



Australian Government

National Rural Health Commissioner

NATIONAL RURAL HEALTH COMMISSIONER

Submission to Productivity Commission

Inquiry into

Mental Health (Draft Report)

February 2020



Acknowledgement of Country

The National Rural Health Commissioner (the Commissioner) acknowledges the Traditional Owners and Custodians of Country throughout Australia. The Commissioner recognises the strength and resilience of Aboriginal and Torres Strait Islander peoples and acknowledges and respects their continuing connections and relationships to country, rivers, land and sea. The Commissioner acknowledges and respects the Traditional Custodians upon whose ancestral lands our health services are located and the ongoing contribution Aboriginal and Torres Strait Islander peoples make across the health system and wider community. He also pays his respects to Elders past, present and emerging and extends that respect to all Traditional Custodians of this land.

The Office of National Rural Health Commissioner

The *Health Insurance Act 1973* (the Act) provides the legislative basis for the appointment and the functions of the National Rural Health Commissioner (the Commissioner).

In accordance with the Act, the functions of the Commissioner are to provide independent and objective advice in relation to rural health to the Minister responsible for rural health.

This submission was prepared by Professor Paul Worley, National Rural Health Commissioner
Lead Researcher: Simone Champion

Terminology

In this submission, the Modified Monash Model (MMM) is used to differentiate areas of Australia in terms of their remoteness and population. The Commissioner acknowledges that there are important considerations beyond distance and size that distinguish one area of Australia from another and that these can be accommodated in planning and implementation. However, for simplicity, this document will occasionally use collective terms to describe certain areas of Australia and those terms should be taken broadly to have the following meanings:

- 'Regional' means MMM 2 and 3 areas
- 'Rural' means MMM 4 and 5 areas
- 'Remote' means MMM 6 and 7 areas

The terms 'Aboriginal and Torres Strait Islander' and 'Indigenous' are used interchangeably throughout this document with respect.

Rural Generalist - A Rural Generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way by providing both comprehensive general practice and emergency care and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.¹

Allied Health Rural Generalist - A service or a position or practitioner delivering services that respond to the broad range of healthcare needs of a rural or remote community. This includes delivering services to people with a wide range of clinical presentations from across the age spectrum and in a variety of clinical settings (inpatient, ambulatory care, community). The primary aim of rural generalist service models is to deliver high quality, safe, effective and efficient services as close the client's community as possible.²

¹ National Rural Generalist Pathway Taskforce. *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*. Canberra; National Rural Health Commissioner; 2018 p. 5.

² Services for Rural and Remote Allied (SARRAH) (2017) Allied Health Rural Generalist Training Positions: an Overview. [Accessed August 2019] Retrieved from: https://sarrah.org.au/sites/default/files/images/info_1_-_overview_20170614_in.pdf

Executive Summary of Advice

In developing this submission, the National Rural Health Commissioner (the Commissioner) has been guided by learnings from Aboriginal and Torres Strait Islander peoples' concepts of health and wellbeing, in the importance of community control and connection to country, and with respect and consideration for the wisdom of Elders and local decision-making.

The Commissioner acknowledges and recognises the importance of this Inquiry and thanks the Productivity Commission for the opportunity to contribute to this work. The Productivity Commission's Inquiry into Mental Health Draft Report is comprehensive and considered. The Commissioner supports the concept that improving mental health outcomes will enhance economic participation and productivity in Australia and the best way of improving mental health outcomes is by ensuring that systems are cost effective and appropriately designed for the populations they serve. Currently, the evidence demonstrates that mental health models of care are not meeting the needs of regional, rural and remote communities.

The Commissioner is concerned that the Productivity Commission's Mental Health draft recommendations, as they are currently stated, would not be successful in delivering high quality mental health services to the seven million people living outside of metropolitan centres - Australia's regional, rural and remote communities. These concerns are based on evidence and insights presented to the Commissioner throughout broad and in-depth consultation with rural medical and health sectors over the last two years (see Appendix 1 for sector consultations). The consultations have identified barriers resulting from systems that have been designed in the cities and which do not work optimally in rural and remote settings.

In rural Australia, mental health services need to be integrated with broader health services, they cannot function effectively as a separate system. Current attempts at a siloed approach are failing both our patients and clinicians. Just as the recent bushfire crisis has highlighted the importance of local generalist clinicians to respond to immediate needs, many mental health acute crisis occur out of hours and end up being cared for by our mainstream health services. Integration will assist both the acute care for people suffering a mental health crisis and in the continuity required in their long term recovery.

Neither can mental health services be developed on a town by town basis – they must be developed through networks of towns to achieve the scale needed to make jobs attractive and services comprehensive.

In order to be effective, mental health models of care should be developed and led by rural and remote communities and have meaningful intersections with health, justice, disability, early childhood, aged care and education using a cross-sector, place based, integrated approach. In this way these services will be cognisant of the bio-psycho-social and spiritual relationship individuals and families have to place and history, along with their aspirations and fears for the future – their own and their community's. Rural and remote Australian communities need to be supported to debate and develop their own plans to address health priorities. This will require significant investment, a networked system of support, data and evidence, and an appropriately skilled workforce.

Strategy without workforce is ineffective. There is currently a very severe maldistribution of the mental health and broader health workforce in Australia which undermines effective implementation of mental health strategy in regional, rural and remote areas.

There is also clear evidence about how to turn this around. Rural and remote communities need services led by, and constructed around, locally based generalists who are supported, only when necessary, through telehealth services and specialist visitors. For continuity and sustainability, the principle responsibility for care and leadership needs to be locally led and remain with those generalists rather

than with distant specialists. These generalists then need to have high level skills in mental health. Employment and funding systems then need to support the use of these skills.

Structured yet flexible rural generalist training pathways can create rural-ready workforces in medicine, nursing and allied health that will meet the mental health needs of rural Australia. This is well recognised and strongly supported by the Commonwealth Government as evidenced by the Stronger Rural Health Strategy, the 2019 rollout of the \$62.2 million National Rural Generalist Pathway, and the recently announced forty new scholarships for Allied Health Rural Generalists working in private practice and non-government organisations. More investment is required. Rural and remote communities need Rural Generalists. They need a workforce who want to work in rural Australia and are specifically equipped to do so.

Rural health has always been a site for innovation – often born of necessity - and carried forward with commitment and vision. More than any time in our recent history, this innovation will be needed to cope with the impact of drought, floods and bushfires. Throughout my consultations, it is clear that the potential for collaborative, cohesive, interconnected networks of training and service provision exists across regional, rural and remote Australia. We need to recognise this potential and take a strength-based approach to policy development that nurtures and builds on the considerable existing strengths of rural communities and the health professionals and structures that serve them.

Advice regarding the draft recommendations

The National Rural Health Commissioner advises that the following inclusions to the draft recommendations be considered to ensure that the Productivity Commission’s Mental Health Report acknowledges, aligns with and supports current national rural health workforce investment and strategies and to ensure rural, regional and remote communities receive efficient, equitable and appropriate mental health services.

Draft recommendation 11.1 — the national mental health workforce strategy

The forthcoming update of the National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services, **<inclusion> acknowledging that specific rural workforce training and employment strategies need to be developed that include high quality rural training and increased employment options for Rural Generalist Medical Practitioners and Allied Health Rural Generalists in mental health teams.**

Draft recommendation 11.7 —attracting, <inclusion> retaining and supporting a rural health workforce

In the short term (in the next 2 years)

The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by **<inclusion> improving rural training**, reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave. This should include:

- greater use of videoconferencing, subject to the availability of communications infrastructure, for health workers to remotely participate in professional development activities and meetings and conferences with peers
- expanding initiatives such as the Rural Locum Assistance Program to fund visiting health professionals to temporarily stand in for rural and remote health workers, including psychiatrists, while they attend professional development activities, meetings and conferences with peers, and take leave.

<Inclusion>

- recognition of medical, nursing and allied health rural generalists as key to any rural and remote mental health workforce attraction and retention strategies
- recognition of medical, nursing and allied health rural generalists as instrumental in rural and regional integrated mental health teams and rural health workforce
- establishing pathways for allied health practitioners with mental health skills to access supported training such as the Allied Health Rural Generalist Scheme
- increase opportunities for longer term high quality, rural placements and end-to-end rural and remote health professions training to develop the future rural workforce
- strengthen pathways that encourage GP registrars to train as Rural Generalists with additional skills in Mental Health related specialties
- supporting the development of team-based regional health service networks that are integrated across primary and secondary care, that include mental health services in the broader scope of practice, and provide flexible employment options and business support for clinicians
- supporting pathways that enable existing rural clinicians and professionals to acquire additional skills in mental health

Draft recommendation 22.1 – a national mental health and suicide prevention agreement

All stakeholder groups, including government, should know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services.

<Inclusion> The Agreement should include the arrangements for appropriately training the workforce including specific rural generalist training.

Draft recommendation 22.2 – a new whole-of-government mental health strategy

A national strategy that integrates services and supports delivered in health and non-health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long term.

<Inclusion> It is recommended that this whole-of-government mental health strategy recognise the recommendations and findings from the 2018 Senate Inquiry into the Accessibility and Quality of Mental Health Services in Rural and Remote Australia and in particular Recommendation 1: The committee recommends the development of a national rural and remote mental health strategy which seeks to address the low rates of access to services, workforce shortage, the high rates of suicide, cultural realities, language barriers and the social determinants of mental health in rural and remote communities.³

³ Commonwealth of Australia 2018 Senate Inquiry into the Accessibility and quality of mental health services in rural and remote Australia. p.29 [Accessed Jan 2020]
Retrieved from: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report

Evidence in support of this Advice

Introduction

Approximately seven million (30%) Australians live outside metropolitan centres in regional, rural and remote settings. Of those, nearly half (44.7%) live in towns with less than 15,000 people.⁴ As well as broader health challenges such as high incidences of chronic disease and obesity, the challenges related to mental health that many people living in remote and smaller rural communities face are significant with higher incidences of suicide, hospitalisations due to self-harm, and family violence when compared to metropolitan rates. While these conditions are problematic across both cities and regions, they are particularly emblematic of the current mental health status of many rural and remote populations, where they are complicated by economic and environmental factors and the reality of historical disenfranchisement.

In rural and remote settings access to appropriate mental health services can vary dramatically. Recent data from the Australian Institute of Health and Welfare indicates that the distribution of medical doctors in non-metropolitan centres is 2.5 per 1000 population compared to 4.1 per 1000 in metropolitan areas.⁵ In 2011, the Department of Health reported there were 4 FTE psychiatrists per 100000 people in outer regional areas, and 6 in inner regional, compared to 21 in major cities. In outer regional areas there were 32 FTE mental health nurses per 100000 people compared to 69 in inner regional and 64 in major cities.⁶ In 2017, 4.7% of psychologists worked in outer regional locations, a decrease when compared to 4.9% in 2014.⁷

This undersupply and maldistribution of the mental health workforce has a significant negative impact on the accessibility of health services for rural Australians and the severity of impact increases with remoteness. This in part can be seen in Australia's suicide rates where Australians living in *Remote* and *Very remote* areas are approximately twice as likely to die from suicide when compared with Australia overall. The rate of suicide in *Major cities* is 11 per 100,000 population and increases with remoteness to 19 per 100000 for *Remote* areas and 24 per 100000 in *Very remote* areas. Rates of hospitalisations as a result of intentional self-harm show a similar pattern.⁸

These statistics demonstrate that in these rural, remote and very remote settings where there are variations in population distribution and geography, and often considerable distance between services, there is heightened complexity and risk which is resulting in disproportionate rates of suicide and poorer mental health outcomes.

The Commissioner has travelled across Australia to work with students, peak bodies, associations and professional bodies, rural medical and health service providers, clinicians, universities and schools, Aboriginal and Torres Strait Islander representative bodies and health services, consumers and consumer groups, and local, state, territory and Australian Government representatives to develop a comprehensive understanding of the current contributors and challenges affecting equity of health services for rural and remote Australians. The Commissioner has seen historical examples of duplication of services between the Commonwealth, States, and philanthropic endeavours which have led to unintended outcomes. However, greater than the duplication of programs has been the challenge borne from underinvestment

⁴ National Rural Generalist Pathway Taskforce. *Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway*. Canberra; National Rural Health Commissioner; 2018, p. 18. [Accessed Jan 2020] Retrieved from:

[https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/\\$File/Advice-to-the-National-Rural-Health-Commissioner-on-the-Development-of-the-National-Rural-Generalist-Pathway.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/2922D6D8BBCE122FCA2581D30076D09A/$File/Advice-to-the-National-Rural-Health-Commissioner-on-the-Development-of-the-National-Rural-Generalist-Pathway.pdf)

⁵ *Ibid*, p. 15; Australian Institute of Health and Welfare. *Medical Practitioners Workforce 2015*. Canberra; Australian Government: 2016.

⁶ Australian Department of Health [Accessed Jan 2020] Retrieved from: <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhsrraev-toc~mental-pubs-m-mhsrraev-8~mental-pubs-m-mhsrraev-8-3>

⁷ Australian Department of Health [Accessed Jan 2020] Retrieved from: <https://hwd.health.gov.au/publications.html>

⁸ Australian Institute of Health and Welfare [Accessed Jan 2020] Retrieved from: <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary>

in an appropriately trained workforce and in critical and appropriate health services in rural and remote Australia.

Models of care designed in cities for cities are not working for Australians who live outside of metropolitan centres. This is widely acknowledged and was supported in the 2018 Senate Inquiry into the Accessibility and Quality of Mental Health Services in Rural and Remote Australia:

Professor Luis Salvador-Carulla, Centre Head of the Australian National University (ANU) Centre for Mental Health Research, explained to the committee that rural mental health is different from urban mental health and the problem with the stepped care model is how it was developed for urban areas:

This model was developed in a highly urbanised area in the Netherlands. It has been tested in the southern part of Norway. It has been tested in urban areas in the UK. My feeling is that it does not work for rural areas. This is just one example of many of how just translating and adapting what has been developed in cities in urban mental health does not work in rural health. We have to develop a new understanding of these services, if we want to change the problems we have in this area.⁹

Similarly, current training models that are primarily based in metropolitan universities, inevitably produce city based health providers who are familiar with city systems. These models are not producing a health workforce that meets the needs of all Australians. This is important to note, as one of the main policy levers available to the Commonwealth Government to ensure that the Australian mental health system works to produce better mental health outcomes for its citizens, is to support the supply of a highly trained and appropriately skilled workforce.

Rural Markets and the Rural Health Workforce

In thin markets, and as remoteness increases, shortfalls in the health workforce worsens, resulting in solo practitioner, locum and small service arrangements becoming more common.

Attracting and retaining health professionals to fill short term and part-time rural positions is an ongoing challenge for public, not for profit and private employers alike. When positions can't be filled, rural and remote communities are often left with no choice but to rely on costly locum arrangements with resulting discontinuity and lack of long term clinician – client relationships – so important to quality of care. In addition, the money paid to these locums, meant to be dedicated to their rural communities, is not spent locally but in large regional centres and cities where the locums are based, further undermining the economic sustainability of rural communities. These challenges are being felt across rural and remote Australia.

These unappealing employment positions are perpetuated by fragmented sector by sector funding approaches and contribute to the vulnerability of local economies and viability of health service models. It is recognised that while rural and remote communities may in theory have access to multiple funding sources from sectors and programs such as the MBS, National Disability Insurance Scheme (NDIS), Primary Health Networks, aged care services, state health departments, local government, education and social services, these sources are often underutilised or untapped by small rural and remote providers because the time and cost required to navigate complex funding, registration, reporting and accreditation processes associated with them renders them unprofitable and unmanageable. These fragmented funding approaches have resulted in a significant shortfall in the per capita provision of health services and professionals in MMM4-7, when compared to their metropolitan counterparts.

These shortfalls mean less choice for rural consumers, and in many cases going without essential care until crisis points are reached. Workforce shortfalls equal service shortfalls and lack of appropriate and timely access

⁹ Commonwealth of Australia 2018 Senate Inquiry into the Accessibility and quality of mental health services in rural and remote Australia. p.29 [Accessed Jan 2020] Retrieved from: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report

goes some way to explaining why rural and remote rates of suicide and hospitalisations as a result of self-harm are approximately double that of city rates, despite mental illness prevalence not being notably different across Australia.¹⁰

It is evident that a different and more integrated employment approach in rural and remote mental health services is required in order for communities to receive equitable health services and to enable mental health professionals to have viable and well supported jobs and successful careers in rural and remote regions. Integration of funding and services is key.

Integrated Regional Networks and Partnerships

The benefits gained through integration and partnerships can be seen at the Institute for Urban Indigenous Health (IUIH) in South East Queensland. The Institute was established in 2009 by four Aboriginal Community Controlled Health Services (ACCHS) to provide primary care services to local Aboriginal and Torres Strait Islander populations and has since expanded to 20 multidisciplinary primary health clinics, with funding partnerships including the Australian Government, Queensland Government, Hospital and Health Services and Primary Health Networks. An independent review of the Institute conducted in January 2019 highlighted the benefits achieved through economies of scale:

In this model, IUIH is systems integrator of regionally led reforms across the IUIH Network of ACCHSs, and has a lead role in strategic planning, service development, business modelling, income generation, data analysis, clinical/corporate governance, quality improvement, performance monitoring, workforce development, cross-sector connectivity and research. This has delivered significant returns on investment, including through leveraging region-wide funds pooling, regionally scaled solutions and generation of economies of scale to harness substantial efficiencies and support reinvestment to significantly expand services (eg allied health & aged care).¹¹

The long term health outcomes and economic benefits of the IUIH model are becoming evident. An independent analysis of IUIH's impact in shifting the Health Adjusted Life Expectancy (HALE) of its patients indicated an improvement of 0.4 years HALE relative to baseline improvement in South East Queensland.

An independent health economic impact study identified a net benefit to society from IUIH System of Care of \$1.43 for every \$1 invested by IUIH. This included estimated savings in avoidable hospital admissions. Conservative modelling calculated \$100 million in net benefit to the community since IUIH was established.¹²

Rural Australia can learn from this Indigenous Health Service. This model of care and employment support can be applied to rural and remote health services with equal success.

Rural Generalist Medicine

Commonwealth and state governments have made a significant investment in programs to address maldistribution of the health workforce in rural and remote Australia, including a combination of incentives and restrictions to direct medical practitioners into areas of need. In the university setting there has been longstanding support for Rural Clinical Schools, University Departments of Rural Health (UDRH), and Regional Training Hubs that offer some undergraduate and junior graduate training in non-metropolitan settings. More recently the Commonwealth Government announced the introduction of the Murray Darling Medical School Network Program which will expand end-to-end training for medical

¹⁰ Commonwealth of Australia 2018 Senate Inquiry into the Accessibility and quality of mental health services in rural and remote Australia. p.5

¹¹ Institute for Urban Indigenous Health (2019) History and performance: Charting the way forward: Independent Review of: The Institute for Urban Indigenous Health [Accessed Sept 2019] Retrieved from: <http://www.iuih.org.au/Portals/0/xBlog/uploads/2019/4/17/NOUS%20Review%20of%20IUIH%20-%20Summary%20Report%202019.pdf>

¹² Institute for Urban Indigenous Health (2018) Annual Report 2017-18 [Accessed Jan 2020] Retrieved from: http://www.iuih.org.au/Portals/0/PDF/IUIH_2017-18_AnnualReport_V8.pdf?ver=2019-01-17-143421-707

students in a number of rural locations. This program is part of a suite of measures contained in the *Stronger Rural Health Strategy* to address education, training and service provision. Yet, despite these measures, the gap in access to services for smaller rural and remote communities persists.

Healthcare for Australia's rural and remote populations is complex and given the challenge of distance and geography, depends on doctors a great deal, and specifically doctors who can integrate skills that are traditionally delegated to separate specialties in urban practice. As well as providing comprehensive General Practice and emergency care, rural communities often depend on their doctors having *Additional Skills* for an extended scope of practice to meet their needs. These *Additional Skills* include the fields of Emergency Medicine, Mental Health, Addiction Medicine, Paediatrics, Remote Medicine, Aboriginal and Torres Strait Islander Health and Health Administration.

The development and use of these General Practice, Emergency and Additional Skills represent the broad scope of practice of a Rural Generalist. To increase the number, and recognising the value of, Rural Generalists in rural and remote Australia, the implementation of the National Rural Generalist Pathway (the Pathway) is currently underway. The structure of the Pathway is end-to-end medical school education followed by five to six years of postgraduate training delivered through integrated teaching and training health service networks across regional, rural and remote Australia.

The Pathway implementation follows the Commissioner's presentation of the National Rural Generalist Pathway Advice paper and its 19 recommendations to the then Minister for Regional Services, Decentralisation and Local Government, Senator the Hon Bridget McKenzie (the Minister), in October 2018. The Minister accepted the Report and all recommendations in November 2018, announcing an initial Commonwealth investment of \$62.2 million in 2019 to begin implementing the National Rural Generalist Pathway.

This work builds on the growing recognition both in Australia and internationally that Rural Generalist medicine – a discipline that combines General Practice, Emergency care and an Additional Skill appropriate to needs of rural and remote communities – is a viable alternative to the current pattern of maldistribution, patient upheaval and reliance on temporary workforce supply. The setting for the Rural Generalist is primarily in smaller towns without the critical mass to support larger medical specialist teams, where they provide additional skills but are still part of regional networks of providers. This is also where the supply of mental health services is most under pressure.

Rural Generalists are already 'filling the gap' in rural and remote areas and delivering specialist mental health treatment in rural and remote communities. Two examples are provided in the profiles below. The abovementioned Commonwealth investment will see a further 350 Rural Generalists graduating per year. Additionally, the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners have jointly applied for national recognition of 'Rural Generalist' as a specialised field within the specialty of General Practice. Any workforce planning in Mental Health needs to incorporate this highly skilled and rapidly growing workforce. To enhance the attractiveness of undertaking additional training in mental health, funding mechanisms, including in State Government Health Services and in the MBS, must ensure that there is at least parity in funding for Rural Generalists in Mental Health with those Rural Generalists who have additional skills in currently more well remunerated procedural areas.

Rural Generalist Profiles¹³

Dr Ebonney van der Meer

Senior Medical Officer (SMO), Provisional Fellow with Advanced Skills Mental Health

I'm just finishing my training as a Rural Generalist with a mental health and addiction advanced skill.

I'm an SMO at Cooktown Hospital, a multipurpose health service. I have a GP psychiatry caseload working with the local Mental Health and Alcohol and Other Drugs (AODS) team in Cooktown. Once a week I have a dedicated Opiate Substitute Program clinic and an outpatient mental health clinic. Once a fortnight I visit the local communities of Hope Vale and Wujal Wujal for a clinic where I focus on mental health and comprehensive primary care. I support the local mental health team in whatever they need medically and to provide that key link between medical and mental health teams locally and to our referral centre in Cairns. The remainder of my time I spend in Cooktown either on the wards, in the Emergency Department or in General Practice. I participate in the on-call roster for one night a week with occasional weekends.

Rural Generalist practice allows me to provide holistic, comprehensive primary and emergency care in a range of settings in my community to best suit the needs of my patients. It is exciting, challenging and thoroughly rewarding medicine. I really value being a part of the community that my patients come from and I am invested in that community. Having the opportunity to pioneer the GP psychiatry service in Cooktown has been an absolute privilege and I look forward to watching the service continually grow and evolve.

Dr Molly Shorthouse

I am a Rural Generalist working in tropical North East Arnhem Land, which is Aboriginal Land belonging to the Yolngu people. It is an area about the size of Belgium but with only about 16,000 people.

My Advanced Skills Training is in Mental Health and so naturally I see a lot of people with the entire range of mental illnesses – from mild mood disorders to bipolar to schizophrenia and hardest of all, trauma. Once you start seeing things through the lens of trauma it becomes apparent how much sadness and pain there is out there.

I have worked across the full scope of Rural Generalist practice here – providing Emergency Medicine services to the local hospital, and extended services in Mental Health and primary care to the private and Aboriginal Medical Services. At the moment I am in a management position for the largest Aboriginal Community Controlled Health Service with clinics across north east Arnhem – Miwatj.

On a professional level, seeing people get well again keeps me going. When I see mental health patients improve the effect it has on their lives and everyone around them is so rewarding.

¹³ Australian Department of Health [Accessed Jan 2020] Retrieved from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-rural-health-commissioner-profiles>

The Rural Allied Health Workforce

Allied health services preserve the quality of life in communities and underpin the health and wellbeing of our nation. They are the quiet achievers of our health, mental health, disability, education, aged-care, and social service sectors. Without them, our schools, workplaces, homes and aged-care facilities all struggle to realise their potential. Communities suffer and economic development stalls.

Clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists are allied health professionals with a breadth of experience in assessing, managing and treating people with mental illness.¹⁴ Psychologists, social workers and occupational therapists make up approximately 35% of the nearly 200 000 strong allied health workforce.

A literature review¹⁵ recently conducted by the Commissioner examined factors that affect the quality, access and distribution of allied health services, particularly in relation to workforce scope of practice, rural training pathways, recruitment and retention incentives, and models of service.

The evidence supports what is also known for medicine and nursing, that a stronger rural workforce can be achieved by selecting rural background students, providing high quality rural-based training, a rural curriculum, strengthening job satisfaction, career paths and ongoing professional training.

Investing in opportunities to increase the number of rural-origin and Aboriginal and Torres Strait Islander students to train and work as health professionals is an effective strategy to improve the distribution of rural health professionals and thus increase access to mental health, health, disability, aged care and school-based services for rural communities. A key mechanism in attracting a rural health workforce is supporting University Departments of Rural Health and Regional Universities to expand the range of health undergraduate and postgraduate courses delivered in regional areas, aligned to population health need, population structure and workforce maldistribution, and offer structured entry pathways to these courses for rural candidates.

An important component in retaining a rural work force is continuing to support rural health professionals by providing structured career pathways and ongoing professional training. Acknowledging this evidence, on November 21, 2019 the Hon Mark Coulton, Minister for Regional Services, Decentralisation and Local Government, announced forty new scholarships for Allied Health Rural Generalists working in private practice and non-government organisations. Importantly the *Allied Health Rural Generalist Workforce and Education Scheme* will provide funds for backfilling as well as travel and accommodation. This is an important step in supporting rural allied health professionals and those considering a rural health career.

There are also opportunities to increase the capacity of existing mental health workers in rural and remote Australia. Registered counsellors and psychotherapists are an existing, well qualified mental health workforce immediately available to help meet the needs of rural Australians. This workforce is university trained and are accredited by one of two national organisations, the Psychotherapy and Counselling Federation of Australia and the Australian Counselling Association and are recorded on a Register of Counselling and Psychotherapy maintained jointly by the two organisations. This workforce complements the existing, but small, current workforce providing mental health interventions in rural Australia.

If this counselling and psychotherapy workforce were recognised by the Better Access program along with psychologists, social workers, mental health nurses, occupational therapists and appropriately trained general practitioners, this would immediately provide over 700 additional well qualified mental health practitioners in regional, rural and remote Australia. This recognition would also open up a rapid pathway

¹⁴ Allied Health Professionals Australia [Accessed Jan 2020] Retrieved from: <https://ahpa.com.au/key-areas/mental-health/>

¹⁵ Literature Review is included as an attachment to this submission.

for existing rural health professionals to develop the additional skills to provide care for patients currently at risk due to suffering from grief, loss, addictions, and mental and emotional trauma and ill health.

The literature also shows that supporting the utilisation of allied health assistants (AHAs) through clear governance frameworks could assist to buffer rural allied health workload. It is broadly acknowledged that appropriate delegation of tasks by allied health professionals to allied health assistants can improve access to allied health services. Formalising pathways between Vocational Education and Training (VET) courses for Allied Health Assistants and tertiary allied health training may enable more rural people to see this as a constructive longer term career. Additionally, Allied Health Assistants can be important as the 'remote end' clinicians in increasing access to mental health services through telehealth.

Barriers impeding career progression for Aboriginal and Torres Strait Islander health workers (Information request 11.1)

The benefits of increasing Aboriginal and Torres Strait Islander participation in the health workforce are well known and articulated in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016- 2023).

It is also well known that, while people living in rural and remote communities experience poorer health outcomes than those in metropolitan centres, the burden of mental illness and suicide in rural and remote Aboriginal and Torres Strait Islander populations is significantly higher and is exacerbated by limited access to appropriate and culturally safe health services. Educational barriers such as institutional racism, rurality and cultural safety are significant contributors to lower employment rates of Aboriginal and Torres Strait Islander people.

Barriers for rural students to enter undergraduate health courses relevant to mental health are considerably higher for Aboriginal and Torres Strait Islander candidates. Existing local responses, such as the Indigenous Allied Health Australia National Aboriginal and Torres Strait Islander Health Academy that create culturally safe, supportive and community-led local pathways into tertiary training, are considered to be models that would directly contribute to increasing the number of Aboriginal and Torres Strait Islander health graduates in mental health related areas.

The IAHA National Aboriginal and Torres Strait Islander Health Academy is a community-led learning model focused on academic achievement and re-shaping the way training pathways are co-designed and delivered with Aboriginal and Torres Strait Islander high school students. The Academy aims to embed culturally safe curricula and to be inclusive of local cultural aspirations for successful outcomes where social, cultural and environmental determinants are addressed with wraparound supports. Students undertake a School Based Traineeship in Certificate III in Allied Health Assistance alongside their year 11 and 12 qualifications. They also undertake a work placement in a health or related sector provider to gain on the job training and experience in their preferred career pathway.

The Academy has Aboriginal and/or Torres Strait Islander health students and graduates supporting them as role models and as mentors, sharing their journeys into health, experiences in further education and the opportunities which exist. The Academy is promoting all health careers inclusive of allied health, nursing, medicine and Aboriginal and/or Torres Strait Islander Health Workers/Practitioners. The Academy promotes the diverse health and related settings where the health workforce is required including disability, aged care, community services, community- controlled health services, hospitals and pharmacy¹⁶

Additionally, the Commissioner notes there are a number of other strategies that could be implemented to support Aboriginal and Torres Strait Islander people in graduating in mental health disciplines:

1. Universal and comprehensive implementation of the Aboriginal and Torres Strait Islander Health Curriculum Framework¹⁹ (the Framework) within health and medical courses. The Commissioner acknowledges that some universities have already implemented the Framework to a high

¹⁶ Indigenous Allied Health Association. Annual Report. IAHA; Deakin: 2019. [Accessed Jan 2020] Retrieved from: http://iaha.com.au/wp-content/uploads/2018/12/IAHA_AReport_WEB-FINAL.pdf

standard.

2. A more systematic approach to health student placements to increase cultural safety and cultural responsiveness and align outcomes with curricula content is required. The establishment of formal partnerships between University Departments of Rural Health and Regional Universities, and the Aboriginal Community Controlled sector, would increase opportunities for health and medical students to undertake placements in Aboriginal Community Controlled Health Services.
3. An improved system of quotas for Aboriginal and Torres Strait Islander intake into health training courses is required. Currently quotas vary across courses and universities.
4. Aboriginal and Torres Strait Islander Training Organisations should be supported to strengthen pathways into tertiary training. Many training organisations provide culturally-safe learning environments that involve local community members in teaching and mentoring roles. An expansion of the roles of these organisations in creating pathways into health training through more formal partnerships with tertiary institutions is required.
5. Aboriginal and Torres Strait Islander-led course development is essential for optimising graduate capability in the delivery of effective health services that are responsive to the needs of Aboriginal and Torres Strait Islander people. Similarly, when people with Indigenous backgrounds deliver the courses, the integrity of teaching is reinforced as students learn directly from those with lived experience. The availability of Indigenous Educators provides Indigenous students with mentorship through access to role models with correlating cultural identities. Furthermore, the effect of Aboriginal and Torres Strait Islander influence during schooling is reflected in statistics from IAHA whose student members demonstrate a 90% completion rate for their studies: much higher than other Aboriginal and non-Indigenous students in comparable schools.²⁰

Conclusion

Rural mental health models of care need to be different to metropolitan models of care. In order to be effective, mental health interventions need to be locally designed and delivered, team-based, networked across towns, and integrated with mainstream health care. They will continue to fail if they are conceived as an outreach from systems designed nationally in metropolitan centres for metropolitan markets, systems of care, and population densities. Rural generalist clinicians with skills in mental health must be the foundation on which patient and family centred models of care are built, and specific training, funding, employment and support systems must be implemented across rural and remote Australia to develop this workforce.

Healthy communities become wealthy communities. Thus mental health professionals are critical to our society's wellbeing and prosperity and rural Australia, particularly those areas affected by drought, floods, bushfires and population drift, deserves its fair share of both.

Appendix 1: National Rural Health Commissioner Consultations

Consultations for the Development of the Rural Allied Health Advice

Commonwealth Ministers' Offices

Minister for Regional Services, Decentralisation and Local Government, the Hon Mark Coulton

Senator the Hon Bridget McKenzie

Minister for Health, the Hon Greg Hunt

Minister for Indigenous Affairs, the Hon. Ken Wyatt

Australian Government

Caroline Edwards – Deputy Secretary of Health Systems Policy and Primary Care Group, Department of Health
Diagnostic Imaging and Pathology Branch, Medical Benefits Division, Department of Health Health Training
Branch, Health Workforce Division (inc. Consultant Kristine Battye)

Health Workforce Reform Branch, Health Workforce Division, Department of Health Indigenous Health
Division, Strategy and Evidence Branch, Department of Health

National Disability Insurance Scheme Market Reform Branch, Department of Social Services Pharmacy Branch,
Technology Assessment and Access Division, Department of Health

Primary Care, Dental and Palliative Care Branch, Primary Care and Mental Health Division, Department of Health

Primary Health Networks Branch, Primary Care and Mental Health Division, Department of Health Rural Access
Branch, Health Workforce Division, Department of Health

Rural and Remote Market Strategy, National Disability Insurance Agency (NDIA)

Australian Allied Health Leadership Forum

Allied Health Professions Australia

Australian Council of Deans of Health Sciences

Indigenous Allied Health Australia

National Allied Health Advisors and Chief Officers Committee

Services for Australian Rural and Remote Allied Health

State and Territory Chief Allied Health Officers and Advisors

Jenny Campbell	Chief Health Professions Officer, WA Department of Health
Andrew Davidson	Chief Allied Health Officer, NSW Department of Health
Hassan Kadous	Principal Allied Health Advisor, NSW Department of Health
Heather Malcolm	Principal Allied Health Officer, NT Department of Health
Donna Markham	Chief Allied Health Officer, Safer Care Victoria
Helen Matthews	Chief Allied Health Officer, ACT Department of Health
Liza-Jane McBride	Chief Allied Health Officer, Allied Health Professions' Office of Queensland, Clinical Excellence Division
Kendra Strong	Chief Allied Health Advisor, TAS Department of Health
Catherine Turnbull	Chief Allied and Scientific Health Officer, SA Health

Rural Health Stakeholder Roundtable

Terry Battalis	NT Branch President, Pharmacy Guild of Australia
Lisa Bourke	Chair, Australian Rural Health Education Network
Karl Briscoe	CEO, National Aboriginal and Torres Strait Islander Health Worker Association
Ashley Brown	Chair, National Rural Health Student Network
Christopher Cliffe	CEO, CRANApus
David Garne	Federation of Rural Australian Medical Educators
Keith Gleeson	Board Director, Australian Indigenous Doctors' Association
Allan Groth	Indigenous Allied Health Australia
Ross Hetherington	Chair, Rural Health Workforce Australia
Claire Hewat	CEO, Allied Health Professions Australia
Eithne Irving	Deputy CEO, Australian Dental Association
Shane Jackson	CEO, Pharmaceutical Society of Australia
Cath Maloney	CEO, Services for Australian Rural and Remote Allied Health
Ewen McPhee	President, Australian College of Rural and Remote Medicine
Gabrielle O'Kane	CEO, National Rural Health Alliance
Melanie Robinson	CEO, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
Peta Rutherford	CEO, Rural Doctors Association of Australia
Shehnarz Salindera	Council of Rural Doctors, Australian Medical Association
Ayman Shenouda	Chair, Royal Australian College of General Practitioners - Rural Faculty

Other National Organisations

Philip Anderton	Convenor, Rural Optometry Group of Optometry Australia
Ashley Brown	Chair, National Rural Health Student Network
Megan Cahill	Chair, Rural Workforce Agency Network
Phil Calvert	National President of Australian Physiotherapy Association
Dawn Casey	COO, National Aboriginal Community Controlled Health Organisation
Deborah Cole	Chair, Australian Healthcare and Hospitals Association
Rob Curry	President, Services for Australian Rural and Remote Allied Health
Mark Diamond	former CEO, National Rural Health Alliance
Suzanne Greenwood	Executive Director, Pharmacy Guild of Australia
Simon Hanna	Clinical Consultant, Optometry Australia
Claire Hewat	CEO, Allied Health Professions Australia
Shane Jackson	Acting CEO, Pharmaceutical Society Australia
Martin Laverty	former CEO, Royal Flying Doctors Service of Australia
Martin Laverty	Secretary General, Australian Medical Association
Tanya Lehmann	Chair, National Rural Health Alliance
Cath Maloney	CEO, Services for Australian Rural and Remote Allied Health
Ewen McPhee	President, ACRRM
Member Meeting	Coalition Of National Nursing and Midwifery Organisations (CoNNMO)
Donna Murray	CEO, Indigenous Allied Health Australia
Anja Nikolic	CEO, Australian Physiotherapy Association
Gabrielle O'Kane	CEO, National Rural Health Alliance

Other National Organisations (continued)

Krishn Parmer	Allied Health Officer, National Rural Health Student Network
Janine Ramsay	National Director, Australian Rural Health Education Network
Peta Rutherford	CEO, Rural Doctors Association of Australia
Ayman Shenouda	Vice President, Royal Australian College General Practice
Edward Swan	Executive Officer, Rural Health Workforce Australia
Alison Verhoeven	CEO, Australian Healthcare and Hospitals Association

Jurisdictional Leaders

Ross Bailie	Director, University Centre for Rural Health, University of Sydney
Leanne Beagley	CEO Western Victoria Primary Health Network
Kate Boucher	Principal Policy Advisor, Allied Health & Community Services Workforce, Victoria
Chris Brenber	Dean of Education, College of Nursing and Health Sciences, Flinders University
Nick Bush	CEO, Echuca Regional Health
Maureen Carter	Nindilingarri Cultural Health Services (aka Fitzroy Crossing ACCHS)
Richard Cheney	Director Allied Health, Western New South Wales Local Health District
Richard Colbran	CEO, NSW Rural Doctors Network
Wendy Cox	Executive Director Medical Services, Murrumbidgee Local Health District
Lisa Davies Jones	CEO, North West HHS
Bob Davis	CEO, Maari Ma
Michael Dirienzo	CEO, Workforce and Allied Health, Hunter New England Local Health District
Vivienne Duggin	Regional Training Hub Project Officer, University of Western Australia
Michael Fisher	Principal, Broken Hill Public School
June Foulds	Regional Training Hub Project Officer, University of Western Australia
Stuart Gordon	CEO, Western Queensland Primary Health Network
Richard Griffiths	Executive Director, Workforce Planning and Talent Development Branch, New South Wales Ministry of Health
Andrew Harvey	CEO, Western New South Wales Primary Health Network
Denis Henry	Chair, Royal Flying Doctors Service, Victoria
Nicki Herriot	CEO Northern Territory Primary Health Network
Matt Jones	CEO, Murray Primary Health Network
Martin Jones	Director of the UDRH in Whyalla
Sabina Knight	Director, Centre for Rural & Remote Health, James Cook University
Jill Ludford	CEO, Murrumbidgee Local Health District
Esther May	Dean, Academic and Clinical Education, Health Sciences Divisional Office, University of South Australia
Jenny May	Director, University of Newcastle Department of Rural Health
Scott McLachlan	CEO, Western New South Wales Local Health District
Richard Murray	Dean, College of Medicine and Dentistry, James Cook University
Murrumbidgee Board of Directors	Murrumbidgee Primary Health Network
Kim Nguyen	Executive Director, Workforce and Allied Health, Hunter New England Local Health District

Jurisdictional Leaders (continued)

Ilsa Nielsen	Acting Director Allied Health, Allied Health Professions' Office of Queensland, Clinical Excellence Division
Stephen Pincus	CEO, Northern Territory General Practice Education
Amanda Proposch	CEO Gippsland Primary Health Network
Greg Sam	CEO, Royal Flying Doctor Service, Broken Hill
Rebecca Sealey	Associate Dean of Learning & Teaching, College of Healthcare Services, James Cook University
Tim Shackleton	CEO Rural Health West
John Smithson	Acting Academic Head Nursing and Midwifery, James Cook University
Tim Smyth	Chair, Western New South Wales Primary Health Network
Lee Stewart	Dean, College of Healthcare Sciences, Division of Tropical Health & Medicine, James Cook University
Catherine Stoddart	CEO, Northern Territory Health
Rachel Strauss	Executive Director, Latrobe Community Health Service, Victoria
Lisa Vandommele	Acting Director of Academic Quality & Strategy, James Cook University
Robyn Vines	Senior Lecturer Mental Health, Western Sydney University, Bathurst
Katrina Wakely	Allied Health Academic, University of Newcastle Department of Rural Health
Luke Wakely	Allied Health Academic, University of Newcastle Department of Rural Health
Judi Walker	Board Director, Latrobe Community Health Service
Trish Wielandt	Academic Head Occupational Therapy and Speech Pathology, College of Health Science, James Cook University
Rebecca Wolfgang	Allied Health Academic, University of Newcastle Department of Rural Health
Ian Wronski	Deputy Vice Chancellor, Division of Tropical Health & Medicine, James Cook University
Jacqui Yoxall	Director, North Coast Allied Health Association
Mimi Ziliacus	Manager, Goulburn Valley Regional Training Hub

Consultations for the Development of the National Rural Generalist Pathway in Medicine Advice

National Organisations

Rural Workforce Agency Network – CEOs Meeting
Regional Training Organisations Network – CEO Meeting
Australian Society of Anaesthetists – Prof David Scott
Australia and New Zealand College of Anaesthetists – Dr Rod Mitchell, President
AMA Council of Rural Doctors – Council Meeting
AMA Council of Doctors in Training - Council Meeting
Pharmaceutical Society of Australia - Mr Shane Jackson, National President
Rural Doctors Association of Australia - Council Meeting
CRANaplus, Mr Christopher Cliffe, Chief Executive Officer
Australian College of Rural and Remote Medicine – Council Meeting
AMA, Presidents Michael Gannon and Dr Tony Bartone and Dr Warwick Hough, Director - General Practice & Workplace Policy
Indigenous Allied Health Australia - Ms Donna Murray, CEO
Australian Indigenous Doctors Association - Dr Kali Haywood, President. Mr Craig Dukes, Chief Executive Officer
Australian Rural Health Education Network - Dr Lesley Fitzpatrick, CEO
Services for Australian Rural and Remote Allied Health - Mr Jeff House, Chief Executive Officer
AHPARR – Ms Nicole O’Reilly, Convenor
Allied Health Professions Australia –Ms Lin Oke EO
Australian Medical Students Association - Ms Alex Farrell, President
National Rural Health Alliance - Mr Mark Diamond, Chief Executive Officer, Ms Tanya Lehmann, Chair
Medical Board of Australia, Dr Joanna Flynn, Chair
Medical Deans ANZ - Helen Craig, CEO; Professor Richard Murray, President
Royal Flying Doctors Service - Board of Directors Meeting
AMSA Rural Health - Ms Nicole Batten Co-Chair; Co-Chair Ms Gaby Bolton; Vice Chair Ms Candice Day
Australian Dental Association - Ms Eithne Irving, Deputy Chief Executive Officer
Remote Vocational Training Scheme - Dr Pat Giddings and Dr Tom Doolan
Federation of Rural Australian Medical Educators – National Executive Meeting
Rural Doctors Association of Australia Specialists Group - Meeting
College of Surgeons - Council Meeting
Council of Presidents of Medical Colleges – Council Meeting
Rural Health Stakeholder Roundtable – Meetings
The Royal Australian College of General Practitioners – Council Meeting
Australian Council of Deans of Health Sciences – Council Meeting
Royal Australasian College of Surgeons – Mr John Batten and Council Meeting
Royal Australia and New Zealand College of Obstetricians and Gynaecologists - Rural Council Forum
RDAA Junior Doctors Forum – Forum Meeting
Australian Medical Council – Council Meeting

Health Professions Accreditation Council's Forum – Forum Meeting
Australian Hearing Services – Ms Sarah Vaughan, Board Director
Australian College of Emergency Medicine - Dr Simon Judkins, President and CEO Dr Peter White
Primary Health Care Institute – Mr Mark Priddle and Dr Shirley Fung
Stroke Foundation – Ms Sharon McGown, Chief Executive Officer
GP Supervisors Association – Dr Steve Holmes, President
GP Registrars Association – Dr Andrew Gosbell, CEO
AMA Federal Council – Council Meeting
Royal Australia and New Zealand College of Ophthalmology – Dr Cathy Green, Dean of Education, and Policy team

Australian Government

Senator the Hon Bridget McKenzie, Minister for Regional Services, Minister for Sport, Minister for Local Government and Decentralisation
The Hon Greg Hunt MP, Minister for Health
The Hon Dr David Gillespie, former Assistant Minister for Health

Federal Parliament

Standing Committee on Community Affairs – Inquiry into the accessibility and quality of mental health services in rural and remote Australia

Commonwealth Department of Health

Senator the Hon Bridget McKenzie, former Minister for Rural Health
The Hon Greg Hunt MP, Minister for Health
Dr David Gillespie, former Assistant Minister for Rural Health
Ms Glenys Beauchamp PSM, Secretary Professor Brendan Murphy, Chief Medical Officer
Mr David Hallinan, First Assistant Secretary, Health Workforce Division
Ms Chris Jeacle, Assistant Secretary, Rural Access Branch
Ms Fay Holden, Assistant Secretary, Health Training Branch
Ms Maria Jolly, First Assistant Secretary, Indigenous Health Division
Mr Chris Bedford, Assistant Secretary, Primary Health Networks Branch
Mr Mark Cormack, Previous CEO, Health Workforce Australia
A/Professor Andrew Singer, Principal Medical Advisor, Health Workforce Division
A/Professor Susan Wearne, Senior Medical Advisor, Health Workforce Division
National Mental Health Commission - Ms Maureen Lewis, Deputy Chief Executive Officer, and Ms Lucinda Brogden, Commissioner
Dr Lucas De Toca, Principal Medical Advisor, Office of Health Protection
Dr Chris Carslile, Assistant Secretary, Office of Health Protection

Australian Capital Territory

The Hon Meegan Fitzharris, ACT Minister for Health and Wellbeing, Higher Education, Medical and Health Research, Transport and Vocational Education and Skills

Aspen Medical - Mr Andrew Parnell, Government and Strategic Relationship Director,

National Health Co-op - Mr Blake Wilson General Manager; Adrian Watts CEO

Northern Territory

The Hon Natasha Fyles, Attorney-General and Minister for Justice; Minister for Health

Mr Stephen Pincus Chief Executive Officer Northern Territory General Practice Education (NTGPE)

Northern Territory Medical Program – Prof John Wakerman, Associate Dean

FCD Health – Ms Robyn Cahill, CEO

Western Australia

Office of the Minister for Health, Neil Fergus, Chief of Staff and Julie Armstrong, Senior Policy Advisor

WA Department of Health - Dr DJ Russell-Weisz – Director General, Dr David Oldham, Director of Postgraduate Medical Education

WA Country Health Service - Mr Jeff Moffet, CEO, Dr Tony Robins, EDMS

WA Primary Health Alliance – Ms Linda Richardson, General Manager

WAGPET - Prof Janice Bell. CEO

Rural Clinical School WA - Prof David Atkinson, Director

Rural Health West - Ms Kelli Porter, General Manager Workforce

Healthfix Consulting - Mr Kim Snowball, Director

Curtin Medical School - Professor William Hart, Dean of Medicine

WA Country Health Services - Dr David Gaskell, DMS Kimberley Region

Broome Health Campus - Dr Sue Phillips, Senior Medical Officer

Kimberley Aboriginal Medical Service Executive – CEO

Nindilingarri Cultural Health Service – Ms Maureen Carter, CEO and staff, Fitzroy Crossing

Fitzroy Crossing Hospital and Renal Dialysis Unit - staff

Broome Aboriginal Medical Service – Dr David Atkinson and staff

Broome Regional Hospital Junior Doctors - Meeting

Rural Clinical School Western Australia – Broome Staff and Students, Meeting

Queensland

Department of Health - Ms Kathleen Forrester, Deputy Director General Strategy, Policy and Planning Division

Darling Downs HHS, Queensland Country Practice – Dr Hwee Sin Chong, Executive Director, Dr Dilip Duphelia, Director Medical and Clinical Services Dr Denis Lennox, Previous Director, Rural & Remote Medical Support

Longreach Family Medical Practice – Dr John Douyere and staff

Longreach Hospital, Dr Clare Walker and staff – Meeting and Multi-Disciplinary Ward Round

Central West Health Service Dr David Rimmer, DMS and other Executive members

Central West PHN, Ms Sandy Gillies, Manager and other staff
Centre for Rural and Remote Health, James Cook University – RG trainees, Longreach
St George Hospital – Dr Adam Coltzou, DMS, GP staff, junior doctors and students
Darling Downs HHS – Dr Peter Gillies, CEO
Stanthorpe Hospital – Dr Dan Manahan, DMS, Dr Dan Halliday, ACRRM Board Member, Vickie Batterham, A/DON Stanthorpe
Medical Practitioners – GPs, Junior Doctors and Hospital Staff - Meeting
Warwick Hospital - Dr Blair Koppen, Medical Superintendent, Anita Bolton DON and RG trainees
Condamine Medical Centre – Dr Lynton Hudson and Dr Brendon Evans
Goondiwindi Hospital – Dr Sue Masel DMS Lorraine McMurtrie DON and staff
Goondiwindi Medical Centre – Dr Matt Masel, staff, Registrars and Students, Doctors Meeting
Dr Col Owen, Past President RDAA and RACGP, Inglewood
University of Queensland Regional Training Hub, Dr Ewen McPhee, Director, Rockhampton
Centre for Rural and Remote Health, James Cook University – Professor Sabina Knight, Director, Mt Isa
Institute of Health Biomedical Innovation - Professor Julie Hepworth

New South Wales

The Hon Brad Hazzard, Minister for Health
Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, NSW Health
Dr Linda McPherson, Medical Advisor Workforce and Planning, NSW Health
University of Sydney - Professor Arthur D Conigrave, Dean, Faculty of Medicine,
The Hon Dr David Gillespie MP
NSW Rural Doctors Network Executive – Meeting
Western NSW Local Health District – Mr Scott McLaughlin and Executive
Senator for NSW, The Hon John Williams
National Party Room Meeting, NSW Government, Sydney
Kevin Anderson, MP, Member for Tamworth, Tamworth
Glenrock Country Practice, Wagga Wagga, Dr Ayman Shenouda, and Ms Tania Cotterill
Royal Far West, Ms Lindsay Cane, Chief Executive Officer
UNSW Rural Clinical School, Wagga Wagga – student, junior doctor and consultant meeting
UND Rural Clinical School, Wagga Wagga – Professor Joe McGirr, Director and staff
Dr Cheryl McIntyre, Inverell Medical Centre
Inverell Town Rural Doctors - Meeting
Professor Rod McClure, Dean, Faculty of Medicine, University of New England
Molong Health Service and District Hospital
University of Sydney Rural Clinical School, Dubbo – Student Meeting
University of Western Sydney Rural Program leaders, Orange
Parkes District Hospital – Staff and junior doctors meeting
University of Newcastle Rural Clinical School, Tamworth – Prof Jenny May, Director
GP Synergy – Dr John Oldfield, CEO
NSW Ministerial Advisory Committee for Rural Health, Queanbeyan

South Australia

The Hon Mr Stephen Wade MP, Minister for Health and Wellbeing

Department of Health and Wellbeing - Christopher McGowan, Chief Executive

Country Health SA – Ms Maree Geraghty, CEO and Dr Hendrika Meyer, Executive Director Medical Services

Rural Doctors Workforce Agency - Ms Lyn Poole, Chief Executive Officer,

Flinders Rural Health SA - Professor Jennene Greenhill, Director

University of Adelaide - Professor Ian Symonds, Dean of Medicine,

Flinders University - Professor Lambert Schuwirth, Strategic Professor in Medical Education,

Flinders University - Professor Jonathan Craig, Vice President and Executive Dean

Mr Rowan Ramsey MP, Federal Member for Grey

Mr Tony Zappia MP, Federal Member for Makin

Dr Peter Clements, Rural Generalist Educator, Adelaide

Dr Ben Abbot, Rural Generalist Surgeon, Jamestown

GPEX, Ms Chris Cook, CEO

Victoria

Professor Euan Wallace, CEO Safer Care Victoria, Melbourne

Mr Dean Raven, Director, and Ms Tarah Tsakonas, Senior Policy Advisor, Victorian Government Department of Health and Human Services Workforce, Melbourne

Monash Health - Ms Rachel Yates, Principle Advisor, Innovation and Improvement

Professor Donald Campbell, RACP

Monash University Rural Clinical School – Professor Robyn Langham and staff, Bendigo

Bendigo Hospital – junior doctor and student meeting, Bendigo

Bendigo Health – Mr Peter Faulkner CEO, Bendigo

Rural Workforce Agency Victoria, Ms Megan Cahill, CEO, Melbourne

Western Victoria Health Accord – Meeting in Portland

Glenelg Shire Workforce Group, Meeting in Portland

Rural and Regional CEO Forum, Melbourne

Prof John Humphreys, Monash University, Bendigo

Murray to Mountains Intern Program – Mr Shane Boyer, Shepparton

Rural Health Forum, La Trobe University and Murray PHN, Mildura

RFDS Rural Health Sustainability Project, Mildura

Attend Anywhere Video Consulting Programs – Mr Chris Ryan, Director, Melbourne

Tasmania

The Hon. Michael Ferguson MP, Minister for Health, Launceston

Department of Health - Dr Allison Turnock, Medical Director GP and Primary Care, Hobart

HR+ Rural Workforce Agency – Mr Peter Barns CEO, Launceston

Dr Bastian Seidel, Rural GP, President RACGP

North West Health Service, Executive Director of Medical Services, Dr Rob Pegram

Professor Richard Hays, Rural Medical Generalist, Hobart

Dr Brian Bowring and Dr Tim Mooney, Rural Generalists, Georgetown

Invited Presentations on the National Rural Generalist Pathway

NSW Rural Doctors Network Annual Conference 2017, Sydney, NSW

Rural Medicine Australia 2017, Melbourne, Vic

RACGP Annual Convention 2017, Sydney, NSW

Rural Doctors Workforce Agency Annual Conference, Adelaide, SA

WHO Global Health Workforce Summit, Plenary Presentation, Dublin, Ireland

WONCA World Rural Health Conference, Plenary Presentation, New Delhi, India

6th Rural and Remote Health Scientific Symposium, Canberra, ACT

Tasmania Rural Health Conference, Launceston, Tas

Victorian Rural and Regional Public Health Service CEO Forum, Melbourne, Vic

Hunter New England Professional Development Program for Doctors, Pt Stevens, NSW

Murray to Mountains Rural Intern Training Program Annual Dinner, Shepparton, Vic

“Are You Remotely Interested?” Conference; Realising Remote Possibilities, Centre for Rural and Remote Health, Mount Isa, Qld

National Regional Training Hubs Forum, Canberra, ACT

Australian Primary Health Care Research Conference, Melbourne, Vic

Medical Oncology Group of Australia Annual Scientific Meeting, Adelaide, SA

Griffith Rural Medicine Retreat, Griffith, NSW

Rural Doctors’ Association of South Australia Annual Conference, Adelaide, SA

Western NSW Primary Health Workforce Planning Forum, Dubbo, NSW

National Rural Health Student Network Council Meeting, Adelaide, SA

Victorian Health Accord Clinical Council Conference, Melbourne, Vic

Flinders University Regional Training Hub Launch, Mt Gambier, SA

10th Anniversary of the Joint Medical Program, Armidale, NSW

National Rural Training Hubs Conference, Sydney, NSW

Seventh Rural Health and Research Conference, Tamworth, NSW

Central Queensland HHS Clinical Senate, Rockhampton, Qld

Medical Deans ANZ Annual Mid-Year Meeting, Canberra, ACT

GP Training Advisory Council, Melbourne, Vic

RACGP Annual Convention 2018, Gold Coast, Qld

Rural Medicine Australia 2018, Darwin, NT

NSW Local Health Districts and Regional Training Hubs Meeting, Sydney, NSW

Australian Medical Council AGM 2018, Launceston, Tas

Royal Australasian College of Physicians (SA), Annual Scientific Meeting 2018, Adelaide, SA

Prevocational Medical Education Forum 2018, Melbourne, Vic