



**FACILITATOR:** Ladies and gentlemen, a round of applause for yourselves, I should have said. It gives me enormous pleasure now to introduce our first speaker for the morning. We're looking at Lessons from the Past. And so I'd like to welcome, to kick off our theme, Steve Clark. Steve is chief operating officer and secretary of council for the Queensland Institute of Medical Research, a former chair of the alliance, a former CEO of the Australian Divisions of General Practice, and a former executive director of the Australian Rural Leadership Foundation. He's going to talk about your obligations, and he has a challenge for you, and particularly moving you towards thinking about the recommendation process of the conference, which is what we'll be talking about this morning.

Please welcome Steve Clark.

## **New agendas and old: an appraisal of previous conference themes and recommendations**

[Steve Clark](#), CEO, Queensland Institute of Medical Research

Thanks very much, Julie.

It's wonderful to be here in Albury. I know that the conference organising committee over the years has had a bit of a challenge about where to hold these conferences. Do you go to the capital cities and engage urban people in the rural debate, or do you bring the conference to places like Albury and put some money into the regional economy? And I need to congratulate the organising committee for bringing us here. This is a magic place and you've done a great job. Thank you.

Ten years ago I wrote a paper Angelita Martini about synthesising the outcomes of four National Rural Health conferences from '91 to '97, and in those days we rewrote all of the recommendations that you'd made over those four conferences. We had to rewrite them because some of them were gobbledygook and some of them didn't make any sense. And I'll tell you more about that later. But we rewrote them into action statements. And I haven't done that this time because I was given another mandate.

Let me just start though to reflect on why you're here. This is the seventeenth year of this conference – nine conferences over 17 years. The alliance doesn't sit on their hands between conferences. As Don said, they develop policy, they put things to government, they're busy all of the time. I'd like to recognise as well that it's not just a conference about health managers or rural doctors. I think you've heard that before. It's not allied health professionals, Indigenous health workers or consumers or community participants. It's all of those people together. This is the only place and the only time in Australia where all of you can get together and sit down and think about the challenges and the solutions. And those solutions I think are really important.

Who in this audience has been to all eight conferences? Stand up. Sabina. John. Look, I need to say congratulations about that. That's fantastic. And it's really good that we've got a young audience here. We're now seeing generational change and I hope that many of you will be here for the next eight conferences.

This was my aim, to collate the major themes of the conferences across all of the eight of them so far; and secondly, to assess the impact of the conference recommendations on government policy. Now, I've done that by looking at all of the budget papers that have been produced over the last 10 years. I haven't gone back further than 10 years. And I've tried to pull out from those budget papers what things you have asked for; what things have you talked about at the various conferences; and what things has the government delivered, based on the sorts of things that you've discussed?

Now, to be honest, not all the things that the alliance discusses have got onto the agenda. The alliance is made up of a lot of member bodies, and sometimes those member bodies go out and lobby and they get some success from their lobbying. But they're still members of the alliance at the end of the day.

So let's have a think about, if you think about all the last eight conferences, there are only two topics that have been discussed across the last 17 years. The first one of those you could guess really easily. The second one probably you wouldn't think about. That's what they were. The only two things you've discussed for 17 years have been Aboriginal health policy and the need for strategic reform – you're self-destructing there, Gordon – and the need for health and medical research and funding for medical research. So those two things have come across for that period of time.

If you look at seven conferences, aged care has been mentioned across seven conferences. Let's go to six. You start to talk about workforce.

**FACILITATOR:** Is it better if Steve uses the hand-held or go back to the lectern? Can I suggest turning off the lectern and I'll just give him a hand-held. Is that okay with you?

**STEVE CLARK:** Yes. Can you hear me okay? All right, six conferences. You've talked about workforce, education, recruitment and retention, health services, especially the access and availability of those services and health financing. I didn't go beyond five conferences, but that's more than the average, still topics about workforce, the need for training, communications technology in rural and regional Australia. Undergraduate and postgraduate issues are really high on the agenda. Community controlled services and local management. Community participation – actual communities getting involved in health decisions. And service delivery, transport issues, have been mentioned across five conferences, which, when you think about it, represents 10 years of thinking around the health conferences that we've had.

In 1999 the health ministers signed off Healthy Horizons. And if you look at Healthy Horizons, that's been going four years. There's only one topic that's been discussed across all of those Health Horizons areas, and that's again to improve the health of Aboriginal and Torres Strait Islander peoples. Three conferences, this Health Horizons has been going, to maintain a skilled and responsive health workforce; and again across three conferences to develop needs-based flexible funding arrangements. So those topics you can see have just come up over and over and over again.

Let's now have a look at what the budget papers have said over the last 10 years. So we'll start with 1996-97. It was then called the Department of Health and Family Services. Aboriginal health got \$24 million over four years for new primary health care services. If you look at rural health, they provided \$20 million for postgraduate and undergraduate support; 27 million over four years for six university Departments of Rural Health. The first two were established at Mt Isa and Broken Hill. They offered a million dollars for locum services for doctors. The conference also said nurses need locum services, and they weren't delivered through that budget. Four million dollars for John Flynn; a million dollars for nurse practitioners to gain access to training and support.

They also mentioned that they would maintain existing programs, for example, the Rural Incentive Program, Health Jobs Australia, Advanced Specialist Training Posts, RESET and the Royal Flying Doctor Service all got mentioned to do with that budget. In terms of health and medical research, public health research increased to 3.6 over three years. Aged care got a major hit with \$60 million for new and continuing respite care.

Throughout the budget, in August '96 and '97 there was a \$3 billion cut in health expenditure. But even though that happened, \$150 million extra was provided for rural health. Now, you have to ask yourself about that. They cut \$3 billion off the health budget, but I think because of all the things that you've been saying, 150 million extra gets put onto rural health.

We go to the next budget – '97-'98 Health and Family Services – that's still what the department is called. This is really intriguing to me. The health workforce crisis was identified and acknowledged. I've never before and never since seen in a budget paper a Commonwealth government come out and say things like this: there are problems of access to continuing health professional education and therefore professional isolation for people working in rural and regional areas. They've never said that again, but they said that in public in the budget papers. There are poor rates of remuneration. There are limited opportunities for work and training in public hospitals and other rural and remote settings. And there are inappropriate perceptions of family life and lifestyle in the bush. I think that's amazing



the Commonwealth government comes out and says that, recognising those problems. And they did it because you told them.

There was a real need for \$17.4 million over four years to target major rural and remote health priority areas. That was considerable structural and strategic reform. And the papers said they want to enable a greater capacity to identify rural and remote health needs and to develop innovative models of health service delivery. You asked for that in '97. You said we need to think about models of service delivery.

They also said we need to establish a more strategic approach to setting and driving a national rural and remote health research agenda. Well, you've asked for that across all the conferences. And they said again, we need to extend specialist medical training.

We've done that across five conferences: they provided \$5 million for a pilot study on obstetric services in rural areas; they offered continued support for things like shortage of doctors, \$20 million; two more university departments of rural health; specialist locums, not nurse locums, which you asked for in that previous conference – they weren't delivered; a million for nurse practitioners; John Flynn Scholarship Scheme kept going; the General Practice Rural Incentive Program kept going; Health Jobs Australia; Advanced Specialist Training Posts; RESET; and RFDS keep going.

Health and Medical Research went to \$165 – I'm going ahead of myself now – and there was a real focus on collaboration. The government said in the papers – we want to work with the profession and consult in order to form our policies. They've never said that again. They did have an emphasis on doctors at that time, but even so, I think we need the budget papers to say they need to listen to you, this is the audience, the alliance, this is the audience that needs to be consulted.

In that same budget, '97-'98, Aboriginal and Torres Strait Islander Health received funding for community controlled health services. In '97 the health framework agreements were signed. The conference said Tasmania and the Northern Territory needed to be included. Subsequent to that conference I believe they were included.

In '98-'99 the Department of Health and Family Services provided money for national injury prevention. Indigenous Australians received 22.6 over four years, focusing on immunisation and STDs, and there was 72 mil for primary health care services. There was 12.4 for a public health evidence base in terms of research. Health and medical research is up to \$165 million over four years, and there's \$13 million extra for rural workforce agencies. In fact they've brought them to \$65 million over four years.

You asked in '99 for multi-disciplinary rural workforce agencies, and I don't think that they've been delivered to date. We still have a focus on DOCS. In '99-2000 the Department of Health and Aged Care came into existence. They brought in place retention payments for rural doctors, 30 new rural health service centres, or MPSs – you asked for those; an upgrade for the Bush Crisis Line; training for remote nurses. The rural health budget was now \$200 million, up from 70, but still the things that you asked for still hadn't been delivered – allied health professionals still hadn't received any funding, dental health was still missing, pharmacists were missing, and health managers were still missing.

So in 2000-2001 the Department of Health and Aged Care, Michael Wooldridge delivers the largest ever country health budget. That was the phrase in the budget papers – \$562 million in three sections. He called it more health professionals, and yet most of the papers refer to more doctors, better services. It was interesting terminology. For the first time ever, the Commonwealth government put money into allied health and the mask of more allied health services was born.

I think this was a really major shift in government policy. Although allied health professionals weren't given direct access to the MBS, that's what some health professional groups were asking, they still got \$49.5 million that had never been delivered before for allied health professionals.

Training and education goes to \$162 million, nine new clinical schools, three new departments of rural health, with an expectation now, delivered from you, that those university departments of rural health are not just about doctors, they're about multi-disciplinary workforce and issues in rural and regional Australia. I think that's been delivered. More health services – receives 185. This is the first time

pharmacies get onto the mat. Assistance for pharmacies to start up or to relocate. Chronic disease was supported. There was a big hit for aged care, and \$30 million to revitalise bush nursing.

In 2001–02 the Department of Health and Aged Care had a focus on diseases. This came from Health Horizons, the first tenet of which is to treat the worst diseases first. So, asthma, cervical cancer and diabetes got a hit in that budget. This was the launch of the National Depression Initiative. It was about practice nurses working in general practice. Rural nursing scholarships. Most of the press at that time said rural nursing scholarships are great, they're very welcome, but they're not enough. There was \$40 million to improve Indigenous access to primary health care services – and that's obviously a type – there was money for Health Connect. There was also money in that budget for mental health.

In 2002–03 in the Department of Health and Aged Care, this was the continuation budget. Savings of \$1.9 billion on the PBS and a major aged care focus. I found around this time a really interesting question that came from the alliance, and it was this: given all the funding that's gone on in the past, this question was raised – “Does funding clinical schools, university departments of rural health and regional health services help the desirable move to collaborative primary health care teams?” An interesting question to be debated.

I think it's the wrong question. The real question perhaps is: will primary health care teams deliver better health outcomes for rural people? I think we think we know the answer for that. It makes logical sense, but there's no empirical evidence I believe to show that that's the case. And that's what we need.

In 2003–04 health and aged care, a major focus on prevention and Health Disconnect gets another \$5 million.

Two thousand and four/five – yes, I'm giving them a kick, they deserve it – Minister Abbott's first budget. He gave Aged Care \$6 billion in additional money for viability for rural homes. Medical research went up to \$200 million, and the National Institute of Clinical Studies got formed with 22.7. For the first time there's now an MBS item for allied health professional services going through general practice and an MBS item for dentists. I'll tell you over a beer one day how that happened. There's \$9.7 million for consumer and community involvement in influencing health decisions, which was a major initiative I think at that time.

Two thousand and five/six it was still the Department of Health and Aged care. There's a major focus again on disease through Healthy Horizons. Pap smears could be delivered by practice nurses for the first time. A hundred and twenty-nine dollars for more practice nurses; 20.6 for rural and remote nurse training support; 17.2 for rural and remote health workers' education and training; and 160 mil for Aboriginal and Torres Strait Islander health over a range of initiatives. This was also the time I believe when allied health professional scholarships were delivered through the budget.

Two thousand and six/seven, the last one. We get \$905 million now for medical research. We get programs to align services for communities less than 7000 population, 400 new medical school places, 1000 nursing places, 840 Aboriginal health worker training places, and 25 Puggy Hunter Memorial Scholarships delivered I think for the first time.

So with all of that the key message is about your obligation. I really believe that you're here, you care about rural health. And if you care about rural health, then you've got to get involved in the recommendation process. I really believe that's your obligation while you're here, and you're failing if you don't. That doesn't mean get involved in the recommendation process and write waffle that the organising committee can't deal with. And we've had that in the past. We have to be honest. You need to write some really smart recommendations – “smart” meaning specific and measurable, containing actions with some revenue and timely. So, think about smart recommendations. Get with people and talk. Talk in your groups and deliver some solutions for rural health, because that's why we're here, not just to talk about challenges, but how can we go forward into the future.

This has been a magic past. You have to say the alliance has delivered and the government has listened. They're going to listen some more, as long as you're smart about delivering those things that you can do.



Thank you.

**FACILITATOR:** Can you stay there for questions, please.

Ladies and gentlemen, thank you very much to Steve. We've got five minutes for questions, so don't hesitate. My beautiful assistant, Cherie, a trainee nurse already with a qualification – a round of applause for nurses please – is empowering upstairs. Does anyone have a question or a very brief comment to kick off? Can you rush towards me, sir, and if you'd just say your name and who you are?

**PETER McNEILL:** Peter McNeill from Wagga Wagga. Hello, Steve.

**STEVE CLARK:** G'day, Peter. How are you?

**PETER McNEILL:** You've come a long way, mate.

**STEVE CLARK:** Just before we go on – where was he before? Like, where's he come from?

**PETER McNEILL:** Well, I first met him in Cairns and he took me sailing in his cat, and I was out on the trapeze, you know, almost drowning. Thanks, Steve.

If I could cut to my question. I'll try to make it brief. I have to be out of here tomorrow morning. But can I suggest that a big issue is providing in-service training for those doctors who are in remote situations, and not only the doctors, but the allied work people because – and nurses of course.

**FACILITATOR:** I might leave it there if I may. So, a very direct request for more in-service training in remote communities. Thank you. And I guess that's something that goes to the recommendation process.

Would you like to comment, Steve?

**STEVE CLARK:** Look, I think that's important. It's been mentioned before, and certainly it needs to be included.

**FACILITATOR:** And it was something the students were crying out for already, more support in their training placements yesterday.

Anyone upstairs? Yes. Do you want to go up there, Cherie, running in a fit, nurse sort of a way. Anyone downstairs before Cherie gets to them? While she just gets to them, I'll ask a quick one. Tell us now how the new item for dentistry came under the MBS, because I'm very keen on knowing why the mouth was never included in Medicare. But perhaps ..... could help with that. But tell us about the new MBS item and its significance?

**STEVE CLARK:** I think at that time I think the alliance had talked about it for a long time. There was a Medicines Australia conference delivered in Canberra. One of my ex-staff was working at the conference and I asked that the chair sit on the PM's table. He sat next to the PM for about three hours and hammered dentistry, and the next day Abbott announced it.

**FACILITATOR:** Individual advocacy, ladies and gentlemen.

If I could just say very quickly: once I was involved in a long series of consultations with rural people in remote New South Wales. The two key health issues that came up at every session was transport to get to health practitioners and dentistry. It just came up again and again.

Up there, please, Cherie.

**STUART HART:** Hello. My name is Stuart Hart. I'm from the Longreach RFDS base in Queensland, and it really is – I work out with rural and remote area people on properties who experience drought and a whole range of other factors that have an impact on health, but the burning question I often come across is when do health practitioners – be they doctors, nurses, allied health and so forth – when do we start working with the broader determinants of health prevention and recovery and so forth and

start associating and working with town planners, recreational services and a whole range of other people who contribute to the overall wellbeing of people?

**FACILITATOR:** Again, Cherie, thanks. If you could move away there now.

Can I just say, this is in a way, Steve, isn't it, going to the sort of recommendations people should be getting specific about in their groups.

**STEVE CLARK:** Yes, absolutely. Look, those things have been mentioned in the past and I guess need to be mentioned in the future. They haven't been delivered. There hasn't been any money put in to those sorts of initiatives, but they're very important. Of course there's lots of things that are happening on the ground where people are doing that on their own accord, without any funding. And I think we need to recognise that. People out there are doing fantastic things and making a big difference in those local areas. But still it needs to be recognised through the formal process, and that hasn't been done to date.

**FACILITATOR:** And the recommendation process is described on page 32 and 33 of your handbooks.

Cherie, if you could go to that person over there and I'll take a question down here while Cherie gets to them. Your name and where you're from?

**ANN ROGERS:** Ann Rogers from Lismore Aboriginal Health Promotion. And I saw before, you've got 17 years of discussing Aboriginal health. It doesn't seem to have changed much. Even though they're throwing a bit of money at it, it's not actually getting down to the workforce or the services. And do you think the government will ever listen?

**STEVE CLARK:** I think it's number one on the list, and has been for 17 years. And I think you're right, it's going to stay on the list number one until some real services and some real support is delivered. It's a really complex issue. And I think if we can't find solutions among this group, then they can't be found. So that's the challenge. What are the solutions that deliver the best support for Indigenous people in this country? The health status, we've heard for too long is appalling. They're sick of being researched. So those solutions-based opportunities that we can deliver here need to be put to government in the most succinct way that we can do it. We don't want the same old same old.

I was going to start by saying—is it really 17 years, or is it one year 17 times? Have we regurgitated the same old stuff across 17 years? I don't actually believe that you have, because actions and recommendations have changed in their emphasis as you've gone on through the years, but the challenge is there. It's been number one on the list, it's going to stay number one. Let's deliver solutions.

**FACILITATOR:** He's really hammering out this message it's up to us to have good, specific, measurable recommendations put forward.

Our final question upstairs, thank you.

**BILL:** Hi. I'm Bill. I'm a medical student and I'm at Bundaberg at the moment. And I just wanted to say to everybody how is it and where are the international medical graduates in the NRHA?

**STEVE CLARK:** That's a good question. I don't know, and I guess one day this will encompass more than an Australian conference. We have had international people in the past and I guess we'll continue to do so, but that's something that the Alliance certainly could take on board.

**FACILITATOR:** Just before I let you go, you've raised the question of what's the right question to ask about the effectiveness of primary health care teams. Could you just spit out what you're thinking?

**STEVE CLARK:** We talk all the time about will primary health care teams deliver better health outcomes for rural people. And we think logically that the answer is yes, but we still haven't got the empirical evidence to prove that that's the case, and they're not happening across the board. We've got some multi-disciplinary things happening in some places, but it's not ubiquitous. And if it needs to be,



then where's the evidence to support that in fact it works and it does make the big difference that we expect that it does?

I mean, I think we all in this room think that that's the case, but we need to demonstrate that that's the case and move on.

**FACILITATOR:** So are you essentially saying you'd welcome a recommendation going to research on the effectiveness of primary health care teams?

**STEVE CLARK:** Well, research gets a lot of money in this country, so yes I think so. John is going to say that it's been done. Are you, John?

**FACILITATOR:** John, do you want to rush towards me and I'll give you an apple? And I'm hoping there is a wild choir gathering behind me. If it isn't, I'd love it if a pink-shirted person would run to me and say, "No, there's not".

Now, sir, your name and where you're from? I'll hold the mike.

**JOHN HUMPHRIES:** John Humphries from Monash University. Actually I'm really Gordon Gregory, but never mind.

**FACILITATOR:** That's funny. That's what we were all thinking.

**JOHN HUMPHRIES:** Julie, look, I think it's really important to stress the message that Steve made, and that is the role of the alliance as an advocate in activating initiatives for rural health.

Can I just cast a word of warning though? At the same time Steve has painted those many initiatives of the government which really respond to a lot of this conference, there are a lot of other things that are happening that disadvantage rural and remote areas. And I point to the 3.8 billion that props up a private health rebate, which does nothing for rural and remote Australia, an area that socio-economically is disadvantaged, where there are poorer access to services, there are fewer providers. So painting this picture is great, but we need to see it in the bigger picture of dollars that are available in the health budget.

And could I suggest that one of the recommendations is to acknowledge the need for public funding of health care services, whether acute primary health care or whatever, in rural and remote areas.

**FACILITATOR:** Ladies and gentlemen, thank you very much again. A round of applause for Steve Clark.

## Presenter

**Steve Clark** is Chief Operating Officer and Secretary of Council of the Queensland Institute of Medical Research. He was formerly the CEO of the Australian Divisions of General Practice and became a member of the NRHA council in 1997. He was NRHA Chair from October 1999 to October 2000. Steve maintains a passion for rural and remote Australia and is constantly inspired by rural people making an extraordinary difference for their communities.

