PLENARY 6  
TUESDAY 4 MARCH 2003  
8.30 AM – 9.30 AM

Opening Video—video clips and images

Frank Meany

Artelude Four—video story

Vivian Schenker, Conference Chair

…I thought there might be more embarrassing moments in that video of last night. They could have been more embarrassing; a few more close-ups!

Welcome back this morning. I am pleased and pleasantly surprised to see how many of you managed to scrub up reasonably well. It was a big night wasn’t it? A very big night for some of us and I am very pleased and grateful to see you here this morning and I am sure that so are our guest speakers who I think were prepared to speak to an even smaller turnout than we have got today.

Our first speaker this morning has looked at many of the issues we have been talking about for the last couple of days from both sides of the fence. Or probably I shouldn’t limit it to two perspectives; he has many. He was a politician, a National Party Member for Warrnambool in the State Parliament of Victoria from 1985 to 1999 so he is used to weighing up the issues; balancing competing issues and … But he also has a longstanding personal interest in mental health. Two of his sons suffered from mental illness so he hasn’t been just a dispassionate arbiter; he has also been a passionate advocate for services, particularly for carers.

So he has held many positions in that capacity including Chair of the Mental Health Council of Australia and a member of the National Advisory Council for Suicide Prevention. To give us a unique insight into the political process please welcome John McGrath.
KEYNOTE 12—POLITICAL KNOW-HOW
Politics and community well-being

John McGrath, Inaugural Chair, Mental Health Council of Australia

Good morning. After what I heard about last night you are all very brave to be here at this hour of the morning. It was obviously a very enjoyable night; as I said to somebody this morning “Last night probably did more for your mental health than I could ever do anyway—you were able to get out there and enjoy yourself.”

This morning is a bit of a challenge for me because I am coming this week to a group of people who I consider to be experts in their field in a very difficult and complex area of delivering health services across a very broad, remote and complex nation. And I have agonised over how I might best do that for you. I though that a lot of what I put together originally was—to use the old farming saying—“teaching your grandma how to suck eggs” and so I re-wrote and re-wrote and I have finally come up with something that I hope you will find acceptable.

Mental health has gone through some very difficult times and ten years on from the Burdekin Report I have got to say sadly that we haven’t advanced as far as I would like. So what I would like to do this morning is to give you a picture of mental health in Australia.

That will probably be clearly biased by my own opinion. Before I talk formally about the national perspective or the rural person’s perspective I want to talk to you about my own personal experience in mental health and what brought me to national advocacy, why it is important and then to close I will give you some thoughts on how I think we should move forward.

I think this morning’s video shows the secret of success in rural and remote Australia and that is working together. And that is why it is a great opportunity for me to come here to this Conference that I see providing an enormous network of opportunity for people to come and share and work together where resources are scarce and issues are very, very diverse. And here is an alliance; a broad alliance of people who can come together and do something constructive about how they can best serve their communities.

So, let me tell you my story. I am a farm boy. I was born in south-west Victoria, and as you heard I was the Member for Warrnambool. I grew up on a dairy farm …. And in those areas, in those days we were smaller in size on farms. And that was where I first learned the art of working together. Having to share equipment, you know, “if you buy the mower, I’ll buy the bailer” and similar arrangements. And that was shared over many, many years of how people in small communities need to work together to be able to survive and to be able to enjoy some of the fruits of technology as it unfolds. So that was my first introduction to life as it is in rural and remote areas and working together, the importance of friendship, the importance of partnership, the importance of trust.
I eventually married and had five children and as Vivian told you this morning I had two boys and three girls. My second son, Shane, started developing highly unusual behaviours in his mid-teens and it was unusual for him because he was a very happy child with a great disposition, full of mischief and always enjoyed life. But he went from that to starting to show little challenging behaviours. We put it down to the onset of puberty and him starting to put his imprint on the world. He became very unhappy, became impulsive, which were complete contradictions to what we had known Shane to be. He had a very good job. He resigned from that job just like that and he bought a ticket to India and he was going to—in his words—save the people less fortunate than himself. And he came back home from India about nine months later and he was what I would describe as a shattered young man. And the next eight or nine years were the most difficult years of life in the McGrath household—and I am talking about the McGrath household because I can only begin to imagine what they were like for Shane. Because he was admitted to hospital and was eventually diagnosed as having a mental illness. They called it schizophrenia and we said, “What’s that?” Because at that stage we were living in a vacuum of information—we knew nothing. And so we were a family on a learning curve and that curve actually went up a hill and turned a full loop because we were upside down for a lot of the time. It was a life that really put us somewhere where we really didn’t want to go.

Shane started that hospitalisation, started medication and sometimes it would work and at other times he would say, “I don’t want this. This is having bad side effects” so he would stop; or he would believe he was better and stop. For those of you here today, and there will be many, you will know that for someone with a chronic mental illness it is diabolical.

His behaviour changed. This was one of the most difficult things to live with. He was punctual, the most hygienic, organised young man you would ever meet. His brother was the complete opposite. Whereas Shane would shower twice a day, he would always hang his clothes up—he was organised. But all of that just went out the window and as a family we had great difficulty. At that point in time our family went into a grieving process, which we didn’t recognise at the time. But it was a grieving process born out of self pity for ourselves because of what had happened to us and born out of sadness for Shane because he was a “Straight A” student who was certainly going to walk through University, who had had a brick wall put in front of him just at that point in time as he was ready to take a stand. And we felt that was unfair. We went through all of those emotions as you do, tearing yourself apart. And to accept that your son—someone you are proud of and love—had what we knew at that time as a scary mental illness, because we still had a convoluted view of what it meant, caused us a lot of pain and heartache.

Shane had some good times during that period. He went through all the processes of voices and people chasing him in the night and he woke up sweating and terrified, and this was all new to us as a family. It was something that we had to learn. And in the end Shane’s insight—he had tremendous insight into his illness—was, if you like, his undoing in the end because he could see that his vision for life was gone and his hopes to go to University had been removed from him. His hope of holding down a full time job, a good job, was taken from him. His opportunity to maintain an ongoing relationship was gone from him. And from that relationship his hopes of having a child was gone from him. And so this process, as we have slowly come to understand it, had happened where he made the decision that death was better than life for him.
and on his fifth suicide attempt he succeeded. And for us that was probably the most tragic event that could ever happen to the life of a family. Somebody said to me when they rang me up shortly after it—it was Joan Kirner, the then Premier of Victoria, “Nothing can prepare you for the loss of a family member”. Because I was going through the process of knowing that Shane tried four times before but nothing can prepare you.

So that was a very, very difficult period of our life. And just prior to Shane’s death Darren had been diagnosed with a mental illness as well. And while not as acute or severe as Shane’s he still required medication and he went through similar experiences to Shane where he would stop taking his medication because he was having bad side effects. He was a wanderer like Shane. He would go away for weeks and you wouldn’t know where they were, whether they were in Sydney, Darwin or Perth or wherever it might be. But eventually, thanks to the effects of new medication, the research, good people in the field, Darren started getting his life together and today he lives a very fulfilling life—not without problems but don’t we all have problems? But he leads a very fulfilling life. He works with intellectually disabled young adults and I am told it makes a tremendous difference to their life. He lives independently, has his own car, enjoys life and has now got back what we would describe as “getting it together”.

Out of all of that you might wonder where you go from there. Well, for me, I went into a tailspin. I got myself into a state where I just couldn’t accept what was happening. I worked 110–120 hours a week, my marriage broke down and I just drove myself to the point where I ended up—I broke down—a blood disorder they called it—and they put me in hospital for ten days on a drip with the door closed. And that was a turning point in my life because what happened in those ten days was—twenty-four hours a day is a long time and that is when I first realised that there were twenty four hours in a day I think because I was awake for most of them and it allowed me to do a lot of thinking. I realised what I was doing was wallowing in self pity, that I in fact had seen that our family had been so badly done by in this world when in fact there were many other families that were doing it far tougher than we were, and far tougher than I was.

And so that experience became for me a motivating factor, a motivating factor about looking at the mental health system, what had happened and what needed to happen. I was well placed, still on the political scene; I still had the opportunity to talk to people and to get out and advocate on behalf of people—that was how it all started. I was already doing that in the local area but I wasn’t really involved on the national scene in the very early time just after Shane died, probably three to four months after Shane died. And so I started to use what I call my personal script—and we can all do that. We all have personal experiences, we all have particular contacts and at the end of the day that is what we have to start doing; we have to start building a passion, building a drive to actually make a difference, to actually get people to stop and listen to us. And there are various ways of doing that. Some of us are practical; some of us are not so practical. And I say that if the passion doesn’t work then go for the other because we have to get radical. If we are going to change the landscape of health services in Australia we have to get radical. We have to be prepared to stand up as a group and start to tell the people that fund our services that they are not good enough. That is the only way we are going to progress.

And so what I say is use the passion and the drive to actually try and do something. So I call on you today to think about your position, about your passion and your drive
because when Shane died a young man who went to school with him gave a Eulogy and he talked about Shane, and he talked about how he realised how he was part of the group, how he was known as the stand-out boy and all this sort of stuff and then he went on to talk about what mental illness did to him and what it denied him and at the end of it he said “But it never took away from the man”. And in that statement this young man said, and he was his friend, from a young boy right through to when he died, stayed with him, was always his friend—Shane was lucky in that sense that five or six of his school friends stayed with him right through. What it said was that this man saw no stigma attached to mental health. And that is the greatest problem in mental health that we face today—stigma. It’s a feeling of shame. If you look at stigma, and the dictionary will tell you, it is a feeling of shame.

And isn’t it a national disgrace that we have people who are sick, feeling a sense of shame because they have an illness that we can’t get on the national agenda because it is not treated seriously? And so I say to everybody in the health field that we have a lot to do—not just in mental health. I talk principally about mental health because that is my passion and that is where I have concentrated but I see it right across the board.

This morning has been a bit of a “come home” morning for me. I have met two people from south-west Victoria this morning who I have dealt with over a period of time on rural health issues so I understand in part what you are battling with and what you are trying to do. But let me remind you that stigma is the greatest problem that faces mental health today and the sad part of stigma is that it is not just community stigma—we had it as a family I guess because we were ignorant and we didn’t know and I owe them a responsibility to go out and talk to families and tell them about mental health and what impact it has on families, what impact it has on communities. So we have a responsibility to educate but the sad part is that stigma is alive and well in the mental health community. If you want to find stigma, in many cases go to the mental health community, and that is what really I find sad and it makes me angry; and I don’t get angry very often. But that makes me angry, when I find that people who are in the system to provide better outcomes, are actually stigmatising; that tells us that we have got to do more education in the system as well.

So, my way forward for all of us is partnerships. We must work together. Mental health has effects right across the community. We are starting to understand now that through the Rotary Program that has gone Australia-wide through the Australian Rotary Health Research Fund, we are starting to get good messages out. One of the messages is that one person in five will experience mental illness at some stage in their life. That is a pretty sobering thought. Just think about the fact that for every five people one will experience a mental illness. So it is more prominent whatever we might think. But today I have a clear picture in my mind about where we need to go and I believe that partnerships are the only real way forward. And I know that when I talk about partnerships, talking about the National Rural Health Alliance, similar to the Mental Health Council of Australia, are probably the best examples of partnerships working together that there are.

So I am not telling you anything new this morning but I want to reinforce it with you that this is the way forward and maybe there are other ways you can do it.

So I will finish on this. The National Rural Health Alliance and the Mental Health Council provide outstanding examples of bringing together into a forum expertise, guidance and enthusiasm, which can be shared and utilised by all, especially those
small bodies that have less resources. When I talk about partnerships I talk about all conditions; but it is particularly important in rural and remote areas where there are many instances of small town rivalries—I am sure you have all experienced those. We understand them but what they do is they provide obstacles to sound working relationships, which in themselves are counter-productive. And they limit recruitment and the availability and quality and services in these communities.

Our partnerships need to include local government, the non-government sector, service providers, community groups, health professionals and any others who can be part of the community that provides community life we must all be proactive, seeking ways to work together co-operatively. We all have the same goals; we want better outcomes for people who are ill. So we must create a system that progressively breaks down all of the barriers we face.

Ladies and Gentlemen, you know as well as I do that this is an enormous challenge but I am absolutely convinced that if we are to find a way forward from the current unacceptable resourcing models—and I emphasise that—unacceptable resourcing models that exist across our nation, we need to be both brave and we need to be passionate. You need to find a passion in you somewhere to drive you to progress these issues. And let’s take on board what Jesse Jackson said, “If my mind can conceive it and my heart can believe it then I know I can achieve it”. Thank you.

**Vivian Schenker, Conference Chair**

Fantastic John. Thank you very, very much. Certainly you are one person that has found that passion and we really appreciate you sharing that with us.

Some of you may already have heard from our next speaker because he has been talking in some of the earlier sessions about Healthy Horizons Outlook 2003–2007. Kim Snowball is a Western Australian. He is the CEO of St John of God Healthcare in Geraldton and he is also the Principal of Healthfix Consulting, which is a firm that specialises in rural health issues. And it was in this capacity that Kim was contacted by Federal, State and Territory Governments late last year and asked to revise Healthy Horizons, a framework for improving the health of rural, regional and remote Australia. Now to tell us a bit about what it is about here is Kim Snowball.
KEYNOTE 13—POLICY KNOW-HOW
The journey to Healthy Horizons

Kim Snowball, Healthfix Consulting

Thank you very much. I am here to talk about Healthy Horizons but what I want to really describe is this is a framework to ultimately address the health disadvantages being experienced by those living in rural, regional and remote areas. So the framework itself represents a joint initiative of both the Commonwealth State and Territory Governments in partnership with the National Rural Health Alliance and it is designed to co-ordinate their actions and harvest their efforts in areas that will make a difference. I was fortunate enough to be asked to revise the framework for the Commonwealth, State and Territory Governments late last year and the revised framework itself has already been agreed by the Australian Health Ministers Advisory Council. And it is now with the Health Ministers for their approval before it is finally launched.

But before I outline the key contents of the framework I would like to spend a little bit of time sharing with you some of the importance of having a national focus on rural health issues. There are three key reasons for having a national framework for action. The first of those is that there are generally poorer health outcomes being experienced by people living in rural, regional and remote Australia and health outcomes for Aboriginal and Torres Strait Islander people are significantly poorer than for other Australians. In general health outcomes worsen with remoteness.

The second reason for having a national framework is that the health risk factors are similarly higher in rural, regional and remote Australia. These health risks themselves signal a continuation of poorer health outcomes into the future unless corrective action is taken. Many of the risk factors relate not only to behavioural risks such as smoking, substance abuse, lack of exercise, but also environmental and social factors like community infrastructure, employment, education and housing. The comparative health outcomes and risk factors have been well documented and in particular the Australian Institute of Health and Welfare has described the level of health disadvantage being experienced in their publication “Health of Rural Australians”. This clearly shows poorer health outcomes in a whole range of measures.

The third reason for a national framework is perhaps a little different. It is a pressing need to be organised in a policy and planning sense and to share our successes. So I would like to elaborate on that third point. Recently I was involved in a conversation about rural health generally and a person who is well respected and has a profile in the health system more generally was asked for his impressions of the rural health system. His answer surprised me because he said the first description that came to mind was “unprofessional”. Now whether you agree with his observation or not it is a perception that still seems to prevail in the wider health system. It was recently reinforced when I was talking to a number of new health graduates—and these happened to be medical undergraduates. Naturally I asked them whether they were going to be working in the country and some were interested and had a good
experience during their graduate years on placements. But their lecturers and their colleagues were trying to talk them out of it, describing it as “career suicide”.

So, where do these perceptions come from? In my own view it is based on circumstances ten or fifteen years ago and things have changed quite radically. When I first came into rural health I would have agreed with both views. In terms of policy and planning rural health was a vacuum and it was filled by disparate (and desperate) set of characters and personalities. It was disorganised and was seen as a backwater to the wider health system. My own personal experience—I first visited a remote hospital and I was told by the people there that they hadn’t had a visit from the Health Department for eight years. So you can wonder what sort of feeling that had for them—how important that made them feel.

But as I mentioned things have changed and I think there were three key events that led to that change. The first of those is that rural doctors got organised—mainly around workforce and pay issues—but they have remained organised and politically active, and they got attention. So their issues are obviously shared by most other health professionals but they got media and they got lots of community support.

The second event was that the first of the National Rural Health Conferences were held and there was passion and raw emotion and anger at what people viewed as injustices and they became advocates for change. The National Rural Health Alliance itself was formed and the Commonwealth, State and Territories began establishing specific rural health Branches and Divisions in their own Departments. And finally, and most significantly, rural communities themselves began to advocate for change and exercise their political power at the ballot box.

So in combination I think those three events put rural health on the agenda. Politicians began listening and governments were prepared to respond. But it doesn’t stop there; I mean once you are on the agenda you need some co-ordinated and clear action.

I think rural health faced an unusual set of circumstances and challenges from a policy perspective. Firstly, the communities themselves are not homogeneous, the populations are not homogeneous; health priorities vary as much as the landscape itself. No one solution or model suited every community. Metropolitan solutions in particular on health issues often failed in rural settings.

The second set of challenges that very small communities face is that economies of scale are difficult to achieve. Distance and isolation create logistical problems: higher cost of services, poorer access to a full range of services and of course attraction and retention of health professionals is often problematic.

Given this set of unique features and characteristics a different approach was needed to tackle them on a national, as well as a State and local level. So while governments were prepared to make an investment and take action they also needed a clear direction for that effort. Otherwise the opportunity to take advantage of the moment would be lost. In terms of government responses while all the States and Territories have rural health units of one kind or another the individuals were still part of a wider health system and needed some clear directions in order to effectively advocate on behalf of the rural communities and health services.
And you need to bear in mind that this is very much a competitive process; this competitive environment—there are some very powerful bodies representing the health system interest groups particularly in teaching hospitals and major institutions. They had similar calls for funding and action and a reinforcement through the media on things like waiting lists and through hospital emergency departments on bypass. So governments need to prioritise and respond to these needs and rural health needs to be well placed in that process—hence the need for a clear voice and a consensus on priorities and a commitment on action.

The combination itself with the National Rural Health Policy Sub Committee and the National Rural Health Alliance on achieving this through the “Healthy Horizons” is in some part delivered through that process. So while the Alliance itself is a high profile advocate for rural health I would like at this point to record that the members of the National Rural Health Policy Sub Committee itself are also passionate about rural health, as passionate as anybody. So you might not see that in the public arena, but you can be assured that you have some strong and very important advocates for change in that Sub Committee and in Government agencies.

The other ways that the Framework seeks to be an influence is really through its actions on other National Health Strategies. So it is there to also influence the National Mental Health Strategy, the National Diabetes Strategy in a way that gives information to those responsible for those strategies about what the needs are in rural areas and how they can be more effective in rural areas.

Similarly to influence other areas the Government—as I said at the beginning, it is actually about housing, employment, socio-economics; there is a whole range of other determinants of health that need to be recognised in this process. There are other Government agencies that had ultimate responsibility in those areas.

And thirdly the Framework tries to identify critical success factors—free information of the wider health system and also for our own organisations.

So in terms of the journey, it was first released at the 5th National Rural Health Conference in Adelaide. It had a very difficult beginning because it was different. It wasn’t one of those National Health Strategies like Diabetes or whatever. It didn’t have a discrete new amount of money attached to it. In fact it met with a higher cynicism from a number of Conference delegates. But I think one of those major comments that I heard was “What good is a strategy without money attached to it?” But nearly four years have gone from then and there has been a Progress Report made on the achievements to date under Healthy Horizons and that document describes a very comprehensive and impressive array of initiatives. And the full report and summary is available—and I have put the website on there for those of you who are interested in following through on that.

So the general consensus is that Healthy Horizons has been a very useful vehicle for action and it has helped a variety of groups to organise their thinking and perhaps the best description comes from the Association of Australian Rural Nurses, and I quote, “Healthy Horizons provides a framework, which supports collaboration across all groups, which are influential in the development of rural health strategies. We applaud the initiatives that have taken place and believe that the ongoing redevelopment of the Healthy Horizons document is vitally important to reflect the ongoing changes, which are being experienced by rural Australians. It is gratifying to
see that many of the goals developed in 1999 have been well advanced and we look forward to the time when some issues in rural Australia are dealt with to such a degree that they don’t require active attention and a focus can be placed on other issues which increase in importance.”

As I said the key intention is to address the health disadvantage in rural, regional and remote communities but importantly this new revision seeks to identify—first of all there is a need for sustained effort in this area and secondly that there is an opportunity to use and add to those actions and principles that are contained in the Framework with some revisions to address contemporary issues.

Healthy Horizons Framework is actually used as a matrix and it has used a matrix across goals, which are there to direct the effort of those involved, particularly Commonwealth, State and Territory Governments, but also Alliance members and other organisations. And the principles themselves are there to inform and influence the manner in which the goals are actually pursued.

So each of the goals contains a series of actions and commitments and accountability has been included in this process and it is a very important component of the Framework and that is a Progress Report to the Australian Health Ministers Advisory Council, which is planned for 2005.

Of the goals, and there are seven, the first of those is to improve the highest health priorities first. And within this what I will try and describe is just a short outline of the actual key parts of those goals and then the emphasis that the Rural Health Policy Sub Committee has determined for this new revision.

The first goal is really targeting Primary Care and public health intervention against the highest health priorities. So while those interventions are largely structured around the National Health Priority Areas they also identify risk factors, in particular causes of disease and illness, which are highest in rural, remote and regional areas. So among those seven priorities, diabetes and injury prevention and control are at significantly higher rates than for the rest of the population. It is also important to note that while national action is being taken, or is proposed in these areas, a key issue is the degree to which poorer outcomes in rural areas are being addressed within the broader strategies. This includes an assurance that there is a fair share of resources according to need and that models reflect the unique nature of rural and remote communities. The key areas of emphasis are in child and new health services—this is for the next four years, and the second area is a stronger focus on older people and a continued emphasis on aged care services, access to services, particularly in rehabilitation.

The second of the goals is to improve the health of Aboriginal and Torres Strait Islander peoples living in regional, rural and remote areas. That is a goal in its own right in recognition of the higher burden of disease and chronic illness experienced by Aboriginal and Torres Strait Islander people in almost every health indicator. So the goal seeks to channel special attention and effort and actions emphasise the importance of respect for culture and the desire for community control and holistic approaches in the way in which services work with and for Aboriginal and Torres Strait Islander people. The key action under this goal largely relies on the development and release of the National Strategic Framework for Aboriginal and Torres Strait Islander health, “A Framework for Action”. This is being finalised by the National
Aboriginal and Torres Strait Islander Health Council and following its endorsement and signing by the Commonwealth, State and Territory Government it will form a large part of the initiatives under this goal.

The focus on improving access to Primary Health Care for Aboriginal and Torres Strait Islander people and the development of effective, culturally secure employment within health services are two further actions under this goal. A key initiative of the Sub Committee emphasis under this goal is to develop resource strategies for those with special needs, particularly the Aboriginal and Torres Strait Islander people.

So while those first two goals seek to address the highest health priorities the remaining five goals are directed towards removing systemic obstacles such as existing funding arrangements between State and Commonwealth Governments, encouraging better co-ordination and planning and delivery of services. The importance and emphasis on flexibility in co-ordination is a common theme throughout the goals and actions to allow local solutions to be developed.

So the actions, and I will go through each of these very quickly and I will add the emphasis:

Research is the third goal and under that is to develop a National Rural Health Research Agenda and a focus on applied research. A lot of the studies, whilst there has been a huge amount of research there is not a great deal of translation of that research into policy and practice in rural and remote areas. This is intended to set an agenda for researchers to ensure that they are taking the areas where we need the information in terms of our own service delivery.

Goal four is to develop flexible and co-ordinated services and the intention here is to move beyond those current models such as the multi-purpose service model, which is about bringing together health and aged care services, and to look at other innovative service models beyond those. The second area of emphasis is while maintaining access to hospital care, to really continue the shift towards preventative approaches and alternatives to hospital care. And that includes a focus on risk factors.

The fifth goal, and a key one, is to maintain a skilled and responsive health workforce and, within that, emphasis on increasing and focusing on employment of Aboriginal and Torres Strait Islander people and educational training programs within health services and to work to monitor the health workforce with a special emphasis on nursing and allied health practitioners.

Goal six are the flexible funding arrangements – this is a key one as well looking at considering whether other indicators of need other than population and distance might be a more effective way of planning and to do so on a regional basis.

And finally goal seven is to achieve recognition of rural, regional and remote health as an important component of the Australian health system.

And that brings me back to the earlier point I made about perceptions of rural health. It is equally important that while we, as a group, can debate amongst ourselves and describe the disadvantages and the issues, we actually need to be out there talking to metropolitan health services and metropolitan universities and others so that there
understanding of the issues that we are dealing with are improved and they become more effective themselves in terms of supporting our issues.

There are also eight principles. I won’t go through each of these but I will add that there is a particular emphasis on community participation and there are new principles of partnership and collaboration, which is essential in the way in which services are delivered and safety and quality. There is to be no compromise in terms of safety and quality in terms of new services that are developed.

Just one final thing: in terms of the emphasis on the reports—I have talked about the accountability—there is also a report being developed by the Institute of Health and Welfare, which will provide a framework for rural health information based on the National Health Performance Framework. They will also be reporting against agreed indicators under that framework and providing a report on mortality in rural, regional and remote Australia, and finally a special issues paper on injury in rural areas. That combination will help us to, I think, start to gauge our progress against the ultimate vision, which is that people living in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities.

So we now have an effective working framework. We have collaboration between Governments and national rural health bodies. There is accountability in the process for those commitments that are made and we have a process to measure our progress against the ultimate vision of Healthy Horizons. So while we are now better organised and disciplined it is important to sustain the effort and ensure the wider health system is made aware of our progress and success. So I would encourage you once this is distributed that you promote it; promote the framework with your colleagues; contribute to it at every opportunity. The overall vision may seem a distant prize but we are indeed on the journey to Healthy Horizons one step at a time. Thank you.

**Vivian Schenker, Conference Chair**

Thanks Kim. It is terrific isn’t it in one session to hear that sort of passion we heard from John McGrath about a personal issue, and a personal feeling and have that translated then into something concrete we can all take away with us.

Well that’s it for this morning’s session. It’s time to move to Concurrent Sessions for the last time this morning.