NATIONAL RURAL HEALTH ALLIANCE INC.

22 November 2016

National Press Club Address: Fixing rural and remote health

Geri Malone, Chair, National Rural Health Alliance

Thank you for the Introduction and it is a great opportunity for the National Rural Health Alliance to be able to provide a spotlight on rural and remote health.

I would like to pay my respects to the traditional owners of this land, the Ngunnawal and Nagambie people, to elders past and present and to future generations.

I would like to tell you a story…

Imagine yourself in a small remote town, population 250 with a broader district population difficult to quantify, and covering a vast geographical area, predominantly agriculture based, some mining activities and tourists.

- The town has a school and a health clinic, a pub, some other small businesses and a policeman.
- The health clinic is staffed by a Remote Area Nurse (RAN) with fly-in-fly-out (FIFO) medical and allied health services.
- The nearest, more substantial town (population of 3,500) has more services, a hospital, including birthing services and is 400kms away.
- The Royal Flying Doctor Service provides a weekly Primary Health Care clinic with a Doctor and Nurse, and responds to Emergencies.
- Allied health services are provided on a FIFO need basis.
- The capital city is 1,000 kms away.

The relieving Remote Area Nurse flew in on the regular, not daily, commercial flight to receive a handover from the Nurse leaving the community on that outgoing flight.

During that face-to-face handover they discussed an ongoing situation with a specific patient, culminating with the plan that the patient was flying out under that departing Nurse's escort. The situation had been managed over a period of time in consultation with various networks.

The patient was a 12-year-old boy who I will call Max, who had been exhibiting anti-social behaviour, disruptive, explosive bursts of anger, had threatened other kids and also threatened to self-harm. He had a history of other similar incidents but never to this extent.

Incidentally, the local mental health service, is one mental health worker in that closest bigger town, 400kms away, a solo outreach position from the main regionally-based team another 300kms away again.

This seemed like a good plan, but unfortunately Max was not happy to go, exhibited behavior which was considered a risk in-flight so that was abandoned.

This left the incoming nurse to manage the situation and a very distressed mother angry and upset on the day's outcome after several days of negotiating and consultation, and with a now sedated son.

The nurse booked another urgent telehealth consult with the city based team and was informed that a peadiatric retrieval team was being sent out from capital city who would further sedate and transfer Max to the paediatric mental health unit.

However, that team flew in, assessed him, then they flew out again without Max, deeming it was too much of a risk or they were not prepared to initiate what was required to undertake this safely from everyone's perspective.

The Remote Area Nurse - a very experienced Nurse - by this time needless to say felt totally abandoned, not just for herself but for Max and his family.

Due to her diligence, persistence and her commitment to her patient and the family, she found some emergency funding that could be accessed to assist the family to drive out, not ideal but a solution.

So it took 10 days from the time of the original incident until Max received the appropriate assessment and intervention from a Child Mental Health team.

Was that a fair result for Max and his family?

Unfortunately, this is a story which will resonate with many rural and remote based health professionals, clients and families, reflective of the inadequacy of health services, not just a lack of resources but also the fragmentation, highly time consuming web and maze to find a solution.

It is important to mention here the importance of telehealth, the access to the mental health workers through this medium are highly valued and a critical link. But it is equally important to highlight that telehealth is not the panacea that many funders and city based bureaucrats would like to think it is, only goes so far and is not and must not be seen as a replacement for on-the-ground services, but an adjunct.

The NRHA is well positioned to inform the discussion on rural and remote health. A 39-member organisation who all have a common goal to improve the health outcomes for people living and working in rural and remote Australia.

Our members are professional workforce organisations across the spectrum.

- Health Service providers such as RFDS.
- Key Aboriginal and Torres Strait Islander workforce organisations.
- Important consumer groups such as the Country Women's Association and Isolated Children Parents Association reflecting the importance of encompassing all the elements contributing to health and well being

Good Health is essential for a good productive life, evidence supports that.

If we can reduce the disparities in health and wellbeing between people in rural and remote areas and people in metropolitan areas, we can dramatically improve participation and productivity, and increase Australia's economic growth.

Access to appropriate affordable health services is a basic human right.

We are not talking about the highly specialized surgical and medical services, … but primary health care services, emergency response including mental health care, and being able to birth and die close to where you live.

For a long time now we have been highlighting the fractured nature of the health service delivery that exists between layers of government and provision of service contracts to different organisations that are not co-ordinated and do not meet the needs of communities.

Models that work in urban settings do not necessarily translate to the rural and remote sector, we need flexible arrangements to provide the services communities need.

_____

Local solutions for local issues, using local knowledge

Access to health services is dependent upon many factors including an appropriate workforce, and not of any one professional group but a team.

Whereby the Aboriginal and Torres Strait Island Health Worker, the Aged Care worker, mental health professionals, Optometrist, Dentist, Ambulance personnel, Speech therapist, Podiatrist is as equally vital to health services as is the doctor

We do not have a health worker shortage in this country at the current time, what we have is a distribution problem – we can't get them out of the cities.

As a health professional I consider myself very fortunate to have worked across rural and remote Australia in variety of Nursing & Midwifery roles

I am also representative of what we know, that having grown up in rural South Australia, I am more likely to go back and work in that environment.

We must focus on growing our own workforce.

There tends to be a bit of an attitude that to work in rural and remote health regardless of which professional group, that you are bit lower down in the pecking order, you couldn't cut it in in the city - so you go bush.

But we know the reality is quite different, that in order to succeed in rural and remote practice you have to be a special kind of person.

As a generalist you need to be adaptable, resourceful, self-motivated, and competent across a very broad scope of practice.

You need to be in tune with your community and you need to be resilient

It is a great career.

Australians will attest they have a strong affinity with the bush, they like to romanticize the lifestyle, reinforce the myths and promote the romantic images of the bush, and they wear the Akubras and moleskins to prove they do?

Politicians included.

I suggest that that connection is superficial.

Scratch the surface and the actual investment in services be they health, education, communications and business is tokenistic at best.

We need to do better.

One size, one approach does not fit all.

7 million people and kids like 12-year-old Max deserve better.

A fair go for rural and remote health.