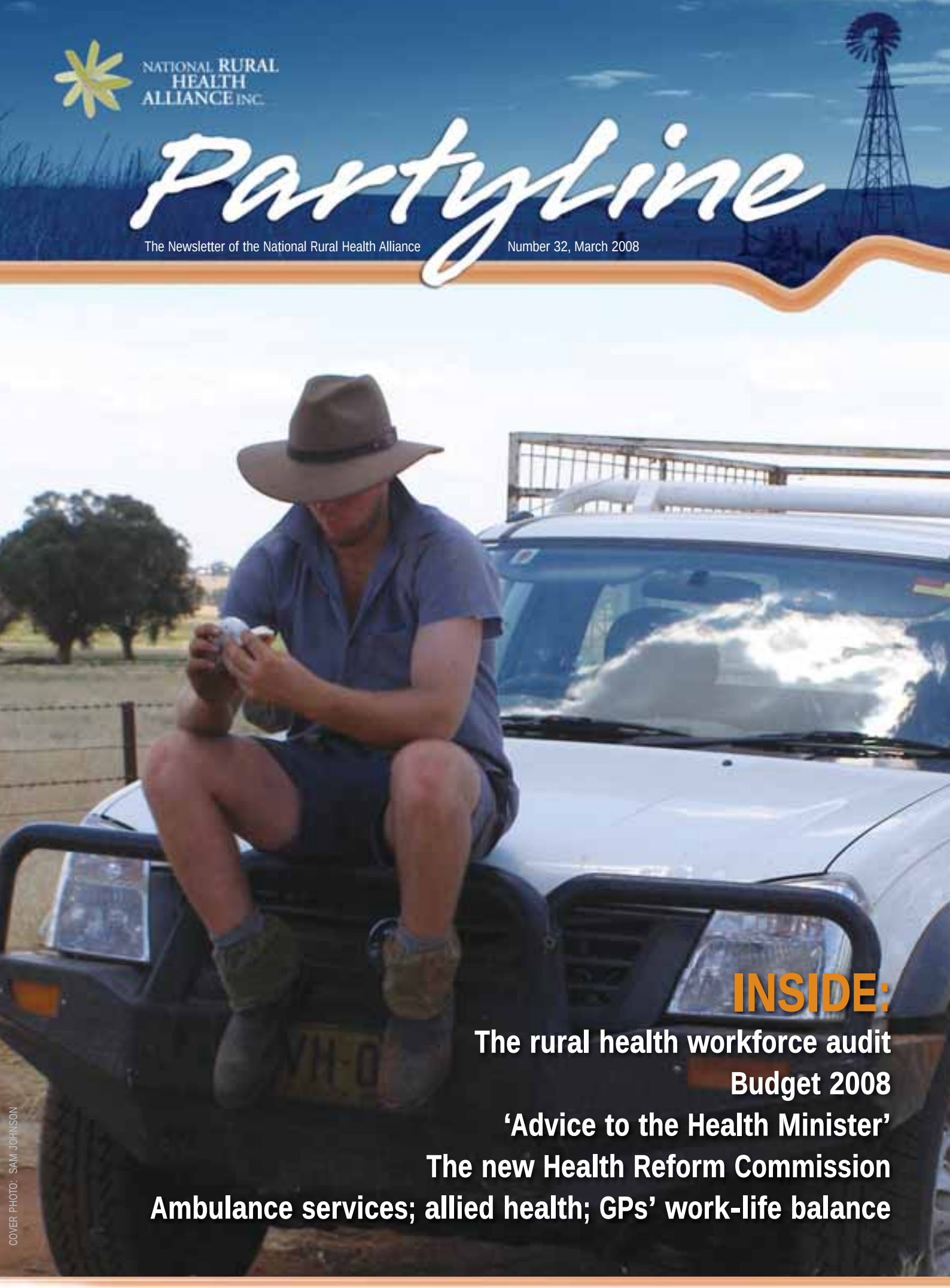
NATIONAL RURAL HEALTH ALLIANCE INC.

Partyline

The Newsletter of the National Rural Health Alliance Number 32, March 2008



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The rural health workforce audit

Budget 2008

'Advice to the Health Minister'

The new Health Reform Commission

Ambulance services; allied health; GPs' work-life balance

COVER PHOTO: SAM JOHNSON

Aboriginal and Torres Strait Islander readers are warned that this newsletter may contain images of deceased persons.

The best of times (may soon be over)

EDITORIAL

THESE ARE WONDERFUL TIMES for Australians. They may be the very best.

While we enjoy them, we have a responsibility to invest in the future - to ensure that future generations have a fair go too.

The growing epidemics of obesity, diabetes (and sitting at computers?) may well mean that the life expectancy of this current generation will exceed that of their children and grandchildren.

The widespread increases in mental health problems now seem to be affecting youngsters - or is it just better data capture, reporting and awareness?

Bondi shouldn't need evacuating, but there is no doubt that the impacts of climate change will affect the health of our nation's ecology and people: food prices are likely to increase, but not as much as the price paid for water, energy and polluting activities. (And hopefully, as attitudes change, the definition of 'polluting activities' will broaden to include some commercial and recreational undertakings that have hitherto been admired.) So our grandchildren will be paying higher real prices for some essentials.

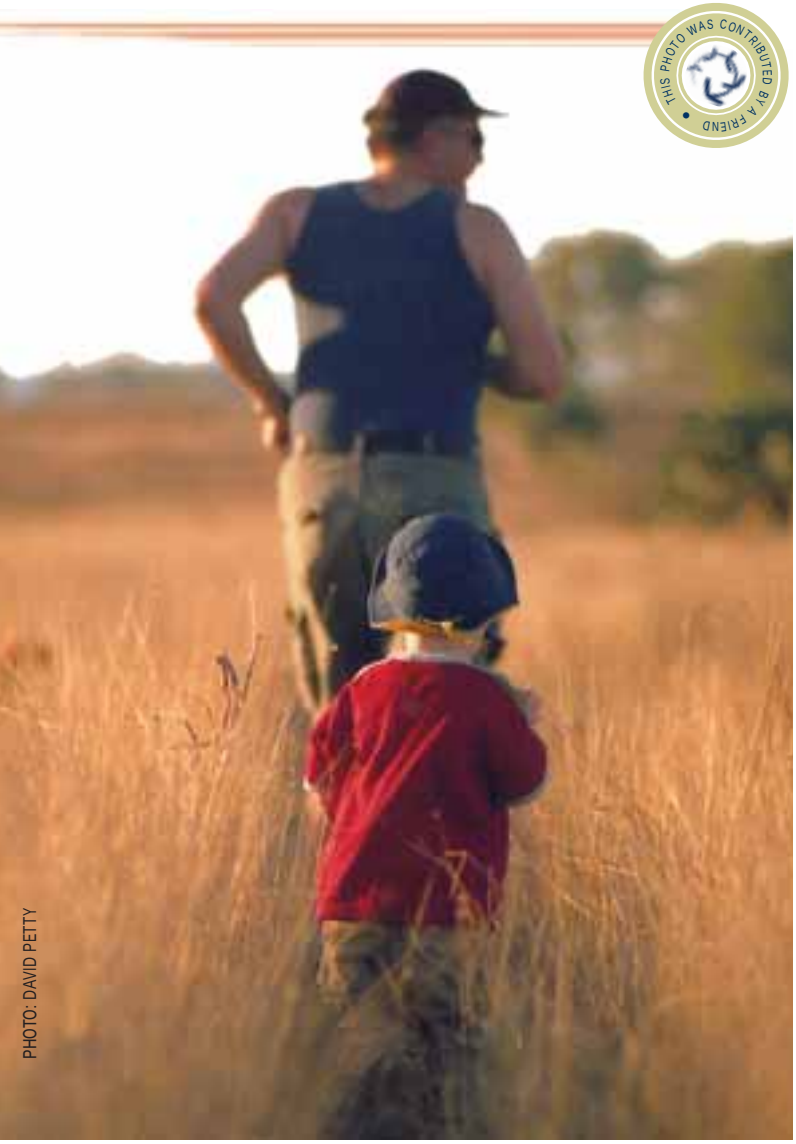

PHOTO: DAVID PETTY

Sam chasing Dad through the home paddock, Darling Downs, Queensland.

'Peak oil' is behind us (as well).

We've been living in the lap of economic luxury for some time now and there's no guarantee it will always be this good. Iron ore and coal have led us to dizzy heights - and Australia is now coupled to two new economic superpowers, India and China, rather than to the US, Japan and Europe. But the rate of growth of these new powers will not be unabated for ever. Australia has experienced a period of low unemployment, inflation and interest rates. Right now we are experiencing some of the downside of strong economic growth and high employment: the inflation monster has stirred, interest rates are climbing, and the current account deficit is attracting adverse notices.

The kind of housing stress currently being experienced by a minority may presage the reality that Australia cannot for long excel on all economic indicators at the same time.

If we are in an almost unprecedented golden age, we have responsibilities over and above the mere enjoyment of it. Those currently in positions of influence have an obligation to use present opportunities to meet major national challenges and invest for the future. What are the grand schemes of the present which will benefit future generations of Australians and make us proud in our (uniquely long) dotage?

Can the Murray-Darling Basin be saved and then enhanced in such a way as to guarantee its ecological, human and agricultural future? Can the nation agree a vision for rural and remote areas which is not determined by the selfish market or the selfish gene but which creates a national community of which we are proud - and a set of policies and programs to colour in the vision?

Can the people of Australia band together to transform the hopelessness of some of our remote Indigenous communities and give their people a fair go too?

Can the present generation restore public transport systems, improve education (especially in rural and remote areas), and provide safe and satisfying workplaces and work-life balances?

Let's be remembered for our responsibility, not our recklessness; and for our foresight and not for heedless hedonism.

Even in such munificent times as we have, it will not be possible to meet all of these challenges at once. But if we fail on all counts we will have failed indeed. ❖

Cox Peninsula wins award

A new multi-purpose community centre at Wagait Beach in the Northern Territory was opened last year by the Administrator, His Honour Mr Ted Egan. Victor Stow, President of the Cox Peninsula Community Government Council, is pleased to showcase in Partyline the achievement of bringing a much-needed community facility to this small and isolated community in the Top End. This project was the winning entry in the rural section of the Australian Local Government Awards 2007.

WAGAIT BEACH IS SITUATED on the Cox Peninsula, about 130 kilometres by road and 10 kilometres by ferry from Darwin. The community of 400 people live in a beautiful coastal village which is serviced by a general store, country club and Council-maintained sporting facilities. The community is isolated from day-to-day medical and general health services.

Wagait Beach Community Centre / Medical Clinic.

The concept of the multi-purpose community centre evolved from a community meeting in 1999 as part of the Council's five-year business plan which is updated annually. Council then started reserving a small part of its annual budget each year as a building fund. Concept plans were drawn up and the Council started lobbying the Northern Territory Government for funding assistance for the project. In 1995 the Northern Territory Government, as a pre-election promise, announced a grant of $350,000 for the project. Because of the need to house approximately 50 per cent of the residents during the dangerous cyclones experienced in the area, Council approached other funding bodies including the Area Consultative Committee and Emergency Management Australia to progress the project.

Prior to this project Wagait Beach was lacking a medical facility and meeting place, and only had limited cyclone shelter facilities that were inadequate for the growing community.

This project has shown that it is possible for small communities to obtain facilities and new services through regional partnerships between the three tiers of government. Since the completion of the Community Centre the Northern Territory Government has signed an agreement with the Council to provide immediate emergency medical services by qualified nursing staff already living in the local area.

Residents participate in a Well Being Diabetic information session.

Demand for the project came from the community because of the lack of facilities on the Cox Peninsula. The Council needed assistance in funding the project because its annual budget is only around $440,000. The Council's building fund was another key to success.

Since the completion of the Community Centre, substantial benefits are being realised. The community now has access to medical services through nursing staff. A doctor will be available soon to conduct clinics on a twice-weekly basis. We have access to up-to-date medical equipment and pharmaceutical products as well as health awareness programs. The community will also benefit from medical support during emergencies such as cyclones and bush fires. The facility provides a meeting place for community groups and social events, and plans are in place to provide activities programs for seniors at Wagait Beach who are approximately 32 per cent of its population.

The building was made possible through the financial generosity of the Northern Territory and Commonwealth Governments, the Cox Peninsula Community with support from the Regional DOTARS Office, Northern Territory Department of Health, The Area Consultative Committee, Emergency Management Australia, the Wagait Beach Community and Cox Peninsula Councillors and Staff.

The project shows that multi-purpose complexes are the best option for small communities because of the varied funding possibilities available. Communities should establish partnerships early in the process to gain increased funding and planning assistance. And allowance has to be made for the fact that building costs can increase significantly after the initial planning stage! ❖

The May Budget

THE FIRST BUDGET of a new government is often 'a horror': the time, well before the next election, to make many of the unpopular cuts thought necessary to protect the surplus, pay for the promises made in the campaign, and begin to build up the war chest for another poll.

This May's has already been characterised in this way, with expectations of $10 billion in cuts to forward programs over a three-year period. The Government is targeting surpluses of 1.5 per cent of gross domestic product (GDP).

Such is the bounty of the Australian economy's bottom line that the fiscal rectitude to be displayed through the May budget is probably not required merely to reach such a surplus target. Large surpluses have, of late, been like white rabbits - only less and less surprising and therefore increasingly grey and faded.

However, if savings are not much needed to deliver a surplus, this is offset by the increased need for the razor gang to help minimise inflation while paying for the election commitments. The Rudd Government's first priorities include meeting these - including the very substantial tax cuts promised in response to the Coalition's early campaign pre-emptive strike.

It is never too late for governments to heed the advice of the majority of Australians who would prefer the surplus to be spent on better services instead of tax cuts. Prime Minister Rudd must be regretting nearly matching the Coalition's tax cuts – the scale of which was described by the Alliance at the time as "insensitive, given recent tragic evidence of the incapacity of Australia's public hospital system and other urgent issues in health". But who's to say how important it was in framing the election campaign?

Now the PM has to promote the tax cuts as relieving the pressure on families experiencing housing stress. For this to be true they will need to be directed differentially at those on low incomes.

As part of the new Government's consultative manner, the Treasurer called for submissions from community groups about the forthcoming May Budget. In its submission, the Alliance called for investments to make up the deficits in rural and remote health status. Improving the health of people in rural, regional and remote areas is not just a human rights and equity issue. It will also meet several of the Treasurer's stated priorities. It will help lift workforce participation and productivity, and require improved training, support and distribution of the health workforce, which is part of the overall skills base of the nation.

The health of country people stands to gain very substantially from the Treasurer's commitment to deliver modern infrastructure and a world-class broadband network, and to ending the blame game between Federal and State Governments. Given sustained economic growth, now is a good time to invest in the nation's workforce, help protect country communities, point the way for health service and other interventions, and enable rural people to share in national prosperity.

Despite such expectations, people in rural and remote areas will accept their share of cuts – as long as evidence of effectiveness is the chief criterion by which they are determined, and as long as there is no reduction in support overall.

Watch this space on Tuesday 13 May. ❖

sunrise storm at Kungurra

PHOTO: JODIE ALTSCHWAGER

Rural workforce audit – just what the physio ordered!

BY BETH ROGERS

WITH DISCUSSIONS UNDERWAY regarding the Government's review of the health workforce in rural and remote Australia, health professionals and consumers will need to work together for reform so that we can move towards equity of health care for people who live outside the capital cities.

Rural and remote communities will always be more seriously affected by the shortage of health professionals than metropolitan centres. The NRHA paper *Under pressure and under valued: allied health professionals in rural and remote areas (2004)* points out that 24 per cent of Australia's allied health professionals service the 32 per cent of Australians living in rural and remote regions. The city of Adelaide has about twice the number of registered physiotherapists per head of population as the Northern Territory. It is generally the case that where the population is dispersed over large areas and health concerns are more pressing, there are very low rates of health professionals to address patients' needs.

Physiotherapists in the bush are sought after and respected by the communities they service. There are certainly challenges – but we try to see them as opportunities, as we forge meaningful careers away from the bright city lights. In recent years allied health professionals have been called on to work in new models of service delivery, such as the remote area teams working out of Katherine in the Northern Territory and Mt Isa in Queensland.

Autonomy and a broad scope of practice are among the attractions of working in remote environments. Professional development opportunities are increasing as we use technology, such as telemedicine and distance learning packages, as mainstream parts of our working week – linking us to our discipline specialists in teaching hospitals and trauma centres. The West Australian Country Health Service is currently working towards 'Clinical Supervision' of allied health professionals working in rural and remote places. Clinical support and mentoring for experienced therapists working in the bush will be welcomed and will further reduce the effects of professional isolation.

An audit of the current rural and remote workforce is welcomed. We need to know where our workforce is located and how this relates to both population and need. As many of our rural communities in Australia are struggling with decreasing populations, maintaining service delivery becomes increasingly difficult. Other areas are bounding along thanks to the resources boom – but in the majority of these areas the number of funded allied health positions has not increased in line with population growth.

There is no 'one size fits all' answer to remote health service delivery. Residential, outreach and 'fly in fly out' staffing models are all seen in our rural and remote communities. We don't need band aid solutions for workforce crises, but models that are appropriate and meet patients' needs.

Neither should we downplay the difficulties that workforce deficiencies impose on professionals working in rural and remote areas. It is essential that moves are made towards universal health care - not just universal medical care. Physiotherapists will always be required to treat the sick and injured, just as medical professionals are.

The key word is 'sustainability' – both of the health care system and of the rural communities themselves. ❖

An audit of the current rural and remote workforce is welcomed.

PHOTO: ANDREW WATERS

Replenishing and refining the Rural Health Strategy

THE RURAL HEALTH STRATEGY is the joint name given to a group of 13 programs that are funded by the Australian Government, partly in recognition of the fact that spending under Medicare and the Pharmaceutical Benefits Scheme is considerably less in rural and remote areas.

It began as the Regional Health Strategy and was introduced by Minister Wooldridge in the 2000 Federal Budget as *More Doctors, Better Services.*

Current funding for the programs lapses on 30 June 2008 and the Alliance's concern about their future was raised with Minister Roxon by Chairperson John Wakerman when they met in Alice Springs. The Minister was not able to give any categorical guarantees.

The programs include (in order of size) the additional Rural Clinical Schools and University Departments of Rural Health, new general practice registrar places, the Regional Health Services program, More Allied Health Services (MAHS), the enhanced rural and remote pharmacy package, and the Medical Specialist Outreach Assistance Program (MSOAP).

In the period 2004-05 to 2007-08, $830.2 million was provided for the 13 programs as a whole.

The Department of Health and Ageing has recently undertaken a review of many of these programs and of others providing special rural health services. In its submission to the review the Alliance argued that the need for special services in rural and remote areas still exists, and is based on poorer health status, the lower density of population, poorer access to the MBS and PBS, and relatively poor access to health professionals.

Despite the bundling of a number of the more important services in the Rural Health Strategy, there has been a piecemeal approach overall to the development of rural and remote programs. This has resulted in a large number of them – with generally poor interrelationships and gaps and overlaps in their operation and coverage.

PHOTO: GILLIAN HUMBERT

The piecemeal approach can be attributed in part to the proliferation in the early days of separate interest groups based on particular professions, disease conditions and locations. The NRHA is working to synthesise the views of particular professions and from particular locations into a service approach that can be rolled out - with due allowance for local conditions - in all rural and remote areas.

A systematic review undertaken through the Australian Primary Health Care Research Institute (APHCRI) has identified some of the key characteristics of success for such services (see page 12).

The Alliance welcomed the Departmental review. There needs to be a systematic approach to rural and remote health services. The National Health and Hospitals Reform Commission will hopefully develop, in consultation with health service providers and consumers, a national health plan and a rural health plan. This could lead to rationalisation of rural health programs through identifying gaps and overlaps consistent with the plan.

People in rural and remote areas will accept some rationalisation of programs as long as the result is better services and access overall.

Finally, there should be a monitoring and evaluation strategy built into the programs.

The future of some of these rural health services is already guaranteed. In the lead-up to the 2007 Election the Labor Party committed to enhancing MSOAP and the Specialist Obstetrician Locum Service and to a doubling of places in the John Flynn Scholarship Scheme.

As for the other programs in the Rural Health Strategy it is anticipated that, even as a new systematic approach is being bedded down, new allocations will be announced in the May Budget. ❖

Nursing with distinction

A FRONTIER SERVICES (AND SUPPORTIVE POLICY) SUCCESS STORY

RICHARD KELLY comes from a family of 14 children. He left school at the age of 16 and worked for a number of years in horse stables.

In 2000 he started work (with no aged care qualification) as a carer at Tracy Aged Care. He then moved to Chan Park (now Terrace Gardens) and started his Certificate III in Community Services Aged Care. He completed that in 2002. In 2003 Richard completed a bridging course to enable him to start his Bachelor of Nursing and started his bachelor of nursing in 2004.

For three years Richard continued to work night duty every weekend, as well as attending university during the week. During this time Richard won a Commonwealth Government scholarship (allocated through the Royal College of Nursing) that was specifically designed for rural and remote students who work in aged care. This scholarship was worth $10,000 a year, which helped Richard to manage both study and part-time work.

Richard's extensive experience in aged care assisted him in completing his units and often gaining distinctions and high distinctions in his assignments.

Richard completed his studies in December 2007 and became a registered nurse in the NT in January 2008. He is currently completing his Graduate year at Royal Darwin Hospital and assists with shift work at Terrace Gardens when he can.

Richard admits to being surprised at his ability to complete a bachelor degree and encourages others to apply for a scholarship. "If I can do it, you can too," he modestly says. "But do a bridging course first - especially if you are a mature age student."

Richard believes his future is in renal care or aged care – or a combination of the two.

We at Frontier Services congratulate Richard on a job well done. ❖

Richard with his dog Rhubarb.

Rural health loses a fine advocate

CONSUMER ADVOCATE, SUSAN MITCHELL, died earlier this year after a six-month battle with pancreatic cancer. Two days later, at the Australia Day celebrations in Centennial Park, Cooma, Susan was named the 2008 Cooma-Monaro Citizen of the Year.

Susan was well-known and much admired in Health Consumers of Rural and Remote Australia (HCRRA), Rural Women's Network and NRHA circles. She worked to advance countless community causes in her lifetime and for a better future for the Cooma region. She was involved in many groups including the NSW Farmers Association, the National Party (she was a candidate for the seat of Monaro in 1981), Capital Region Development Board, Rural Financial Counselling Service, Cooma Unlimited, Monaro Domestic Violence Committee, Capital Region and Snowy-Monaro BECs, Consumers Health Forum and the National Council of Women.

Mrs Mitchell was informed of her award in the lead-up to the Australia Day ceremony and was said to have considered it a great honour. ❖

When in Roma: Encouraging words

ON FRIDAY 7 DECEMBER, within a week of having been sworn in, the new Prime Minister visited Roma. That in itself was of some significance. Even more so was what he said.

> "I said when I became Prime Minister of Australia that I intended to be Prime Minister for all of Australia, and that included being the Prime Minister for rural Australia. - - And the reason I've come here is to underline - - that we take the interests of rural and regional Australia seriously and that they will remain central to the concern of the Government that I lead."

He spoke about climate change, agricultural production and the nation's Gross Domestic Product. And then this.

> "The other part of our concern as an incoming Government of Australia and helping rural Australia is this. It goes to the core challenges of the adequacy of the supply of rural doctors and nurses. - - And what we propose to do is this: we will conduct now an immediate audit of the shortage of doctors and nurses and other health professionals in rural Australia, number one. Number two: we will examine the reasons for these shortages. And three: we'll be asking the Department of Health and Ageing to provide us with a range of options for attracting and retaining health professionals in rural Australia. - - you can't expect people to come out and farm these parts of Australia unless you've got basic health services."
>
> "I'm also mindful of the other challenges in rural Australia when it comes to education. I laid out our plan for an Education Revolution and a broadband revolution. That includes rural and regional Australia as well, not just in the cities."

PHOTO: ROMA TOWN COUNCIL

Bottle Tree Heroes Ave, Roma.

By the time you read this, the Department will have reported to Minister Roxon on its rural health workforce audit. Hopefully the follow-up action will have begun.

The Alliance made a quite detailed submission to the Department's rural health workforce audit. It distinguished the demand for health professionals from the demand for health care, and argued that the emphasis should be on the latter. In a time of serious and growing global shortages of professionals, a balanced outcome in Australia between demand and supply will require changes on several fronts.

If, as a nation, we focus only on workforce numbers, and do not systematically address other health system factors, we will continue to struggle with health care shortages. We need to reform the health system, find productivity gains from the health workforce, moderate the demand for health care and change the way in which it is supplied. There are very substantial productivity gains to be made in the health sector from better utilisation of personnel, and these gains will to some extent moderate the demand for new entrants to the health professional workforce.

These broader issues must be seen as key parts of the response to the health workforce challenge and after the audit there will hopefully be further debate about scopes of practice, multidisciplinary teams, the relationship between health professionals, and the increasing importance of self-care.

Where workforce numbers are concerned, in its submission the Alliance emphasised the need to ensure that a fair 30 per cent of the graduates from health science courses (not just medicine) are enthused about and trained for practice in rural and remote areas. The number of new medical graduates will rise from about 1350 to

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Singing in the Spring at Mt Magnet

BY KAREN MORRISSEY

SKIPPERS AIRLINE SPONSORSHIP of the *Magnet Wannabes* 'Singing in the Spring' enabled members of this small outback community a rare opportunity to sing with renowned WA choir master John Christmass.

Mt Magnet is Western Australia's longest producing gold mining centre, with gold having been mined continuously since first discovered here in 1891. Eight years of drought and news of the closure of the gold mine left community members struggling to find something to lift everyone's spirits.

Local people considered community singing which is widely recognised as beneficial for health and wellbeing. John Christmass was generous in his response to our request for assistance, with community support from Outback Gold accommodation, the Swagman and Country Arts all contributing to the success. Through the support of Skippers, 'Singing in the Spring' enjoyed a flying start in Mt Magnet!

Singers drove in from the stations and townsfolk arrived in their cars, on a scooter or just walked. Everyone began with breathing exercises and singing in unison. Then, under skilful guidance, we moved on to part singing. The songs over the three weekly sessions were as varied as the singers, and genuine talent mixed with much fun and laughter – singing is indeed good for the soul! Singing in Mt Magnet was a great event and much enjoyed by all - and some pretty good music came out of it as well.

While in Mt Magnet, there was time before the return flights for John Christmass to tour the sights. There is plenty to see of historic interest, and the ancient landscape is stunning even in drought, with the highlights of Warramboo Hill, Amphitheatre and ever popular Granites.

Kathy Winsor (Mt Magnet Nursing Post staff member, Skippers attendant and *Mt Magnet Wannabe*) with John Christmass (at Mt Magnet airport.)

John Christmass returned to Perth and the New I Voci for the Christmas and Vienna Pops New Year's Eve Concerts – while the New Mt Magnet Singers resumed their daily lives feeling uplifted! ❖

When in Roma: Encouraging words

...CONTINUED FROM PAGE 8

2500 a year in the next five years. It is to be hoped that other health professions soon have increases in undergraduate numbers of a similar order of magnitude. For this to happen, major new investment will be required.

For people in rural and remote areas, the most important thing will be to ensure that sufficient of these new professionals are skilled for and committed to practice in rural and remote areas so that, at any given time in the future, rural and remote areas have their fair share of the nation's health professionals.

In such a large and complex area as health workforce planning, it will not be possible to advance on all fronts simultaneously. The Alliance believes that the priorities in the workforce planning must include Indigenous primary health care, oral and dental health, mental health, maternal and child health, and care in the aged care sector.

Meanwhile, the Alliance is seeking immediate action on a higher education contribution scheme (HECS) reimbursement program for nursing, allied health and dentistry/oral hygiene; a national rural undergraduate placement scheme for health professionals; and an improved and more uniform patients' assisted transport scheme. ❖

Once the 2007 Federal Election was over – and before the appointment of the new Health Minister – the National Rural Health Alliance approached its network of friends for their priority advice to the incoming government. Here is a small selection of the pieces we received. Never let it be said that only the Minister for Health and Ageing has the benefit of advice from friends of the Alliance!

Advice to the Minister

It all starts with healthy babies

Please make sure babies are breast-fed. This would be the one single intervention a government could make to improve every individual's physical, psychological, emotional and social wellbeing in one dose. They will be better able to care for their own health, attend their education and participate meaningfully in society. ❖

Edwina Champain

Infant, child and adolescent mental health social worker, Mullengandra, NSW

Partnerships for maternity services

I am looking forward to the support you may provide for rural maternity services, in partnership with State government services. Your governance of the health portfolio may be aided by roles such as senior nursing and midwifery advisory team. Rural midwives in particular need individualised educational funding support to enhance clinical skills and maintain clinical confidence.

- Provide support for midwifery care as a real choice for rural women's pregnancy care (not just through the 16400 Medicare item).
- Provide support for rural based maternity care research.
- Improve internet technology access and reducing costs for rural and regional areas. ❖

Amanda Whittaker

Confronting the isolation and bleak scenery

One of the major issues for my family is the isolation and constant bleak scenery. Years of drought have taken their toll on every individual as well as on whole communities. Hearing horrible stories of deaths by one's own hands leave us feeling helpless and useless. The burn-out rate for workers is so high that at times a position can be empty for up to twelve months or longer. My advice to the Minister is to consider increasing incentives for rural workers to make the positions more appealing. ❖

Wendy Angell
Drug and alcohol project worker

Expanding practice to address workforce shortages

Workforce issues are important, but I would like the Minister to change the focus from getting "1000 more doctors into rural areas" to looking at other members of the health workforce who could be used to provide clinical skills. My interest has been in getting physician assistants or others, such as paramedics and Indigenous Health Workers, into the Australian workforce to expand the practice of many already there. Nurse practitioners and remote area nurses already do much of this work but we need more than nurses if we are to address the health of rural and remote Australians. ❖

Teresa O'Connor
Research Fellow, James Cook University, Qld

Dental workforce, accommodation, nutritious food and employment

Double dental school places! Make dental nursing and dental hygiene attractive careers. Provide more accommodation - for Aboriginal people (to reduce overcrowding and domestic violence) and for health workers (poor quality housing is a key factor in poor retention).

Affordable healthy foods are needed in remote communities and towns (maybe more community garden projects would help too?). Fund early intervention and more effective child protection. Increase opportunities for Aboriginal people to succeed in the workforce. ❖

Jenny Allen, Derby, WA

Rural health and education

I would like policies that support the education and health of the rural sector. For example - a certain percentage of university funding could be quarantined for rural campuses that are providing educational opportunities for rural and remote area students in the health area (eg nursing, medicine and allied health), thereby providing appropriate opportunity and support for students who wish to remain in the country to further their education.

Advice to the Minister

Alternatively, a subsidy could be provided for students who are studying a health subject on a rural campus. The students need support for travel and accommodation costs while in the clinical areas. Nursing students in particular are hard pressed to meet their financial commitments. ❖

Pat Nesbitt

Adequate resourcing to do the job

Adequate funding for allied health is needed!

It is easier to attract and retain staff if rural allied health services are adequately resourced:

- with adequate FTE allocations per head of population;
- with allocated allied health space to see clients individually or in groups, to provide programs we were trained to do;
- with funds for consumables and equipment so therapists don't feel that they are always having to approach management with 'cap in hand'; and
- with vehicles suitable for home visits across flooded rivers and boggy roads, with capacity to carry wheelchair, wheelie-walker, shower-chair, over-toilet chair and commode. ❖

Rose Brooks
Occupational therapist, Dysart, Qld

Please visit

Put all health funding under the Commonwealth and alleviate the cross-border issues between State and Commonwealth. Pursue co-location of General Practice into Primary Health Care facilities (both Aboriginal Community Controlled and 'mainstream') to maximise access to primary health care staff and facilitate coordinated care. Continue to enhance Medicare to encourage GPs to participate in early intervention and chronic disease management. Increase funding to address lifestyle issues such as smoking cessation, weight management and physical activity. I invite the Minister to do a tour of the more remote areas to appreciate first-hand the complexities and challenges of service delivery in the bush. ❖

Margo Anderson
General practice clinician manager, Lightning Ridge, NSW

Telehealth and telemedicine to combat workforce shortages

With worsening workforce shortages in the bush there must be a strategic and comprehensive approach to telehealth and telemedicine through development and support for reliable information and communications technology, including professional development for staff. A consultative, continued and specific approach for improving Indigenous health is also necessary. ❖

Andrew Waters, South Hedland, WA

Recipe for rural health

I think the Minister needs to make a soup with ingredients of consultation, expertise, passion, far-sightedness and large sums of money!

The first priority should be equal opportunity for health so that no matter where you live or what your income is you have the chance to receive basic health care. This will mean doing some things now as well as planning for later. Now we need money injected into buildings and equipment giving rural facilities the chance to meet standards for quality and safety. We need first class telecommunications, money for public transport and a flexible workforce supported with good education and training. We need some far-sighted people to look at rural communities and start planning for their health needs now. This will include sensible workforce projections including proven programs supporting retention of health professionals in rural communities, a good look at the needs of the greying population and how e-health can work. ❖

Jenny May, Tamworth, NSW

Review and plan

It is important to bring the health professions' representative bodies together for the development of a comprehensive rural primary health care strategy - using consultants to chip away at existing policy is inadequate. We need a comprehensive review of the numerous strategies in play at the moment, many of which are 10-15 years old, and a fresh strategic plan for the next 10-20 years. ❖

Richard Lawrance
National Manager Rural, Royal Australian College of General Practitioners

PHOTO: LEXIA SMALLWOOD

Mundubbera Medical Centre, Qld.

The recipe for successful rural and remote health services

AFTER ALL THESE YEARS of trials and experimentation with rural and remote health services, surely it must be possible to describe the recipe for success? People in the bush certainly hope so, as they are fed up with trials and want to have ongoing funding for programs that do work.

This was the hope behind research undertaken by a team funded through the Australian Primary Health Care Research Institute (APHCRI), and led by Professors John Humphreys and John Wakerman.

The work set out to find what the evidence says about why some models of primary health care in rural and remote Australia are sustainable and others are not. Rather than focusing on workforce issues, the study looked at primary health care service models, with a view to seeing what works best where, and why.

To do this the authors undertook a systematic review of all the literature they could find relating to primary health care in the bush - both published material and the so-called grey literature.

Not surprisingly, the study confirmed that there is no 'one size fits all' health service model. Successful service models address the disparate distributions of population by aggregating a critical population mass, whether as a discrete population in a country town or a dispersed population across a region. The study concluded that:

> "Based on current experience, it would appear that a minimum population base of about 5000 for rural and 2000 to 3000 people for remote communities supports an appropriate, sustainable range of primary health care activities. Successful implementation is linked to systematically addressing *environmental enablers* (appropriate policy, compatible Commonwealth/state relations and community readiness) and a number of *essential service requirements* (funding, workforce, governance/management/ leadership, infrastructure and linkages)."

The study also concluded that the policy framework is a critical contributor to the sustainability of services. Funds pooling can be effective in enabling services to meet community needs.

> "Agreed Commonwealth-state relations and accountabilities facilitate appropriate service development. Australia needs a national rural and remote health policy and plan. And community involvement is essential."

Perhaps surprisingly, the study concluded that notwithstanding the importance of workforce issues, they may be significantly de-emphasised when other linked 'essentials' are addressed, especially human resource practice. Effective human resource practice requires recognition of and training for managers.

On workforce, the study emphasised that recruitment and retention are different phenomena requiring different sets of incentives. A successful workforce retention package, supported by good management and governance, would include:

- adequate staffing with reasonable workloads;
- adequate infrastructure, including housing, vehicles and appropriate IT;
- realistic remuneration that includes retention bonuses;
- a workplace culture that values workers with adequate continuing professional development, support and mentoring; and
- an attractive workplace environment, including orientation and career pathways.

Finally, the study's authors reported that health service planning for small rural and remote communities will only be effective when it takes account of the need for comprehensive, sustainable and systems-based solutions that address all components in an integrated way.

Hopefully it is such sustainable and systems-based solutions that the new National Health and Hospitals Reform Commission will identify and support for rural and remote areas. ❖

PHOTO: FRONTIER SERVICES

The Andamooka Community Health Centre is situated in the opal fields some 500 to 600 kilometres from Adelaide in South Australia. Remote Area Nurses, Diane Bilka and Debbie Sach, have been called out to an accident in a remote area.

Ambulance service delivery models

BY LYN PEARSON

AMBULANCE SERVICES ACROSS AUSTRALIA provide the sick and injured with emergency and non-emergency pre-hospital care and transport; inter-hospital patient transport; specialised rescue services; response to multi-casualty events; and capacity building for emergencies[1].

Due to the vastness of Australia, providing these services in rural and remote areas can be even more challenging than in the metropolitan areas. A variety of ambulance service delivery models is used to ensure that communities have access to appropriate pre-hospital care. They use various combinations of first responders, volunteer ambulance crews, paramedics, extended care paramedical services, air ambulance and rescue, and related agencies that provide aeromedical and rescue services - with all of them being supported by efficient and effective communication systems.

Never forget that ensuring that the majority of your community has appropriate first aid skills to assist until ambulance services arrive will impact on the survival of a sick or injured person.

Ambulance volunteers throughout Australia are primarily involved in providing front line care in the delivery of ambulance services, often on an on-call basis. Many ambulance services use volunteers as first responders in an emergency, to provide first aid care until the ambulance arrives. Volunteers are also used to provide a wide range of administrative support.

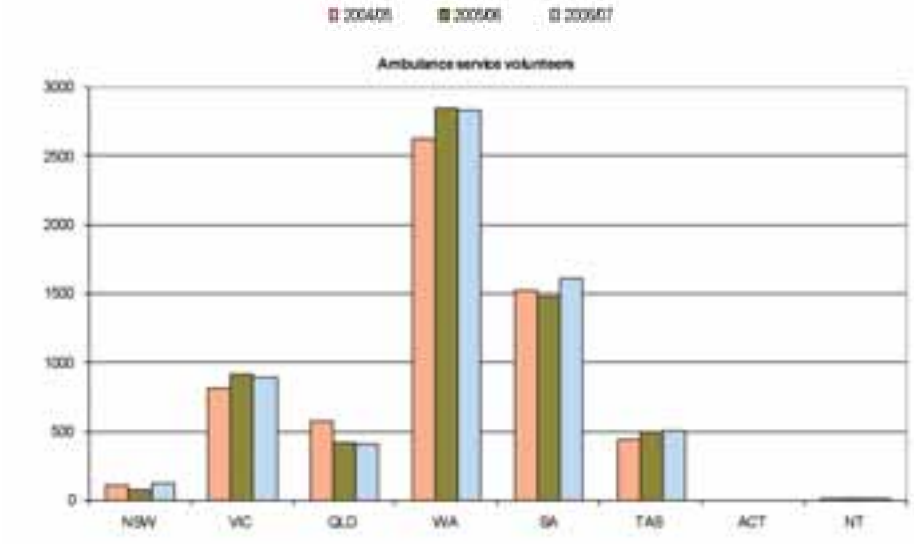
In 2006/07 Australian ambulance services consisted of 6,409 volunteers (5,265 operational, 1,144 support staff). As demonstrated in figure 1, volunteer numbers vary considerably between ambulance jurisdictions. WA has the largest number with 2,839 volunteers and ACT has none.

In 2006/07 there were 1091 ambulance response locations in Australia, 61.7% of them salaried staff units, 30.1% wholly volunteer, and 7.4% mixed stations. This distribution varies, with country services in Western Australia, South Australia and Tasmania relying primarily on volunteers.

Aeromedical services are provided through a variety of arrangements. Some State/ Territory ambulance services provide them themselves; some use subcontractors; some are provided from outside the State; and other arrangements involve a mixture of these.

The Australian Government provides some capital and recurrent funding to these services through the Flying Doctor Service.

Figure 1: Ambulance Service Volunteer Numbers



Across Australia the paramedic's role is expanding both formally and informally to provide primary health care, improve emergency response capabilities and strengthen community healthcare collaborations in rural and remote communities[2].

The paramedic is well placed to play a key role in contributing to better health outcomes of Australians, particularly in rural and remote areas where their services are often underutilised. Ambulance services can play a key role in contributing to service and health outcome improvements in rural and remote Australia through workforce redesign and by contributing to the sustainability and social capital of these communities.

A survey of ambulance jurisdictions in 2007 found that in rural and remote locations paramedics' roles are being redeveloped to provide services in the following[3]:

- assisting nurses in hospital emergency departments;
- coordinator roles primarily aimed at supporting ambulance volunteers; and
- promoting injury and disease prevention and providing integrated health services in partnership with other health professionals.

In the current environment of scarce health resources, the future of rural and remote health care requires a coordinated and collaborative approach between all health care professionals to ensure rural and remote communities are provided with better health outcomes. ❖

1 SCRGSP (Steering Committee for the Review of Government Service Provision). (2007). *Report on Government Services 2008*. Productivity Commission, Canberra.

2 Stirling, C.M., O'Meara P., Pedler, D., Tourle, V., and Walker, J. (2007). Engaging rural communities in health care through a paramedic expanded scope of practice. *Rural and Remote Health*. 7: 839. Accessed 17th December 2007. http://www.rrh.org.au

3 Council of Ambulance Authorities Inc. (2007). *CAA expanded scope of practice: An Australasian overview of emerging paramedic models of care* – unpublished internal document.

Commissioning better health in Australia

NOW THAT THE MEMBERS of the National Health and Hospitals Reform Commission have been appointed, we move from expectations to action.

A great deal is expected of this new body. First, it is to provide advice on the new Australian Health Care Agreements. These take effect from 1 July 2008 and the Commission will then move on to the work required to develop a long-term health reform plan, with an interim report by the end of 2008, and a final plan in mid-2009.

According to the Media Release from the Prime Minister and the Health Minister, the Commission "will provide a blueprint for tackling future challenges - - including the rapidly increasing burden of chronic disease; the ageing of the population; rising health costs; and inefficiencies exacerbated by cost shifting and the blame game".

Of particular interest to readers of Partyline will be the next sentence from that release: "The Commission will focus on health financing, maximising a productive relationship between public and private sectors, and improving rural health."

There was a mixed reception to the announcement of the ten Commissioners. Some interest groups expressed disappointment that they were not specifically represented; others were pleased to see a break away from such segmented, fractious thinking - which has underpinned the development and operation of the fragmented health system so many are keen to improve.

If individual Commissioners had been appointed to 'represent' consumers, doctors, managers and nurses, the scene would have been set for just the sort of discourse from which the health sector needs to escape. If an individual Commissioner is appointed as a consumer or as a remote nurse, it is incumbent upon them to take the traditional positions expected of such parties.

Far better to have ten individuals with a range of experience in the health sector and to know that they will all have the interests of health consumers in mind. One may come largely experienced as a remote nurse: but they understand that the challenge to which they will apply their knowledge is to improve the health outcomes for Australian citizens by improving the health system to which they have access. Another might emphasise quality and safety: but as a lens through which health interventions and health outcomes for individuals may be scrutinised. A third may emphasise cost effectiveness: not simply to save public money but, rather, to ensure that the money available for health is spent in such a way as to optimise the health outcomes for Australia's citizens.

There can be no doubt that the new Commission is faced with very significant challenges. This group of ten, with whatever secretariat

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PHOTO: BEV COOK

Commissioning better health in Australia

...CONTINUED FROM PAGE 14

support is provided to it, is charged with solving puzzles that thousands of good public servants over many years have not been able to solve. And they are to do this while working as Commissioners for two to three days a week.

But the Commission is not starting with a blank sheet. Their task is to evaluate proposals for a new way forward - not to invent them. All the potentially good ideas have been suggested by someone some time in the recent past:

- invest considerably more in health promotion and illness prevention;
- enhance the universality of Medicare and consider its scope;
- focus on healthy pregnancies and a baby's first three years of life, as the best investment in healthy lives;
- strengthen primary health care so as to keep people out of hospital;
- broaden the Australian Health Care Agreements and reform the system of special purpose payments - perhaps even having one single broadbanded health agreement;
- build a system which deals better with extensive chronic disease, including through the encouragement of chronic disease self-management;
- invest for as long as it takes in better primary health care for Indigenous Australians;
- have collaborative Commonwealth-State investment in improved oral and dental health;
- invest and reinvest in maternity services;
- restrict the availability and cost of the private health insurance rebate;
- hand all health funding to the Commonwealth or to hand to the Commonwealth all responsibility for those over 70 years of age;
- allow funds pooling on health, aged care and community services between a willing State and the Australian government and/or pool funds for a community of 300,000 or 30,000 or 3,000;
- recruit and retain greater numbers of health professionals – and have an emphasis on the relationship between them, health teams, multi-disciplinary practice, inter-professional learning;
- lead improvements in the productivity of the health workforce through improved relationships, flexible scopes of practice, reduced restrictions on practice;
- agree a system for using personal health records to improve the effectiveness and safety of health interventions; and
- enhance the value of e-health.

The Commission can succeed by stimulating and legitimising the government's progress on a number of these ideas. (Currently all of these ideas are 'out there'; governments can more confidently move forward on one or more them if they have the imprimatur of an independent Commission.)

Whatever the government chooses to progress will not be novel ideas - but they may well be newly-endorsed by those organisations and interest groups that need to embrace them in order for the proposals to succeed.

And make no mistake: we need to succeed. People in rural and remote areas are among those who have most to gain from an improved health system. And in this, we are not looking for a victory for the remote nurse on the Commission but, instead, a victory for all ten Commissioners and for the government and the people of Australia for whom they work. Because all of them will recognise the current inequity of poorer health outcomes and services in rural and remote areas. ❖

PHOTO: FRONTIER SERVICES

Juninga is managed managed by Frontier Services on behalf of the Gwalawa Dariniki Association - the traditional owners of the land on which the facility is situated. Getting it right for the elderly Indigenous residents includes providing opportunities to sit on wide verandas that bring the outdoors inside, to take part in Men's and Women's events, to fish or walk, and to live in an environment which reflects the environment that so many of them call home.

Beyond Sorry Day

ON 13 FEBRUARY 2008 the Prime Minister, on behalf of the Parliament of Australia and with support from the Opposition, reflected on the impact of past laws and policies of successive Parliaments, and apologised for the grief, suffering and loss that some of them had inflicted on Aboriginal and Torres Strait Islander peoples, particularly through the forced removal of children from their families and communities. It was acknowledged that many people and communities continue to suffer the consequences of these actions.

The Prime Minister's speech in Parliament moved from reflection on the past to anticipation of a future based on "mutual respect, mutual resolve and mutual responsibility".

Responses to the national apology were varied.

Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner of the Australian Human Rights and Equal Opportunity Commission, described the day as historic, pleased that national leaders had chosen "dignity, hope and respect as the guiding principles for the relationship with our first nations' peoples." He acknowledged the support of non-Indigenous Australians "who have walked with us on the path of reconciliation and justice", and paid tribute to the members of the Stolen Generations for their resilience and dignity.

"… simply saying that you're sorry is such a powerful symbol. Powerful not because it represents some expiation of guilt. Powerful not because it represents any form of legal requirement. But powerful simply because it restores respect"

– Kevin Rudd, election campaign 2007

Reconciliation Australia recalled the recommendation from *Bringing them Home*[1] that the first step in healing is the acknowledgment of truth and the delivery of an apology.

Christine King, from the Stolen Generations Alliance, spoke of the emotion and importance of the day, and of the great meaning attached, in her community, to the word sorry, with its connotations of empathy, compassion and understanding

President of the Australian Indigenous Doctors' Association, Dr Tamara Mackean, hoped the apology would contribute towards healing some of the physical, psychological and spiritual damages inflicted upon Indigenous people.

Dr Mick Adams, chair of the National Aboriginal Community Controlled Health Organisation, sees new opportunity for leaders to work together with respect on addressing Aboriginal disadvantage in areas of health, housing, education and employment.

PHOTO: ANGELA TITMUS

Indigenous Affairs Minister Jenny Macklin said an apology does not attribute guilt to the current generation of Australian people.

Noel Pearson, Director of the Cape York Institute for Policy and Leadership, has summarised some of the complexities of the issue: "People were stolen, people were rescued; people were brought in chains, people were brought by their parents; mixed-blood children were in danger from their tribal stepfathers, while others were loved and treated as their own; people were in danger from whites, and people were protected by whites. The motivations and actions of those whites involved in this history -- governments and missions -- ranged from cruel to caring, malign to loving, well-intentioned to evil." He warned against accepting a "psychology of victimhood".

So much for the 13 February 2008. But what of the days and years to come?

Most urgent goals for the future include removing the inequities that exist in life expectancy, educational achievement and economic opportunity. Hopefully bipartisan support will extend to necessary additional expenditures for as long as it takes to achieve this goal. In health, for example, the current annual underspend for Aboriginal and Torres Strait Islander people (through MBS, PBS, dental services and other primary care activities), adjusted for the level of health care need, is estimated to be $350-$500 million. This provides opportunity for immediate action, with clear plans for the allocation of funds already in place. NACCHO's Health Equity Plan is a detailed plan for increased funding for primary health care infrastructure, staffing and service provision, as well as particular investment in dental health, health education programs and the availability of fresh food.

Sorry Day cannot be left as just a symbolic gesture. If it is to have real meaning, it must lead to actual improvements in policies, programs, services and outcomes for Aboriginal and Torres Strait Islander people. ❖

1 *Bringing them Home* - the report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families and released in April 1997.

"Thank you"

Sorry Day has come and gone, and it has resurrected many memories for long-time country doctor, Bruce Harris.

AGAINST A BACKDROP of war babies, refugees and orphans, European poverty and Christian charity, Australians did a few things wrong and a few things right.

For some of us working in the bush before 1970 the memory is of 'rescuing' children from apparent neglect. In the small town I worked in we had a shocking infant death rate for those living in 'the camps'.

When relatives could not be found our restored babies were put out for adoption – a very painful process as the adopting parents knew that a much-loved infant could be reclaimed later.

Our nurses loved, cared for and raised a lot of babies – some of whose parents had disappeared. Many of these are now healthy adults somewhere and it is impossible to be sorry for what those good nurses, good people, did.

In the paperwork of the time our babies were to be classified at birth by the attending doctor or midwife. We were required to specify degrees of 'colour'. I can tell you that we Australians (apart from not understanding it) in general found this requirement pretty repulsive and simply refused - writing 'nice baby' or something equally cheeky in that particular box.

Doctors were not paid for 'honorary work' and endless on-call - and the Aboriginal camps were in a fearfully filthy mess. Lots of dead babies were the alternative - and just who says 'thank you' while everyone is saying 'sorry'?

It's a painful issue. Those of us who cared for the children can remember the joy of saving them...so it's still very personal.

Most Australians who now read the media were not working in the places and the times referred to. When I express opinions on personal experiences 30+ years back they are as I recall them - and way out of the context of the political pressures of this present time.

It has parallels with our nation's Vietnam involvement. Young people went away in good faith to do what they were asked and had reason to believe it was 'in the national interest'. Most returned to an indifferent community and a parliament that showed no great respect. Thirty years later, we in the surgical teams received our war medals and RSL membership in the post. But, at the time, when returning home it was hard to get off the plane and just go back to work. No expressed gratitude was really wanted or needed - we just saved a lot of babies from dying during a war that we didn't understand.

I first saw how Australia's Aboriginal people lived in 1954 when I was 17 and living in the top end of South Australia. The station camp was by the river behind the house and behind the chooks and dogs - those 500 yards made a world apart from our group in the big house. Later we students got really noisy in support of Aboriginal welfare and in 1957 at University we held rallies to make the horrors go away. We are still holding rallies in support of rural Indigenous health reform. Now there are also glossy brochures and conventions.

Generally as a doctor I have been privileged - there are many I admire who have worked further out with great dedication in pretty gruesome places to save the babies. There is a place for some honest admiration for the generations of missionaries, clinicians, heroes and misfits who tried to help - with all their heart - and who should not now be shamed because they didn't understand. ❖

PHOTO: STEVE LOVEGROVE

Campfire '07

SOUTH AUSTRALIAN UNDERGRADUATE RURAL HEALTH FORUM

BY TOM CROWHURST, MEDICAL STUDENT, AURHA

CAMPFIRE '07, the South Australian Undergraduate Rural Health Forum, took place in September and was attended by about fifty delegates from the three National Rural Health Network clubs in South Australia: Adelaide University Rural Health Alliance [AURHA], Flinders University Rural Health Society [FURHS] and Rural Outlook for University Students Towards Allied Health [ROUSTAH]. The event was held at the picturesque Pichi Richi Park, near Quorn, in South Australia's striking southern Flinders Ranges.

The program was action-packed! Delegates were treated to excellent presentations from guest speakers from around the state and the country, and interesting reports from fellow student delegates regarding their research or clinical experience. Sabina Knight and Dr Ross Diplock travelled from the Northern Territory to talk to us, and many local practitioners (including social worker Dan McKenzie, Dr Tony Lian-Lloyd and 'The Sugar Man' Mike Porter) also gave up their time. There were skills sessions on massage, strapping and emergency first aid; needless to say, the massage station was particularly popular. During the nights, delegates were kept busy – on Friday drinks were around the open campfire, and on Saturday we had a barn dance at the nearby Quorn Town Hall.

The key issues included in the forum were Indigenous health, Indigenous culture and its importance in the delivery of healthcare, diet and diabetes in rural and remote communities, and working as a health professional in rural and remote locations. There was a decidedly multi-disciplinary flavour to the weekend and all delegates left with a much greater understanding of the role of different professionals in the modern multi-disciplinary healthcare team – with particular reference to rural and remote areas.

Campfire '07 was characterised by the enthusiasm and optimism of the delegates. Although participants came from different backgrounds, and many were studying very different professions, there was a common link in the sense that each and every delegate had an interest in rural and remote health and future work in the country. The weekend was infused with the sense that everyone was working towards a common goal – and that the old model of distinct silos of health professional activity was being broken down before our eyes!

Campfire '07 succeeded from both academic and social perspectives. Delegates will look forward to the chance of attending another similar South Australian Rural Health Forum in the near future. ❖

Thank you to Mike Porter for his letter 'A Star is Quorn' (Partyline letters: October 2007) and his kind comments regarding the value of events such as Campfire '07. As you can see from Tom's account, the students enjoyed this weekend and learnt a great deal from speakers such as Mike. I would like to acknowledge that during the organisation of both Campfire '05 at Spear Creek and Campfire '07 at Pichi Richi Park, the SA rural health clubs received a great deal of support from local people and a great deal of help from many health professionals and community members in Port Augusta, Quorn and Whyalla. In particular, neither forum would have been possible without the help of Pika Wiya Health Service (particularly Angela Russell, our angel in residence) or the local staff at the Spencer Gulf Rural Health School. The strong support we received from the staff of health services in these areas (such as Dr Nigel Stewart, Dr Tony Lian-Lloyd, Tom Anthoney, Fiona Coulthard and Bronwyn Herde, just to name a few) during the first Campfire forum in 2005 was one of the main reasons we decided to hold the 2007 forum in the region, as it highlighted two very attractive features of rural practice: a beautiful environment and wonderful people!

Dr Lydia Scott, 2007 AURHA President for the organising teams of Campfire '05 and Campfire '07

Participants at Campfire 07.

RAMUS – annual scholar report

Rural Australia Medical Undergraduate Scholarship holder, Julieanne Lovell, completed her medical course in 2007. With her permission, we share some of her final report with readers of Partyline.

THIS YEAR WENT BY with such velocity and content that it almost feels as if two or three years have past since I wrote last year's report. But no, it has only been one year, and as I look back on all that has happened I am proud of myself that I got through (with a distinction!) and now greet next year with more anticipation and confidence than the last. Throughout the year a close friend died, another became severely disabled, I myself fought off depression and all the while the drought back at home just tightened its grip and things became even tougher. I even limited phone calls home as each one hurt to hear of the news – no rain, no rain and no rain.

Because of the financial strain on the family, I had to spend most of my year in the city to continue working which meant that contact with my mentor was limited. However, when I was back in my home town I was once again welcomed with his big warming smile, being one of the reasons why I chose this career path in the first place. His positive encouragement and hands on approach combined with the generosity of his patients (that I find overwhelming in rural areas) allowed me to do some suturing on my own much to my great excitement. Asking for consent never seems to be an issue in the country as opposed to the city, with many replying, "Why of course, we all have to learn somehow."

One of the learning goals I achieved was further developing my understanding of mental health services in the country. One of my friends at university has a parent in country Victoria who works in the mental health area and was able to set me up some days in a mental health clinic. I was able to sit in on screening consultations which taught me a lot but was confronting at the same time. The health worker, in one particularly difficult but inspiring consultation, was so understanding and gentle. I was pleased she was able to help the patient get her life back on track. This case really touched me as she was a girl similar to me, but in unlucky circumstances and with limited support systems. It really made me appreciate all the support and encouragement that I have received from my family and friends throughout my life.

Strapping workshop at Campfire 07.

However, my most rewarding and extended rural activity this year was most definitely my rural placement through the Bachelor of Medicine/Bachelor of Surgery (MBBS) course. I was placed in Kyneton and my activities throughout the weeks took me to other small towns nearby such as Castlemaine, Woodend and Bendigo. This travelling I thoroughly enjoyed as I was able to see more of the countryside, the differences between each small community and also the connections between each community. Because these towns are in such close proximity they all rely on each other for different services – mental health in one town, radiology in another etc. This was a phenomenon I have never seen before, as where I come from towns are far apart.

This placement was especially rewarding as it allowed me to gain experience in some of the different fields of rural health, such as spending time with a pharmacist, working with doctors, going on rounds with the nurses and spending a few days in a nursing home. This allowed me to see how the whole spectrum of care works in unison.

Because of the challenges that health workers face in the rural area, the structure and proceedings of such a setting has developed into a health care system focused around teamwork. Reduced support has lead to the development of an arrangement centred on the patient and their community. This supportive structure is a quality that the urban setting could include to advantage in its practices.

My fondest memory is when I was helping out in one of the medical clinics in Woodend. A woman came in who had experienced heart palpitations and extreme vertigo while driving. It was my first real emergency and, while the staff worked quickly around me, I was able to hold the woman's hand and tell her that she was in good care while comforting her young baby. The woman's shaking slowly subsided and the small bit of comfort that I provided to her seemed to make a big difference. I really felt as if I was a part of the medical team for the first time.

Another fond memory from this time includes spending a day with the Castlemaine nurses. The endurance, humour and patience they exhibit throughout the entire day is something to be admired. In a country hospital it is clear that most of the organisation and hard work is done by the nurses. For me, this was the smallest rural hospital I

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Finding empty beds in public hospitals

BY TIM WOODRUFF - PRESIDENT, DOCTORS REFORM SOCIETY

PUBLIC HOSPITALS are desperately short of empty beds and waiting times are too long for many patients.

To remedy the situation we need to be clear about the many and complex reasons for this:

1. a lack of aged care places;
2. patients are admitted who should never have needed admission but became too unwell in the community because of a lack of access to appropriate primary care;
3. the lack of staff;
4. a lack of money; and
5. bureaucracies asked to do too much with too little, thus acting incompetently.

PHOTO: NSWRDN

The staff shortage is a nationwide and even worldwide problem, and is partly a matter of distribution. There appear to be enough surgeons, anaesthetists and nurses for a private patient to get a hip replacement done within a month in a private hospital, but it takes a year in an adjacent public hospital.

The growth of the private hospital sector, funded by taxpayers, contributes to the difficulties public institutions have in finding staff. But providing more money to public hospitals will not solve the staffing problem as the public sector will never be able to compete with a publicly funded private sector.

As a rheumatologist I see patients every day I should not need to see and it is probably the same for other specialists. Emergency departments see patients they should not need to see – both those who cannot access a GP there and then, as well as those experiencing a true emergency only because they should have seen a GP a week previously but didn't for all sorts of reasons and now need admission to a bed that doesn't exist.

Aboriginal Australians get about 40 per cent of the Medicare/PBS funding of non-Aboriginals, but they end up having as many health dollars spent on them because they need hospital care for preventable diseases.

It is in everyone's interest to improve people's access to primary health care. ❖

RAMUS – annual scholar report

...CONTINUED FROM PAGE 19

have been in and it was incredible to see how efficiently everything ran.

It never ceases to amaze me that no matter where I have traveled in Australia, rural health workers are extraordinarily generous and will always go beyond their professional boundaries to help out their community. The responsibility of working in a small town seems overwhelming. However, I have always planned to go back to a rural area and work. It is where I grew up and the only place I feel truly comfortable.

In the tough times it was hard to find the time and funds to travel the twelve hours home to fulfil learning goals, so I am utterly grateful to the RAMUS scheme and its very helpful team members, and I wonder where I would be with out its support. ❖

MABEL to monitor work-life balance of GPs

IN A SPEECH AT ROMA, in Queensland, Prime Minister Kevin Rudd vowed to make the rural health workforce a key focus of government policy in 2008 (see page 8).

For years the increasing demand for health care, ageing of the medical workforce, rise in the number of women entering medicine and changes in doctor preferences, have impacted on the capacity of the system to provide care.

Despite this there is little knowledge or understanding of how doctors make critical decisions about their own work-life balance - matters such as how many hours they work and where they will practise, including whether or not to move to rural or remote areas.

Such issues have important implications for patients' access to care and will affect their health status and the quality of care they receive.

To counter this lack of knowledge, the National Health and Medical Research Council (NHMRC) is about to launch a longitudinal study on how changes in the working lives of Australian doctors influence the healthcare they are able to provide.

Research under the Medicine in Australia: Balancing Employment and Life (MABEL) program will examine changing patterns in the working lives of 15,000 doctors over four years. The object is to better understand shortages and surpluses, and the pivotal role of doctors in the total health care system.

Changes in family circumstances, job satisfaction, earnings and the nature of their work will be examined to determine the most effective policy responses for maintaining the size, motivation and productivity of the medical workforce.

PHOTO: NSWRDN

Those surveyed will include GPs, private specialists, hospital doctors, and doctors in specialist training, with the first wave of the survey due to start in May 2008.

Professor Anthony Scott, Professorial fellow of the Melbourne Institute of Applied Economic and Social Research, will head the research team that includes Dr Catherine Joyce, from Monash University, Professor John Humphreys, from the School of Rural Health at Monash, and Associate Professor Guyonne Kalb from the University of Melbourne. ❖

Online enquiries to enquiries@mabel.org.au or email Professor Scott directly at a.scott@unimelb.edu.au

nPEP to prevent HIV transmission

NON-OCCUPATIONAL Post Exposure Prophylaxis (nPEP) is a significant new development in preventing HIV transmission. If the treatment is begun within 72 hours of exposure to the HIV virus, the infection can potentially be prevented from establishing itself.

The treatment – a four week course of HIV medication – is not a 'morning after' pill as it is not guaranteed to work and comes with a variety of significant side effects including diarrhoea, abdominal pain and headaches. Condom use remains the more practical method of preventing HIV transmission.

To obtain the treatment, clients can call the nPEP hotline on 1800 022 226, where a registered nurse will assess the client's eligibility to access the treatment. Most rural hospitals are equipped to place clients on starter packs which cover the first five days of treatment. This must be followed up with completion of the treatment as soon as possible. While the treatment does represent some possible discomfort and inconvenience, these pale in comparison to the severity, expense and life changes associated with HIV. It is also important to remember that the privacy of clients is protected by professional codes regarding confidentiality. ❖

e-feedback

LETTERS TO THE EDITOR

Need for dialysis chairs

I am writing to inform your readers of the need for dialysis chairs in smaller community centres, particularly in light of the fact that renal failure (as a complication of diabetes) is an increasing problem among Aboriginal people. This has become an important issue for Aboriginal Carers as people diagnosed with renal failure are usually moved away from their families, extended family support networks, and their communities to which they are intrinsically linked. This has often contributed to an early and untimely demise. If dialysis chairs were available in centres such as Hawker, Leigh Creek/Copley, it would help to alleviate this growing problem.

Sue Rodda
Indigenous Carers Project Officer, Carers SA-Northern Country

Registered Nurses – locum study

I am a Doctor of Philosophy (PhD) Scholar with the University of Queensland, School of Nursing and Midwifery. My study *What are the issues that impact on the recruitment and retention of locum nurses in rural and remote Australia?* aims to identify the perceptions, opinions and experiences of locum nurses in rural and remote areas of Australia.

One theme that continually arises in the literature on the recruitment and retention of nursing staff in rural and remote areas is the availability (or lack) of locum staff that enables permanent staff to take leave (recreational, study etc). The locum nurse role is very important to ensure that rural and remote communities across Australia are provided with continuous access to nursing services.

I am seeking Registered Nurses who work, or have worked, as a locum in rural and remote areas of Australia within the last two years to participate in this study. You will be invited to take part in an individual interview that will require approximately one hour of your time either face-to-face or via telephone, depending on where you live.

Please email me at susanne.becker@unisa.edu.au

Susanne Becker
Lecturer, University of South Australia

Grateful for scholarship

Our daughter Rachel received a Rural Australia Medical Undergraduate Scholarship (RAMUS) for the six years of her Medical Degree and has just graduated in December 2007.

We want to express our thanks for this generous scholarship. It has made a huge difference to our family's financial situation and we are extremely grateful. Facing six years of study away from home for Rachel and having another daughter to support in Melbourne at University at the same time was potentially a huge financial burden for us. But the RAMUS scholarship has allowed Rachel to be largely independent of us. We have also seen the huge benefit to her of having had a Doctor in Bendigo as her mentor, seeing his work at close hand and being made aware of issues in Regional Health.

We trust that the Government will continue to fund RAMUS and would like our appreciation to be conveyed to the appropriate Minister so that people in Government will know what a positive impact a scholarship like this can have for a family and for the student involved. We believe in time that it is highly likely that Rachel will return to practise medicine in the country.

Kathryn and Stephen May

News from Philippines

I met NRHA staff when I was in Canberra for my internship a few years ago. I would like to thank you for keeping me on your mailing list. I appreciate getting the newsletter and the email updates as well as the calendar.

Even if we are from different countries, our health providers face almost the same problems in remote and rural areas. We work all over the country and many areas are remote and hard to reach especially the areas of our Indigenous Communities. An example is that in one of our areas, I had to travel overnight by bus for about 13 hours just to reach the place. I am better off since I am able to

Distribution of Medicines in Indanan, Sulu.

e-feedback

LETTERS TO THE EDITOR (CONTINUED)

manage some sleep somehow in the bus but the people I am meeting have to walk a few hours just to attend our meeting.

Like the Aborigines of Australia, the Indigenous people of my country lack access to quality health services and they have poor health conditions.

I hope to learn more from your experiences in working in rural Australia so that I can develop some strategies for our rural areas.

Maricar Vallido
(dated 31 August 2007)

Rural health issues in East Timor

I'm writing from East Timor to keep you informed. Thanks very much for keeping me in the list to receive your messages. I am still promoting development of our health care system in the remote areas through mobile clinics which are run by the nurses with motorcycles and increase the quality of services in a hospital base. Factors such as bad political situations, low income, and lack of education about health contribute to increasing infectious diseases, malnutrition, high birth rate (3.2 per cent every year) and death rate, etc.

Extension of care for those suffering chronic diseases and the elderly is forgotten. For the moment, I'm blind for ideas and solutions. Where to start? We are short of nurses and midwives. Through the East Timor Nurses Association we will advocate starting again in 2008 with the Nursing Faculty at Dili National University. We are struggling also to find a shelter for the nurses and midwives (including myself) who still live in tents around the hospital back yard because they lost their property in the last crisis.

Any way we are rich in spirit to move forward.

Madalena Hanjan Soares
Vice President, East Timor Nurse Association

(dated 10 July 2007)

Remote hardships!

One trouble with living in a remote strait of islands is that one's choice of where to spend Christmas day is so limited. Given these limitations, friends and I decided that the deserted tropical island of Pentrik – with its crystal waters, bordered by a reef full of tropical wonders, littered with patches of tropical rainforest, swarming with rainforest birds and sea birds, and with a possibility of being awoken by visitation from shelled turtle creatures coming ashore to lay eggs – would have to do! (Pentrik neighbours Masig, where the mini series RAN [remote area nurse] was filmed and is where my friends live.)

Pentrick Island.

Here is a picture of where we had Christmas day and night 2007 - although at 4.00am it didn't look quite so tranquil as a tropical storm rolled in and we had to take cover under our flapping tarp...well rather we had to seek cover where we could around the dog that managed to secure the driest, cosiest place!!

I hope you all had a lovely Christmas and many good wishes to you for a safe, adventurous, fun 2008 with many good times to be had with your friends and loved ones... ❖

Robyn Glynn

Incentives, increased wages and training

The lack of podiatrists and allied health professionals in rural areas - particularly within the public sector - needs urgent attention. Incentive programs could combine increased wages with accreditation and learning programs. There would be benefit in promoting job sharing amongst women with families to encourage return to part-time work. ❖

Debbie Marks

Consumer education for realistic expectations

There should be an education campaign for health consumers about how the health system really works, their rights and responsibilities, and how to get the best out of the health system. The disconnect between expectations and the reality causes so many problems, many of which are avoidable. ❖

Ann Mara

Rural continence services

INCONTINENCE DIRECTLY AFFECTS over four million Australians and the Continence Foundation of Australia (CFA) is determined that regional and remote Australia should not miss out on training and resources on bladder and bowel health.

Over the next three years the CFA will provide health professional training under the banner *Every Body's Business*. The *Every Body's Business* forum will involve local and interstate experts presenting on the link between incontinence and major chronic conditions such as diabetes, arthritis and Alzheimer's.

Every Body's Business has been to Rockhampton, Qld, and will be in Port Macquarie, NSW, on 17 April. Over the next two years the CFA intends to hold more than ten similar events across the country, mostly in regional Australia.

Incontinence is rarely a 'stand-alone' health problem. It is usually associated with diabetes, obesity, kidney problems, disabilities, or neurological, heart or chronic respiratory problems. Urinary incontinence for men is often prostate-related. Pregnancy and childbirth or menopause put women into the high-risk group for pelvic floor weakness and related poor bladder or bowel control.

Incontinence is important to the quality of life of many Australians. It has profound social, emotional and financial impacts on people's lives. Importantly, incontinence can always be better managed, treated and frequently cured.

The CFA is encouraging health professionals in rural and remote areas to expand their continence management expertise, raise their awareness of the lifestyle impacts of incontinence, and educate about the presence and treatment of incontinence (often undetected) within other health conditions.

Other ways the CFA is supporting regional Australia is through the National Continence Helpline which provides information and resources to both health professionals and consumers. The Helpline is not just a 'call centre' type of service, but is staffed by specially trained Continence Nurse Advisors who will actually talk to you for as long as you need! The free call number is 1800 33 00 66. ❖

If you would like to know more about the CFA's work visit the CFA website at www.continence.org.au. If your organisation wants to work with the CFA in bringing 'Every Body's Business' to a location close to you, call CFA Education officer, Catriona Bastion, at the CFA's National Office, 03-9347 2522, or email catriona@continence.org.au.

National Continence Helpline 1800 33 00 66

The Helpline helps consumers and at-home carers and health support workers. Continence nurse advisors can assist with enquiries about bladder and bowel function. The service is also available for health professionals from GPs to community nurses, pharmacists to OTs.

A great range of free information materials on products, funding schemes and local services is available through this confidential, Australia-wide service. There are special ranges of resources suitable for ATSI or ethnic communities.

If you are working in a healthcare environment, you can order a range of resources free and in quantity - a full listing of all titles and Order Form are available by phoning 1800 33 00 66.

The Helpline is an Australian Government initiative managed by the Continence Foundation of Australia.

PHOTO: GILLIAN HUMBERT

Phone support for people at risk

A NEW TELEPHONE counselling service has been launched by the Commonwealth Department of Health and Aging to help ensure isolated and rural Australians at risk of suicide have access to ongoing professional support via the telephone.

Managed by Crisis Support Services, the new Suicide Helpline Call Back Service (SHL CBS) has been funded for a three year period, and has been designed to fill the gaps in service delivery that exist post emergency admission and post incarceration.

The aim of the SHL CBS is to reduce the national suicide rates and the frequency of hospital admissions. The nationwide service provides approximately six 50 minute sessions of telephone counselling to every client. The frequency of these calls can be decided by the client, depending on their individual needs.

During each of these sessions, clients are supported through counselling, information and referral. Sessions focus on the maintenance of safety for all individuals and encourage self responsibility throughout this process.

SHL CBS counsellors are highly trained in risk assessment, crisis management and solution-focused interventions. The service is run according to evidence-based processes and relies on feedback from clients for this purpose.

To be eligible, clients must be isolated, unsupported and be at risk of suicide (or supporting someone who is at risk). Clients who are bereaved by suicide are also eligible. To access the service, clients need to contact Suicide Helpline Call Back Service on 1300 659 467. ❖

Health promotion in rural areas

AUSTRALIA CURRENTLY SPENDS a shameful and surprising two per cent of its health dollar on health promotion and illness prevention. This will hopefully soon be significantly increased. When it is, people in rural and remote areas will expect and deserve a third of the attention. When this happens, there are some obvious dos and don'ts for public health campaigns in rural and remote areas:

1 don't assume people have full-time power, eg to watch TV;

2 don't assume people go to public meetings: consider habit, travel costs, etc;

3 remember that many people still don't use the internet; and some who do have very slow access and can't download or print;

4 communicate with people where they go: sports events, pubs, agricultural shows, school P and C, shire office;

5 use a suite of communication means, not just one;

6 use arts for communications: theatre, music, verse;

7 enlist local service groups, eg Lions, Rotary;

8 enlist local government;

9 remember it takes time to change attitudes and behaviour: be persistent, eg over five years, not a one month 'blast';

10 be confident that health promotion expenditure will be offset by lowered acute care costs, reduced absenteeism and higher productivity in the workforce. ❖

Renewable energy in remote Queensland

CLONCURRY, IN REMOTE outback Queensland, is aiming to have a thermal power plant within two years that will provide Cloncurry's 4,500 residents with all the electricity they need. The Queensland Government's plans involve 8,000 mirrors reflecting sunlight onto graphite blocks, generating 10 megawatts of solar thermal power. Cloncurry currently holds the record for Australia's hottest day – 53 degrees Celsius in the shade in 1889 – and with temperatures regularly rising above 40 degrees in summer is an ideal choice for a solar power plant. It is anticipated that success with the project in Cloncurry will make this idea of renewable energy widely appealing. ❖

PHOTO: REBECCA TURNBULL

THIS PHOTO WAS CONTRIBUTED BY A FRIEND

Wanted: new *friends* committee

AFTER SIX EVENTFUL YEARS as Chair of *friends* of the Alliance and a member of Council, Irene Mills is about to relinquish the post. Her term will officially end in August ahead of the 2008 face-to-face meeting of Council.

The Alliance is establishing a new *friends* committee, and looking for someone to take on Irene's role as Chairperson. They are big shoes to fill.

Born in Perth and having lived her entire life in Western Australia, Irene was for a while the only Sandgroper on Council. Although she is no longer the only voice from the West, Irene continues to push the interests of consumers and the smaller and more remote communities that abound in the larger States.

"My six years as Chair of *friends* has been a very rewarding experience for me, although I'm not sure what it's been like for the Alliance," Irene said. "I have met some wonderful people from rural and remote Australia whose motivation is to improve and retain services and to encourage others to do the same.

"Over the years I have been a strong advocate by encouraging others to join *friends* by promoting how beneficial it is to be involved as a supporter of the Alliance," she said.

How much has she influenced Council policy?

"In reality no more than any other member of Council, but being from a non-academic background and having a community focus, I sometimes see things differently from the provider members who have a professional interest."

What legacy would she like to leave once she returns to the farm at Pithara, 250 km from Perth on the Great Northern Highway?

"I'm not sure," she said. "I hope I've been able to influence Council into looking at issues from a community perspective, and to take on board the value of small rural communities and the importance of their survival to all of Australia.

"Throughout my life I've been committed to community involvement and have worked for the enhancement of facilities and lifestyle, not only for my local community, but also at a State and national level for all rural people. I know that whoever succeeds me will be just as committed."

Semi-retired from active farming, Irene and husband Malcolm are looking forward to tending sheep as they assist his younger brother and two sons to run the farm in a shire with a population of just 1400 people.

Her beloved kelpie, Bess, is waiting keenly to assist. ❖

Calling for nominations to *friends* Advisory Committee

Members for a new *friends* Advisory Committee and a new Chair for *friends of the Alliance* are now being sought. Would you like to be on the *friends* Advisory Committee? Or would you like to nominate someone to be on the Committee? Only 2008 financial members of *friends* are eligible to nominate and/or vote in this election.

Nominations are now open and will close on 31 May 2008. After the closing date, *friends* will be asked to vote for two delegates from each State/Territory. Elected members of the Advisory Committee will then elect one of their number to be the Chair of friends.

The Chair of *friends* becomes a member of Council of the Alliance and is therefore involved in setting strategic directions for the Alliance's work and can play a major role in policy development issues.

The *friends* Advisory Committee helps keep the Alliance informed about current issues in rural and remote areas, particularly at a grassroots level. The Committee also supports the Editor of Partyline by contributing articles and offering suggestions for stories and potential authors for publication. Health consumers representatives are encouraged to apply.

A nomination form is on the back of the mailing slip with this edition of Partyline and can also be found on the friends' page of the Alliance's website. Return completed forms by 31 May 2008 to NRHA, PO Box 280, Deakin West, ACT, 2600 or email to friends@ruralhealth.org.au or fax to (02) 6285 4670.

For information, please contact Leanne Coleman from the Alliance on 02 6285 4660.

NRHA under the microscope

WITH THE SUPPORT OF the Department of Health and Ageing, which provides the core grant for the NRHA, an external evaluation of the Alliance is nearing completion. It is expected to show that the communications activity of the Alliance is highly valued and is a major contributor to the cohesion generally demonstrated by the rural and remote health sector in Australia.

The evaluation has been undertaken by Urbis, with the consulting team led by Duncan Rintoul. Over 570 people completed the online survey for the evaluation, with Urbis also undertaking surveys with a wide variety of stakeholders, as well as Council and staff of the organisation.

From the outset, both the Department and the consultant have emphasised the importance of the external evaluation for helping to frame the future directions for the NRHA - as well as assessing the effectiveness and value of its present operations.

Over 40 per cent of those who responded to the 'open survey' were members of one of the Alliance's 27 Member Bodies, and one third of respondents had first heard of the organisation in the last three years. In contrast to this, one in five of those who provided views to Urbis had been working in rural or remote health since the 1980s.

The National Rural Health Conference is the Alliance's most high-profile activity and nearly half the respondents had been to at least one conference. Over three quarters of respondents were aware of the Alliance's public advocacy, with much of the awareness due to work undertaken during the 2007 Federal Election. Three quarters of those interviewed were aware of the Australian Journal of Rural Health, with the same proportion aware of the Alliance's website.

The survey results indicate that the Alliance is seen as being most effective at distributing and sharing important information about rural and remote health. About one third of those who receive the Alliance's communications pass them on to other people. (Perhaps you are one of those??)

PHOTO: DYANNE PHOTOGRAPHY

Marily Cintra, keynote speaker at the 9th National Rural Health Conference, 2007.

There was some criticism of the extent to which the Alliance has followed up on its policy position papers, and concerns about the extent to which its work is dominated by a relatively small number of health professions.

There were suggestions that the clearinghouse function of the Alliance could perhaps be formalised, especially as it encompasses the so-called 'grey' (ie unpublished) literature. Other proposals for change concerned the possibility of the Alliance offering information and lobbying advice to local organisations around the country - instead of doing all of this type of work in and through Canberra.

The final report from Urbis on the external evaluation will be provided to Council and the Department soon, and readers of Partyline will be kept informed of both the results and likely developments in the Alliance's work. ❖

Partyline is the Newsletter of the National Rural Health Alliance, the peak body working to improve health and wellbeing in rural and remote Australia. The Editorial Group for this *Partyline* was Lexia Smallwood (Editor), Gordon Gregory, Leanne Coleman and the *friends* Advisory Committee.

Articles, letters to the editor, photographs and any other contributions are always welcome. Please email these to: partyline@ruralhealth.org.au or send to: Lexia Smallwood, Editor, *Partyline*, PO Box 280, Deakin West, ACT 2600; Phone (02) 6285 4660; Fax (02) 6285 4670.

The opinions expressed in *Partyline* are those of contributors and not necessarily of the National Rural Health Alliance or its individual Member Bodies. The Commonwealth Department of Health and Ageing provides the Alliance with core operational support. *Partyline* is distributed free. To subscribe, email your contact details to partyline@ruralhealth.org.au *Partyline* is also available online at www.ruralhealth.org.au

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The drought breeze

BY OWEN ALLEN

The breeze played with the orange-berried tree
whose name I did not know.
The branches
tousled the russet wall,
scritching under the cerulean sky.
The air was dry.
The grass was dead.
The shade was kind.
The breeze played.

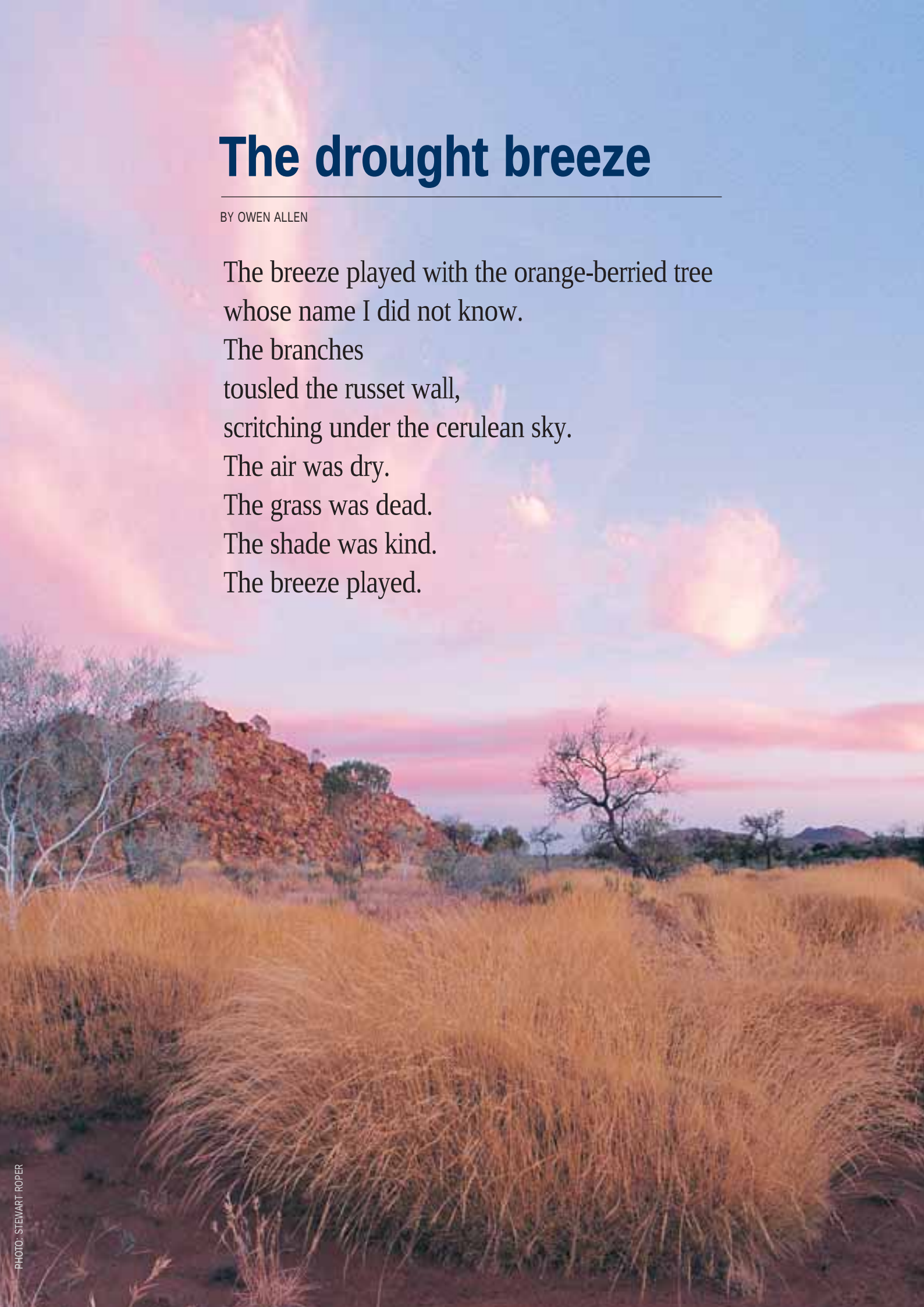

PHOTO: STEWART ROPER