SPECIAL EDITION

10th National Rural Health Conference

The social determinants of health

New professions and expanded roles

Change management in health

Arts in health

Cancer services

BUILDING TRUST FOR INDIGENOUS HEALTH

Mick Dodson: 2009 Reconciliation Lecture

Aboriginal and Torres Strait Islander readers are warned that this newsletter may contain images of deceased persons.
A dog’s breakfast – or mere spin?

There is a debate underway about whether Australia can really make substantial improvements to its health system. Which way would you vote?

Arguing for the negative are those who point out that Australia has the second highest life expectancy in the world. Their case relies on averages and on one measure: mortality. Their case gives no credence to distributions around the mean, or to how the benefits of good health and long life could be shared more evenly.

Also on this side of the debate are the pragmatists (realists?) who agree that the health sector in Australia - like all else - is over-governed but that nothing can be done to improve the situation. The three levels of government all have a strong interest in retaining their involvement with health and wellbeing. Their position is strengthened by the early stance adopted by some State Premiers who have taken an “Over my dead body” approach to significant changes in responsibilities for health.

These are joined by some of the health professions - at least at the organisational level - who see significant change as a threat to their historical patterns of work, status and/or income, with these concerns often cloaked in concerns for safety and quality.

Arguing for the affirmative are many from within and outside the health sector, including researchers from the fields of policy, economics and governance; and highly credible ex-managers of public service and private sector entities.

Tony Abbott, both as Health Minister and since, has shown himself, at least in theory, to be on the affirmative side. He has described his frustration with “the dog’s breakfast of divided responsibilities in health” and is on the record as saying that “it would certainly make organisational sense if one level of government had overall responsibility for health”. He distinguishes, however, the funding of the system from its operation.

Those on this side of the debate refer to the lack of continuity of care for patients, the fact that health resources are distributed largely according to the location of service providers rather than health need, and to the high level of adverse incidents in hospitals.

Fifty years ago, Australia was prosperous because of its abundant natural resources and the stable polity in which they could be harvested and mined. Some might say that this tendency to rely on our luck, and to be careless about innovation and productivity, was a national characteristic until the wake-up call provided by the global financial crisis.

And it might be that we have the second longest life expectancy in the world due to our natural advantages rather than to a clever health system. What will be the wake-up call for health sector reform? Will it be more communities without doctors, midwives, dentists, nurses and podiatrists?

“The challenge is for the community and its governments to design and implement an even better health system - or for everyone to accept that nothing better is possible.”

More local people without access to dental, maternity, mental health or child care services?

We need to protect safety and quality but clear away workplace demarcations and restrictive practices. Health has around 600,000 employees or 7 per cent of the civilian workforce, and two-thirds of health expenditure is labour cost.

We need to be better with IT applications for the health sector. (One of the 19 priority recommendations from the Cairns Conference was on that subject.) There need to be stronger reporting and accountability requirements for hospitals and other health service providers - but simpler ways of providing them (“less red tape”).

There has to be a greater emphasis on illness prevention and early intervention.

Most importantly, we have to improve governance of the system: “ending the blame game” between Federal and State Governments.

Additional resources are not required; it is a matter of helping the “good people working in a faulty system” through better use of existing resources. And distribution between population groups and areas is a key issue.

The challenge is for the community and its governments to design and implement an even better health system - or for everyone to accept that nothing better is possible.

What does your own personal experience tell you about the debate? Are you for or against the proposition that we really can do better? ✯
“…a small country town, flying and nursing”

Caroline Rogers, the 2009 Des Murray Scholarship winner, talks about her ambitions and aspirations for rural health.

I am from Narembeen in Western Australia and was very grateful for the support to attend the 10th National Rural Health Conference. Thank you to my boss, Pam Keenan, for nominating me and thank you to the National Rural Health Alliance for the Des Murray Scholarship.

In June 2009 it will be ten years since Des Murray passed away. People like Des who believe in others are so vital to rural communities. This scholarship is a reminder of him and of the great contribution he made to rural and remote Australia.

I was born in Perth in 1980 and grew up in Corrigin in Western Australia’s wheatbelt region. I have just moved to Narembeen which is 45 minute drive from Corrigin but I still work at the Corrigin Hospital as a Patient Services Assistant.

I am a single mother to two children, Nathan (3) and Bella (22 months). When I finished year 12 I trained as a flight attendant/travel agent because I thought that was what I wanted to do.

After a series of events and changes of career, including as a rouseabout, waitress and bar attendant, I started working at the Corrigin Hospital. I had never really considered becoming a nurse until an elderly patient by the name of Sue Abe encouraged me to do so. Like Des, Sue was a gentle and compassionate person who enjoyed helping others. She not only encouraged me to do nursing but also offered to pay for my degree. She was my inspiration and I am eternally grateful to her and her husband David. Sue was a wonderful lady who gave me an incredible opportunity. Sadly, Sue died in 2003 from a brain tumour.

I want to work in rural Australia because I love it out here. The weather is just the way I like it, not too hot and not too cold; the people are warm, the communities are generous and it is a great lifestyle to have when raising kids. I grew up in a small country town and I am glad that my children will get that chance as well.

I plan to get my pilot’s license because I love flying. I read in the Aviator magazine that “Once the aviation bug has bitten, flying is not a luxury; it then becomes an essential part of life. It’s a difficult task but we somehow have to explain it to partners, loved ones and over-zealous accountants that we simply must fly every now and again...” (Simon Holloway, Editor, ‘Aviator’, November 2008). This quote sums up the experience of flying beautifully. It truly is exactly like that and that is why I want to fly.

I am not exactly sure what my future rural plans are but I can guarantee it will include a small country town, flying and nursing. I am sure I will find lots of reasons to stay rural. I am currently looking in to what it will take for me to work with the Royal Flying Doctor Service and hopefully there is a future there for me provided I finish my studies before I get too old!!

I would like to say thank you once again for the incredible opportunity that the NRHA provided me with. I really enjoyed the Conference and it was brilliant to see how things are discussed and changed within the federal health system. I certainly gained a lot from the experience and no doubt my friends are all sick of hearing my stories that start with “When I was in Cairns...” Ha! *

Caroline Rogers, Des Murray Scholar 2009.
Keynote themes

Keynote speakers at the 10th National Rural Health Conference covered a range of issues that are important for rural and remote health outcomes. Of particular interest were their views on the social determinants of health, the state of Indigenous health, new and expanded scopes of professional practice, and change management in the health sector.

The social environment is integral to health

In his address to the opening session, Joshua Tepper, from HealthForceOntario, said that the main health divide in Canada is between urban and rural. He made the point that the difference is not attributable just to health care, but also to the determinants of health, including education, environment, housing, employment and climate change. As in Australia, geography is also a significant determinant of health, with rates of injury, morbidity and mortality increasing with remoteness.

Monique Begin, for eight years Minister of National Health and Welfare in the Trudeau Government, and more recently a member of the World Health Organisation (WHO) Commission on Social Determinants of Health, was another who drew on the Canadian experience. She supported the view that the health care system is only one factor affecting health. “It’s a key one – we absolutely need it – but it’s only one determinant, and many others from other areas of human activities are part of the equation,” Begin said.

“The gap between the top 20 per cent wealthiest and the bottom 20 per cent poorest is both shocking and widening.”

The findings in the WHO Commission’s report refer to ‘class’ and ‘gradient’ and demonstrate that health is a matter of social class and deteriorates as wealth reduces. “The gap between the top 20 per cent wealthiest and the bottom 20 per cent poorest is both shocking and widening,” Begin said.

Flinders University’s Fran Baum, who also serves on the Commission on Social Determinants of Health, highlighted its view that there is absolutely no point in treating people’s illnesses while giving them no choice but to return to the conditions that made them sick in the first place. Fran pointed out that the social environment determines both access to health services and also lifestyle choices.

Daily living conditions - where people are brought up, where they live, where they work, where they play, where they get their health services - absolutely determine health status. Communities that give people access to basic goods, that are socially cohesive, designed to promote good physical and psychological wellbeing, and are protective of the natural environment, are essential for health equity. Additionally, money, power, resources, gender equity and the extent to which people have political empowerment are also important drivers of health status.

Fran Baum pointed out the risk in focusing only on behaviours and not addressing their causes. “There is a need for better knowledge and monitoring of the social determinants of health and improved skills for understanding them,” she said.

“The social determinants have a very powerful, but often hidden, impact on rural health, and we really need to have an understanding that responding appropriately requires responses that go below the surface.”

“What good does it do to treat people’s illnesses but to give them no choice but to go back to the conditions that made them sick in the first place?”

These speakers agreed that how well health is distributed can be seen as a measure of the success of a society – and the availability of services for First Nation people is included in this measure.

Monique Begin identified the situation of Indigenous people as the single most dramatic area where urgent reform is needed “for both your country and mine.” She said improvement in Indigenous health must be one of the ‘non-negotiables’ for Australia’s health in 2009.
New professions and expanded roles

In her keynote address entitled *New professions... new solutions*, Ruth Ballweg, Director of the Physician Assistant Program at the University of Washington in Seattle, spoke about the American experience with the introduction of physician assistants (PAs) and nurse practitioners (NPs). At present there are almost 80,000 PAs, many of them female, and around 125,000 NPs. Forty years since their establishment both professions are now well integrated throughout the US health care delivery system and are particularly valuable in rural settings.

Ruth Ballweg said that nurse practitioners emphasise their potential for independence and place a high priority on the culture of nursing. PAs see themselves as generalists; their curriculum is very broad. Both professions have standards – degrees for nurse practitioners, and a national certifying exam for PAs. Licensing and regulation are undertaken for nurse practitioners and physician assistants by nursing and medical groups respectively. Both professions strongly support team practice, and the best way to achieve effective teamwork is to learn together in the first place. It is important, Ruth said, “to delegate to people’s strengths and teach to people’s weaknesses” – and not only for PAs and NPs.

The US experience shows that these professions should be built on the idea of partnership, not competition. These new professions help to ensure the best use of human capital. Currently there are many people in the health sector not making best use of their skills and having a greater number of PAs and NPs will help with this. Ruth emphasised the importance of Australia having a system for PAs and NPs that is uniquely its own and which allows for new roles that are developed through new technology.

“Paramedics look after some of the sickest patients in the most unsupported circumstances. They do miracles!”

Joshua Tepper spoke positively about the expansion of scopes of practice in Canada and of the value that this brings to rural and Indigenous health. He observed that having dental hygienists able to clean teeth and do basic limited prescriptions “without the direct supervision and touch of a dentist” means that the longstanding need for basic oral health care in reserves, in long-term care homes and in seniors’ facilities can now be met.

He commented on the value of having dieticians able to “do blood work”, physiotherapists who can order X-rays and MRIs, midwives who have greater access to blood work, lab tests and more prescriptions, nurse
practitioners who have broad prescriptive authority and pharmacists who are able to renew prescriptions and adjust dosages.

In responding to reservations about the safety of physician assistants, Joshua Tepper reflected on his experiences working with paramedics. They “look after some of the sickest patients in the most unsupported circumstances. They do miracles! And they are completely unregulated.”

Change management in health

Monique Begin said that to gain political traction the rural health sector must demonstrate that a demand for change exists. She identified five factors necessary for successful change in rural health:

1. the rural health sector to move from plural to singular;
2. continuity of committed leadership in the Department of Health (“constant turnover at the leadership level is very, very, very bad for any kind of reform”);
3. strong support signalled “from the top” (e.g., the Prime Minister or the Premier);
4. development of an intersectoral or whole-of-government approach and mechanism; and
5. adoption of a social determinants of health focus, instead of a health promotion focus.

A move from the plural to the singular would involve the rural health sector changing from being a coalition of places and stakeholders to having an integrated approach from the rural community of Australia. She recognised that local needs differ in particular places, but asserted that the core problems are the same – being forgotten, lacking health professional human resources and not receiving even the 30 per cent of health and related budgets corresponding to the rural 30 per cent of the national population. She said rural health should be “in the face of Australian public opinion” as one single, powerful, sociological entity. There needs to be a move away from the siloed structure of bureaucratic response to rural health needs.

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Monique Begin emphasised that adoption of a social determinants of health focus is not always an obvious choice but is extremely important. The temptation is great in any government to address individual lifestyle factors while ignoring the socio-economic impediments to optimum health.

A focus on individual lifestyle is important (e.g., anti-smoking) but the risk is that focusing on negative individual lifestyles, while providing easier targets with good mid-term results, can lead to blame-the-victim approaches, when it is society’s structures that should be challenged.

Joshua Tepper spoke about four types of change in health systems: developmental change (i.e., more of the same), transitional change (i.e., old methods in new infrastructure), reactive transformational change (i.e., responding to the unplanned and unexpected in a rapid ad hoc way), and conscious transformational change (i.e., “a planned death and a planned rebirth”). Conscious transformational change is informed by a series of iterative pilots, evaluation and feedback cycles that move towards a new system in a deliberative way. Joshua advocated the value of more conscious transformational change in health care.

He also advocated the use of appreciative inquiry, a method largely driven by building on existing strengths. He saw rural settings as the ideal environment for appreciative inquiry because rural necessity breeds so much successful innovation. Appreciative inquiry asks: What works? Why does it work? and How can we spread it everywhere?

“We started to look at some of the great things that people have done and began to make isolated examples of excellence the normative standards of care,” Joshua Tepper said.

Joshua observed that in bringing about workforce change, the difference between success and failure of strategy is leadership. He acknowledged a debt of gratitude to Australian, Roger Strasser, who has recently opened an innovative medical school in Northern Ontario. This year 90 per cent of its graduates are people from rural and northern areas.
“This is the smallest medical school class in Canada, yet in absolute numbers that class will have more Aboriginal students graduating from it than the rest of Ontario medical schools combined,” he said.

And the trend is being maintained – with 90 per cent rural and northern students entering this medical school each year, and with Grade Point Averages for entry just as high as other medical schools in Canada. “You guys should be very, very proud of your export,” he said.

By working in new and different ways, Strasser has achieved phenomenal success and a fundamentally different group of people are becoming qualified.

How to move forward

The National Rural Health Conferences have traditionally generated recommendations for rural health (as Louise Lawler recalled in her keynote review of the last nine Conferences, the proposal that there be a National Rural Health Alliance was a recommendation from the first National Rural Health Conference in 1991).

Joshua Tepper commended this approach. “It is very inspiring for speakers like me to feel we have to put recommendations in,” he said. His five recommendations for the rural health sector were:

1. create a conscious, fundamental change agenda;
2. develop leadership for the new health system into which we are moving;
3. use appreciative inquiry to foster creative and diverse solutions to all problems;
4. put value for the patient at the centre of the health system; and
5. pay attention to the mind, the heart and the bodies of yourselves, your colleagues and your patients.

He observed that the final recommendation looks the easiest but is in fact the hardest because it’s about focusing on ourselves. All health care is hard. Rural health care is harder. “If we can’t care for ourselves, we can’t care for our colleagues, we can’t care for our patients, we can’t care for our communities,” he said.

Monique Begin also brought recommendations for the future. She began by describing the difference between health inequality and health inequity. “Health inequality is the observable difference of health status between individuals or groups. Inequity of health, or of society in general, is a moral category, rooted in values, social stratification, embedded in political reality and in power relations.” The way to reduce health inequality is to aim for health equity and equity in society generally.

“If we can’t care for ourselves, we can’t care for our colleagues, we can’t care for our patients, we can’t care for our communities.”

“Significantly reducing health disparities will require profound structural changes, including income redistribution in most of our contemporary societies. The question then becomes – how much do Australians – how much does Australia – value an egalitarian society?”

Both Monique Begin and Fran Baum presented specific and direct challenges to the National Rural Health Alliance with regard to raising the political profile of the social determinants of health. Monique proposed that the Alliance engage ‘non-health’ allies in the cause of advocacy for social change by broadening the membership of the NRHA to include more and new players from rural and isolated Australia, such as farmers’ associations, vets, teachers, women’s groups, seniors and also businesses and corporations. She said the key challenge is to be innovative in developing a network of groups who, in the normal course of events, never see each other but who can play an important role in health improvement, particularly through addressing the social determinants.

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Monique Begin provided political insights.

Louise Lawler on the recommendations from nine conferences.

Keynote addresses, communiqué and recommendations from the 10th national Rural Health Conference are available at www.ruralhealth.org.au
**Art effects**

Through storytelling, singing, performance, multimedia, photography and painting, the arts-in-health stream at the Conference wove a picture of how the arts are an important indicator of the health of a community, how the arts can be used to disseminate health messages and what the arts are doing in regional Australia to help create healthy communities.

Overall, what stood out was the strength of conviction and belief of the many presenters in their work and how warmly received they were by delegates.

Storytelling, capacity building and wellbeing were the three key areas highlighted in the arts-in-health stream.

One of the storytellers, Moya Sayer-Jones, comes from Mullumbimby in NSW and started her session by handing out her ‘Only Human’ badges and talking about being part of the human family. She explained how storytelling can help human beings to understand and learn from each other. Moya described how she records and presents people’s stories honestly and compassionately. She starts off by talking with individuals and family members and then uses their own words to tell compelling stories and communicate their experiences with others.

Moya also talked about the impact of the arts-in-health stories in Regional Arts Australia’s publication ‘Big Story Country’: stories which show the tangible and practical effects of the arts in the management of rural health issues.

Many delegates visited the story lounge created by Moya where they relaxed, read, shared stories, picked up books and learned more about how storytelling can be a powerful force for change.

Cairns-based mural artist Kim Davis vividly showed how over the last ten years, the organisation she has been working with in Australia, Bali, Africa and other countries, uses the arts to raise awareness about AIDS. The mural created by Kim and Conference delegates was a stopping-off point for many people, who quickly became absorbed in the painting and gained a first-hand understanding of how creating art together can also tell a story, build connections and shared understanding, and deliver powerful health messages.

James Newton and Kim Schneiders from Access Arts Link in Launceston, Tasmania, work with artists experiencing physical and intellectual disabilities. They offer employment, run projects and provide individual tuition. Some of their projects have helped to change the artists’ perception of themselves and what they can achieve. At the same time, projects like the calendar with images of the artists wearing body art are challenging the general public’s stereotypes about what people with disabilities can and should do - and about what can be beautiful.

Focusing on community wellbeing, Zoe Scrogings gave an inspirational presentation about ‘The Peace Initiative’. Over the last six years this program has helped to decrease intercultural violence in Brisbane’s South West Corridor and is helping to change young people’s aspirations for their future. Participants from diverse cultural backgrounds are building positive relationships while creating and performing music. Several of the participants are now employed on the project as arts workers, youth workers and cultural consultants.

Cairns-based arts organisation Arts Nexus worked with Regional Arts Australia and local artists and arts groups to put together papers, performances and installations for the 10th National Rural Health Conference. It turned out to be a very successful, varied and stimulating part of the event.

**Ruth Smiles**  
Regional Arts Australia

PHOTO: KIRKLAND  PHOTOGRAPH

PHOTO: KIRKLAND  PHOTOGRAPH

PHOTO: KIRKLAND  PHOTOGRAPH

Kim Davis and the 10th Conference mural.

DanceZone

Simon Mansell: healing with words and song.
Cancer stream

Cancer is Australia’s largest disease burden, with more than 106,000 new cases and more than 39,000 cancer deaths in 2006. About one-third of people affected by cancer live in rural, regional and remote areas.

It is well established that rural cancer sufferers have poorer survival rates than those in the major metropolitan centres. Several factors are thought to contribute to this:

• rural patients are often diagnosed at a later stage, meaning the cancer is more advanced and more difficult to treat successfully;
• poorer access to specialised treatment;
• relative shortage of health care providers in rural and regional areas; and
• a higher proportion of disadvantaged groups such as Aboriginal and Torres Strait Islander peoples.

The first national mapping of cancer services in Australian rural and regional hospitals, conducted in 2005 by the Clinical Oncological Society of Australia (COSA), found marked deficiencies in clinical services in rural and regional areas of Australia. COSA’s report concluded that the quality and availability of services was directly related to the lower survival rates for people in rural and regional Australia.

Because of its significant impact on the lives of rural Australians, cancer care was the subject of a concurrent stream at the 10th National Rural Health Conference, supported by COSA and the Medical Oncology Group of Australia (MOGA).

Conference delegates heard about two major national initiatives for improving the accessibility, quality and coordination of cancer services for people in regional and rural areas:

• construction of new regional cancer centres – a model that has been advocated by COSA and other organisations – received a $560 million commitment from the Federal Government in the 2009-10 Budget; and
• development of networks linking regional and metropolitan cancer services in all States and the Northern Territory (the CanNET program).

Both approaches necessitate a significant change in thinking about health care delivery – shifting the focus from treating rural patients in city centres to providing ‘hubs’ of cancer care expertise in regional areas and linking and supporting services in rural centres. While capital grants for regional cancer centres are welcome, the success and sustainability of these centres depends on the availability of oncology, allied health professional and specialist services.

Treatment for cancer is often complex, involving many disciplines and therapies which are not always available locally. Having multiple care providers in multiple care settings creates many opportunities for rural people to become ‘lost’ in the system and to experience fragmented and sub-optimal care.

Case studies of some COSA initiatives for better care coordination and more patient-centred approaches included:

• use of videoconferencing to support delivery of chemotherapy in rural Queensland;
• taking skin cancer clinics to a remote Queensland population;
• the development of ‘shared care’ oncology services (a partnership between metropolitan oncologists and local nurses) in Cooma; and
• a patient-focused dietetics service for rural patients in the Tamworth area.

Delivery of safe, quality and timely cancer services to people with cancer, regardless of their location, depends on the availability of sufficient, and appropriately skilled, trained and supported, health professionals. There was an emphasis on the need for effective educational resources to engage and support non-cancer specialists, such as GPs and nurses, in their increasing role in cancer care. Such resources include the Enhancing Palliation in Patients with Advanced Cancer in Rural Areas of Australia and Education Program in Cancer Care (EPICC) and the National Cancer Nursing Education (EdCaN) program. Other supports should address the risk of burnout in cancer professionals, which has significant implications for patient care and for the future of the cancer workforce.

This piece is adapted from a report on the COSA/MOGA Cancer stream at the 10th National Rural Health Conference by Lisa Herron.
Cairns community day

For the early risers in Cairns on Sunday 17 May, the community skills workshop, *A healthy place to be*, helped to set the scene for the 10th Conference’s focus on community engagement.

In the workshop’s opening address, *How the health sector works – and how to influence its outcome*, Dennis Pashen outlined how people in local communities can contribute to turning good policy into practice, rather than letting it remain as a document on a website. The overall message was that if your community has a health issue to be addressed, get together and work strategically to fix it. Find the facts about the issue and talk with people in your community and health service networks. Try to understand the processes that will allow effective dialogue between all of those involved. Talk to people in local industries outside health too, such as mining and forestry, as they might have other avenues of influence with government or opportunities for funding. Make sure that your message comes from different directions and is heard at local, regional, State and national government levels, tied where possible to relevant programs. Don’t forget that you often have a better idea of the complexities and needs of your community than the national health planners.

The community skills workshop was an opportunity to share expertise among people in the Cairns region. Keynote speakers were invited to apply some of the main conference themes to the region, such as the impact on health of climate change and predictions on future demographic changes in Far North Queensland that may impact on health service planning. Presenters from the Cairns area spoke about programs in the region such as training for community groups in mental health first aid and the Cairns Palliative Care Service being run out of the Gordonvale hospital.

Those who attended the ‘writing on health for the media’ workshop were invited to express a personal perspective on rural health in three sentences. Here are three of those submitted.

**Are we going backwards?**
QCWA provided accommodation for waiting mothers from the 1930s until transport and medical services made it unnecessary. Today, as birthing services are being removed from our rural and remote areas, waiting mothers are once again needing accommodation away from their homes and the CWA is asking ‘are we going backwards?’ We would prefer to bring these medical services back to our smaller hospitals and can see some hope in the current trends towards rural generalists, nurse practitioners and physician assistants.

**Win or lose**
Climate change is the most important problem facing our children. Good parenting and good will amongst world leaders is urgently needed to bring ALL the people to agreement about cutting emissions in Copenhagen this year. Rural Australians have much to gain from new opportunities for a greener future but they can be ‘The Biggest Losers’ if nothing changes.

**Vital vacation for those with a vocal vocation**
Voice is your most essential tool. Professional voice users have a 60 per cent risk of voice disorders. Our vocal boot camps teach you new skills for your profession, social life and personal interest in rural and remote areas. Contact: Gail Rogers, Cairns Speech Pathology Clinic, vocalbootcamp@hotmail.com

The community skills workshop was an opportunity to share expertise among people in the Cairns region.

The workshop also provided delegates with a range of skills to use in their own lives and their communities. Personal skills were covered in sessions such as *Self-care for carers* presented by Carers Queensland and *CPR skills* by the Queensland Ambulance Service.

Participants welcomed the energy of sessions run by health students, and the student’s participation and questions in other sessions. The interactive session on leadership in rural areas was well received. People valued the opportunity to talk in small groups and to recognise that many of us have leadership roles in the workplace, at universities and in our communities, as well as at a state or national level.

**Helen Hopkins**
NRHA
friends light up Cairns

The 10th Conference proved to be a great opportunity for friends of the Alliance to network and participate in the planned activities.

Lunch areas, hampers and the state of our health...

Many thoughtful friends contributed to the hamper at the Alliance booth and their generosity meant that two hamper prizes were presented, rather than one. The lucky winners were Don Perlgut from the Rural Health Education Foundation and Jane Giles, Clinical Nurse Manager at Woodville in South Australia.

The friends meeting area proved to be a very popular spot for friends to take a break and mingle over lunch. Other Conference delegates remarked how lucky friends were to have their own special place to sit down – a great opportunity to encourage people to join!

The Alliance booth was very active with a range of Fact Sheets for collection (still available at www.ruralhealth.org.au) and a number of people contributed to the message book with details of the state of health in their region.

Your images, words and winners

The photo and poetry competitions were a great success due to the high number of entries in both categories. Conference delegates were impressed with the diversity of subjects and the quality of the entries. The entries of finalists in both competitions can be viewed on the friends page of www.ruralhealth.org.au Below are the winners in each category:

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<thead>
<tr>
<th>Photo Competition</th>
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<tr>
<td><strong>First Prize:</strong> Katrina Morris (see front cover this edition)</td>
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<td><strong>Second Prize:</strong> Tracey OBrien</td>
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<td><strong>Highly Commended:</strong> Barb Woolford</td>
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<th>Poetry Competition</th>
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<tr>
<td><strong>First Prize:</strong> Shelley Davies – All quiet in KA (see back cover this edition)</td>
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<tr>
<td><strong>Second Prize:</strong> Hugo Spooner – Outback bride</td>
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<tr>
<td><strong>Highly Commended:</strong> Cheryl Ann Ingerson – A rural life path, journey and destination</td>
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James Easterbrook
Manager, friends of the Alliance

Inaugural Unsung Hero Award

The Unsung Hero Award is designed to highlight the contribution made by so many selfless people who contribute to health and community wellbeing in rural and remote communities.

The Alliance received very positive feedback about the institution of this new Award.

**Lynette Clyde** was recognised for her services to the remote community of Lock, on the Eyre Peninsula in South Australia, where she worked with the Country Women’s Association to secure a medical centre in the local community. Sister Clyde was a nurse at the centre and also a St John Ambulance leader and instructor.

**‘Uncle’ Col Walker** is an Elder in the Yorta Yorta Nations People in Barmah in Victoria. Uncle Col was nominated by six different groups and has been recognised for work among Koori people, particularly as a volunteer with the Koori Courts at Shepparton, working with both the victims and perpetrators of crime to promote healing and reconnection to their local communities and cultures.

**Peter Sergeant** was recognised for his work developing sustainable models of ‘Men’s Sheds’ for use in country and rural communities including Far North Queensland and the Torres Strait. Men’s Sheds are recognised as a means of delivering medical help and assistance to men suffering from isolation, loneliness, mental health conditions and those in need of respite.

**Marj Fraser** from Thorpdale in Victoria and **Garry Orvad** from Coober Pedy in South Australia were highly commended.
Priority Recommendations

01 This Conference believes that the time is right for major changes to the structure of the Australian health system. The range of issues covered in the interim report of the National Health and Hospitals Reform Commission, and their complexity, should not distract from the overriding urgency of improving health governance. Whichever of the options the Commission favours, the new system should be based on the following principles:

- a national health system, with a regional focus for fund holding and service delivery;
- genuine community engagement at the regional level in the design, implementation and evaluation of regional and local health services;
- governance based on appropriate regional areas, which in more remote areas will be relatively small populations determined by natural communities of interest;
- funding equivalence between all regions, moderated by health need; and
- delivery of health and related services in an integrated manner.

02 To help meet rural and remote health workforce shortages and to improve care, the Conference emphasises the need to speed the rate of development of new health professional roles (eg physician assistant, nurse practitioner and advanced allied health practitioner) and the expansion of existing roles (such as ambulance officers, paramedics and Aboriginal and Torres Strait Islander Health Workers) as appropriate. This will require the establishment and funding of additional positions as well as structural change in the professions and further consideration of revised models for funding health services. These changes will enable the implementation of the innovative service models needed in rural and remote areas and must be driven by patients and their needs.

03 Conference called for the early investment in the adoption of individual electronic health records so that people in rural and remote Australia have their health information where and when they need it. It is critical that people and health services in rural and remote Australia begin to build their capacity using the technologies currently available so they can participate in the improvements in broadband connectivity and adoption of NEHTA standards as health applications improve. The experience of e-Health-NT provides a working example.

04 The Conference recognises the great improvements to health which would be made through implementation of existing national strategies related to health. For example, the National Indigenous Education Strategy includes a number of evidence-based and potentially effective initiatives for this urgent and critical issue. The priority must be on implementing these policies at the local level.

05 The Commonwealth, State and Territory governments, in conjunction with the NRHA, should develop a national rural health plan to succeed Healthy Horizons, the strategic framework which lapsed in 2007. The new plan will incorporate benchmarks, targets and programmatic elements along the lines of those already included in State and Territory rural health plans. This national plan should:

- have strengthened emphasis on the social and economic determinants of health;
- reflect genuine national partnerships relating to Aboriginal and Torres Strait Islander health;
- for the first time, consider the impacts of climate change on health and prepare the rural and remote health sector for these impacts; and
- draw on the demonstrated capacity of rural Australia to develop innovative and effective services that are underpinned by community ownership and resources that are focused on local needs.

06 The 10th National Rural Health Conference calls for greater equivalence of incentives for education, training, recruitment and retention of rural and remote health professionals across all disciplines.

07 Those at the Conference welcome the commitment to a new national health workforce agency and the substantial resources allocated to it including for rural placements. Conference delegates call for ongoing tracking of undergraduate, post-graduate, training and practice trends in rural areas for all disciplines.

08 The Conference recommends that climate change be recognised as a core issue for health, and that its impact on health policy, planning and service delivery be considered in all health priorities and initiatives. This should encompass:

- proactive mitigation strategies;
- enhanced environmental literacy;
- incentives for renewable energy generation and energy conservation (an economic opportunity for rural and remote Australia);
- health infrastructure (eg hospitals) using best practice renewable energy and energy-efficient design; and
- a national conference on climate change and health.

09 The Conference welcomes the Budget commitment to establish ten regional cancer care centres in rural areas. This initiative needs to be supported by funding for adequate staffing and by effective relationships with smaller communities.

10 The new National Men’s Health Strategy must include specific measures for rural and remote areas.

11 As part of a comprehensive primary health care system, the Conference delegates call on the Commonwealth to take responsibility for ensuring that adequate oral health care is available for people in rural and remote areas. This care should include screening, education and preventative care within routine health checks, acute care where necessary and regular preventative oral health care. Aboriginal and Torres Strait Islander Health Workers should have a key role in the development, management and delivery of services in their communities.

12 Given the particular challenges that mental illness poses in rural areas, one area in which increased resources and attention would be effective is in prevention and early intervention in the school systems. This would include additional effort through school counsellors, school nurses, mental health professionals, other allied health professionals and general practitioners.

13 Conference delegates call for targeted funding for Aboriginal and Torres Strait Islander community controlled health services for initiatives such as smoking cessation and oral and dental health programs.

14 That the Australian Health Ministers’ Council agree on the means by which patient assisted transport schemes (PATS) will be better funded, more available and more uniform.

15 Conference calls on the NRHA to develop a position paper on the important role played by arts-in-health in health promotion and community engagement. This paper will help make the case to funding agencies for support of arts-in-health activities.

16 Natural Disaster policy should include ongoing elements for community capacity building.

17 Improving food security in remote areas offers a positive focus for investment in community infrastructure, transport, personal health, nutrition, child education, community education, social cohesion and physical and commercial activity.

18 The Conference calls on the Australian Government to permanently reinstate the Racial Discrimination Act for the Northern Territory.

19 Governments should publish the results of analytical and evaluative studies it undertakes or commissions relating to the health sector.
Building trust

Professor Mick Dodson presented the 2009 ANU Reconciliation Lecture: “How well do we know each other?” Professor Dodson drew lessons and hope from the findings of Reconciliation Australia’s Reconciliation Barometer. This edited version has been specially prepared for Partyline.

I have identified the education of our children as the central, thematic issue of my term as Australian of the Year. Education is fundamental to improving every aspect of the circumstances of every family and community in this country. It underpins our concept of ourselves, our health, our participation in the workplace, our productivity: it shapes our place in the world.

Education is also fundamental to achieving reconciliation between Indigenous and other Australians.

And there is close relationship between material reconciliation and interpersonal reconciliation. At present there remain great material inequalities of life experience and a gross differential in life expectancy.

The COAG National Indigenous Reform Agreement is integral to the Australian Government’s strategy of Closing the Gap on Indigenous disadvantage. It identifies targets for closing the life expectancy gap, halving the infant mortality rate, equalising access to early childhood education, halving the year 12 attainment rate and halving the gap in employment outcomes.

The shortest time-line to achieve any one of these targets is a decade. The longest is the more baggy concept of a ‘generation’. And several of the targets are not about achieving equality but merely a 50 per cent reduction of the present levels of inequality.

Equality is the base-line of any meaningful sense of material reconciliation. And that will take a considerable amount of time.

But at least with the Closing the Gap targets, we know roughly where we stand. The targets have tangible, measureable end-points. They form, if you like, the skeletal structure of reconciliation.

“Equality is the base-line of any meaningful sense of material reconciliation. And that will take a considerable amount of time.”

Building the soft tissue of reconciliation – reshaping the inter-personal relationship between Indigenous and non-Indigenous Australians – is just as critical: but it is a less tangible, more amorphous endeavour. In this field of inter-personal reconciliation our essential task is to build the social tissue of understanding, trust and respect that will unify Indigenous and non-Indigenous Australians.

I believe we have already taken many important steps towards this unity. They include the headline events - the Redfern Park speech, the Sea of Hands, the bridge walks – right through to the recent formal Apology to the Stolen Generations made by the Prime Minister. Each is a marker and a catalyst of a new relationship founded on equality and respect.

All this is positive. The concept of reconciliation is broadly accepted. The fruits of reconciliation, based on respect and trust, are strongly desired. We have moved from important gestures and statements of principle to action – to community and institutional engagement – to make a material difference and to build a new relationship.

The Reconciliation Barometer measures and compares the perceptions of Indigenous and non-Indigenous Australians. The findings do not tell us so much who we are, as who we think we are and what we think of each other.

Both as an Indigenous person and as Australian of the Year, I am deeply heartened by the strongly held view shared across our country that the relationship between Indigenous and other Australians is important to Australia’s future. There is a close convergence of thought on this: 100 per cent of Indigenous and 91 per cent of non-Indigenous Australians agree that our relationship is important to our country. You can’t build a better future unless you believe in it.

The most graphic demonstration of this lies in the Barometer’s measurement of our perceptions of ourselves - and each other - as Australians. There are striking similarities in the way both Indigenous and non-Indigenous Australians see themselves. There is a shared perception of our core national characteristics.

A consistently high percentage of Australians across the board (between 84 and 96 per cent) believe we are welcoming, good humoured, friendly, good at sport, proud, easy going and family oriented.

There is another way of looking at these figures.

If you turned the lights out, and asked Australians to form into various groups based on their perception of the degree to which they possessed these seven qualities - within a margin of 10 per cent - blackfellas and whitefellas would form one group based on their own perception of their identity.
The Australian Reconciliation Barometer

“The barometer is a national research study that looks at the relationship between Indigenous and other Australians. Designed to be repeated every two years, the Barometer explores how we see and feel about each other, and how those perceptions can affect progress towards reconciliation and closing the gaps. This is the first time we have compared core attitudes and values of Indigenous Australians to those of other Australians.”

Reconciliation Australia Q&A factsheet.

So in our perceptions of ourselves there is a far greater shared identity than is commonly understood. At a personal, interior level – in the way we see ourselves – we stand closer than we think.

However, only eight per cent of the national sample believed Indigenous people had a high level of trust in all Australians; and only 11 per cent of Indigenous people expressed a high level of trust in all Australians.

Only 12 per cent of the national sample believed all Australians had a high level of trust in Indigenous people; and a meagre 5 per cent of Indigenous Australians thought all Australians had a high level of trust in Indigenous Australians.

Despite the strong common belief that the relationship between Indigenous and other Australians is important for our country, the trust necessary to give real substance to a strong, constructive relationship is low.

“So in our perceptions of ourselves there is a far greater shared identity than is commonly understood. At a personal, interior level – in the way we see ourselves – we stand closer than we think.”

Perhaps the most unexpected and disturbing perception revealed by the Barometer is that Indigenous people considered themselves less hard working than they rated Australians in general: 69 per cent compared with 61 per cent. I believe this perception is directly related to reality. It reflects the chronic Indigenous experience of exceptionally high rates of unemployment and low rates of participation.

The causes are manifold. They include living where there is effectively no employment market, lack of education and - ironically - the perception that Indigenous people are not disciplined or hard working. This stereotype about discipline and hard work is shaped by reality and helps to reinforce that reality.

There is a dynamic interaction between perception and performance. The way we are seen by others, and the way we internalise that view, has the ability to affect material outcomes. The damaging effects of this vicious cycle are most clearly observed in the field of education.

Poor educational outcomes have less to do with poverty than with the strength of racial stereotypes and expectations of success.

Our thoughts give shape to reality. And reality shapes our thoughts.

Real progress in *Closing the Gap* in life expectancy, infant mortality, education and employment outcomes is essential to improving the perceptions that so profoundly affect the relationship between Indigenous and non-Indigenous Australians at a personal level.

“We now know that we share a great deal more in common as Australians than we previously thought, and that there is a great desire to know more about each other.”

We must be frank in recognising that the Reconciliation Barometer currently shows a low level of mutual trust – but it also shows us another previously unobserved fact – from which I take courage.

While levels of trust remain low, the national sample shows a higher level of trust in Indigenous Australians than Indigenous people believed existed, and Indigenous people report a higher level of trust in Australians generally than the national sample believed existed. In fact, we have a higher level of trust in each other than we think.

We now know that we share a great deal more in common as Australians than we previously thought, and that there is a great desire to know more about each other.

On this we can build.

Mick Dodson is Director, National Centre for Indigenous Studies, ANU; Co-Chair, Reconciliation Australia; and Australian of the Year 2009. The full text of this lecture is available at www.reconciliation.org.au

Blackrobats displaying balance and trust in Cairns.
Cobar’s Primary Health Centre - A winning formula

Cobar Shire Council was winner of the 2009 National Awards for Local Government, small council section (councils with less than 15,000 ratepayers) in the category Health and Wellbeing.

Cobar Shire in Western NSW covers over 44,000 square kilometres and has a population of around 6,000. It is a mining town, with the closest regional centre being Dubbo, 300kms to the east.

Mining is one of the most dangerous industries in Australia and most industries in Cobar, including Council, require employees and contractors to undertake a pre-employment medical. Cobar has a basic hospital, although most medical emergencies result in the RFDS flying patients out to Dubbo.

In 2004, Cobar had three GPs operating in separate practices. Council received a 50:50 grant from the Australian Government to build a medical centre where all the GPs could be located together. The aim was to keep overheads at a minimum, employ a shared receptionist, keep medical records in a central location and provide an incentive for doctors to come to Cobar and operate out of a walk-in, walk-out centre.

Despite this, in January 2008 Cobar was without the services of a single doctor. Residents had to travel great distances to seek medical attention and businesses struggled to have potential employees cleared with medicals. It was difficult to attract new residents and employees to a town without a doctor. Cobar has a large elderly population who found it difficult to travel and there was increased pressure on the hospital. Council unsuccessfully called for Expressions of Interest from bodies to manage the centre and advertised around Australia, NZ and the UK for doctors.

The major employers in town (of which Council is one) got together and organised a public meeting seeking volunteers to sit on a community committee that would work with Council to ensure adequate medical services were available to all Cobar residents. The Committee identified the need for a practice manager and after many discussions, the Outback Division of General Practice (ODGP) agreed to run the centre.

Council agreed to lease the centre for three years to the ODGP, with a further three year option. Previously, Council had met all expenses and had no income from the Centre. Under the new arrangements the Council makes a profit through rent, no longer has the expense of recruiting doctors (which was costing around $20,000 per year) and Cobar has a holistic approach to affordable health care with a preventative focus.

Staff are well trained, quality systems are in place, a large range of allied health services are provided and there is a minimum of two full-time doctors at the centre at all times. There are also permanent services of an Aboriginal Health Worker and an exercise, rehabilitation and smoking cessation nurse. The nurse also undertakes pre-employment medicals, freeing up the time of the doctors. Visiting specialists include a paediatrician, women’s health GP, physiotherapist, podiatrists, audiologists, optometrists and ophthalmologists, counsellors and a psychologist.

Demand for services is high. An ultrasound machine is now available two days a month, which means at least 25 people every month no longer need to travel to Dubbo. In the first three months, the optometrists referred 50-60 patients to see the ophthalmologists.

Managing health care centres is not Council core business. Forming a partnership with the community and partnering with a group such as the ODGP has had enormous benefits for the Cobar community. Council resources are freed up, a large range of health services is now available (most are bulk-billed), and less money is leaving the community as people travel less frequently for medical services. Waiting times have fallen from three weeks to same-day or next-day service. All records are kept on-site and residents are not charged around $40 to access their own records when a doctor leaves town (as has happened in the past). The local pharmacy (a large employer) is once again a profitable business. The centre employs at least five staff and is not-for-profit, so any money generated is put back into improving services and facilities. Because it owns the health centre, the community is willing to fundraise for it and support it in other ways.

Angela Shepherd
Cobar Shire Council
Outcomes in rural health

In a time of financial constraint, it was pleasing that the rural health sector was given some special attention in the 2009 Federal Budget.

The highlights include:

• funding for infrastructure for ten new best practice regional cancer centres and associated accommodation (but not as yet for the more specialised staff needed to provide the services);

• a package of measures to improve maternity services and options for women, including through access to MBS and PBS for midwives working in collaborating teams, through expansion of the Medical Specialist Outreach Assistance Program, additional scholarships for GPs and midwives and professional indemnity for midwives;

• infrastructure funding in rural Australia for both public and private primary care services in 40 locations, with grants of up to $500,000, as well as funds for major expansions of hospitals in Townsville, Rockhampton, Alice Springs, Launceston, Darwin, an integrated district health service in Narrabri, and other infrastructure in Broome and the Kimberley;

• providing access to the MBS and PBS for nurse practitioners (nationally - not just in rural areas) to strengthen the health workforce and to improve access for patients.

There was $6.7 million to extend mental health services in rural and remote areas, $5.2 million for continuation of the support for drought-affected communities, and a further $7.5 million for support for communities affected by the Victorian bushfires. The Budget also provided incentives for continuing professional development for mental health professionals.

Good news: the RFDS is here!

There is provision for a 35 per cent increase in GP training places - to 800 places per year; a new National Locum Relief program; and expansion of the Training for Rural and Remote Procedural GPs program.

There will be a new GP relocation incentive scheme that is ‘scaled’ for remoteness, with a new geographic classification scheme (known as ASGC-RA) to replace RRMA. Under this new framework, an estimated 2400 extra doctors will become eligible for rural incentives and there will be a tiny number of potential losers (who will be ‘grandparented’ at the previous rate). The classification system reflects ‘remoteness’ only, not town size, SES or some of the other variables that are of importance. However, the system is such that these additions could be made in the future, if there was a desire to do so. People wishing to identify the level of remoteness for any town may do so using the ASGC-Remoteness Area Locator: http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/RA-intro

Funding to support improvements in the health and wellbeing of Aboriginal and Torres Strait Islanders was targeted mainly at continued support for the Remote Area Health Corps program in the Northern Territory ($131 million). New programs were $58.3 million for eye and ear health and $11 million for oral health. A new Centre of Excellence in Indigenous Health and Education is to be established in Darwin.

Since the Budget, experienced parliamentarian Warren Snowdon has been appointed to the new Ministry for Indigenous Health, Rural and Regional Health and Regional Services Delivery.
Younger onset dementia

Lack of awareness of younger onset dementia among doctors and other health professionals is a significant issue.

In far too many cases younger people face protracted misdiagnosis and it often takes much longer than for older people for them to be correctly diagnosed. When diagnosis takes several years, individuals, their families and carers can suffer a great deal of anxiety.

This journey to correct diagnosis can be even longer for younger people who live in rural areas. A lack of health services and poor understanding of younger onset dementia further complicate the issues. The great distances needed to travel in order to reach medical services or appropriate support services can lead to increased stress for the person with dementia and their carer and family.

The challenges faced by people with younger onset dementia are quite different from those faced by older people, and include declining employment choices. Younger people are more likely to be at a stage where they remain socially and physically active.

These issues can have a profound impact on the family. A lack of support services or appropriate care in the area places pressure on family members to take on caring roles. As well, the requirement to face financial issues can have a huge impact on the family dynamic.

Many small towns are already facing the growing dementia needs of their community. Bega, with its ageing population, is facing the possibility of having the largest population with dementia per capita of any small town in NSW. In rural and regional Australia an increasing frequency of people with dementia will place further pressure on the limited services available for people with younger onset dementia.

“The challenges faced by people with younger onset dementia are quite different from those faced by older people.”

Alzheimer’s Australia aims to provide support and information to families in rural areas with programs such as the NSW Dementia Advisory Service and the different State and Territory Mobile Respite Response Teams.

Planning for the future is an important consideration that younger people with dementia must face. The person with dementia, their family and carer need to discuss the various care options available. Some major issues that should be discussed early in the diagnosis include money management, business affairs, medical treatment and making a will.

To help with the challenges of younger onset dementia, Alzheimer’s Australia commissioned the Prince of Wales Medical Research Institute to provide information, practical approaches and strategies for dealing with these issues. The resulting publication, Younger Onset Dementia – A Practical Guide, is available for free download from www.alzheimers.org.au Hard copies can be purchased for $7.50 each by calling (02) 6254 4233, emailing admin@alzheimers.org.au or downloading an order form from the website.

Ten out of ten conferences

Robyn Williams, Conference MC, quizzes John Humphreys and Sabina Knight about attending all ten National Rural Health Conferences to date. John and Sabina: “No, no – it was more for the networking and the papers!”

Helping Harald’s House

Did you buy a tattoo at the 10th Conference? Even if it has worn off by now, you will be pleased to know that $2,419.55 was donated to the local Cairns charity ‘Harald’s House’.

The donation was made up from the sale of the tattoos, an allocation from the conference budget and the generous donation of the prize money by one of the winners of the poetry competition.

Harald’s House provides street kids with meals and support and aims to give them strength, dignity and a desire to achieve in life. The House Committee is currently raising funds to build a complex capable of sleeping twelve children. Donations can be made at www.haraldshouse.com
Poverty and rural health

Right around the world there is a close correlation between income and health. Even in a nation as generally affluent as Australia, poverty is a widespread killer and a suppressor of health, wellbeing and longevity.

Every year, around October, there is a special week when the nation can focus on how poverty might be eradicated – but it would be better if plans for doing so were permanently high on the political agenda.

Poverty is not just associated with lack of material possessions, leisure choices and disposable cash; it is also a determinant of poor health. In the quest for improved health, the level of poverty is one of the factors that is amenable to intervention and reduction.

A number of measures can be used to indicate poverty, including level of income, nature of income and location. Available data indicate that levels of poverty are higher in rural areas.

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<tr>
<th></th>
<th>Capital cities</th>
<th>Outside capital cities</th>
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<tbody>
<tr>
<td>Gross household income*</td>
<td>$1,410 per week</td>
<td>$1,122 per week</td>
</tr>
<tr>
<td>Pensions are principle source of income*</td>
<td>23 per cent</td>
<td>32 per cent</td>
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(AIH: *2005-06 figures)

Furthermore, the latest available figures (reported by the AIHW, 2005) show that 34 per cent of people in Major Cities lived in Australia’s least disadvantaged areas, compared with:

- 14 per cent in Inner Regional areas;
- 8 per cent in Outer Regional areas;
- 10 per cent in Remote areas; and
- 2 per cent in Very Remote areas.

Conversely, 20 per cent of people in Major Cities lived in Australia’s most disadvantaged areas, compared with:

- 26 to 33 per cent in regional and Remote areas; and
- 53 per cent in Very Remote areas.

Because economic and social inequalities go hand in hand, their combined impact results in limited opportunities and life chances for many who are affected by them.

Those with the highest socioeconomic status are those who have the most resources, opportunities and power to make choices, whereas those with the lowest status have the least of these. This forms a ‘social gradient’, with overall health and wellbeing tending to improve at each step up the socioeconomic ladder. Thus, people with a higher income generally enjoy better health and longer lives than people with a lower income (Marmot et al. 1984). The rich tend to be healthier than those in the middle, who are, in turn, healthier than the poor.

Rural communities gain from funding boost for health infrastructure

From Bega in NSW to Yalgoo in WA, 27 rural and remote communities will be able to build new medical centres, buy new medical equipment, and expand the range of medical and allied health services like podiatry, dental, psychology and optometry, after the announcement of the outcomes of the second funding round of the National Rural and Remote Health Infrastructure Program, worth more than $5 million.

The new funding, announced on 18 June 2009 by the Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery, Warren Snowdon, will support projects which will improve rural and regional access to essential health infrastructure and equipment.

“This $5 million investment helps create jobs for rural and regional communities – both during the initial construction phase, where capital works are required, and as a lasting legacy of increased health workforce employment.

“Round two builds on the 53 projects worth almost $12 million that were announced in January, some of which are already complete, and a further 40 projects totalling $13.9 million were announced as part of the 2009-10 Budget.

“This is a highly competitive selection process, and I congratulate all of the successful applicants who have secured funding,” Mr Snowdon said.

The NRRHIP was established as part of the 2008-09 Budget and amalgamates the former Rural Private Access program and the Rural Medical Infrastructure Fund. The NRRHIP is a competitive grants program which provides for improved opportunities for partnerships and multidisciplinary approaches to the delivery of health care in rural and remote communities, through better access to funding for infrastructure.

The NRRHIP will direct more than $46 million in funding over four years (2008-09 to 2011-12) for essential health infrastructure (capital works and equipment) and strategic service planning for small rural private hospitals, thereby supporting the establishment of new, or the enhancement of existing, health services.

Applications received under the third funding round are now being assessed. The Government will make further announcements about the successful applications under this round later this year. A fourth funding round will be advertised later this year.


CareSearch

CareSearch is an Australian online resource that promotes the evidence-based practice of palliative care.

It provides good quality, practical, up-to-date information and resources. All the information on CareSearch is peer reviewed in an Australian context.

CareSearch provides information written especially for GPs to help in the management of palliative care patients in the community, including on managing symptoms, ‘making it work in your practice’, following up the bereaved and professional development.

CareSearch also provides information written specifically for patients, carers, their family and friends to give understanding of palliative care, guidance for living with illness and caring for those who do, and help in dealing with bereavement, grief and loss. GPs can direct patients to the web pages to view, or print out the information to initiate discussions. An online medium can be appropriate for those in rural and remote areas, so CareSearch includes information and resources written especially for patients in rural and remote areas, and for health professionals about palliative care for rural and Indigenous Australians.

The CareSearch website has recently been updated and revised.

BOOK REVIEW

Fight your dark shadow

*Fight Your Dark Shadow* by Therrie Rosenvald is a welcome addition to the self-help literature for those who are experiencing depression and the family and friends who are supporting them.

While it is authored by academics, and has the firm evidenced-based foundation of sound research behind it, the book is not an academic text, but rather a comprehensive, easy to read tool kit that is both understandable and accessible.

Based on the authors’ extensive experience in assisting people manage their depression, *Fight Your Dark Shadow* offers descriptions of the different types of depression, the various symptoms that sufferers experience, and the range of medications used to treat depression. Most importantly, the book offers a wealth of information about Cognitive Behavioural Therapy (CBT) and how this treatment really does work for depression. The strength of the book lies in its succinct presentation of thoughts and emotions, and in the assertion that understanding cognitive distortions and core beliefs, as well as challenging these distortions, can sponsor the journey towards managing the symptoms of depression. *Fight Your Dark Shadow* offers many practical tips on how to fight depression, build self esteem, and access our all important but oft forgotten support systems. Unlike other books on depression, this book does not stop here, but provides additional information on preventing relapse.

*Fight Your Dark Shadow* offers a bio-psycho-social approach to the management of depression. It offers a straightforward, consumer-centered approach, full of solid information and illustrated by apt cartoons. The strength of the book is its focus on dealing with depression as a problem outside the person, rather than an internal illness, and its emphasis on personal responsibility for healing. This is a rare find that will be appreciated and respected by both practitioners and their clients for filling the gap between ‘too academic’ and ‘too simplistic’.

*Fight your dark shadow* is published by the Australian Academic press.

Jillian Bull
PsyD (Clin), MAPS

ALLIANCE NEWS

Alliance www.ebsite news

The facts at your fingertips

A series of Fact Sheets aimed at highlighting the current state of health in rural, regional and remote Australia is now available. They cover such topics as ageing, obesity and nutrition, education, regional development, cancer services, oral and dental health and mental health.

There are currently 19 in the series, which will grow over time and be updated on a regular basis.

The place to be for Conference news

The 10th Conference website is now a post-Conference website with easy access to keynote transcripts and presentations, the Conference Communiqué and recommendations, a photo gallery and e-satchel. Some concurrent papers are on-line and the remainder will be uploaded as they become available.

Student perspectives

Ten RAMUS scholars received support through the RAMUS Conference Placement Program to attend the 10th Conference. Their reports are on the RAMUS Conference Reports page of the Alliance’s website.

www.ruralhealth.org.au

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), Leanne Coleman, James Easterbrook, Gordon Gregory 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 Australian Government 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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All is quiet in KA...
Miss, I can’t hear you
Miss, look up from your book,
Walk close to me, tell me what to do
Please talk slow to me Miss, come here have a look.

Hey Miss, I can’t hear you!
I don’t know what to do next
“Hey Michael what’s going on, you show me what to do.”
Come, help me do some work here.

I’m not yelling Miss, I don’t know what to do
I can’t get it, is it my turn now, is this my pencil?
Do we have sport today?
Can I sit with the new boy?

Ah, don’t worry about it Miss ...... I can’t hear you.

We all yell at my house,
We can all hear each other.
People think we squabble and fight
Nuh, that’s how we talk in our way.

We didn’t go to Esperance these holidays
Aunty used to take us but the car is broken down.
There’s a funeral on Friday everybody’s comin’ to our place,
Its good fun having all my cousins ‘round.

Hey Miss, I can’t hear you
I’m not going to school today it’s boring
Only get troubles from my teacher
‘Cos I never know what to do.

Hey Doc, I know you are telling Aunty something.
I see you talk about me but I can’t hear you.
You’re looking in my ears again, you’re not looking at me.
You smile back at me, when I smile at you.

But I still can’t hear you...

More pink medicine, another day off school,
Hey I’m not sick, I just can’t hear you.
Home all day, riding my bike all night and the pool’s shut.
Hanging with friends, we’re not bad, we just can’t hear you.

Aunty I’m trying to listen, I know what you say,
But Miss, she don’t talk to me that way!
I’m no good I can’t learn and I won’t stay there!
Because... I... just... can’t... hear... you!

by Shelley Davies

1ST PRIZE WINNER IN FRIENDS POETRY COMPETITION 2009