journey of primary health reform, by clearly articulating the need for change and ensuring there was proper time and process to enable that.

In commissioning relationships, PHNs are much more closely involved in working with providers to ensure that services are flexible and responsive to community’s changing needs, he said, rather than the “old style, set-and-forget contracting where resources are handed out under a contract and you report back every 12 months”.

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Stories from Primary Health Networks – small fish in poorly mapped, choppy seas

#ruralhealthconf
Edmondson said the Aboriginal community controlled sector was at the forefront of responding to the social determinants of health. “We have much to learn from the way in which they approach delivery of services to their communities,” he said.

While there was growing acknowledgement at all levels of the health system about the importance of addressing the social determinants of health, there was much more work needed in this area, he added.
What are the identified priorities for rural health? (And what’s missing?)

This is the final instalment of Croakey Conference News Service coverage of the National Rural Health Conference in Cairns.

It is in three parts:

• a reflection by Melissa Sweet on the strengths and limitations of the rural and remote health sector;

• an overview of key conference themes by David Butt, CEO of the National Rural Health Alliance;

• and a Twitter-wrap of some #ruralhealthconf discussions not previously covered by Croakey.

Lift your gaze

Melissa Sweet writes:

At the recent National Rural Health Conference in Cairns, the collective strength of the rural and remote health sector was evident.

As one speaker privately observed, it would be rare to find anyone talking about “New South Wales health” or “urban health” with the passion that unites people around rural and remote health.

No doubt this reflects the solidarity of those who share a sense of grievance that rural and remote health fares poorly, in access to both the social determinants of health and to services. It probably also reflects the belief that there is something special about rural and remote communities, notwithstanding their immense diversity.
However, perhaps there also are some drawbacks to this sense of exceptionalism. The rural and remote health sector often looks to what distinguishes it from the wider health sector and broader public debates, rather than emphasising the commonalities of the issues affecting everyone’s health.

The impacts of social and economic inequality on health are not only a concern for rural and remote communities. A failure to link concerns about rural health inequalities into wider national and global debates about inequality is a missed opportunity, both for raising awareness about the issues at play, as well as for identifying potential solutions.

It seems unlikely that we could ever end rural health inequities without addressing wider social, economic and health inequities. People living in rural, remote and regional areas are affected by wider policies that entrench poverty and punitive approaches for people already doing it tough (such as plans for drug testing of Centrelink recipients), as well as more general determinants of health such as structural racism.

A report published last year found that 55 per cent of Newstart recipients and almost one-in-five of all children under the age of 15 are living below the poverty line.

Another report, published last year by KPMG, recommended increasing Newstart payments, and cited the Business Council of Australia stating that the inadequacy of Newstart was “a barrier to employment” that “risks entrenching poverty”. It also cited OECD concerns about the inadequacy of Newstart.

Clearly, rural and remote communities have much to gain (including better health and wellbeing) if the influential rural health lobby could find its way to join up with wider advocacy campaigns addressing poverty and inequitable policies across the board.

Poverty is directly mentioned in only one of more than 120 recommendations from conference participants in the Sharing Shed’s online forum although, as the tweets below show, it did feature in at least some conference discussions.

However, the social and economic inequalities that underpin poorer rural and remote health outcomes are not explicitly mentioned among the key themes to have emerged from the conference (as outlined below).

### Key Themes

1. National Rural Health Strategy
2. Aboriginal and Torres Strait Islander Health & Wellbeing
3. Healthy Start in Life
4. Digital Health and High Speed Broadband
5. Arts in health
6. Research and Evidence Based Practice
7. Health workforce
Glaring omissions

Climate change is another obvious gap in these key themes, although conference participants put forward three related recommendations.

Perhaps the omission is not surprising given that climate change was not a high-profile topic throughout the conference.

But it is surprising given that the impacts of climate change on rural and remote health and wellbeing are already very evident to many, and are only going to increase.

It was also surprising to discover (thanks to a Sharing Shed recommendation) that the National Rural Health Alliance does not have a formal position paper on climate change and rural health. In response to Croakey’s queries, however, the Alliance did provide this statement:

The National Rural Health Alliance acknowledges that climate change poses a growing risk to the health and wellbeing of people living in regional, rural and remote communities, through more frequent severe weather events, longer droughts and changes in rainfall patterns. This will impact upon the health and economic and social welfare of individuals and communities.”

Perhaps the next National Rural Health Conference, in Hobart in 2019, will incorporate a meaningful focus on climate change – not least because we will soon have our first Framework for a National Strategy on Climate, Health and Well-being, thanks to work led by the Climate and Health Alliance.

This document is scheduled for launch at Parliament House in Canberra next month. Significantly, the launch is to be co-sponsored by Minister for Aged Care and Minister for Indigenous Health Ken Wyatt, Shadow Minister for Health and Medicare Catherine King, and Leader of the Australian Greens Senator Richard Di Natale.

Given that King committed at the Cairns conference to supporting a National Rural Health Strategy, it seems likely that this topic will also feature prominently at the 15th National Rural Health Conference.

Hopefully this next conference will continue to ensure strong representation from Aboriginal and Torres Strait Islander health experts and community members, a noted feature of the Cairns program, as suggested by the tweet below, commenting on the presentation by Janine Mohamed, CEO of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).
Conference reflections

David Butt writes:

Four days of frenetic activity. That is probably the best way to describe the 14th National Rural Health Conference. Every two years, the National Rural Health Alliance gathers together the most influential people in rural health in Australia and Internationally and from the broader social and human services sector to discuss rural health and wellbeing in Australia.

The result is a Conference that is at times insightful and at times confronting with moments of inspiration and exhilaration.

The role of the Arts in promoting and inspiring better health is an intrinsic component of the Conference and at the end, Conference recommendations were handed to the Assistant Minister for Health, the Hon Dr David Gillespie MP.

This year, the keynote speeches that were central in setting the themes that emerged from the conference were those by:

• Sister Anne Gardiner, the 2017 Senior Australian of the Year who asked us all to stop trying to close gaps and instead build bridges; and

• Professor Jonathan Sher, who advised that it is better to stop gaps from opening up through delivering primary preventive care, commencing with preconception.

The need for a new National Rural Health Strategy and Plan was a strong message from the Conference. The last iteration of a National Rural Health Plan was developed in 2011 but is now no longer in use. Conference called for a new national rural health strategy and long term funding for an associated national implementation plan.
Professor Jonathan Sher’s call (as reported previously at Croakey) to address primary prevention, commencing at preconception, was also a central pillar of the conference discussions.

Delegates believed this issue should be taken up through COAG, which should be tasked with developing and implementing a manifesto for childhood development across all levels of government.

The manifesto should:

• recognise the moral, social, scientific and economic case for the importance of building strong families and acknowledge the 1001 critical days from when a baby is conceived until age two

• recognise this period of life is crucial to increase children’s life chances and that it is essential to ensure all babies have the best possible start to life, and

• target those most in need and most at risk, with a particular focus on those who are disadvantaged in rural and remote Australia, and among Aboriginal and Torres Strait Islander peoples.

Supporting a broadened focus on primary prevention could be through a fund established to support pre-conception health at academic, clinical and community levels through a national grants program.

Broadband access: an ongoing concern

One of the continuing issues in rural and remote communities that impacts health and all sectors is the need for reliable, stable access to high-speed broadband. This is vital to health to support the use of telehealth in rural and remote Australia and has been a theme of past Conferences.
Despite progress with the NBN roll-out, many rural and remote communities still do not have access to broadband sufficient to support telehealth – particularly those communities only able to access satellite broadband. The Conference sought the introduction of minimum service obligations legislation, to ensure universal access to high-speed broadband in rural and remote, as a fundamental enabler of health, education and business.

The Arts and health movement has been a long-term collaborator with National Rural Health Conferences and the benefits of the arts in improving health are largely untapped. The Conference sought to develop the Arts in Health sector to improve health through connecting people, opening conversations and delivering physical and psychological benefits.

Research and research translation is at the centre of innovation and service development in rural and remote Australia. The Conference is a showcase for developments to support rural and remote Australia and the work undertaken through the research facilities dedicated to rural health.

Among the research needs identified by the Conference, it was noted that a national Rural Health Excellence Network modelled on Creative Commons is necessary for the dissemination and application of examples of effective practice, quality research and timely data to inform service planning, policy development and further research.

The Multi-Purpose Service (MPS) program was developed in Australia to provide a flexible service model that was well adapted to deliver culturally appropriate health and aged care services in small rural and remote communities.

Conference delegates suggested this model should be expanded to include social support, disability and education services (including VET and University training), so they are responsive to local community needs, have strengthened viability and support local employment.

**Anticipated appointment**

The appointment of the first National Rural Health Commissioner later in 2017 is being anticipated by the rural health sector. The Conference strongly supports the Rural Generalist Pathway, the Commissioner’s first major activity, being broadened to embrace the full rural and remote health professional workforce (including allied health professionals).

However, it was strongly recognised that the Rural Health Commissioner would not and could not be the single solution to the challenges of rural and remote health and wellbeing.

In particular, it was important that the Australian Government did not abrogate all policy and implementation issues to this single position. Rather, the Government must continue to be accountable and responsible for a long-term reform agenda, which works to bridge the divide in health outcomes between rural and remote communities on the one hand, and metropolitan communities on the other hand.

In contrast, the Commissioner should be focussed on a few key priorities and should work to make sure those priorities are done well, in consultation with rural and remote stakeholders.

The Alliance will be working with its Council to determine which of the recommendations it will be including in its work program for the next two years and will be disseminating all the recommendations of the Conference widely, encouraging other health organisations to take up the challenges identified through the Conference.
Wrapping the #RuralHealthConf: Geri Malone and David Butt

Final selection of tweets

Further details about the presentations referenced in the tweets below can be found in the conference program.
What are the identified priorities for rural health? (And what’s missing?)

#ruralhealthconf
What are the identified priorities for rural health? (And what's missing?)

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

Read more about this work with the CWAA and FARE here.

Professor Sabina Knight (above) was commenting on a presentation on primary healthcare reform by the University of Queensland’s Professor Claire Jackson.

#CWAA calls for mandatory regulation rather than self regulation of #alcohol advertising #boozefreesport #ruralhealthconf

Opportunities for practices - a really useful guide & validated tool
#ruralhealthconf pic.twitter.com/ab36Kwpqvs

Anthea Gellie @AntheaGellie · Apr 28
#ruralhealthconf Lesley Williams suggests developing a resource like communitycommons.org (from the US) to help drive rural health improv
Indigenous health

A strong theme from many sessions was the “cultural incompetence” of many health services and professionals, and the harms this causes.
Dr Megan Williams presented on #JustJustice (Watch a recording of her presentation).

What are the identified priorities for rural health? (And what’s missing?)

Dr Megan Williams presented on #JustJustice (Watch a recording of her presentation).

Recommendations for justice given it is a key determinant of health #ruralhealthconf @croakeyblog #SDoH

14th NRHC Recommendation 720

That the Commonwealth Government add a justice target to Closing the Gap

Recommendation Type:
Delegate Recommendation

Emerging Theme:
Aboriginal and Torres Strait Islander health
You can track Croakey's coverage of the conference [here](#).

What are the identified priorities for rural health? (And what’s missing?)

Dr Mark Wenitong presents…

Suzanne Greenwood @Healthier_Aust · Apr 27
Never enough resources in the system for rural & remote says @WWeno7
@Apunipima @chaaustralia #ruralhealthconf

Suzanne Greenwood @Healthier_Aust · Apr 27
Agedcare has been underdone in Indigenous communities for long time
@WWeno7 @Apunipima @chaaustralia #ruralhealthconf

Emily Fitzpatrick @Emily_Fitzp · Apr 30
#ruralhealthconf presenting research results together representing remote
Aboriginal Communities of the Fitzroy Valley, the Kimberley, WA.

Yarning circles as a community response to ice (crystalline methamphetamine):
Stephanie King

Sabina Knight @nwgrn · Apr 27
Building confidence and experience of youth in Mount Isa @stephjessking
inspiring work #ruralhealthconf
What are the identified priorities for rural health? (And what's missing?)

### What is a Yarning Circle?

- The Yarning Circle® is a place where stories and knowledge can be shared in a caring environment that’s relaxed and comfortable.
- A place where people can participate to our own level, in our own time and by sharing their own unique journey.
- The Concept came about by Yarning Circle® Creator, Lee Townsend, is an Aboriginal woman born and raised in Blacktown, NSW.

### The power of yarning circles in tackling hard issues, developing knowledge and skills

@stephjessking @MICRRH @jcu
#ruralhealthconf

### Our Recommendations

- Youth Specific Yarning Circles
- Research Project
- Improved access (opening hours, programs and a possible healing centre in Mt Isa)
- Support for local organisations
What are the identified priorities for rural health? (And what’s missing?)

Advocacy
- Queensland Aboriginal and Torres Strait Islander ICE Round Table - Brisbane 2015
- Input into Strategic Plans Qld Mental Health and wellbeing plan
- Qld Health, My Health, Queensland future: Advancing health 2026

Results
- Feedback was used to inform local approaches in addressing government priorities and this evidence now forms a starting point for future research projects.
- The group has delivered a number of community mobilisation projects to build the strength of young people and all members in an effort to decrease the risks associated with drugs and alcohol.

Other sessions

Jenni Campbell @jennicampbell9 · Apr 27
Yarning circles informing priorities and funding investment in #MountIsa
#ruralhealthconf @IndigenousX

nicolebloomfield @nbloomfield2011 · Apr 28
#ruralhealthconf Russell Simpson

WA Country Health Service
“Your Footsteps, Our Future”
Aboriginal Mentorship Program
Mr Russell Simpson, Area Director, Aboriginal Health Strategy
What are the identified priorities for rural health? (And what’s missing?)

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

What are the identified priorities for rural health? (And what’s missing?)

Read more about the Food Ladder program here (using “the most effective technologies to feed the most disadvantaged communities in a global social enterprise movement”.)
What are the identified priorities for rural health? (And what’s missing?)

Digital health discussions were prominent

Melissa Vernon encouraging patient to tell their story, as a way of giving feedback, quick response provided. Good idea. #ruralhealthconf

The virtual consumer voice:
Connecting with country consumers online to improve services.
Ms Melissa Vernon, Chief Operating Officer Strategy & Reform
Ms Meredith Waters, WACHS Board Consumer Member
WA Country Health Service

Prof Branko Celler CSIRO Telehealth trial ROI $5 - and they hardly used
Telehealth. #ruralhealthconf

Summary of Results of Telehealth Trial
- Rate of expenditure on medical services fell by 46%
  - Savings over the first year was 26%
- Rate of unscheduled admissions to hospital fell by 53.2%
  - Reduced number of admissions over one year 24-50%
- Rate of length of stay fell by 70-76%
  - Reduced length of stay over first year 34-42% (7-3-9 days)
- Mortality was reduced by 45-48%
- > 83% user acceptance and use of telemonitoring technology
- > 89% of clinicians would recommend telemonitoring services to other patients
What are the identified priorities for rural health? (And what’s missing?)
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#ruralhealthconf
What are the identified priorities for rural health? (And what's missing?)

#ruralhealthconf

Croakey
"Conference News Service"

Next stop, Hobart
Analytics

Conference participants were fantastically engaged in sharing the #ruralhealthconf news – read 30 pages of Twitter transcript.

On Twitter, there were 45 million impressions and more than 1,500 participants.

The #ruralhealthconf influencers

The Numbers

44.977M impressions
10,889 Retweets
1,518 Likes
13 Avg Tweets/Minute

The #ruralhealthconf Participants

Croakey Conference News Service

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- Layout and design by Mitchell Ward