Shedding light on remote area nursing

REGIONAL DEVELOPMENT is small business the answer?

Healthcare addictions

Rural benefits from dental scheme

GP locum initiatives

Aboriginal and Torres Strait Islander readers are advised that this newsletter may contain images of people who have died.
Unhealthy addictions

Reforming the health system would be much simpler if it were not for a number of addictions or fixations Australians tend to have.

For one thing, we depend too much on our doctors. Almost whenever governments look to roll out a national plan - whether for immunisation, childhood obesity, mental health or diabetes – the easiest thing to do, both logistically and politically, is to dump it in the laps of the GPs.

This would be all well and good if they weren’t already so busy – and if the location of GPs reflected the distribution of the need for primary care. But it does not. What it does reflect is the collective outcome of the decisions of individual doctors, many of whom see themselves both as clinicians and business people.

In recent years there has been an encouraging expansion in the employment of practice nurses, who help general practitioners to focus more on what they and they alone are competent to do.

Feminisation of the general practice workforce and changes in its cultural mix mean that the balance between clinical, family and commercial determinants of doctors’ business decisions has changed. It is a challenge to attract Gen Y professionals of all kinds to communities with cultural and spatial characteristics with which they are not comfortable or familiar.

In recent years there has been an encouraging expansion in the employment of practice nurses, who help general practitioners to focus more on what they and they alone are competent to do. More of such changes in the distribution of activities that in the past have been seen as ‘doctoring’ need to be encouraged. The current moves to give selected midwives and nurse practitioners access to the PBS and MBS is an important part of this.

If the structural, financial and attitudinal challenges can be met, it will allow physiotherapists, nurses, podiatrists, oral therapists, paramedics, physician assistants and others to contribute more to what has traditionally been thought of as ‘doctoring’.

A second limitation on reform is a fixation on fee-for-service health practice. It would help if, in redesigning the health system, we were more confident about consumers’ indifference about the funding system underpinning services on the ground, and about the range of business models preferred by practitioners themselves. Not all doctors or physios want to be running their own business and their professional associations are likely to be relaxed as long as there is no intention to remove the option for individuals to engage in fee-for-service.

People in rural and remote areas are familiar with the situation in which a local authority, for example, is underwriting the local GP’s income and perhaps providing accommodation or a place in which to practise. This is an example of how fee-for-service can be retained in a mixed payments system. If, despite such a system, it is still impossible to attract a GP who wants to be a fee-for-service business entity, the options include the employment of a salaried doctor. Such a service is neither a threat to other models or inherently second rate. It is much better to have primary care provided by a GP than by the emergency staff at a hospital – which often happens in isolated regional centres that are short of doctors and other primary care providers.

Third, as was confirmed by the first round of health reform announcements, as a nation we tend to be fixated on hospitals and their (undoubtedly essential) services, rather than on the broader health system. The rather dysfunctional part this addiction plays in the current health reform agenda is described elsewhere in this issue of Partyline.

As a nation we have failed to advance as quickly as we might have done with ‘hospital in the home’ type care, and on support for rehabilitation and care for people in their own homes. through more allied health positions for example. Improved application of technology can help in several ways, including for patient monitoring and messaging, discharge planning and other continuity of care, and e-health records. The government’s renewed emphasis on a health promotion agenda should help in this respect but it will also require workforce changes to augment the supply of professionals who provide domiciliary care.

Finally, we have a bad case of the aorta syndrome. It is not letting governments off the hook if we are encouraged to assume greater responsibility for our own care and illness prevention. One doesn’t need to be a critic of the Nanny State to agree that “Aorta look after me” is both an ineffective and unaffordable approach to personal health and wellbeing.
A good Foundation for rural dental care

The Australian Dental Association Inc (ADA) has for several years been recommending to Government to fund a post-graduate ‘intern’ program in dentistry.

It therefore provided in-principle support for the National Health and Hospitals Reform Commission Final Report’s recommendation for a “one year internship scheme prior to full registration, so that clinical preparation of oral health practitioners (dentists, dental therapists and dental hygienists) operate under a similar model to medical practitioners”.

The ADA followed up with a proposal for a National Dental Foundation Year Program and has provided this to Government. The ADA believes the concept has considerable merit in not only enhancing the initial experience of first year graduates but also in addressing problems relating to the lack of access to dental care faced by many Australians. Such a program would need to be different from the medical practitioner model because dental graduates are trained to work autonomously immediately upon graduation.

As proposed by the ADA, the main purposes of a National Dental Foundation Year Program would be to:

• provide dental graduates with a predictable and structured transition to fully autonomous dental practice;
• develop community leaders with a strong social and ethical understanding by expanding their experiences, such as in rural and regional areas, aged care facilities, hospitals, Indigenous communities, special needs dentistry and supported residential facilities;
• foster a culture of lifelong continuing professional development; and
• consolidate the dental undergraduate clinical and education experience.

Secondary benefits of the Program would be to:

• enhance the safety, quality and efficiency of Australian dental services;
• encourage dental practitioners to live and practise in rural, remote and other areas of dental care need;
• encourage the recruitment and retention of dental practitioners to the public sector;
• improve access to treatment for people eligible for public dental care; and
• increase the use of preventive and evidence-based dental care.

It has been emphasised by the ADA that the Program is not to be seen as just a solution to workforce distribution issues. It must, first and foremost, provide a valuable learning experience for participants. It must offer broad general practice experience in a range of practice settings to enable program participants to develop their skills before becoming fully registered.

The Foundation Year would need to be a joint venture of Federal as well as State and Territory Governments. Before embarking on a fully-fledged nationwide mandatory scheme, a pilot program is proposed for Victoria, South Australia, Tasmania and Northern Territory where there is sufficient infrastructure to conduct such a voluntary program.

Under the Program, eligible patients for treatment would primarily be those healthcard holders who currently experience difficulty accessing care due to financial or geographic disadvantage. In this way it would address an access problem while at the same time giving new graduates a great foundation to their careers.

Rotational clinical placement options would include rural and remote parts of Australia, Indigenous communities, hospitals, public dental clinics, facilities for people with special needs, aged care facilities, schools, and private-sector dental clinics in areas of dental care need. People in rural and remote regions eligible for public sector treatment would receive priority. These rotations would give rural communities opportunity to promote themselves to new graduates and encourage them to stay.

The Program will fit well with the other recent major recommendation of the ADA to the Federal Government, the ADA’s DentalAccess Plan. This Plan counters the National Health and Hospitals Reform Commission’s Denticare proposal. The DentalAccess Plan will deliver a comprehensive suite of services to financially disadvantaged Australians. This is in contrast to the Denticare proposal of universally providing only basic dental services. Together, the ADA’s Foundation Year Program and DentalAccess Plan will mean that dental fitness can be effectively delivered to financially and geographically disadvantaged Australians.

The ADA has met and will continue to meet with public sector representatives, senior university academics, departmental officials and other stakeholders to further develop the Program.

Robert Boyd-Boland
Chief Executive Officer of the Australian Dental Association Inc. www.ada.org.au
Marking time in a timeless land

“You need to return for your needle at the next full moon”

A small, dark child sat in the observation chair in the neighboring room. He appeared no older than ten or eleven. Of small stature, his head hung low without much eye contact.

He had just received a deep, painful intramuscular injection of LA Bicillin, a penicillin shot that is akin to thick white aching goo. No tears were shed. He was accustomed to the pain: he had had these injections for as long as he could remember.

This is the dusty, remote centre of Australia, where I live - or rather exist - in an Aboriginal community. I share air, space, land and water with a community of nearly 350 people of the Alyawarra tribe. I work here, I sleep here, I treat here, I adapt here: I am a Remote Area Nurse.

There are many patients like this young child who we treat monthly. These patients are a tragic anomaly in a developed country: they have Rheumatic Heart Disease (RHD). For most of the world, this disease is eradicated, but here on this parched and desolate plain, the disease persists in remote Indigenous communities with rates amongst the highest in the world.

About two thousand patients are currently diagnosed in the Northern Territory as having RHD. These are the ‘known’ cases and the number does not include the many who possibly remain undiagnosed. Aboriginal and Torres Strait Islander people are eight times more likely than non-Aboriginal people to be hospitalised for RHD and nearly 20 times as likely to die from it. The illness usually strikes children between the ages of 5 and 14, although symptoms can last well into adulthood. These are extraordinary circumstances. Like most Western health professionals, this is a disease I had only ever seen referred to in the fine print. Yet the prevalence in this minority group makes it a daily, or at least monthly, clinical finding for me here.

I found myself listening intently to my co-worker stress the importance of the patient’s return next month. “You missed last month’s injection and the month’s before that. I need to see you every month. Be sure to watch the moon. Come and see me when it is full.” The child nodded in understanding; he would try to remember next month.

RHD is caused by repeated attacks or ‘rheumatic fevers’ of the joints, brain, skin and heart by a bacterium (streptococcus A) prolific in remote Indigenous communities. This bacterium can be sourced to an infection of the throat (or possibly skin) and, if left untreated, it usually results in lasting damage to the valves of the heart. If caught early, delivering penicillin injections every four weeks easily prevents end stage RHD. At a minimum, the injections must be given for 10 years. Missing injections greatly increases the recurrence of the ‘rheumatic fevers’ which are both extremely painful and, with each attack, detrimental to the valves of the heart. In the severest form, the patient either dies and/or is reliant upon heart surgery, i.e. valve replacement. It is thus extremely important to stay on a strict monthly schedule of LA Bicillin injections.

Yet, persistent throughout the whole of the Aboriginal culture is the essence of ‘timelessness’. Without a continual need for clocks, watches, hours or minutes, most Aboriginal people do not follow points in time, as I am accustomed to doing. There is no strict timed schedule to their days, no timetable to their lives. Most watch the sun or the moon, living from ageless adaptations to the seasons and the weather. How then do you keep time when there is no time to keep?

As part of a creatively managed campaign to promote increased patient self-management and enhance compliance, a “full moon calendar” has been developed. Because the injections must be given every four weeks, a full moon serves as a prompt from nature for patients to remember when prophylaxis is due. Literally, the full moon signals the patient to return to the clinic and keep the visits on a monthly cycle.

Creativity and compromise are the keys in health planning for many of the patients in this area. The full moon calendar is a brilliant compromise for the rheumatic heart patients. Monthly they must receive an injection and monthly the moon rises.

... The small child trudges out, bare chested and dirty. He stops at the doorway, with his hand on the doorframe. “Thank you for not making it hurt,” I hear him say with a glimmer of a smile. I grin to myself knowing that I’ll never look at the moon the same way again. ✴

Stephanie Jane Holcombe
REGIONAL DEVELOPMENT

A key role for small business

Momentum is building behind a new approach to economic development in the US, with the Florida legislature providing substantial funding and others to follow.

The focus of the approach is small business development in response to:

• only mediocre results from chasing relocating industries (that rarely become permanent);

• statistics that show for the 2000s, almost all of the growth in employment is coming from businesses with 1 to 100 employees while companies with more than 500 employees have been reducing employment by around 3 per cent per year (www.youreconomy.org); and

• new technologies that enable new ways for small businesses to operate and new ways to operate small business support programs.

The seeds for this approach were sown in Littleton (suburban Denver) around 20 years ago with recognition of the hidden innovative potential inside small businesses, especially those small established companies with between 10 and 100 employees.

In Australia, there are few instances of innovative regional development programs beyond industry attraction, while we are almost devoid of significant small business policies. And small businesses dominate the structure of most non-metropolitan regional economies. Even then, more of those small business units are franchises or branches of city-based firms. The role of locally-owned and managed businesses is declining in most regions.

In 2003, the Keniry committee noted many disadvantages faced by regional businesses. Federal government programs tend to provide generalised business support measures such as investment allowances. State government programs are most common, but few enjoy the trust and respect to work successfully with businesses.

At the local level, there are many economic development officers, but few are qualified as business development officers. The best solution may lie in collaboration between local government and private enterprise to provide these services. An example is the Port Macquarie-Hastings Council (PMH) business development program delivered by Economic Gardeners (see www.hastings.nsw.gov.au/www/html/3246-cultivating-local-business.asp).

This approach uses a mix of workshops, individual sessions and business networks to build planning and business operating capacity. The program is paid for by the Council and the participating businesses.

It is based on the proposition that ‘businesses create wealth’ and that well-run, innovative, small businesses determine the distinctive character of the local economy. Locally owned and operated businesses also generate the largest local economic multiplier impacts, because they normally use local services and supplies in operating and managing their business.

The PMH program is an investment in building the capacity of these people to run businesses – building skills, enabling the use of business management and operating tools and providing access to specialist resources.

The results include increased confidence among the business operators, focused business and marketing strategies, improved financial outcomes and more robust organisation structures.

The challenges in such a program lie in:

• finding businesses where the operator seeks to grow the business, recognises the need for assistance and is prepared to co-invest in the program;

• finding suitable people to operate the program of workshops and direct consultation who have suitable experience to earn the trust of the participating businesses; and

• securing the resources to support such a program over five years or more to make a difference.

Here are some of the actions needed to start down this pathway.

1. Make business development a key plank in your economic development program.

2. Prepare a business plan complete with a vision, a set of objectives and the outline of a strategy to achieve it.

3. To underpin the design of the program, build a database of businesses in your area and start talking to them about their needs.

4. Be prepared to consider all types and sizes of businesses; just like a sporting team – it begins with nurturing promising talent.

5. Have considerable flexibility in the types of programs that are offered so that they can be customised to the needs of participant groups.

6. Secure some patient resources to underwrite the program.

Roy Powell
Director, Economic Gardeners P/L
Bushfire doctor shows the value of locum work

Rural medicine has taken Dr Katrina White from the icy Canadian Yukon to bushfire-ravaged Victoria. Along the way she has experienced minus-50 degree winters, patched up burns victims and run clinics in remote North American Indian settlements.

Now practising as a GP on the Mornington Peninsula, she still spends two days a month as a rural locum because she enjoys the change of pace.

“Locum work keeps me going because it is diverse and challenging,” says Katrina. “It is also a good way to hone your skills while providing an essential service to small towns where the local doctor needs a break.”

Katrina’s locum work is part of a personal commitment to assist the recovery of bushfire victims in Victoria. She is one of eight locum GPs operating from a clinic in Kinglake that services surrounding fire-affected communities.

She moved to Victoria from New South Wales last year after volunteering to help survivors of the Black Saturday fires. “Patients needed treatment for wounds, breathing difficulties and irritated eyes,” she recalls. “Most of all, though, people were completely shell-shocked ... and that can take a long time to heal.”

Before coming to Australia, the Canadian-trained doctor completed her medical studies at the University of Calgary. She then took up a locum posting in Dawson City, a remote Yukon town of 1200 people about 600km from the nearest hospital.

“The work was both challenging and rewarding, and it taught me to be very independent,” Katrina says. “My clinical skills improved markedly. It ended up being five adventurous years that certainly furthered my career and changed how I practise medicine.”

There are now more opportunities for doctors like Katrina White to experience life in a country practice thanks to the Federal Government’s new $6.1 million Rural GP Locum Program.

The program is being delivered by Rural Health Workforce Australia (RHWA) in association with the Rural Workforce Agencies (RWAs) in each state and the Northern Territory.

Funding under the program is being used to subsidise:

• 50 per cent of locum fees to a maximum of $500 per day for a total of 14 days per annum;
• travel time for locums at $200 per day to a maximum of $400 per placement; and
• travel costs to a maximum of $2,000 per placement.
Progress with healthcare identifiers

The Healthcare Identifiers Bill was introduced to Parliament on 10 February 2010. The legislation allows for a unique 16 digit number to be created for every Australian and all health care providers by the middle of this year.

The Individual Healthcare Identifiers (IHIs) will be in addition to Medicare numbers, as part of creating a single process to accurately and consistently identify patients and healthcare providers. At present, when a patient visits their GP for a check up, the identifying number on their health record is different from the number at the pharmacy where they have the prescription filled and from the record at the pathology laboratory where they have the blood tests done. All these different identifiers increase the risk of error – eg mismatching of records and tests, information being missed, or tests needing to be reordered.

The Minister for Health and Ageing underlined the importance of this legislation in the Government’s reform agenda. The final report of the National Health and Hospitals Reform Commission identified electronic health records as “one of the most important opportunities to improve the quality and safety of healthcare, reduce waste and inefficiency and improve continuity and health outcomes for patients.” Without healthcare identifiers, there cannot be an integrated, consistent e-health system in Australia.

People who live in rural and remote communities are more likely to have chronic conditions and more likely to need to travel some distance for their health care than people who live in urban centres. This makes them more vulnerable to delays in transfer of health information and to errors in matching the information with the right patient and the right healthcare provider. For example the impact of being sent home again because all the paperwork has not arrived, or because the right pre-admission instructions were received, is much more significant for a rural person who has made a trip to the city for health care. Rural health professionals working at a distance from their colleagues are also more vulnerable to delays and inefficiencies in receiving the complete and correct information about their patients.

Medicare Australia will be the initial operator of the Healthcare Identifiers Service, which will assign, issue and maintain the three sets of unique healthcare identifiers for individuals, healthcare providers and healthcare organisations from mid 2010 (subject to the current legislation).

The healthcare identifiers are not a health record but they are an important building block for a national individual electronic health record system in the future. A new consumer website, www.ehealth.gov.au, opened by the National E-Health Transition Authority (NEHTA) on behalf of Federal, State and Territory health authorities, explains how information technology is contributing to the health system and provides updates on new developments.

Individual electronic health records are a means for people who live in rural and remote communities to have their essential health information where and when they need it, whether receiving care at or near home, visiting a GP, travelling to a regional centre for specialist allied health or medical advice, in hospital or in an emergency.

Privacy, confidentiality and medico-legal concerns need to be acknowledged and addressed at each step in this process. People in rural and remote communities are particularly vulnerable to complex privacy and other administrative arrangements across state borders, especially where information to address these concerns is not readily available or is unclear.

If the full benefits of improved efficiencies through the Healthcare Identifier Service are to flow to rural people, a focused rural implementation effort will be required. Potential bottlenecks such as the higher cost of technology compliance and the stretched capacity of the rural and remote health workforce will need to be overcome.

Rural and remote workforce challenges mean that it is especially important for nurses, paramedics, allied health professionals, dentists and medical specialists in private practice to become a part of the national e-health strategy as well as general practices, pharmacies and hospitals. Technical and change management support for health services and private practitioners in rural and remote community settings will be a major issue for effective and timely implementation of the new Healthcare Identifier Service.

The National Rural Health Alliance is working to ensure that e-health development supports better health services in the bush, while building on existing experience and capacity. *
 WORKING FOR INDIGENOUS HEALTH

Indigenous Allied Health Australia

Indigenous Allied Health Australia (IAHA) is the peak body in Australia representing Aboriginal and Torres Strait Islander allied health professionals and students.

Incorporated in June 2009, IAHA is governed by a Board of Directors who are committed allied health professionals from a diverse range of working experiences in rural, remote and urban localities. They are committed to achieving the IAHA vision of the same quality of health for Aboriginal and Torres Strait Islander peoples as that of other Australians. IAHA has three key objectives:

1. Contribute to improved knowledge and competencies of allied health practitioners working with Aboriginal and Torres Strait Islander peoples and communities by:
   - advocating for excellence in tertiary curricula addressing socio-cultural and economic determinants of Indigenous health; and
   - providing educational events, resources and learning opportunities for allied health practitioners to gain the understanding, knowledge and skills to be culturally competent.

2. Contribute to improved allied health services for Aboriginal and Torres Strait Islander peoples and communities by:
   - encouraging and facilitating a greater number of Aboriginal and Torres Strait Islander allied health professionals; and
   - developing and contributing to Indigenous health policy and planning.

3. Provide effective support to Aboriginal and Torres Strait Islander members of IAHA by facilitating collegial networks of Aboriginal and Torres Strait Islander allied health professionals.

IAHA is represented on a number of key national committees such as Close the Gap Campaign Steering Committee; Workforce Expansion and Recruitment External Technical Advisory Group and the Aboriginal and Torres Strait Islander Health Workforce Working Group.

Indigenous allied health professionals and students are eligible to be full members of IAHA. Non-Indigenous allied health professionals and students and Indigenous health professionals who are not allied health professionals are eligible to be associate members. Health professionals and students interested in joining IAHA are encouraged to do so.

Information on allied health courses, scholarships and support services for young Indigenous students, discussion forums and member services is available at www.indigenousalliedhealth.com.au or contact Craig Dukes on 0417 237 694 or office@indigenousalliedhealth.com.au

IAHA is supported by funding from the Australian Government Department of Health and Ageing.

New association for Aboriginal and Torres Strait Islander Health Workers

In January 2009, the Aboriginal and Torres Strait Islander Health Workers Association was launched by Warren Snowdon, Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery. The Association will bring together Indigenous health workers and provide them with a strong professional voice. It will provide advocacy and mentoring for Indigenous health workers, and will work towards national consistency through upskilling and training support. For the next two years the Association’s major focus will be on national registration and accreditation strategies.

Minister Snowdon said the nation’s 1,600 Aboriginal and Torres Strait Islander health workers are a key part of the health workforce and the government had committed $1.2 million over three years towards establishing the Association.

The interim chair is Kathy Abbott. Web: www.natsihwa.org.au

SARRAH (Services for Australian Rural and Remote Allied Health) is holding its 2010 National Conference in Broome, WA on 20–23 October 2010. The call for abstracts is now open and closes on 26 March.

For more information visit the conference page on the SARRAH website www.sarrah.org.au
Partyline regularly features reports from recipients of Rural Australia Medical Undergraduate Scholarships. The following excerpts are from a selection of 2009 end-of-year reports.

Tale of two placements

I began the year with a six-week elective in the Solomon Islands, working at a small, underprivileged Regional Hospital in the Western province called Helena Goldie. Beset by an absence of doctors, a lack of medical supplies and poorly maintained equipment I was thrown into a world of battlers, typified by hardships and sorrow, devoutness and miracles. During my stay I was faced with septic neonates, undiagnosed advanced cancer, tuberculosis and a host of weird and wonderful maladies. Fighting my own battle with malaria and the aftermath of witnessing my first death in hospital, my understanding of remote health care developed exponentially.

My second notable rural experience was a university general practice rotation in the small Kimberley town of Derby. The placement included remote clinic flights, Aboriginal primary health care, chronic disease surveillance, emergency presentations and work in Aboriginal run health services. This cemented my interest in rural health and piqued my curiosity in the disarray the state government has created with respect to Aboriginal empowerment and health intervention. I look forward to a long and prosperous career in rural and remote health, particularly with respect to Aboriginal health care.

Jahde Dennis

Serving a mining community

The highlight was a visit my mentor arranged for me to the hall of mines. In the extensive display I saw an air legging machine and attempted to pick up the 70 kg machine that men still use today to drill smaller tunnels in the search for gold. Men carry these machines down ladders into stopes and tunnels not wider than one square metre day in and day out, working 12 hour shifts. I have developed a very healthy respect for the contemporary air leg miner. At the last stage of the tour the guide asked me to turn out the lamp and just listen. The blackness and quietness was eerie. I could only imagine how it must have been for the Beaconsfield miners trapped in conditions like this. I feel that it has helped me truly understand what a miner does each day, and what medical and health implications manifest from this harsh and unforgiving occupation. The reality for the Kalgoorlie GP is that many of their patients are these miners who continuously expose themselves to these conditions that not only increase their risk of developing respiratory and musculoskeletal disorders, but also of depression, alcohol abuse and tobacco addiction.

Michelle Harris

Rural setting offers wealth of experience

I was very fortunate to spend the second last year of my medical degree in Geraldton, Western Australia, a city of approx 30 000 people, serviced by 2 hospitals, a specialist centre, Aboriginal Medical Service and GPs. During the year I studied paediatrics, obstetrics and gynaecology, ophthalmology, general practice, oncology and medicine, spending time at most of the services in town. The year was a fantastic experience, and the highlight of my studies to date. I feel I have gained so much clinically during this year because staff were happy to let me get involved. The patients were extremely welcoming, and there were many opportunities that you just wouldn’t have in the city, such as being involved in resuscitations in ED, and working with Indigenous Australians in remote communities. We also had some great teachers, who sometimes utilised less conventional approaches. For example, we refined our suturing-skills by suturing rosemary and garlic into a goat, which we then spit-roasted!

Tulene Kendrick
Finding ‘gold’ in desert placement

My final year of medicine afforded me with an experience in rural medicine that has changed a great deal of my values, goals and perceptions about my future career. This year we had our rural general practice term and I was posted out in the middle of the goldfields for four weeks. I would be lying if I said I wasn’t initially disappointed. I had anticipated my rural GP experience would involve barramundi fishing in the Kimberley on the weekends and camping in picturesque wild Australian scenery. Instead I

I made some fantastic friends and I intend to return there for some locum work in the near future.

was in the middle of the desert about as far away from a barra as one could get. But here I saw a different side of medicine. There wasn’t all the fancy machinery and technology one finds in a tertiary hospital in Perth. You couldn’t make decisions based on the results of the head CT. You couldn’t refer to the specialist because he was 1300km away. You could call a specialist in Perth if you got really stuck but that was about it. It was a serious decision to call up the RFDS – firstly because it involved a five hour delay before the patient would be seen by someone in Perth and secondly, because it costs an average of $15,000 for a call out. They had honed skills in medicine that are not necessary in the city because there are other, easier, fancier ways of doing the same thing. (What impressed me was that the results we achieved were not much different from those in the city.) I made some fantastic friends and I intend to return there for some locum work in the near future. The medicine I saw practised there had a personal flavour that is hard to come by in the city, and I now realise that this is what makes rural medicine so special. This has been the greatest experience in my six years of medicine.

Yannick Cucca

Placement at Galiwinku

It was my general practice rotation that provided the highlight of my year, and perhaps my degree. Much to my delight, I was placed at Galiwinku, on Elcho Island, remote north east Arnhem Land. The island is home to approximately 1000 people, a traditional Indigenous community with a rich and vibrant culture and an amazing medical clinic. I fell immediately in love with the place and the people and spent the next four weeks living in a tropical paradise. I experienced a multitude of different events including some emergencies for which the air service was required. I was able to gain valuable skills in specific areas such as paediatrics and obstetrics and gynaecology and truly learned first hand the problems that face Indigenous communities instead of simply reading about them in the text books and journals.

Amanda Cuss

Scholarship valued

I imagine people working for RAMUS wonder how successful it is for recruiting doctors to the country. In my experience, the RAMUS scholarship provides a group of people who are otherwise suffering a considerable disadvantage the opportunity to follow their dreams. While my city friends often complain we are so ‘spoilt’ I have to emphasise that as a rural student we do not have a choice about moving out of home; it is necessary if we want to study – and often before we have a house, licence, or financial and emotional support established. While my rural friends moved out of home at 18 years old (at the latest), my city friends have only just begun to move and can always go home for dinner, a hug or a working computer. While being a rural student is really not so bad, these little things can make a difference in exams when boyfriends have left, housemates are being evil or family members are ill. So the RAMUS scholarship really helps. I can see myself returning to rural health at some stage in my career and would very much like to thank the RAMUS team for providing me with the opportunity to study medicine, something that as a farmer’s daughter I was very unlikely to have achieved otherwise.

Jikol Friend

Amanda Cuss ‘on duty’ at Galawinku.
Opportunities for rural health research

The Australian Primary Health Care Research Institute (APHCRI) was established in 2001 as part of a program funded by the Commonwealth Government to improve the nation’s capacity to produce high quality primary health care research. The Institute is now firmly established as a leader on the primary health care research scene.

The last five years have seen the commissioning of 40 chief investigators and 143 researchers across the country, resulting in the production of 62 reports, including seven on rural and remote and Aboriginal and Torres Strait Islander primary health care. The Institute has also funded Linkage and Exchange Fellowships, International Visiting Fellowships and supported early career researchers’ exchanges.

The Institute is in a great position from which to launch into its next phase, having recently been awarded a further five year contract by the Australian Government. This all takes place in a very exciting time for primary health care research in Australia - an ‘age of reform’ - with the recent release of three major government reports. According to Prime Minister Kevin Rudd, “evidence-based policymaking is at the heart of being a reformist government”.

A common thread in the various research projects is the need for sensitive development of roles, mutual trust and respect between rural health team members, leading to effective communication and collaboration amongst the primary health care team.

Evidence from APHCRI’s research shows how the Australian primary health care system could be more effective and efficient if it were built on multidisciplinary teamwork, with nurses and allied health professionals having a strong role in treatment and prevention. This is particularly the case in rural and remote Australia, where communities are not receiving equitable health care services.

A common thread in the various research projects is the need for sensitive development of roles, mutual trust and respect between rural health team members, leading to effective communication and collaboration amongst the primary health care team. My advice to primary health care researchers who want to improve services to rural and remote communities is to ‘watch this space’, because there will be much work to be done.

Bob Wells
Director, Australian Primary Health Care Research Institute

The Australian National University (ANU), initiated the National Health Reform Series last year. The series was launched at Parliament House, Canberra, by Professor Ian Chubb, Vice-Chancellor of the University, and the Honourable Warren Snowdon MP, Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery. The topic of the launch event was Can we fix the health system without reforming the workforce? The National Health Reform Series will help spread an understanding of the recommendations from the health reform reports released in 2009 and how they can be converted into policy and action. Another five events will be held in the first half of 2010 covering topics such as access to primary health care services, governance and funding arrangements.

The National Health Reform Series will contribute to the health reform agenda in Australia by putting the evidence in the public arena and making it available for comment and debate. The series principally targets policymakers, parliamentarians, health groups and the media, and is aimed at stimulating informed debate on the health reform process. People will be able to watch the events through live online streaming and submit questions during the panel discussions involving primary health care experts.

Over the next five years, APHCRI will support the National Primary Health Care Strategy through the generation of an increasingly strong evidence base; research activities relevant to the Commonwealth’s health reform agenda; and providing expertise to inform decision making for primary health care systems and services.

The Institute will fund research that will feed into the Australian Government and Council of Australian Governments’ reform agenda. A key focus will be engaging with policy advisers, health professionals and consumers through the research process and translating research findings into practice and policy. My advice to primary health care researchers who want to improve services to rural and remote communities is to ‘watch this space’, because there will be much work to be done.
APHCRI Researchers: John Wakerman and John Humphreys

Through research projects commissioned by the Australian Primary Health Care Research Institute (APHCRI), John Wakerman and John Humphreys have formed a strong team to improve health care in rural and remote communities.

Wakerman is the Inaugural Director of the Centre for Remote Health, a joint institution of Flinders University and Charles Darwin University, in Alice Springs. He has a long background in remote primary health care services as a medical practitioner, senior manager and researcher. As a researcher, he is particularly interested in remote health services research, and for the past several years has been investigating the nature of sustainable primary health care services to remote and small rural communities.

Humphreys leads rural health research in the Faculty of Medicine, Nursing and Health Sciences at Monash University. He has undertaken extensive fieldwork on rural health issues in north-west Queensland, the Wimmera-Mallee region of Victoria and the Orana and Far West region of New South Wales. Humphreys’ research interests focus on rural communities, health service provision in rural and remote areas of Australia, rural workforce recruitment and retention, rural health policy and the evaluation of rural health programs.

Individually, they have demonstrated a passion for translating their research into policy and practice, and have been able to achieve this through activities both nationally and in their local communities.

More recently, they have been unravelling workforce retention issues in small rural and remote health care services.

Wakerman is the Chair of the Central Australian Rural Practitioners’ Association (CARPA) which produces the CARPA Standard Treatment Manual - the gold standard for remote clinical practice in Australia. He was recently announced as a member of the National Health and Medical Research Council’s Health Care Committee and is a member of the advisory committee to the National Health and Hospitals Fund. He is the immediate past Chair of the National Rural Health Alliance, a position he held from 2005 to 2008.

Humphreys has worked in the Victorian Health Commission and the Commonwealth Department of Health and Human Services in Canberra where he took a lead role in developing the first National Rural Health Strategy 1994 and later the National Rural Health Strategy Update 1996. He has reviewed several national rural health programs, including the Rural Undergraduate Support and Co-ordination program in Australian Medical Schools. Humphreys has been a member of numerous reference groups and Advisory Committees for the Australian Department of Health and Ageing.

‘The two Johns’ first worked together through APHCRI to investigate primary health care service models in rural and remote Australia. From this study they were able to come up with a set of evidence-based principles to guide the development, funding and evaluation of rural and remote health services.

The pair examined the issue of continuing professional development (CPD) to discover if opportunities to maintain a strong knowledge base to develop further skills and meet with other professionals in a learning environment contributed to GPs’ commitment to rural towns. They discovered that while CPD was a contributing factor, it was one of a ‘package’ of components that kept health professionals in rural and remote Australia – including spousal and family support, the ability to access locums and medical team work.

More recently, they have been unravelling workforce retention issues in small rural and remote health care services.

John Wakerman says that APCHRI has allowed the pair to carry out the research they had been discussing for some time. “John Wakerman has a profound understanding of health care in the remote setting,” says Humphreys. “We have been able to undertake a progression of work through APHCRI on sustainable primary health care models and workforce retention in rural and remote regions.”

There is still more work to do to ensure that people living in rural and remote Australia get equitable access to health care services. With that reality, the two Johns will continue to combine forces to find ways of improving those services.

Will Wright
Media and Communications Consultant, Australian Primary Health Care Research Institute
Health Reform: Breaking the drought

The winter deluge of health reform reports has been followed by a summer drought of information from the Federal Government about what action might follow.

The Australian Health Care Reform Alliance (AHCRA) has continued to lobby for reform and provided a full analysis of the National Health and Hospitals Reform Commission (NHHRC) report. The NHHRC’s recommendations were analysed against AHCRA’s principles, and the analysis was sent to the Federal Minister in October. It is available on the AHCCRA website at www.healthreform.org.au

AHCRA has also met recently with Minister Roxon’s office (see box for key points made). Further, AHCRA is arranging meetings to discuss health reform with State Health Ministers. We will highlight that this is a ‘once in a generation’ opportunity to create a single effective and equitable health system.

From occasional leaks and observers’ perceptions, it appears likely the Commonwealth will take over the funding role for primary health care. AHCRA would welcome this as a first step but its value will need to be based on a variety of factors, crucially on the development of a single funding model that can foster the spread of comprehensive primary health care services. These would need to have a variety of health care professionals working together as an integrated team (not just co-located). Funding should allow consumers to receive care from the most appropriate health professional.

Victorian community health services provide one successful model, as do some progressive general practices. However future funding will need to allow a variety of models to meet local contexts (especially rural and remote), whilst meeting common principles and fostering the creation of a single national system over time.

Other media reports have floated the establishment of a National Health Commission with initially a benchmarking and monitoring role, rather than funding responsibility. NHHRC’s model of the Commonwealth paying 40 per cent of hospital costs has also emerged. Although this does not go far enough, it may be a valuable step towards an integrated system.

States appear split on the degree of collaboration with the Feds on a highly integrated system. Victoria wants its successful Board system for health services (or groups of services) adopted. Some other states are more reticent about this it seems. There does however seem to be more support (although it is not clear how unanimous this is) for the Federal government to be the overall funder of the primary health care system.

Of course there is a danger that discussions between Commonwealth and States have now moved into the arena of politics, rather than health policy. AHCRA hopes that horse-trading will not take over from crucial concerns about access, equity, prevention, and a simpler, more effective system.

Tony McBride
Chair of the Australian Health Care Reform Alliance
HEALTHCARE REFORM

Hospitals and more

(A narrow focus is not useful for rural and remote health.)

In 2004, as Minister for Health, Tony Abbott described the public hospital system as a “dog’s breakfast”. Six years later, as Opposition Leader, he has proposed a plan for intervening in the management of New South Wales and Queensland public hospitals.

His aim is to give more say to the doctors, nurses and the community over how their hospital is run because “doctors and nurses are often the ‘meat in the sandwich’ having to explain to patients the consequences of decisions and policies over which they have no say.” He says his plan could develop into a public hospital version of the emergency intervention in the remote communities of the Northern Territory.

There have been various responses to Mr Abbott’s proposal.

Rural GP, Dr Sue Page, says it’s more important to have regional health boards than hospital boards and wants to see a move away from the hospital as the focus of the health debate. She reminds us that there are many towns that don’t have hospitals.

Professor Ian Hickie, Director of the Brain and Mind Research Institute, also identified the strong focus on hospitals as a “danger” – but for other reasons. He says Australia already has an over-hospitalised population with a lack of community and subacute infrastructure, and hospitals are traditionally disconnected from the much wider range of health-related activities.

Executive Director of the Australian Healthcare and Hospitals Association, Prue Power, fears the Abbott proposal will entrench the current fragmented approach to health care “with hospitals becoming fiefdoms”, isolated from the rest of the health system. This view is supported by some in rural health practice who consider that hospitals are already isolated from the rest of the health system.

Ian Hickie is concerned the proposal would lead to hospitals competing with each other. In such cases, he said, the better resourced areas will always do better. Sue Page points out that the better resourced communities will have easier access to people with financial and governance training to serve on their Boards, whereas the smaller ones are likely to have greater health need but less governance capacity. She believes that the shape of reform proposals are being skewed by the use of waiting list numbers as a measure of the problem. She says if there was a genuine belief in health equity, the focus would be on closing the gap between the top and bottom quintiles of health status.

Australia already has an over-hospitalised population with a lack of community and subacute infrastructure, and hospitals are traditionally disconnected from the much wider range of health-related activities.

The Australian Medical Association has described the Coalition’s proposal as a step in the right direction. AMA President, Dr Andrew Pesce, says the AMA has for some time been calling for more clinical input to public hospital management at the local level. He says this will ensure that the clinicians who diagnose, treat and care for patients have direct input to the administration, management and funding decisions at the hospital level.

Also supporting the proposal to turn the state’s public hospitals over to local boards is Dr Paul Cotton, a Queensland health lobbyist, who believes the current system suffers from hospitals being run by people who live in places removed from the community. He says people have lost faith in the system where there is no local ownership and no local empowerment and where decisions seem to be based on fiscal issues rather than on community needs and expectations.

The WA Minister for Health, Dr Kim Hames, is re-introducing health boards throughout Western Australia, beginning with a country health board. However, he says he doesn’t support having a board for each individual hospital because past experience has shown this to be “contrary to the best interests of the overall management of a health system”.

Fiona Armstrong, political lobbyist, argues that the health debate is much bigger than just about ‘fixing hospitals’. She says the deficiencies in public hospitals have more to do with inadequate funding than failed governance models. Chair of the Australian Health Care Reform Alliance, Tony McBride, observes, “It’s a bit like introducing better spark plugs when the road system is not joined up properly – useful but it will only help once the highways and side roads are connected simply and effectively.”
Oral health competency for the community services and health workforce

High levels of oral disease and neglect are common among people on low incomes, Aboriginal and Torres Strait Islander people, those living in rural and remote parts of Australia, and some immigrant groups with non-English speaking backgrounds.

In response to action areas identified in Australia’s National Oral Health Plan 2004-2013 – Healthy mouths healthy lives, the Community Service and Health Industries Skills Council (CS&H ISC) has been funded by the Department of Employment, Education and Workplace Relations (DEEWR) to develop new national training competencies in oral health to be taken up by non-dental workers in the community services and health industries.

The Project has begun to identify and describe oral health functions that may be performed by community services and health workers to meet the needs of clients, and the specific skills and knowledge required to do this work. This will lead to expansion of appropriate work roles to meet specific service delivery outcomes.

The aim is to have more skilled people to support those currently providing oral health services, in particular for rural and remote areas.

The aim is to have more skilled people to support those currently providing oral health services, in particular for rural and remote areas. For example, this development could enable disability or residential aged care workers to play a greater part in identifying and preventing their clients’ oral health conditions, performing appropriate oral health assessment for referral and recognising the presence of basic oral abnormalities for referral. Other outcomes may enable a broader range of workers to inform, educate and motivate clients and groups to improve their oral health care.

The Project Industry Reference Group has helped draft national competency standards that have been released for validation by industry stakeholders. The Project is due for completion in September 2010.

The CS&H ISC is travelling to all States and Territories in March 2010 to receive feedback on the first draft of the new units of competence. To be involved, have your say and find out more about the project please visit www.cshisc.com.au (Current Projects) or call 02 9270 6600.

The Alliance’s response to the Prime Minister’s announcement of 3 March can be found on its website: www.ruralhealth.org.au
‘Rural and remote’ health – a misnomer

Unless you have worked in both rural health and remote health it may not be clear how different they are. They are as different from each other as rural health is from that of major cities.

Too often, they are lumped together as a single entity by health policy-makers, politicians, journalists and city-based health authorities. This has negative consequences for both providers and consumers of remote health care.

Last August I attended a Canberra roundtable presented by RDAA on violence against professional women in rural and remote areas. Of the approximately 40 people present I was one of only a handful of participants representing women in the remote nine-tenths of the continent and the only one to have lived and worked full-time on a small remote community.

The remote workforce becomes more feminised the further one moves away from urban environments. All remote health practitioners, delivering what is euphemistically called extended care, are minority groups within their professions. Remote area nurses represent only around 3 per cent of all nurses and remote doctors represent only around 10 per cent of the rural medical workforce.

Extended care describes the situation where nurses, mostly female, are thinly scattered across a huge area - through 1,223 discrete Indigenous communities - working as ‘doctor substitutes’. Here doctors, about a third of whom are female, are mostly located in hospitals in the larger remote centres performing many tasks which are usually the preserve of specialists in the major cities. As mentioned in Partyline 37, remote area nurses are not nurse practitioners although, I contend, they have been doing the work of uncredentialed nurse practitioners for over a hundred years.

Remote area nurses living on the communities are the leading health care providers in the area, relying on advice and support from doctors hundreds of kilometres away in the larger remote centres.

By contrast, the rural health service is led by doctors, the majority of whom are male, working within their credentialed training parameters with the support of nurses in their rural clinics and hospitals. The towns they live in will probably have ambulance, X-ray, police, SES and fire services, few of which are present in remote communities.

The client populations of remote health are mostly Indigenous people practising their traditional cultures, often holding different beliefs from mainstream Australia about many things, including the meanings of illness and death. They usually live in communities where, for those who speak it, English may be a third or fourth language. The elderly residents and pre-school aged children may understand no English.

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Culture shock on arrival will likely be the first of a unique set of challenges for the new remote health practitioner. At the professional level, achieving an accurate patient history, assessing mental health problems, gaining cooperation and compliance with treatment plans, managing the care of people with chronic illness who disappear to other communities for many weeks at a time, are just a few of them.

In the delivery of health care in rural towns and larger regional centres amongst people mostly from one’s own culture and language group, these issues are largely absent. Support in many forms from the surrounding community for the endeavours of the local health team is much more likely to be forthcoming in rural than remote areas.

Remote practice, which mostly takes place in areas of climatic extreme, isolates workers from collaboration with colleagues, from effective communication with employers, from opportunities for further education, from scrutiny of their practice and from accountability to an unsophisticated client population who lacks an awareness of its rights. Such isolation also heightens the risks of exploitation, exhaustion and burnout of workers - with consequent rapid staff turnover. All of these issues are easier to avoid or resolve in the rural health setting where access to a variety of supports from colleagues and structures in major cities is a matter of hours rather than days away.

The relatively greater strength of the rural health lobby tends to see its interests predominate where rural and remote health are viewed as a single entity. They should be uncoupled in the public and professional minds and their very different needs given equal but separate attention.

Sue Currie
National Rural Women’s Coalition

The seven organisations that make up the National Rural Women’s Coalition met recently in Perth with members from the Isolated Children’s Parents’ Association to discuss our current projects and future planning.

Our Sustainable Communities project is about telling the positive stories of people who have used innovative ideas to turn their community into a place where you would want to live. We have collected stories from around Australia and will be putting them onto our website as examples of what can be done as an inspiration to other communities. The ABC is currently conducting a competition to identify communities that have turned themselves around and we will be working with them to post their stories on our website as well.

We are investigating ways of updating a pamphlet on Domestic Violence that we distributed a couple of years ago. That distribution of over 100,000 pamphlets was very well received by health professionals in communities and also in schools.

At the meeting we discussed the issue of rural women accessing tertiary education to undertake subjects such as education, health, agriculture, etc and we plan to develop a position paper on how we can facilitate access for rural women to attend university.

Following an election promise and a recommendation that was made at the Rural Women’s Summit in 2008 we have undertaken consultation with stakeholders into the formation of a National Rural Women’s Network. We are ready to establish this network and have the support of stakeholders in all states and the Northern Territory. This web based network will provide two-way communication, allowing rural women from around Australia to be connected and have access to information, as well as providing a means for them to inform us of their issues. We hope to be able to involve women who are not aligned with any organisation while also looking at ways to inform those women who have no access to the web.

The National Rural Women’s Coalition was formed in 2002 and over the years we have become a force to be reckoned with. Following a review of all the secretariats undertaken last year, tenders have been invited from existing and new groups interested in receiving funding. We have submitted a tender for funding for the Coalition, which will enable us to continue to highlight the issues that are important to women in rural and remote communities and proceed with projects currently in train. Our ability to continue into the future is reliant on funding and a decision was made at this meeting that if we were unsuccessful in gaining funding we will be unable to continue. We have finalised some of our projects but others will not continue without funding.

For further information on the NRWC and our projects please go to our website www.nrwc.org.au

Irene Mills and Lesley Young

STOP PRESS

Late news from Irene and Lesley: The National Rural Women’s Coalition has received funding to continue its work, including the development of the Rural Women’s Network. Other very good news is that an Aboriginal and Torres Strait Islander Women’s Alliance has also been formed and funded.

Kim Snowball, Acting DG

In January 2010 Kim Snowball took office as Acting Director General of the West Australian Department of Health. He will act in the position for six months while an independent selection process is undertaken.

Kim’s previous positions include CEO of the WA Country Health Service (which employs around 5,500 FTE staff) and senior posts with St John of God Health Care. Kim has also worked at a national level, and is well known as a WA representative in the rural and remote activity of Health Ministers over many years.

Members of the rural health sector recognise Kim’s contributions on many levels to improved health for people in rural and remote parts of Australia and congratulate him on his appointment.
The PM’s health plan: Part one

As Partyline goes to print the Prime Minister has just announced plans for the National Health and Hospitals Network.

Not surprisingly, given the huge weight of expectations for health reform, the Prime Minister’s announcement (3 March) of the first part of ‘the blueprint’ has met with a variety of responses. Most were based on the professional, sectoral or ideological interests of the particular commentator concerned and so were partial in their appraisal. Little attention has been given to the fact that the hospitals announcement was timed and designed for particular political reasons and that its purpose was more related to medium-term federal financial relations than to ‘health reform’ as usually perceived.

Mr Rudd promised further announcements on primary care, hospital beds, workforce, aged care and mental and dental health services. Once these have been made it will be time to subject the whole package to close scrutiny - including through the prism of particular interests, including those of people in rural and remote areas.

In the meantime, there is some room for speculation about the likely effects of the announcements to date.

Most people in regional areas will welcome more localised determination of priorities for their hospitals, and the proposal for local networks which would see individual hospitals providing mutual support to each other. Also critical is the fact (page 20 of the Government’s plan) that hospital networks in rural areas and with high Indigenous populations will receive additional funds to take account of their particular needs. The Prime Minister has said “there is nothing in the Australian Health and Hospital Network which would justify the closure of a single hospital or a single hospital bed”. Nicola Roxon has confirmed that “country prices will not be set with city assumptions”. The “national efficient price” will have “special loadings for rural service delivery”. It will be interesting to see how these loadings are calculated and whether they lead to broadly equivalent health outcomes for people in all areas.

It is encouraging to believe that efficient hospital operators will have money left over which can be spent on ‘innovations’ or additional services, and that the Commonwealth would cover funds for growth, capital and teaching, training and research. This could give hope for the revitalisation of rural hospitals.

Involving clinicians, consumers and local experts in the governance of the local hospital networks provides the opportunity to harness local knowledge, clinical expertise and community commitment to make the best use of resources to meet local needs. The boards must have funding flexibility so they can genuinely act upon their local knowledge.

500th friend!

It’s only February and already 500 people have either joined or renewed their membership with friends of the Alliance.

The 500th person to register as a friend in 2010 was Martin Butler. Martin’s interest in rural health is longstanding. He was founding Convenor of the Rural Social Work Action Group in 1988 and has served in that capacity for 18 years, and currently sits on the Victorian Committee of Management and represents the Rural Group on the national social policy committee. Martin is also a member of the National Farmers Health Centre Advisory Group and is currently involved in promoting the sustainable farm families program.

The Rural Social Work Action Group provides professional development opportunities for rural social workers, including a biennial conference, and forums and other opportunities for social workers across the country to exchange information. They also provide representatives to government and non-government policy groups when asked.

Martin first joined friends in 2006. He would like to see more contributions from social workers in Partyline because they play a significant role in community health and welfare. (He promised the editor he would contribute such a piece for a future edition and will encourage his colleagues to do so!)

Membership of friends is open to individuals and organisations with an interest in rural health. See www.ruralhealth.org.au

It is pleasing that the Commonwealth plans to take full funding and policy responsibility for primary care, which is more fragmented than hospital services. One single system would give the Commonwealth both the authority and the incentive to put primary and preventive care at the heart of the system and make wellness rather than acute care the major objective.

What is uncertain is how the new hospital networks and the (regional?) primary care services will be integrated for coordinated planning and service delivery. There is also no clear statement about how much extra money will be available when the whole package is announced.

Once the full package of reforms is in the public’s gaze, the true test will be how those with highest health needs, including Aboriginal and Torres Strait Islander peoples and those with chronic conditions, will benefit.
Mobile services to rural communities

The Australian Government recently launched Australian Government Mobile Offices. Building on the model provided by the Drought Bus program, the Mobile Office initiative is a means of providing government services to people living in small rural communities.

In its three years on the road, the Drought Bus program has helped more than 39,000 people – the majority of whom had never previously approached agencies such as Centrelink for help.

The Mobile Offices are physically much larger than the Drought Bus and provide a full range of Centrelink and Medicare payments and services. Australian Hearing will also provide hearing tests at selected locations. The full flat floor (an Australian first) allows easy wheelchair access. All of its computers and printers operate on wireless technology.

Launching the initiative, Minister for Human Services Chris Bowen said, “The Drought Bus showed us that taking services to the people, rather than expecting people to come to the service, was a better way to reach those living in rural areas.”

To see the schedule of upcoming Mobile Office visits go to www.centrelink.gov.au (choose ‘M’ from the A-Z listing in the top left hand corner).

Rural Health: Challenges and opportunities

A new publication from the National Health Committee in Wellington, NZ, focuses on how to protect and improve the health status of people living in rural New Zealand communities which are diverse with small populations spread over large geographic areas.

The report, entitled Rural Health: Challenges of Distance, Opportunities for Innovation, examines the challenges faced in delivering sustainable, comprehensive health and disability services to rural communities. Its recommendations highlight the need for improvements in three key areas: service delivery; system performance; and planning, data collection and research.

Available online: www.nhc.health.govt.nz/moh.nsf/pagescm/7663/$File/rural-health-challenges-opportunities.PDF

24/7 assistance on mental health

The e-hub research and development group is based at the Australian National University and provides free and anonymous online mental health services that are rigorously researched and based on the best available scientific evidence.

All programs are available 24/7 and participation is free of charge and anonymous:

• BluePages: about depression and anxiety and their treatments www.bluepages.anu.edu.au
• BlueBoard: online support group for people affected by depression, bipolar disorder and anxiety disorders www.blueboard.anu.edu.au
• MoodGYM: interactive program which teaches cognitive-behaviour therapy (CBT) skills for preventing and coping with depression www.moodgym.anu.edu.au
• e-couch: includes modules for social anxiety, generalised anxiety and depression, including cognitive, behavioural and interpersonal and relaxation and exercise www.ecouch.anu.edu.au
• Beacon: information for consumers and professionals about e-health online applications for mental health and physical health disorders www.beacon.anu.edu.au

Online orientation manual for practice nurses

An Australian General Practice Network (AGPN) orientation manual for practice nurses new to general practice is now available online.

The online program Orientation Manual for Nurses New to General Practice highlights the key responsibilities of a practice nurse and provides education on topics like legal issues and how Medicare and bulk billing work.

The manuals were developed at the request of nurses moving from ward nursing to general practice who have good knowledge of the medical aspects of practice but wanted a guide to understanding the day-to-day running of a general practice and its working environment.

Nurses in rural and remote areas will benefit most from the program. Previously they had to attend training in urban areas, but now they can access the training online. The manual also aims to showcase to nurses the opportunities for career and skills development which practice nursing offers. www.agpn.com.au
New e-health webpage

People living in rural and remote areas stand to benefit from e-health with its potential to help in overcoming the effects of distance - and there will be greater benefit if we share our knowledge and experiences. The place to go is: nrha.ruralhealth.org.au/e-health

The NRHA is inviting readers to:

- offer feedback on its new e-health webpage, including the consultations and submissions we post on it;
- share information about e-health solutions that are working in rural and remote Australia, including their strengths and weaknesses;
- provide links to useful resources on e-health such as newsletters, websites and conference presentations; and
- submit case studies of e-health applications being used by you or your organisation.

AJRH leads the way

The Australian Journal of Rural Health (AJRH) has been awarded a B ranking by the Australian Research Council in its recent Excellence in Research for Australia (ERA) audit. The independent study of more than 20,000 peer-reviewed scientific journals ranks the AJRH alongside the US Journal of Rural Health.

The AJRH, now in its eighteenth year of publication, is owned and managed by the National Rural Health Alliance (NRHA) in partnership with its Journal Associates, the Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia, CRANAplus and Services for Australian Rural and Remote Allied Health.

Editor, Professor James Dunbar, welcomes this confirmation of the journal’s high standards in the area of research on rural and remote health issues and believes the ranking will encourage researchers and health professionals to seek publication in the AJRH. Manuscripts may be submitted (and subsequently tracked) at mc.manuscriptcentral.com/ajrh

11th Conference

Save this date now! The 11th National Rural Health Conference will be held at the Perth Convention Centre from 13-16 March 2011. Information regarding the Conference and the call for abstracts will soon be on the Alliance website.

www.ruralhealth.org.au

Farewell to Lyn Eiszele

Those of you who have attended any of the National Rural Health Conferences since (and including) the 6th in Canberra in 1991, will appreciate the fine touch and organisational skills brought to those events by Lyn Eiszele, the Alliance’s Conference Manager. After ten years with the Alliance, Lyn has recently retired to enjoy a quieter lifestyle. Alliance staff will miss her many contributions to the life of the office and she takes with us our best wishes for the future.

Letter to the editor

Your readers might be interested in a book called The Checklist Manifesto by Atul Gawande. The author proposes checklists as an antidote to avoidable medical errors and other adverse events. He cites case studies which illustrate the effectiveness of the checklists – including a cleanliness checklist which virtually eliminated a serious hospital-infection from an intensive care unit. The checklist principle is applicable at many levels, and the book would be of interest to anyone who wants to avoid careless errors and ‘get things right’.

Elizabeth, Braidwood, NSW

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), James Easterbrook, Gordon Gregory, Helen Hopkins, Susan Magnay, Andrew Phillips 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 Partlyline is also available online at www.ruralhealth.org.au
I live as I live for I was born unto this country and this land,  
Kindred spirit of my environment, creatures, plant and man.

Growing, living and loving who and where I choose to be,  
I have created and have been created by this, my life reality.

I came to find and learn that if I tripped or stumbled along my way,  
There was always a hand extended to raise me up from where I lay.

It has taken a lifetime of being immersed in my rural community,  
To realise and appreciate that this is where I choose and truly want to be

Now I use my deep connection, passion and truth to lure others,  
A siren of the bush, one of the lucky, chosen, student mothers.

To take a person who is of city creation nurture and birth,  
Then to grant them a love and foster a connection to the earth.

To bathe and steep them in community, humanity in its purest form,  
Taking brave new steps to make existing and mattering but the norm.

Is a gift that can shape and change a life, brave power to the one,  
Who will then go on to save a life under this our Australian, rural sun.

Cheryl Ingerson