Engaging with consumers and communities

Super Hero MC James Fitzpatrick wowed delegates at the 11th National Rural Health Conference with his warmth, style, knowledge, energy and sense of humour.

Aboriginal and Torres Strait Islander readers are advised that this newsletter may contain images of people who have died.
The true value of the King’s Shilling

Anzac Day 2011

If there’s one thing that’s certain by way of a philosophy for life, it is that nothing is more important than human relationships. One can design the very best system in the world but, if it involves human beings, the effectiveness of its operation will depend on the relationships of those within it.

Given that so much importance is attached to human relationships, it is not surprising that the activity which institutionalises the absolute opposite of love, respect and friendship assumes such significance and remains feared and unfathomable. To go willingly to war is to accept that politics can and sometimes must override all human passions and principles. It will be said that, occasionally, a political decision to send one nation of human beings on a mission to destroy another is necessary to protect the very human characteristics that are regarded so highly. For there can be no true respect or close friendship without basic freedom and mutual tolerance.

So it may be necessary to contravene the highest human principle – respect for others – in order to protect it.

It is perhaps because of this foulest irony that, for thousands of years, human institutions have celebrated both success and failure in war, and held up to great esteem those individuals who have performed well in it. But why is it that, against all fiduciary odds, the value of the King’s Shilling has kept pace with inflation for all that time? How is it that those who serve in war for three months receive the blessing and the bounty of their nation for the rest of their life, while people who contribute their life to wiser and more civilised agendas do not?

This morning someone leaves for three months’ service to people in a Pacific nation whose health status and living conditions are every bit as frightful as may be observed on a battlefront. Yet the cause they serve will not be recognised through national ceremonies or the award of personal pensions.

Tony Benn used to speculate about the effects it would have on civilisation if we were to institutionalise, on a daily basis, our concerns for those in the world who are hungry, sick and underprivileged in the same way that we record, each passing business day, changes in the value of shares and currencies. Why has it remained impossible to shift our society even a small bit in this direction: to have each evening before the seven o’clock news an update on the number of people who have died through malnutrition, had to collect and carry their own drinking water, had nowhere to call home?

The battle at Gallipoli was no doubt one of the most tragic in the long history of such misbegotten events. But even that immeasurable tragedy found the time, at its centre, to demonstrate a higher human value than institutionalised violence. The eight-hour truce on 24 May 1915 resulted, it is said, in a renewed appreciation by the men on both sides of the humanity of their opponents.

After so long celebrating the defence of realm and principle in good wars and bad, why should we not now expect our political and civic leaders to grow systems that reward those who contribute to international peace, health, equality and good will? Let’s do better at institutionalising returns for good human works.

Drought has broken, canola is flowering and the dam is full: The northernmost tip of the Grampians, North West Victoria.
Memorable keynote and concurrent speakers

This overview of the Conference is compiled from reports received from students and early career professionals who attended.

Food and health

There was a strong focus at the Conference on the need for food security in rural and remote areas and the need for food sovereignty in Australia generally. Speakers differentiated between food relief, food subsidies and food security and described the different impacts of these constructs on communities in need. They also examined the relative health benefits of food security and food relief, with the latter potentially giving insufficient attention to what constitutes a healthy diet.

Amanda Sheedy spoke about techniques used in Canada to increase food security. They included networking processes associated with the people’s food project, the management and renting of land for food gardens close to major cities, and the need for sustainable farming practice. Her presentation underpinned the strong support at the Conference for the national food plan being developed in Australia.

Speakers in the concurrent sessions that followed focused on various food projects and studies in Australia, which highlighted the fact that poor coordination of programs can lead to overlap in some areas and deficits in others. It was noted that only two food charities in the NT used nutritional guidelines, with many of the others distributing cheaper high energy/low nutrition foods.

At the end of the Conference the call for food sovereignty and food security in Australia was among the priority recommendations and the Government was urged to give emphasis in the National Food Plan to the particular needs, capacities and vulnerabilities of people in rural and remote areas.

Another project canvassed was the Garden Tucker Program through which people are assisted, with workshops and newsletters, to grow their own gardens. The health benefits come not just from the produce but through information on healthy cooking provided in the workshops and through a general increase in the volume of fruit and vegetables consumed by participants.

Closing the Gap

Close the Gap coordinator Tom Calma and Colleen Hayward addressed particular issues relating to Aboriginal and Torres Strait Islander health. It was an honour to hear Tom Calma speak about the Close the Gap campaign and to witness his quite evident commitment to tackling Indigenous smoking. He emphasised the need for specific public health messages that are culturally appropriate and practical for Indigenous people, and reflected on the importance of harnessing the ‘power of the people’ in lobbying governments and individual parliamentarians during the growth of the Close the Gap campaign.

Smoking alone accounts for approximately 20 per cent of all deaths in the Australian Indigenous community and explains some of the disparity in health between Indigenous people and other Australians.

Tom’s address highlighted the fact that every health professional needs to be involved and take a lead in acting as an advocate for social change and community development.

Workforce issues

A number of speakers argued that it is the distribution of resources, including the workforce, that is holding rural areas back, not their absolute supply. As a nation we need to make better use of the resources devoted to health. Compared with the World Health Organisation’s recommended ratio of health consumers to health professionals, Australia has 6.5 times more health professionals than required. And yet some of our population are still severely under-supplied.

John Menadue and Robyn McDermott were among those who prosecuted such a case, criticising the government’s perceived obsession with hospitals and with a provider-driven (as compared with citizen-driven) health care system which is inappropriate for the management of chronic disease. They both agreed that it is people in rural and remote areas who bear the brunt of the maldistribution of resources.

In their view the current number of doctor visits is unsustainable and better use must be made of the skills of other health professionals such as nurse practitioners. We should be designing truly integrated systems of care with funding models that reward illness prevention and fund lifestyle programs, for instance, instead of costly and overprescribed medications.

Rebekah Adams, a GP registrar, addressed what she called ‘career induced infertility’. This arises from advice to female trainees to postpone starting a family. Because she had a child before her internship, Rebekah found
Population health

Mike Daube reminded delegates of the challenges and potentially significant rewards of working to maintain good health. Preventive health still only receives two per cent of government funding, and rural areas largely experience only the ‘backwash’ of metropolitan programs. Mike spoke about the importance of specific targeted campaigns and outlined a practical approach to advocacy; his hints included personalising the issue, praising politicians for their contributions, and being patient; it took 20 years to get results in the tobacco campaign, but it is now known to have been successful in the broader population.

In one of the concurrent sessions, Nettie Flaherty presented a particularly challenging talk on the definition of child neglect in the NT. Although there appears to be general agreement about what child neglect means in extreme circumstances, there is no agreed standard by which it may be measured. In the absence of such a standard, assessment is based on worker discretion and judgment. Definitions of neglectful behaviour are dependent upon societal standards of acceptable parenting and these vary across communities. This is particularly problematic across cultural settings and among impoverished families. In some communities health professionals can initially be quite shocked by what appears to be the ‘norm’, but become accustomed to it over time. This presentation raised many questions about the approach that should be taken to children living without access to adequate food and in poor home environments exposed to toxins and overcrowding. Is it more harmful to leave these children where they are because that is the way they have always been raised or to put them into care? No straight answers were given and to some listeners none seem to exist.

Success stories

While the Conference revealed some problems in health, it also highlighted some brilliant success stories. An example was the presentation by Christine Jeffries-Stokes and Annette Stokes on their work in designing and implementing the Western Desert Kidney Health Project. It is an inspirational story which demonstrates that two women from a rural and remote area can have a huge impact on the health of their community. As part of this project a small group of people visit schools in Western Australia in a couple of trucks to teach children about how to care for themselves and prevent the development of type II diabetes mellitus which is as one of the most significant contributors to Disability Adjusted Life Years (DALYs) in Indigenous people and indeed in most Western societies. With the assistance of an artist, the school students make videos – using sand to tell a story about diabetes - its patho-physiology, aetiology, complications and prevention - in a succinct and informative fashion. The project is culturally appropriate, relevant and sustainable. One can go to YouTube to see some of what those kids created!

It is an inspirational story which demonstrates that two women from a rural and remote area can have a huge impact on the health of their community.

There were a number of other sessions on the positive health impacts that art and sporting programs have had on rural communities. One project promoted mental health through sporting clubs with two principle focuses: reducing alcohol use in sporting clubs and recognising depression in the community. The project provided training for prominent members of the local sporting club in mental health first aid and the recipients then became the contact people from whom other community members could get support if necessary. The club provided a community accessible ‘bluey’ (beyondblue) stand in their premises and hosted awareness raising events for the whole community, such as wearing only blue for one of their games. The project was beneficial on many levels, including through the health benefits of reduced alcohol consumption, becoming a more family-friendly club, and providing more support and reducing stigma for people with depression.

Children were trying music and performing. Local bands were mentored and invited to participate in joint gigs.

Many of the projects described or showcased in the arts and health stream had similar positive effects. One memorable session, called Sand Tracks – remote touring in central Australia, described how a well known Indigenous
band from NT travelled into WA conducting workshops and gigs in small communities on the way. A documentary was shown which revealed an overwhelming community response to these visits. Children were trying music and performing. Local bands were mentored and invited to participate in joint gigs. It was an alcohol-free event and promoted greater community cohesion. The project clearly brought the communities visited much joy and it will continue into 2011.

Diane Treble’s presentation on ‘Connecting rural and remote women through online social media’ raised many points about the huge potential for this to become a mainstay in rural health and support services. In another session delegates heard about the rural generalist scheme in Queensland that provides a well supported pathway for rural proceduralists in that state.

There was a good international focus at the Conference including from Peter Macdonald, President of Australian Doctors International, on a project in Papua New Guinea.

**Responding to natural disaster**

The final day of the Conference looked at the impact environmental stressors have on farmers and other members of the community. Three plenary speakers focused on the recent floods, black Saturday bushfires and communication during natural disasters. Their delivery was moving, with each speaker drawing on their own experiences of devastating events. Colin McAllan spoke of his experience on Black Saturday and of the changes that had occurred in the community since then. The grants they had received were now being put to creating community spaces, leadership programs for the youth and community events. Community cohesion had increased with big turnouts at all the events and the young people creating their own programs for the community. It was inspiring to see that so much could be achieved with limited resources and the good that can eventually come out of such devastation.

**Recommendations**

One of the strengths of the Conference was that every delegate was asked to draw on their own professional and personal experiences to contribute to a set of recommendations. Other recommendations were generated from concurrent sessions at which students attending the conference had been asked to act as scribes to record the key ideas presented. (Go to [http://11nrhc.ruralhealth.org.au/recommendations](http://11nrhc.ruralhealth.org.au/recommendations) if you’re interested).

**Contributors to this Conference report**

*Living in Alice Springs as a junior doctor, it can often feel isolating in regards to career pathways and opportunities ahead. The Conference allowed me to network with other health professionals and community members who are also dedicated to rural and remote areas. From discussions, I learnt a great deal more about exciting projects, diplomas, resources and training pathways that are available to me in an external manner. This has given me confidence that I can gain adequate training and qualifications while staying in a rural area. I was fortunate to attend the RAMUS luncheon which provided opportunity to liaise with senior and junior colleagues, staff and mentors.*

**Sally Banfield, junior doctor based in Alice Springs, RAMUS Alumnus**

*It was quite appropriate that in March this year I left my paediatrics rotation in Bendigo, regional Victoria, for one week to attend the National Rural Health Conference in Perth. On my rotation I have been involved in the care of children from all over the state. It was impossible not to notice the significant distance families travel for services in Bendigo, the importance of the primary healthcare providers facilitating the children’s admissions to hospital and the impact on these families of living in a rural area. These issues relating to rural and remote healthcare were at the core of Conference discussion and were especially timely in the wake of a number of natural disasters across Australia. I can’t recommend strongly enough for my fellow students to apply to attend conferences such as these and to seek funding through the NRHSN Conferences of National Significance (CoNS) program.*

**John Clark, 4th year, Monash University, WILDFIRE**

*I was very fortunate to be able to attend the 11th National Rural Health Conference in Perth, which I found to be the most positive and inspiring of all the conferences I’ve attended. A lot of the topics were relevant to my situation in Broome where I am studying this year. The social aspect was great with the best Conference dinner and band I’ve ever experienced. The other students were so much fun and the people I met so like minded. It was a great opportunity and privilege to meet and listen to people doing truly amazing things for their community. After this, all I want is to start doing projects in my own community; I’ve never felt so inspired. For example, I would like to coordinate a Garden Tucker Program in the Bidgyadanga community near Broome. I am pleased to have had the opportunity to attend this Conference. It was interesting and I’ve learnt a lot, and it has made me want to go into rural work more than ever before.*

**Susanna Hoffmann, RAMUS scholar, 5th yr at Broome Rural Clinical School, Uni WA, SPINRPHEX**
My goals prior to attending the Conference were to gain some insights into becoming a rural doctor and the challenges, opportunities and other important factors that this entails. I soon came to realise that this Conference would provide much more than that. I met a huge group of like-minded and committed students, made new contacts with rural practitioners, people involved with further training and potential employers and/or mentors in the exhibition area, and was inspired by knowledgeable, enthusiastic and engaging speakers. It was a fantastic opportunity to expand my understanding and knowledge in a very supportive environment. All the speakers were extremely approachable, willing to discuss their topic areas and give advice to a medical student.

Sally McKenzie, James Cook University, RHINO

As I have spent the majority of my time at medical school on rural rotations and with a strong interest in future rural practice, I was interested in the insights that this Conference would provide about emerging issues in rural health. I benefited from an excellent rural clinical school in East Gippsland and was impressed to hear about similar rural schools in other states and how they had evolved. In particular I related to the University of Tasmania program founded by Professor Judi Walker who is now heading the Monash School of Rural Health and was pleased to be able to speak with her afterwards.

Cassie Rickard, RAMUS Scholar, 4th year Monash University, Gippsland Medical School

Scholarship supports Tamworth student

In 2010, Nationals Senator for New South Wales, John Williams, established a scholarship to support a commencing dentistry student from regional NSW for their first year of study. Senator Williams committed $4,800 of his own funds to the scholarship for each year of his current Senate term.

The New South Wales Regional Dentistry Scholarship for 2011 has been awarded to Jessica Powell, a Bachelor of Dental Science student at the Orange campus of Charles Sturt University.

Jessica has moved from her home town of Tamworth to Orange to commence her studies. Senator Williams said: “Jessica has been active in her local Tamworth community and has demonstrated a commitment to improving the oral health of people living in regional NSW”. As part of her scholarship, Jessica will also receive mentoring support from Dr Chris Cole, an experienced dentist in Armidale.

The NSW regional dentistry scholarship is managed by the Alliance.

Winner of the 2010 scholarship, Olivia Jom, writes for Partyline:

The Scholarship provided by Senator Williams has enabled me to soar through my first year at university with peace of mind, confidence and a constant network of support. This included mentoring support from Dr Chris Cole, whose contribution to my learning experience as a dental student has been invaluable. Observing and consulting with experienced rural dentists and specialists has given me valuable insight into the rural dental workforce. The scholarship has opened my mind to the broad career opportunities available in rural communities.

I would encourage future commencing students from regional NSW to apply for the scholarship as it gives a professional support base beyond what is normally provided in first year of University.

Full proceedings of the 11th Conference, including keynote addresses, communiqué and recommendations are available on the Alliance website: www.ruralhealth.org.au

Students getting into the ‘super-hero’ spirit at the Conference dinner.

Olivia Jom, 2010 scholarship holder.

Minister acknowledges the inequities and re-commits to action

In her speech to the closing session of the Perth Conference, Nicola Roxon ticked many of the boxes on rural and remote health interests and recommitted the government to working with the sector for further improvements.

The Minister acknowledged that rural and remote health has a number of advocates in Federal Parliament, and complemented the sector on the innovation it has frequently shown, some of which is “far in advance of what we get from elsewhere”.

She reiterated the view that “regional Australia is far too important to Australia’s overall health to let services deteriorate and infrastructure degrade” and was at pains to point out that this was the case long before the hung Parliament. At the same time, it was true, the Minister said, that the Prime Minister’s agreement with the regional Independents “allows us to redouble our efforts to address health inequalities in our regional communities”.

Evidence of this regional emphasis includes the regional priority round of the Health and Hospitals Fund; primary care infrastructure grants to upgrade general practices, primary care, community health services, and Aboriginal medical services; and establishment of the Department of Regional Australia (“to coordinate government effort, improve service delivery, and oversee regional infrastructure investments”) and a regional health agency in her own Department. The new Rural Health Agency “must have the seniority of leadership and status to coordinate funding and policy, as well as argue the benefits of regional health funding across government”.

The Minister said that what works for big hospitals with economies of scale does not necessarily work for smaller regional hospitals. “We will retain block funding for these hospitals, where activity base funding would not deliver the resources they need to maintain their community service obligations,” she continued.

The new Rural Health Agency “must have the seniority of leadership and status to coordinate funding and policy…”

Her speech also included a focus on greater transparency in the use of resources and the outcomes achieved, and the significant role in this of the new National Health Performance Authority. “It will require hospitals and health services to provide standardised and consistent reporting on their performance. And I know ... that many of you see this as the key to identifying where extra resources are needed in rural and regional Australia.”

Some of this important work would be delivered through Medicare Locals and Local Hospital Networks, with “new services designed specifically to meet real community needs, through a model that enables a much stronger engagement with local health services and local communities”.

“It needs you engaged and prepared to participate in those structures,” the Minister urged.

Another significant element in the Minister’s speech was a focus on educating and training health professionals who would be ready, willing, and able to spend at least some of their careers in regional Australia. “The stress that many of you have worked under for your entire careers is no longer acceptable. Long and late hours, lack of support, fear of taking well-earned breaks because you don’t know who will cover for you, all inevitably take their toll.”

On the workforce front, the Minister reminded the audience of recent action to boost the training of specialists through the Specialist Training Program. “Through this program, our government is spending $356 million to train medical specialists, with about 50 per cent of the new training places for medical specialists outside hospitals and that will be in rural and regional locations.” While in 2007 there were 51 of these Federally-funded medical specialist training places, the Minister had recently announced 518 placements for medical specialists “with, for the first time, a focus on getting people to be trained outside hospitals and into parts of the country where training has not necessarily occurred before”.

Minister Roxon also spoke about the government’s investments in work to close the gap in life expectancy and life opportunities for Indigenous Australians – “the nation’s most compelling health challenge” – and about some of its expectations for e-health.

She concluded by saying that 2011 is to be a year in which many of the benefits of investments already made would come online: “Regional patients and healthcare professionals will be front and centre in this drive to address the historic inequities that you have seen over many of your careers.”
Staying fresh during a drought

Drought is inevitable for any dry land farming enterprise. With it comes the stress and anguish as the family watches crops fail and livestock lose weight. While nothing can be done to make it rain, there are ways of improving the mental health of farming families during these dry periods. One way is for the farmer to seek employment off-farm, outside the farm business.

A strategy developed by the Department of Agriculture and Food in Western Australia seeks to improve the viability of farms in the low rainfall, marginal regions of the northern eastern wheatbelt. North East Agricultural Region (NEAR) in Western Australia has seen a number of extremely variable seasons in the last ten years. 2006 and 2007 provided the lowest and second lowest growing season rainfall on record. During this period a number of farmers in the region went off-farm to work, short term, in areas other than agriculture.

Their experiences were captured by a recent project designed to determine the practicality and value of such a strategy during drought. The findings from the project reach across many sectors of the community.

The major finding from the project was that the mental health benefit from working off farm was the greatest help to the farm and family. This boost came through stimulation provided by new circumstances, a break from depressing weather conditions, and a brief reprieve from difficult decision making.

With drought can come feelings of helplessness, loss and often a mental ‘staleness’. This ‘staleness’ comes about because of the reduced activity on the farm and also because farmers realise that, while the return on their work on farm during drought is greatly reduced, the workload may not be. The farmers interviewed in the project acknowledged that having a break and new stimulation is important to keep the mind active – and that an active mind is a healthier one.

...having this break enabled them to make better decisions when returning to the farm.

Mental stimulation is easy to achieve through off-farm work. For the farmers interviewed the work away from farm was not out of their skill range but it was out of their immediate familiarity. Perhaps it was carting iron ore from a mine site to port: truck driving was a known skill while mine and port procedures were somewhat different to the farm. Or perhaps it was within the building industry as a leading hand where the manual tasks are different to those of farming.

Further stimulation is the challenge of new social situations. The farmers were challenged through meeting and working with new people in new environments. Often there was a need to communicate and function as part of a team, as would be the case for a crew working during time-critical mine maintenance. Farmers are renowned for being self reliant individuals and achieving the majority of farm tasks with little help from external sources. The team work was a change of mindset - from working “by myself, for myself”, to working with others for someone else. Even with this change of mindset there was still a sense of job satisfaction and achievement.

All of these factors – new social situations, new skills and new ways of thinking – were a great benefit for those farmers choosing to work off-farm. Of those interviewed, most said that having this break enabled them to make better decisions when returning to the farm. During dry seasons there are times when there are difficult decisions to make. Farmers returning to the farm with a refreshed mind believed that they improved the decisions they made and the outcome for the farm and family.

One farmer describes his experience working off farm during the droughts of 06 and 07, including how he did it and some of the family structure issues that had to be dealt with, in this YouTube video: www.youtube.com/watch?v=pIN8HAF0-F4

Wayne Parker
Department of Agriculture and Food WA, Geraldton
A new voice for Aboriginal and Torres Strait Islander physios

The health status of Aboriginal and Torres Strait Islander peoples is significantly lower than that of the general population. For years, Government and non-Government reports have detailed the problems, identified potential solutions and called for action. Yet little seems to have changed.

Now, a group of Aboriginal and Torres Strait Islander physiotherapists are planning on making their voices heard to help address these issues and make a difference in the health of their communities.

The National Association of Aboriginal and Torres Strait Islander Physiotherapists, Inc. (NAATSIP) was incorporated in January this year by the members of what had been an informal network of Aboriginal and Torres Strait Islander physios and physio students. The association’s main aims are to advocate on relevant issues concerning the physiotherapy profession’s role in addressing the health needs of Aboriginal and Torres Strait Islander peoples, and to provide culturally sensitive and professionally appropriate support to its members.

Representing the largest collective of Aboriginal and Torres Strait Islander physiotherapists and students, NAATSIP was created in response to concerns that issues surrounding Aboriginal and Torres Strait Islander health, and the role that physiotherapy can have in addressing these issues, were not being adequately addressed by existing organisations. In becoming a national body in its own right, and through building positive relationships with key stakeholders, NAATSIP plans to facilitate change in the way the physiotherapy profession addresses Aboriginal and Torres Strait Islander health.

Though just established, NAATSIP is already looking at opportunities to start making a difference. Current NAATSIP activities include the provision of a mentoring program for Aboriginal and Torres Strait Islander students studying physiotherapy, and promotion of physiotherapy as a career to Aboriginal and Torres Strait Islander high school students. NAATSIP is also considering a number of initiatives as part of developing its strategic plan, including: investigating access to, and availability of physiotherapy services to, Aboriginal and Torres Strait Islander peoples; developing cross-cultural sensitivity and safety amongst non-Indigenous physiotherapists through course curriculum and professional development; and promoting the role and benefits of physiotherapy as a primary health care service to Aboriginal and Torres Strait Islander communities.

Building strong relationships and partnerships with key stakeholders has also been given a high priority in order to ensure that all those involved in delivering physiotherapy services play their role in addressing the health inequities of Aboriginal and Torres Strait Islander peoples. NAATSIP is keen to explore how physiotherapy can help meet the needs of Aboriginal and Torres Strait Islander peoples in rural and remote communities, and has already started to develop positive relationships in the rural and remote sector through the National Rural Health Alliance (NRHA) and Services for Australian Rural and Remote Allied Health (SARRAH).

NAATSIP welcomes membership from Aboriginal, Torres Strait Islander, and non-Indigenous physiotherapists, assistants, and students, and organisations involved in the provision of physiotherapy services, education, or policy, or involved in addressing Aboriginal and Torres Strait Islander health.

Further information about NAATSIP can be found on their website: http://naatsip.org, or directed to: admin@naatsip.org.

Ray Gates
President

Bec Sykes and Sam Prince ‘speed dating’ at the 11th Conference.
The rural primary care deficit quantified

People living in rural and remote parts of Australia are missing out on health dollars. But just how much?

It turns out that the Medicare deficit of about a billion dollars is just the tip of the iceberg.

The report commissioned by the Alliance from the AIHW - Australian health expenditure by remoteness - was released in January 2011. The report deals with the 56 per cent of recurrent health expenditure that can at present be allocated according to rurality. In order to provide a complete picture, the NRHA produced a complementary report that reviews the likely deficits in the 44 per cent that could not be so classified.

Together these publications have demonstrated the size of the total rural and remote health deficit – both in terms of dollar figures and services lacking. Between them, the reports show a primary care deficit in regional and remote areas of at least $2.1 billion. This translates to an annual shortfall for country people of more than 25 million services.

The $2.1 billion underspend was comprised of a $660m out-of-hospital Medicare deficit, a half a billion dollar underspend through the Pharmaceutical Benefits Scheme, and at least a billion dollar inequity relating to dental and allied health services (including for other pharmacy and aids and appliances).

It is true that some substantial investments in rural health have been made ... but there is no evidence that the deficit has been reduced.

The findings are based on figures from 2006-07 – the most recent period for which data on expenditure by rurality are available. It is true that some substantial investments in rural health have been made since the data in these reports were collected, but there is no evidence that the deficit has been reduced.

This huge annual underspend on primary care (doctors, dentists, pharmacies) contributed to the poorer health of country people and led to the need for an extra $830 million to be spent on acute (hospital) care for people from rural and remote areas. This represented some 60,000 extra acute care hospital episodes. Through improvement to general health, a fairer share of public expenditure on health promotion, primary care and early intervention in rural areas would reduce acute care episodes and keep people out of hospital.

Referring to the recent findings from the AIHW and the Alliance on the rural primary care deficit (see opposite), the Minister reflected on the difficulty of reining in overspends and called on interest groups to help to identify and support savings. She recognised an inherent tension between the flexibility the Alliance seeks for rural programs and the desirability of universal national standards. Representatives of the 31 organisations in the Alliance attended the meeting from around Australia. *

Health Minister reports to Independents

In February, the Alliance was invited to be present in Parliament House when Health Minister Nicola Roxon reported to the Independents on matters relating to rural health and regional development in their agreement with the Gillard Government.

The Minister’s wide ranging report referred to the recent COAG agreement on hospital funding, plans for design of the new rural health agency, and Medicare Locals as the means of effecting what she called “a fundamental shift in the centre of gravity from hospitals to primary care”.

The Minister encouraged people to be patient on Medicare Locals – which would not reach their “almost unlimited” potential quickly – and emphasised the importance of having community leaders supportive and involved at the developmental stage to ensure that MLs grow into what is needed.

... be patient on Medicare Locals...

Health Minister, Nicola Roxon with Rob Oakeshott, Independent Member for Lyne and Jenny May, Chair of the National Rural Health Alliance.
Charity should begin very close to home

Australian Doctors International (ADI) is a non-profit, non-government health care and development aid organisation aimed at strengthening primary health services in Papua New Guinea (PNG). It deploys doctors and other health workers into remote parts of PNG.

In the ten years since it was established, ADI’s focus has been the Western Province.1 Around 200,000 people live in the Western Province, where there are three government hospitals to which it is difficult to attract sufficient medical and other health staff. There is one mining hospital in the Province: at Tabubil. New Ireland has ten doctors serving 160,000 people – but all of them provide acute care through one of the two hospitals, with none doing primary care.

PNG is Australia’s closest neighbour, just five kilometres from the Torres Strait Islands. Its health is in crisis. All the indicators are appalling. Whereas maternal mortality rates in Australia are approximately 8.4 per 100,000 live births, in PNG the figure is 733. Infant mortality is unacceptably high, malaria is rife, TB is out of control, and the rate of HIV is the highest in the Pacific. There are severe staff shortages and health centres are closing.

There are great logistical challenges in PNG, health infrastructure is failing, and preventable diseases are rife.

ADI runs Doctor Supervised Integrated Health Patrols. In their four month assignment, its doctors and health managers go into remote areas for three to four weeks at a time, come back for one week for a rest and go out again. The essence of these patrols is to treat patients, to provide community and school health education, and to train local staff.

Three quarters of ADI’s doctors are women. Most of the doctors and health managers have experience in the Top End or in northern parts of Western Australia and Queensland and have some general practice background. To have a lasting benefit, improving the management of the health centres is crucial, so the patrols have both a doctor and a health manager.

PNG’s Western Province is divided into three districts: North Fly, Middle Fly and South Fly. ADI operates in North Fly and Middle Fly – with South Fly being a huge challenge because of its remoteness. There are 60,000 people in South Fly and there is no doctor on the mainland, with the result that many of its people cross to access health services in the Torres Strait.

There are great logistical challenges in PNG. The rainfall in Western Province is up to eight metres a year and most travel has to be by water or air. ADI’s doctors have to battle along muddy tracks and over rickety bridges and may have to live on sago and banana for weeks on end.

The infrastructure is failing throughout PNG and many of the health facilities have no power, no water and no fridges. The morale of many local staff is at rock bottom: often they are not being paid. Some of the health centres are dirty and poorly attended, with patient records scattered around. Some of them are only half completed, others termite-ridden and falling down. There are wards with no beds – but with patients waiting patiently for attention.

There is minimal equipment and much of it is out of date. The drugs are out of date. There are major problems with TB and leprosy; ADI’s doctors encounter up to eight cases per patrol of leprosy in the remote parts of the Western Province. The organisation has major problems sourcing drugs for leprosy (seen in children as young as five) and TB due to a complex supply chain and huge geographical challenges to timely distribution.

To help combat malaria, ADI has distributed over 50,000 bed nets in the Western Province. In conjunction with education this has led to a dramatic drop in malaria in the targeted areas. Health education must be provided as part of an integrated health service and ADI’s doctors teach some first aid in the clinics.

ADI sometimes has logistical support from the mining companies in PNG, such as helicopter transport to the most remote patrol areas.

The organisation’s doctors and other professionals bring a measure of hope and advocacy. ADI is dedicated to drawing attention to the plight of the people in PNG – contacting provincial and national governments to bring about an improvement. If more people realised how appalling the health and health service situation is in PNG it would be impossible for governments to remain indifferent.

You can find out more about ADI at www.adi.org.au.

ADI volunteer doctor Denise Wild runs a health clinic for remote villagers in Kotale, Papua New Guinea in a district where there is no local doctor at all for 74,800 people.

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1 It is currently starting a program in New Ireland Province.
Colloquium on Community Engagement

A feature of the 11th National Rural Health Conference was a series of colloquia held during the concurrent sessions at which four presentations were followed by a 30 minute discussion between delegates and speakers.

It was an opportunity for delegates to engage more closely on some issues of importance. This report on the colloquia on community engagement was written for Partyline by Heather Hanks and Susan Magnay.

The community engagement colloquium followed immediately after a plenary session on the community participation movement, food sovereignty and citizens’ juries. The plenary session had generated a lively dialogue and the high level of interest continued into the colloquium.

Each of the four papers presented in the colloquium in its own way addressed the question of the community as an ally in the primary prevention of chronic illness and, more broadly, in rural and remote health care.

The colloquium explored strategies to help meet community needs. It considered ways in which communities can work as allies in the rural and remote health care sector, and some of the ways in which successful community engagement occurs in rural and remote communities.

Judy Taylor analysed the situation in eight communities in rural South Australia and North Queensland which are partnering with the health sector in activities such as peer education for chronic illness prevention and emotional wellbeing, and in the promotion of healthy lifestyles.

In her paper Dianne Penberthy described community partnerships involving local government, the Area Health Service, clinicians, non-government organisations and community hall committees in the Port Macquarie-Hastings area of New South Wales. These partnerships were founded and developed to capitalise on existing facilities and social strengths in order to improve access to primary care. The use of community halls came to represent the connection between health and community.

Lesley Barclay discussed the ‘Healthy Start to Life’ research project as a means of facilitating community engagement. The project mapped the patient journey through childbirth for Aboriginal women and infants in a remote Northern Territory community. The project successfully engaged many members of the local community, presented data regularly to stakeholders, built local research capacity and identified data collection as a tool for advocacy and to help redesign services.

The use of community halls came to represent the connection between health and community.

Beth Smith and Karyn Parker identified their community of interest as the staff at the local health care facility. Their case study involved internal engagement leading to the transformation of a small rural hospital from a poorly performing service to a cohesive, high quality healthcare team working in a state-of-the-art facility.

According to Judy Taylor, rural and remote communities sense that by engaging effectively with the health sector locally they can help develop employment opportunities, economic prosperity and social inclusion. Improved health outcomes are welcome secondary gains.

Dianne Penberthy also referred to the value of enhancing the local sense of place. In the case of her study in the Port Macquarie-Hastings area it was through the refurbishment of community halls in ten small communities and their use as the centres of new community partnerships. In addition, the exercise itself and the programs that were then run in those new centres of community provided a boost to the mental and physical wellbeing of many local residents.

Lesley Barclay and Judy Taylor agreed that community groups can increase their technical knowledge and capacity to advocate through experiencing community engagement. Partnerships between independent researchers and communities can be influential in connecting community needs to the political processes. Furthermore, community partnerships are useful for the health sector in identifying the ‘hard to reach groups’ and moving to address their needs.

Beth Smith and Karyn Parker demonstrated that continuous communication, persistence and reference to external standards and models can be powerful aids in leading and guiding change within a workplace community.

Those at the colloquium agreed that efforts to remedy the current inequities in health care delivery in rural and remote Australia can be supported by enlisting local communities as partners in the delivery of primary care, especially where chronic disease is concerned.

The papers from the colloquium are available on the Alliance’s Conference website www.ruralhealth.org.au
The Boulia School project

The Mount Isa Centre for Rural and Remote Health (MICRRH) is a university department of rural health. The centre facilitates placements for health students from universities around the nation. For the two years I was there as the pharmacy academic, I was involved in placements for pharmacy students.

It is my belief that students on a rural placement must be immersed in the community to gain the full benefit from it and to increase the chance of their returning to rural practice at some stage in the future. I also believe that student placements must benefit the community that hosts them.

With these two points in mind I modelled a program that owed something to research undertaken in France which found that placing engineering students in primary schools where they interacted with students in science activities and conversations about university education led to an increase in the number of students studying science subjects later in their education and considering university entrance as an option.

The hub of many small towns is the school and the school in Boulia was a good place for my students to learn about the community and build relationships within the community. With the co-operation of the school principals, pharmacy students participated in science lessons at the school each week using fun experiments that were designed to tie in with the school curriculum. One theme was water. The students grew a garden (quite an achievement in Boulia) and were able to eat the fresh vegetables grown and learn about healthy eating as well. When food was served at school social functions the students reinforced appropriate food choices and serving size.

The activities expanded to include assisting with reading, sport and other activities. The presence of health students increased the number of people who were reinforcing messages about hand washing, blowing noses and appropriate ways to reduce transmission of viruses when sneezing and coughing.

The relaxed and ongoing interaction with the students from several universities over the time proved to be one of the few experiences the school children had with a health professional when they were not sick. They learnt about a pharmacist’s role in the health workforce and the pharmacy students observed at first hand the impact of conditions such as foetal alcohol syndrome, rheumatic fever, poor access to dental care, nutrition and overcrowded housing.

Involvement with the school gave the students on placement an awareness of what was happening within the Boulia community. Two students on placement formed part of the Boulia XI cricket team that played against Bedourie, others ran the sausage sizzle for state of origin events (the school has a big screen for open air movies, TV etc), some went on farm stays, RFDS fund raising activities, camel rides etc. The pharmacy students were excellent positive role models for the school students.

Students on placement also had the opportunity to advance their practice skills at the clinic. They maintained the dispensary at the clinic, introduced a handbook of essential counselling points for the most common medications, dispensed under supervision and maintained the patient recall system for the management of chronic patients. They selected medical charts for review each week by the RFDS doctor. This kept all the patient charts current and accurate. There is a sole nurse running the Boulia clinic so the professional isolation was also broken for that person as they had others to interact with on a clinical level.

Prior to sending students to Boulia they were required to participate in the Cultural Awareness program provided by the staff at MICRRH. Due to the remote location of Boulia, MICRRH’s Indigenous support staff were always available to assist with issues that might arise during the placement. Students lived in comfortable accommodation provided by MICRRH on the Queensland Health Clinic site which is conveniently located across the road from the clinic.

It will be interesting to observe the long term outcomes from the project.

I’m pretty passionate about the Boulia story and I know that this model would be transferrable to many of our small communities. 🌟

Heather Volk
A conference to empower

Empowering Australians. The self-management conference: *Doing It Ourselves in Aged Care, Chronic and Mental Illness, Disability and Special Education*. Melbourne 2-3 May 2011

Although not directed specifically at issues in the bush, it’s likely that some of the themes of this conference (being held as we go to print) will be of interest to readers of Partyline.

One of the speakers is Anita Gordon. Anita has been using a wheelchair since she had a stroke in 1998. Over the last two years she has been developing a method of self-managing her ACT disability support package.

By self-managing her funding and directly employing her own support staff, Anita has found that:

- she has been able to increase her number of support hours by three times, after cutting out administration and brokerage fees payable to agencies;
- her costs of purchasing equipment have dropped by up to 50 per cent compared to the cost of purchasing through government;
- support workers have become affordable on weekends and public holidays; and
- relationships with support workers and continuity have improved by selecting and dealing directly with support staff.

Siegfried Drews has been coordinating care for his wife Mardi after she developed Motor Neurone Disease. This involves 24 hour nursing support, and having carers coming through the house at all hours.

He has developed a technology platform to support the planning, logistics, administration and reporting functions associated with supporting Mardi’s care to avoid the nightmare of doing it manually. Because of unreliability of some agencies that supply carers he developed a match-making system to enable families needing carers to find and employ them directly. It’s like an internet dating service for families who need carers. The result is a portal through which Mardi’s carers can be employed, rostered and paid electronically, other supports and services can be budgeted for, purchased and accounted for, and her public funders (the Victorian DHS) can view the flow of people and money as they wish. The portal integrates planning, budgeting, financial transactions, reporting, and local networking (if required) in a format applicable to children and adults in disability, chronic illness, mental health, aged care and education. Siegfried wants to make the portal available to interested people for no more than the cost of set-up and optional customisation.

Another speaker is George Vassilou. George is a pioneer in family-management of disability supports for his daughter Natasha and his elderly mother. Following a profile of his family-managed arrangements on *The 7.30 Report* on ABC Television, and with approval from the Federal Minister for Aged Care, George has established the precedent that families are entitled to self-manage *Home and Community Care* funding packages for their family members if they want to. George is willing to make available tools for managing the package, supply information and support on how to proceed, and direct families to appropriate host agencies willing to host family-managed arrangements.


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**Australian Journal of Rural Health**

The April 2011 issue of the Australian Journal of Rural Health offers original research articles on a range of topics including: rural adolescents’ help seeking intentions for emotional problems; cultural barriers to health care for Aboriginal and Torres Strait Islanders in Mount Isa; and an examination of the initial 18 months of the first multi-disciplinary regional pulmonary arterial hypertension clinic in Coffs Harbour (NSW). There are articles on workforce issues and reports on H1N1 and managing hepatitis B in a remote primary health care setting.

Learn more about AJRH at [www.ruralhealth.org.au](http://www.ruralhealth.org.au) and access AJRH contents on line at [http://onlinelibrary.wiley.com](http://onlinelibrary.wiley.com)
Do family carers need to be health system navigators?

No primary health care system will be able to respond in the long term to changing demographics and health needs, or to clinical practice and societal influences, without carers. Acknowledgement of this should be implicit in all elements of the primary health system.

Primary health care in Australia has undergone many changes in the last two decades, reflecting (among other things) changes in the health profile of Australian society. Our population has aged significantly, the incidence of disability and chronic illness has increased, and we are living longer with disabilities. At the same time three major policy shifts have occurred. There are shorter hospital stays, an overall shift from institutional care to community care, and an increased focus on ageing at home.

Children and young people, people of working age, older people, Indigenous Australians, those in rural and remote areas, and people born outside Australia – all of these support health professionals to provide the ongoing care that has enabled these policies to be possible. However, the impact of this shift on those providing the care, the family carers, has not always been considered.

Family carers, often with little training, guidance, information or resources, are called on to provide care and support for people with chronic, complex conditions such as cancer, dementia, diabetes, Parkinson’s disease, motor neurone disease, heart disease, physical disabilities, autism and mental illness. Additionally, family carers often provide the main support and care for those with a terminal illness.

Carers accompany their family member to appointments with health professionals and are a critical element of the package of care provided to patients. However they often do not feel like fully participating members of the team and at times it appears there is an ‘invisible contract’ binding them to substantial, quasi-professional care work. The lack of formal acknowledgement of family carers and their vital role in the primary health care system has long been a concern for carer advocates.

The characteristics of health system navigators

- Active learners
- Active listeners
- Active researchers
- Committed to best case outcomes
- Assertive, sometimes fearless communicators
- Committed to open collaboration
- Team players

Identification at point of entry to the primary health care system is the first step to ensuring vulnerable and at-risk groups have access to clinically and culturally appropriate health services that are timely and affordable. This is particularly relevant for carers – and, most importantly, for young carers. The idea that young people, even children under age 10, are undertaking caring responsibilities goes against general societal norms. As a result those administering adult services, particularly in the health sector, often fail to recognise that a young person is taking an active caring role in the family. Often their particular needs are ignored and they can be excluded from discussion about patient treatment or services for the family.

Carer advocates believe that a ‘whole-of-family’ approach to care provided within a primary health care setting would lead to better health outcomes. The Australian Commission on Safety and Quality in Healthcare (ACSQH) acknowledged the important role played by carers in the health system and defined ‘patient-centred’ broadly to include consumers and their carers and families. This definition should be used and understood in a primary health care setting. A major barrier for carers is the frequent lack of inclusion in processes relating to consumer assessment, discharge and ongoing care. As a consequence, they are not appropriately provided by the treating clinician with, or linked with, the necessary supports.

Family carers in rural and remote areas have identified isolation, lack of services, weakening of community and social networks, escalation of costs associated with caring (eg petrol, food, equipment), and an inability to be able to plan for the future, as impacting negatively on their own health and wellbeing.

The health and wellbeing of carers can be better managed within the primary health care setting. Education and training for health professionals about the role of carers would assist delivery of clinically and culturally appropriate services. Family carers should be identified and supported as partners in care planning and management. This could be achieved with a “Carer Participation in Primary Health Care” strategy. Successful implementation of any carer participation policy will require planned and coordinated education of health professionals and service providers to be driven by governments and professional bodies.
A lively arts and health program was co-ordinated and produced by Country Arts WA.
Conference award winners

The HESTA Super Heroes Conference Dinner was a memorable evening of good food and conversation, and of dance and celebration. Guests came attired in purple and green outfits or in their favourite super hero costume. It was the perfect occasion to celebrate the super heroes of rural health, so Jenny May (Chair of the Alliance – and a bit of a superhero herself) announced the three winners of the Des Murray Scholarship: Jess Lopes, Stephanie Tran and Ashleigh McArthur. Janie Smith, Chair of friends of the Alliance, then sang some of the praises of the friends Unsung Hero, Kylie Stothers.

**Jess Lopes** has a degree in public health from Adelaide University and works as a Research Associate at the Centre for Remote Health in Alice Springs. She has a strong interest in rural and Indigenous health and presented a paper at the Conference on an evaluation of the DVD *Suicide Story*, a localised training resource about suicide prevention for Indigenous communities.

As a first time presenter it was a great experience and an exciting opportunity to share research from my honours project. The Conference provided me with an enhanced understanding of rural health on a national scale and increased my awareness of the diverse work that is being undertaken in the rural health field. Many of the presenters and keynote speakers were very inspiring. Overall, the Conference increased my passion and motivation to pursue a career in rural health and I hope to have the opportunity to attend another Rural Health Conference in the future.

**Stephanie Tran** is a graduate optometrist who was recently a member of a multi-disciplinary project travelling through rural areas of South Africa delivering sorely needed eye and vision screening, examination and treatment. Back in Australia, Stephanie has joined a rural practice in Green Hills, NSW.

As a recipient of the 2011 Des Murray Scholarship, I was invited to attend the national Rural Health Conference in Perth. I found the Conference very inspiring and eye-opening. As a new graduate optometrist, I enjoyed going out on eyecare ‘camps’ but was quite sceptical about whether it would have much impact in the bigger scheme of things. Listening to and meeting all these speakers from around Australia and from many different aspects of health care made me see that every little bit adds up to making a difference. Following this Conference, I’m even more excited to go on short eyecare ‘camps’ knowing that I’m doing my bit for rural communities!

**Ashleigh McArthur** is involved with the Community Service Committee at Warwick State High School in southern Queensland. Ashleigh is a member of the Headspace Southern Downs Youth Advisory Group and participated last year in the health stream of the Queensland Youth Forum.

**Kylie Stothers**, the 2011 friends Unsung Hero, is a Jawoyn woman from Katherine, a social worker and researcher with a passion to see local people gain quality education and become skilled initiators of change. As the Unsung Hero, Kylie represents the thousands of individuals throughout rural Australia who, like her, are providing energy, compassion and competence to strengthen their local communities.

Kylie was nominated for the award by Faye McMillan, President of Indigenous Allied Health Australia (AIHA), who says, “Kylie has a generous spirit and is warm, encouraging, fair and ethical - a wonderful role model in her community.”

In presenting the award, Janie Smith described Kylie as a woman who not only demonstrates strong and continuing commitment to her work and to the advancement of Aboriginal and Torres Strait Islander people, but who also has the balance and energy to be a caring daughter, and a loving mother and wife.

Other award winners were also recognised.
Brenda Masutti, from the Royal Flying Doctor Service in Cairns, won the prestigious Louis Ariotti Memorial Award, sponsored by the Toowoomba Hospital Foundation, in recognition of her long-term innovation and excellence in rural and remote health. Brenda manages the Improved Primary Health Care Initiative to enhance chronic disease services to remote Aboriginal communities on Cape York. Brenda has acted as Manager of Primary Care for the whole of the RFDS’s Queensland section. She has worked for the RFDS since 1996 and has been involved with its Rural Women’s GP Service. Prior to that she worked for the School of Distance Education, for CRANA and for the Far North Queensland Institute of TAFE. She is a registered nurse and midwife and a public health nurse who has worked in Doomadgee and Mt Isa.

The Toowoomba Hospital Foundation’s Rural and Remote Health Research Awards went to Sue Charlton, physiotherapist from South Australia, and Priya Martin, an occupational therapist from Rockhampton.

The Rural Australia Medical Undergraduate Scholarship (RAMUS) Mentor of the Year Award went to Mark Zafir of Albany WA. Dr Zafir has participated in the RAMUS Scheme as a mentor since 2005. He has mentored and taught many medical students through the RAMUS Scheme, John Flynn Placement Program and the Rural Clinical School at Albany. Natasha Moseley, one of the students who nominated Dr Zafir, described him as “a very willing and enthusiastic teacher …pushing students beyond their comfort zones, always believing in them and always keen to get them involved in as many aspects of medicine as possible.”

Two new mobile screening units for BreastScreen SA

More than 30,000 women living in rural and remote South Australia will benefit from the free breast screening provided by two new replacement mobile screening units, unveiled in late 2010.

BreastScreen SA General Manager, Lou Williamson, said the mobile units make possible equal access to free, high quality breast cancer screening for women living in rural areas. The new units are purpose-built to ensure the safety and comfort of clients, staff, transport contractors and site contractors. They have state-of-the-art digital technology, and replace the units that have been in operation for more than 16 years.

The exterior montage on the mobile screening embodies BreastScreen SA’s aim of caring for women from ocean to outback. Travelling more than 10,000 kilometres across the state, going north to Marla, south to Mount Gambier, east to the Riverland, west to Ceduna, and across the water to Kangaroo Island, the units visit 26 rural locations every two years, which is the recommended screening interval.

Clients with a disability have direct access to the mammography room via an automated wheelchair lift located at the rear service door. BreastScreen SA’s statistics show that women living in country South Australia have a better screening participation rate than women living in the city.

Free screening is primarily recommended for women aged 50 to 69 without breast symptoms and a doctor’s referral is not required; women just need to phone 13 20 50 for an appointment.

Women from 50 to 69 years are encouraged to take advantage of the state-wide travelling service, as early detection of breast cancer is the key to simple and successful treatment. Health professionals should recommend screening to women in the target age group, as a 2010 survey of BreastScreen SA’s new clients revealed that 36 per cent listed a discussion with a GP or other practitioner as the main prompt for screening attendance.
From Galiwin’ku to Perth

One of the early respondents to the 11th Conference Call for Papers was Timmy Galalingu from the Galiwin’ku community in the NT.

Timmy asked for an opportunity to speak with Conference delegates about the pollution problems threatening the sea life around Elcho Island and to share with them some aspects of his culture.

In the weeks leading up to the Conference, arrangements gradually fell into place which saw Timmy confirmed as a Conference delegate who would have his own space in the Exhibition Hall, where he would be able to interact with delegates during lunch and tea breaks.

“...The Conference showed me many good things, and I want to show those good things to my community,”

Throughout the Conference, delegates were drawn to Timmy’s space to listen to him, to chat with him, and to watch him demonstrate his skills as he painted a didgeridoo, woomera and spear and played the didgeridoo. A DVD clip featuring Timmy dancing at a recent Gharma festival was screened at the National Rural Health Alliance booth.

Timmy’s message to delegates is reflected in two of the Conference recommendations:

• Given the dependence of the residents of Elcho Island on the surrounding waters for provision of fish and other marine life as a primary food source, it is important that action be taken by those agencies responsible to provide waste disposal systems on the island to prevent island waste being blown into the seawaters.

• As part of the National Food Plan being developed, a new funding stream should be established for the support of community gardens – especially in more remote areas which experience isolation from supplies of fresh food, such as Elcho Island.

Once back home on Elcho Island, Timmy was eager to share with his community what had happened at the Conference. “The Conference showed me many good things, and I want to show those good things to my community,” Timmy said. “Everybody was real happy that I was able to go to the Conference.”

The result has been positive for Galiwin’ku community. Timmy reports that people there have a renewed enthusiasm for dealing with the pollution issue and for working in the local community garden. “More people are getting involved and there is interest in growing different types of vegetables,” Timmy said.

The National Rural Health Alliance is grateful for the assistance provided by Miwatj Health Aboriginal Corporation, Airnorth, Elcho Island Arts and individuals who helped support Timmy’s attendance at the Conference. *

Timmy spoke with delegates about his family and the Galiwin’ku community.
Multi-Purpose Services in Australia

One of the recommendations from the National Health and Hospitals Reform Commission in 2009 was for the expansion of the Multi-Purpose Service program.

This program – well-known and popular in rural and remote areas – is a joint Commonwealth and State/Territory government initiative. It was developed in the early 1990s to make health and aged care services sustainable in smaller rural communities where hospitals were closing, health and aged care services were limited, often dispersed and disconnected, funding structures were rigid, there were shortages in the health workforce and populations were small and ageing.

The Multi-Purpose Service program offers a lifeline to regional communities by enabling them to work in new ways – principally to expand community-based services and primary care in integrated settings.

The Multi-Purpose Service program offers greater opportunities to deliver:
• improved quality of care through a strong patient focus and better integration;
• better access to health care by enabling it to be localised; and
• cost-effectiveness, with potential savings from lower overheads for community based care.

Multi-Purpose Services pool the Commonwealth’s aged care and Home and Community Care funds with those from the State for hospital and community health, and often with local government resources as well. Funds are used to deliver an expanded range of health services in areas such as health education and promotion, community care, community health, basic acute care, residential care, mental health, community care and child health. Multi-Purpose Services form networks with other health service providers (for example, general practices, diagnostic and other specialist services and ambulance services) to build referral networks resulting in coordinated care.

The value of various Multi-purpose Service program elements is affirmed in a number of the National Health and Hospitals Reform Commission’s recommendations. With a focus on improving health by bringing primary, acute hospital and aged care together, the program has developed as a national rural health service delivery strategy based on many of the integration principles identified as necessary for wide reform of the Australian health system. It already has a carefully thought out, clearly stated policy intent, supported by a framework for implementation. Within this framework, health needs, health service plans, health and aged care service delivery arrangements, governance, and funding are locally (rather than centrally) defined and managed.

The most obvious feature of Multi-Purpose Services is their diversity. This is an outcome of their different locations and geography, environments, history and cultures. It is also the outcome of their ability to pool funds from all sources and allocate them to service delivery in accordance with service plans based on the health needs of their communities and strong local relationships. They are characterised by the wide range of services they provide and differences in the governing, organisational and funding arrangements established to secure local health services. There are Multi-Purpose Services working within regional governing structures, those with individual Boards of Directors and one in Queensland that is a non-government organisation. One of the characteristics they have in common is the placement of community engagement at the centre of service planning and delivery. This is critical to community ownership of service provision, confidence in service planning and management and long term sustainability.

Over the last 15 years, Multi-purpose Services have been able to survive the multiple challenges thrown at them by significant change. While a formal national evaluation of Multi-Purpose Services has not been undertaken in the last ten years, anecdotal evidence shows that they are a sustainable model of integrated health service delivery for rural and remote communities.

In 2009, there were 126 Multi-Purpose Services operating in all jurisdictions across Australia except the ACT, and most are our country’s smallest rural and remote (and often most vulnerable) health service organisations. There are even more today. *

Lyndon Sey’s
CEO, Alpine Health
Recipients of Rural Australia Medical Undergraduate Scholarships (RAMUS) provide reports each year on their rural placements and other rural experiences. The following excerpts provide snapshots of experiences, insights and evidence of impacts on career choice.

**RAMUS scholars reflect on their rural experiences in 2010**

From questions asked at the end of the high school information session, it seems that a big part of whether a rural kid decides to embark on tertiary education in a metropolitan centre rests on whether or not they believe they’ll be able to cope living away from home in a ‘big city’ as much as, if not more than, the demands of the study they undertake itself. …

I’m still not exactly sure where the line between ‘doctor’ and ‘social advocate’ should be drawn, but my visit to an Indigenous health centre prompted me to think about my capacity as a doctor to work for positive social change in ways that are meaningful and ultimately sustainable. …

I think it’s a common misconception amongst uni students that to ‘go rural’ automatically means you will be a GP. My ophthalmology placement in a rural town was very informative. The practice was super busy and it brought home to me how much demand there is for certain specialists outside the city centres.

**Sarah Marks**

I learnt that some rural health professionals perform daily round trips of over 250kms to see clients. The region’s nurses, social workers and mental health workers would share workloads to provide mental health care to patients – with nurses performing many of the duties of social workers, and vice versa – because the sheer distance involved meant that health care workers must often have overlapping roles if they are to provide a modicum of service to those in isolated townships.

I saw first-hand how the burden of depression and mental illness has hit rural areas, and how difficult it was for many people to access sufficient mental health care. However, there was also some good news – the overwhelming opinion amongst staff was that recent attempts by the government and other health services like beyondblue had done a lot to increase the awareness in regional Australia of mental illness, and helped greatly to reduce the associated stigma. However, one of the stopgap measures meant to address the deficit of rural services has had both a positive and negative impact. While many patients are happy to access telepsychiatry services and address a computer screen with a distant doctor’s face on it, it would be concerning if the advent of such services was to become one more barrier for doctors (especially specialists) moving to rural areas to practise if they can use telemedicine to interact with patients one day a fortnight without ever leaving the cities they call home.

**Veronica Doig**

We saw the facilities that Monash had to offer – they have some amazing gadgets like a dummy which breathes, coughs, sweats, knows what drug you inject and so much more. The students and interns alike stressed how much more experience they gained from being in a rural area.

**Gizel Erol**

When I reflect on my five years of medicine as a RAMUS scholar one word comes to mind – opportunity. RAMUS has provided me with the opportunity to concentrate on my studies with much less financial burden. It has given me the opportunity to forge a strong bond with a mentor and a local community. RAMUS has provided me with the opportunity to attend a conference relevant to a potential future rural career.

**Joseph Speekman**

During the year I held the position of Australian Medical Students’ Association representative for the University of Sydney. In October, the AMSA council endorsed the rural background entry policy which recognises the fact that rural students are at a disadvantage when planning to study medicine. It calls for greater encouragement for rural students to apply for medical school, and attempts to negate the disadvantages that currently bar the way for these students, particularly the financial and educational disadvantages. This policy will be used to advocate for rural students to ensure that a greater proportion of medical students are from rural or remote settings.

**Cameron Gofton**
Rural arts projects that suc-seeded

How does a small rural community respond when its young men drive at excessive speeds (and kill themselves and others), and its young women of 22 are tired of going to funerals?

Well, in Burnie (Tas) where this was a serious problem, one answer came in the form of a community film project which engaged the at-risk young men as film makers. Their film, *Drive*, became the focus of an intense community dialogue and has been integrated into the Year 10 curriculum in Tasmanian schools. Additionally it has had showings at film festivals in South Korea, Iran and Denmark.

*Drive* is just one of 13 great arts and health stories grown in regional Australia and featured in *seeded* - a new publication of Regional Arts Australia (RAA), published with the support of the National Rural Health Alliance (NRHA) and launched at the 11th Conference in Perth. The RAA and NRHA share a commitment to supporting the arts because of the positive role they can play in the health and wellbeing of individuals and communities. Over 90 arts and health projects were considered for the book – clear evidence of the extent of this important activity in regional Australia.

A strong element in many of the stories is the emphasis on process. Sensitive involvement of target groups is as essential as the end product. The southern Ngalia Dance Camps story documents an inter-generational project created by women Elders of the Warlpiri people to pass on traditional knowledge. The Western Desert Kidney Health Project seeks to combat the very serious issue of early onset Type II diabetes through contemporary community arts practice. With an emphasis on fun, the Kidney Health project relies on culturally appropriate and meaningful materials but it is firmly anchored in contemporary practice. Shadow puppets and sand animations are popular elements but, with the addition of animator skills and computers, these traditional arts have been launched on YouTube.

The diversity of projects is impressive. *Beyond Roundabouts*, based in Cooma, NSW, activated young parents to address mental health issues through photography and film. (In 2010, *Beyond Roundabouts* won the NSW and National Arts Health Foundation Awards from the Australian Business Arts Foundation.) *Dust* is a major community theatre production focussing on asbestos which had its origin in Ballarat and later toured to Melbourne and regional Victoria. The *Rock Hole Long Pipe project* had an international flavour bringing renowned British arts and health advocate Allison Clough to work with WA communities on a reconciliation project. The dis|assemble dance project drew physically and intellectually disabled people into dance workshops and performances with able dancers.

Writer Moya Sayer-Jones has captured the voices of key project managers with great immediacy and authenticity. The stories come alive through striking images. This is not a 'how to' book. It’s a celebration of creativity focused on health outcomes. Read it for inspiration. Read it to admire rural resilience and achievement. Read it for enjoyment.

Peter Brown

*Through the looking glass* is Melanie Jai’s intensely personal story of her journey with her autistic son and the creation of a special visual arts exhibition which is touring regional Queensland and NSW until 2012.

*Moya Sayer-Jones planting ideas about rural arts and health.*
Partnerships for rural and regional health research

The early March sun shone down on us, light filtering through the trees. “It would be good to work with you guys on this,” the man said, “I don’t know how you see it, but Australia is a bit harsh for vulnerable people… it’s extremely economically rational.

We need genuine partnerships, in order to get the most out of the system.” Yup. It was end of month 6 at La Trobe Rural Health School (LRHS) and this was the finish of one of many meetings with community-based agencies – agencies that will need to become, as the man said, ‘genuine partners’ for the LRHS vision to be realised.

LRHS officially commenced in January 2010 and I started there in September 2010. We have some real research challenges. We have four campuses: in Wodonga, Shepparton, Mildura and Bendigo. Our allied health and nursing numbers at these sites have grown rapidly, but on some campuses numbers are small and many work part-time. The majority have moved from being capable clinicians into an environment requiring teaching and research training and a PhD. We are working to build research capacity across our sites. Staff have to move as quickly as possible to writing for A and A* journals and get Category 1 grants. While most staff are hungry to do ‘research’ and communities are excited to have local providers, the challenges lie in getting local people truly research-ready. There are significant differences between thinking you are a researcher and actually being a good, self-aware researcher. Researchers must not do more harm than good!

...the presence of local health services and health professionals impacts on the economic, social and human capital of rural places.

LRHS is travelling down a road where the service delivery potential of allied health professionals, nurses, generic health and human services personnel and communities will be a focus of exploration. Simultaneously, there is great potential for linking up with other regional faculty – in planning, sociology, business studies, environment and, importantly, with rural and regional communities, for addressing community wellbeing. Service delivery and community wellbeing are closely linked. A goal to achieve equivalent accessibility to services, or certainly equivalent outcomes, resides with a social justice agenda.

Evidence indicates that services don’t directly raise levels of health; however, when people are ill they require accessibility to needed services. Also, there is evidence that the presence of local health services and health professionals impacts on the economic, social and human capital of rural places.

Health is generally worse in rural Australia compared with metropolitan areas. This phenomenon is not seen in European countries (where rural and urban health status is similar) and is directly linked with higher disadvantage in rural Australia. Research is required that looks at how different types of areas can get access to the health care they need. In a Scottish study, when we did this, rural people universally highlighted a desire for expert emergency triage, surveillance/anticipatory care for vulnerable people and community (health) development leadership from locally based workers. Such competencies may be provided by many types of workers, if appropriately skilled, trained and supervised.

This phenomenon is not seen in European countries (where rural and urban health status is similar) and is directly linked with higher disadvantage in rural Australia.

LRHS’ other research focus – community wellbeing – is a tricky issue. There is strong evidence of factors linked to individual and community ill-health. Policymakers urge resilience. In a Scottish study, we tested rural older people’s capacity to provide basic services. While transport schemes, meeting places and community care were developed, volunteering was limited and catalytic (external) mentors were considered vital. LRHS seeks to work in a multi-disciplinary fashion, with other local universities and, most importantly, with communities to find ways to achieve aspirations and measure process and outcomes. Like the man said, this requires genuine partnerships of many kinds. 

Jane Farmer

Felicity Shagwell (Julianne Bryce) and The Joker (Tim Kelly) at the 11th Conference dinner.
Pleasant rural placement, good rural prospects

Positive experiences during a rural student placement can be the start of a long health career in rural and remote areas. As an allied health student I have completed a number of placements, including some in rural areas. These experiences opened my eyes to what makes a placement successful (or otherwise) in attracting a professional back to rural practice.

One of the main disincentives to returning as a professional to rural areas is isolation – and this can be experienced and ‘learned’ through a placement. Students on placement are away from their usual place of residence and isolated from friends and family. A sense of loneliness can heighten the stress of placement. This factor can heavily influence the experience of placement.

Placements are much more enjoyable if support networks and friendships are formed in the early stages.

Placements are much more enjoyable if support networks and friendships are formed in the early stages. It is helpful if supervisors and mentors make the effort to show students around the town and nearby towns, and point out key areas and attractions such as grocery stores, the local gym, cinema, or other social centres. It is also useful to give local knowledge about areas where it may be safe or unsafe to walk around after dark, what the local pub and café are like, etc. All this initial information can add value to the experience. Another suggestion for making the placement experience more enjoyable is to have a weekly or fortnightly social activity for students, staff, and locums, etc to allow students to meet staff in a social setting. It may also be appropriate to send students in pairs to placements so they have peer support and a greater social network.

A major factor for consideration is the nature of the accommodation provided. It should not only be comfortable and affordable, but should also be made ‘liveable’. For example, it will be helpful to confirm before the student arrives if it is appropriate for the student to stay in mixed sex accommodation; that the kitchen facilities are suitable for the number of people and with useable cutlery, crockery, pots, pans and microwave, etc; that the common areas are suitable for the number of people, ie enough chairs, a TV which works, etc; and that the amenities are appropriate for the number of people in the facility. (Having 26 people sharing two toilets and showers which are cleaned once a week is not a pleasant experience.)

Because equipped and accredited locations for placements are limited, a student may not have a choice about where they go. In such cases it is important for placement coordinators to be mindful of the unavoidable on-costs associated with the rural placement. Increased costs can be attributed to transport, higher food prices, extra costs such as gym memberships and accommodation which are on top of costs to maintain those services in the student’s usual place of residence.

To build confident and competent professions, students need to be given as much authority and independence as possible. This is particularly important for rural and remote practitioners who are more likely to be working in a solo practice and need high levels of confidence and skills to be competent in their work.

The student’s experience on a placement is likely to be better if their expectations are known and – as far as possible – met. For instance, if a student has requested to go to NT they may particularly hope to be introduced to working with Aboriginal and Torres Strait Islander people.

To build confident and competent professions, students need to be given as much authority and independence as possible.

Supervisors, service managers, other health staff and the host community and practice can all play a role in improving the rural and remote placement experience. And it’s well worth the effort if it means there will be one more trained health professional bursting to go rural!

Megan Andrews

“The breadth of the program was more than one could fathom, and the inspiration priceless.”
Pasqualina Coffey, delegate
Recollections from London

Jenny Smith is a nurse/midwife from London who travelled to Perth to attend the 11th Conference. She has written for Partyline about some of her Conference highlights.

The 11th National Rural Health Conference was an experience I will hold with me for the rest of my life. The rich tapestry of Aboriginal heritage interwoven throughout the whole Conference was spellbinding; the dance, the music and the arts provided a creative platform from which to focus on a range of health issues.

The speakers chosen were inspirational, pro-active and passionate in the work they do, determined to improve healthcare for the people of Australia’s rural and remote communities.

Sam Prince reminded us of the challenges and stark reality of differences in health in Australia by pointing out that its Indigenous people rank 103rd in the global table of health status, compared with non-Indigenous Australians who are ranked 4th or 5th. Australia’s Aboriginal and Torres Strait Islander people have a life expectancy 13-17 years less than that of non-Indigenous Australians.

A paper published last year in the UK, Fair Society Healthy Lives by Michael Marmot, noted an improvement in life expectancy for everyone; however, within lower socioeconomic groups health overall was poorer than average because of persisting social and economic inequalities.

At the Perth Conference there was discussion of such questions as: “What is the point of living longer if health is poor?” and “If you have no prospects in life, what is the point of being healthy?” These are global issues.

The story of the lost emu, represented in a film made through the work of the Western Desert Kidney Project, touched my soul. It was an incredible film made through sand animation by the children, in which one strong little emu encouraged his whole family to be healthy by giving up a poor diet of junk food. To me this poses a message for the world in the battles against obesity and diabetes – it takes just one step to make a difference and we must walk in each other’s shoes before deciding solutions.

Another highlight for me was ‘speed dating’. It was with some trepidation that I booked up for this session, not exactly sure what I was in for. I now consider it to be an ingenious idea that proved to be networking at its best, sharing a few moments with the people “making the difference”. One of my speed dates was James Fitzpatrick, a true humanitarian and visionary leader with incredible energy and passion and whose achievements are stellar. I was also fortunate also to have had a brief encounter with Sam Prince - another outstanding leader and successful business entrepreneur and doctor who is working to eradicate scabies.

This conference has energised me to look “outside the box...

Due to these networking escapades I missed a key lecture on “midwifery and medical students working together in rural communities”, a passion of my own. When doctors and midwives collaborate closely, the art and science of childbirth can be truly realised.

The only thing I’d want to change for the next Conference is to have a little more debate on childbirth issues.

This conference has energised me to look “outside the box” and keep going in my own small way with my own embryonic “Jentle Childbirth Foundation” which was started by women who were passionate in campaigning for better childbirth.

With wonderful memories of Perth and my footprints in the sand alongside the Indian Ocean, I hope our pathways can remain linked and I look forward to attending the 13th National Rural Health Conference in Adelaide in 2013.

Delegates listen to Tom Calma during a plenary session.

1 Western Desert Kidney Health Project http://www.youtube.com/watch?v=clzA5PNHNg

2 Jentle Childbirth Foundation www.jentlechildbirth.org.uk
Travel and cost are major barriers to care

A report published by the Bureau of Health Information has confirmed that travel and cost are important barriers to healthcare in NSW.

Healthcare in Focus: how NSW compares internationally is the Bureau’s first annual performance report, and compares NSW with the rest of Australia and 10 other countries, using almost 90 measures of performance.

It showed that almost one in 10 NSW adults (9 per cent) said there was a time in the previous year when they did not visit the doctor because of travel difficulties.

More than one in 10 adults said concerns about cost created a barrier to accessing healthcare – discouraging them from seeing a doctor (14 per cent), from having a recommended test, treatment or follow up (15 per cent), or from filling or fully following a prescription (13 per cent).

Generally, adults from NSW were more likely to report cost as a barrier to healthcare than those from any other surveyed country except the United States.

Relying on data mainly from the Commonwealth Fund International Health Policy Survey and the OECD, the report showed a dramatic 47 per cent drop in deaths from ischaemic heart disease and a 37 per cent drop in deaths from stroke over the past decade, placing NSW alongside the Netherlands and Norway in leading the way on cardiovascular health gains.

Nevertheless, people living in rural NSW continue to have a lower life expectancy than those living in cities. For 2002-2006, life expectancy at birth showed a clear relationship with rurality, decreasing as levels of remoteness increased.

In 2010, six in 10 people across NSW said that the last time they were sick or needed medical attention they were able to get an appointment to see a doctor or nurse on the same day (43 per cent) or the next day (20 per cent).

People living in very remote areas of NSW were 2.3 times more likely to have a preventable hospitalisation than the residents of major cities.

However, less than half those who needed after hours care in NSW on evenings, weekends and holidays said it was either very easy (14 per cent) or somewhat easy (23 per cent) to access medical care without going to the emergency department. The proportion who reported after-hours access difficulties was higher than in almost all other countries surveyed.

People living in very remote areas of NSW were 2.3 times more likely to have a preventable hospitalisation than the residents of major cities.

In 2006-07 Aboriginal people in the State had an age-adjusted hospitalisation rate around 1.6 times the rate for non-Aboriginal people. And when compared to the rest of the population, Aboriginal women are less likely to receive antenatal care in the first 14 weeks of their pregnancy, and are more likely to smoke during pregnancy and to have low birth weight and premature babies.

The Bureau’s report found that in 2010, surveyed adults in NSW and in the rest of Australia were positive about the care they received but said change was needed to make the healthcare system work better.

Bureau Chief Executive, Dr Diane Watson, said the report showed NSW did well by international standards but should seize opportunities to improve healthcare.

“NSW also gets value for its health dollar,” Dr Watson said. “Higher health spending does not necessarily mean better healthcare. There are some countries that spend much more than NSW and have worse health outcomes.”

Kellie Bisset
Senior Communications Officer, Bureau of Health Information

The Bureau is an independent, board-governed statutory health corporation established in response to the Garling Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. The reports can be downloaded from the Bureau website www.bhi.nsw.gov.au
Students set sights on healthy change for rural Australia

Students are the future of rural health ... that’s why the National Rural Health Students’ Network (NRHSN) exists.

Since 1996, the NRHSN has been bringing together people studying nursing, allied health and medicine – with the aim of encouraging them to pursue careers in the bush.

It is Australia’s only multi-disciplinary student health organisation, reflecting the nature of health work in rural areas where teamwork is a necessity. As a result, many of the network’s activities have a multi-disciplinary focus to better equip members for life in the field once they graduate.

The network spans 29 university Rural Health Clubs from Hobart to Broome, representing more than 9,000 members.

In 2011, a new executive team has taken the reins for what promises to be a busy year of networking, professional development and promotional activities.

Student leaders Francesca Garnett, Jacinta O’Neill and Catherine Ryan have been joined by Executive Officer Helen Murray, the Director of Future Workforce Programs at Rural Health Workforce Australia.

Each of the students brings a particular strength and focus to the NRHSN. Francesca, the daughter of two Ballarat-based psychologists, is studying medicine at the University of New South Wales and has a passion for Indigenous health.

Catherine, a former jillaroo, wants to round up more nurses for careers in the bush. Raised in Baynton, Victoria, she is a second year nursing student.

Jacinta, a former PE teacher, is keen to drive the rural high school visits program as a way of inspiring secondary students to consider tertiary studies in health. An active patrol member of the Torquay Surf Life Saving Club, she is studying medicine at Deakin University.

Together they are building a jam-packed calendar that includes the National Rural Leadership Development Seminar in partnership with the Australian Medical Students’ Association, club participation in high school visits and Indigenous festivals, and professional development opportunities such as mental health first aid.

The clubs will again be running events, such as Rural Appreciation Weekends at country properties, which engage city students in rural life. The clubs also provide a social base for rural students moving to the city for study.

At a practical level, the network continues to support rural career pathways with conference funding, scholarship information and publications. It also advocates on behalf of health students, presenting the case for more rural placements and improved training and accommodation support.

The network remains committed to Closing the Gap on Indigenous health and partners with Indigenous festivals to deliver programs on healthy eating, diabetes and general wellness.

Another core activity is the Rural High School Visits program, where club members speak to young students about healthy habits and the career opportunities that exist in health. In 2009, 400 Rural Health Club members volunteered for this program and 300 schools were visited.

The importance of rural high school visits is underlined by research showing that students from rural backgrounds are more likely to return to their home communities to live and work when they finish their studies.

Intertwined with the above, the new executive has also set itself three key goals for 2011:

• increasing membership and involvement among allied health and nursing students;

• promoting greater collaboration between clubs; and

• encouraging continuity of activity through the club and executive handover process.

Assistance and mentoring will be provided by RHWA’s Helen Murray, who has extensive experience in advocacy, business management and policy development in the agribusiness sector.

The NRHSN is managed by RHWA with funding from the Federal Department of Health and Ageing.

Kerryn Eccleston
National Rural Health Students’ Network

2011 Student Executive Team - Francesca Garnett, Jacinta O’Neill and Catherine Ryan.
A new media opportunity for rural and remote health

What rural and remote health issues would you or your community like investigated by experienced journalists?

Communities now have the opportunity to commission and help support public interest journalism, thanks to the recent launch of YouCommNews (www.youcommnews.com), a non-profit, people-powered news site run as part of the Public Interest Journalism Foundation (PIJ Foundation) based at Swinburne University of Technology, Melbourne.

YouCommNews uses the internet to crowd-source ideas and resources for high quality, community-driven journalism. YouCommNews help members of the public to commission the stories they want investigated. Story ideas are 'pitched' on the site and anyone can then pledge funds to support the projects. The resulting stories are made available for publication in mainstream, independent and online media through a Creative Commons license.

Melissa Sweet, a health journalist who is Secretary of the Public Interest Journalism Foundation, says there were many issues raised at the recent National Rural Health Conference in Perth that could be pitched to YouCommNews. “I’d love to see a pitch for an investigation into the impact of coal seam gas extraction on the health of rural communities,” Melissa said.

For example, an article entitled Is the AMA’s power over policy healthy? (http://youcommnews.com/tips/26-is-the-ama-s-power-over-policy-healthy) which looks at the extent of the AMA’s power over public health policy, was pitched by Professor Lesley Barclay, Director of the Northern Rivers University Department of Rural Health.

Is there an issue you feel hasn’t been investigated, or a story which needs to be told? Suggest, support or start a Story at www.youcommnews.com. Contact Tara Peck, the Foundation’s project officer, for more information: tpeck@swin.edu.au

Working life and mental illness: what’s your experience?

SANE Australia, the national mental health charity, is currently conducting an on-line research survey on working life and mental illness. They want to hear about the experiences of people who are in work and who live with a mental illness (and from their carers). They are looking for information about the challenges people face, the type of support that has helped, and the type of support that would help to keep them employed.

About 45 per cent of Australians experience a mental illness in their lifetime and for these people finding and keeping a job can be a major challenge. It can also be an issue for family members and other carers who also need workplace flexibility and support from time to time.

This short survey will help SANE to better understand this issue to assist their campaign for improved workplace education and the development of training and support services.

The short questionnaire can be accessed by clicking on www.sane.org or by contacting the SANE Helpline on 1800 18 SANE (7263). All respondents remain anonymous.

James Fitzpatrick – new adventure

James Fitzpatrick and a team of fellow outback enthusiasts are hitting the bush tracks of the Gibb River road on mountain bikes for five gruelling days to raise money for police legacy.

The 770km ride from Derby to Kununurra in the remote Kimberley region of WA begins on May 7. It is part of the 2011 Gibb River Road Mountain bike challenge that has been organised to raise money for police legacy. In addition, James and his team will be raising money for two charities that support outback communities:

True Blue Dreaming, an Outback Youth Mentoring program that provides inspirational mentors to young people in outback towns; and

Eyeballs (The Lions Eye institute), raising money to provide ophthalmology services to remote communities.

To support these charities please go to:


The donation process is easy to navigate. All donations are tax deductible and a receipt will be provided immediately via email.
Breaking new ground to break the chain

One in two Indigenous Australians smoke and one in five die from diseases related to smoking. For Aboriginal people, smoking is the number one cause of chronic conditions and diseases such as cancer and cardiovascular disease. To help address this situation the government has launched an anti-smoking campaign featuring an Indigenous woman presenting a very personal message aimed at persuading Aboriginal people and Torres Strait Islanders to break the chain and quit smoking. This is the first time an Indigenous-specific television commercial has been used in a national health campaign. It has been welcomed by Dr Tom Calma, National Coordinator, Tackling Indigenous Smoking, for the information and support it will provide to help people make informed choices to give up smoking and address unhealthy behaviours.

For help to quit smoking, people should consult their doctor or pharmacist, call the Quitline on 13 78 48 or visit the Quit Now website at www.australia.gov.au/quitnow

Environmental determinants of health

The Australian Institute of Health and Welfare (AIHW) has recently released a compilation of research evidence on how human health can be positively and negatively influenced by the environment.

The report, *Health and the environment: a compilation of evidence*, summarises the findings from many studies relating to 15 selected environmental factors: temperature, walkability, extreme weather events, ultraviolet radiation, indoor and outdoor air quality, water fluoridation, transport, food and water safety, green space, vector populations, environmental noise, housing condition, and overcrowding and hazards in/around the home.

Copies of the report may be ordered through the AIHW website: www.aihw.gov.au/home

Updated Rural and Remote Health Papers DVD

Individual and organisational members of *friends* will receive a copy of the updated DVD ‘Rural and Remote Health Papers 1991–2011’ shortly. The DVD is a valuable resource on rural, regional and remote health and the 2011 update includes all proceedings from the 11th National Rural Health Conference.

The DVD includes:
- full proceedings of all 11 National Rural Health Conferences;
- full proceedings of the Infront Outback Rural Health Scientific Conferences;
- PARTYline newsletters;
- the Alliance’s Annual Reports; and
- other Alliance position papers, policy documents and submissions.

If you are not already a member and would like a copy of the DVD, contact James Easterbrook, Manager of *friends* of the Alliance, on (02) 6285 4660 or email friends@ruralhealth.org.au

New Indigenous health resources

Australian Indigenous Health Infonet advise that the following resources are now available.


Digital storytelling release

*In my own words* uses a variety of presentation styles – text, still images, narration, poetry, song and film – to describe the experience of four people living with mental illness. Participants share their stories about bipolar disorder, depression, psychosis and schizophrenia.

Each disc comes in a double pack with a CD Rom of *Well Ways* information fact sheets about mental health from the Mental Health Coalition of South Australia. Packs are available for $5 each or $4 for orders of 20 and more. Contact tracey.davis@mhcsa.org.au or Ph 8212 8873.
Conference photographic winners

The winner of the photo competition was Irene Mills, a West Australian friend. The photo shows her dog Haley with the wind in her face and loving it. Second place went to Stewart Roper with his shot of Pitjantjatjara children at Victory Well rockhole in the Everards, in the far northwest of South Australia. All of the short-listed entries in the poetry and photographic competitions are available on the friends page of the Alliance website.

friends Advisory Committee election

The biennial election for State and Territory representatives to the friends Advisory Committee will be held in May 2011.

We are seeking nominations from financial members of friends in all States and Territories to hold office for a two-year period. There are two positions available for each State and Territory. friends Advisory Committee Terms of Reference and Position Descriptions are available on request.

Further information about the friends Advisory Committee is available on the friends page of the Alliance website: www.ruralhealth.org.au

If you are interested, please contact the friends manager James Easterbrook on (02) 6285 4660 or email friends@ruralhealth.org.au to request a nomination form. Nominations close Friday 20 May 2011.

The friends Advisory Committee swapped their usual teleconference meetings for a face-to-face breakfast meeting at the 11th Conference.

Attention Rural Specialists!

Are you looking for Continuing Professional Development opportunities?

www.ruralspecialist.org.au

RHCE Stream One provides education opportunities that support continuing professional development (CPD) for specialists in rural and remote locations in Australia

RHCE Stream One supports rural specialists in the following ways:

- Individual CPD participation grants; and
- Grants for CPD projects that promote multi-disciplinary based learning and help to build vocational support.

To find out more
Please visit the RHCE Stream One website www.ruralspecialist.org.au and subscribe to the RHCE eNewsletter.
The winner of the poetry competition was Fred Miegel from the Northern Territory with his poem ‘No straps to secure her’. The runner up was James Fitzpatrick with his poem ‘A breeze flowing strong in the Country’.

**No straps to secure her**

I loaded an old lady into a troopy today  
A mattress on its floor, not legal I’m sure  
A four hour trip back to her bit of land  
A joy for her, if the trip she could stand

No straps to secure her only on top for supplies  
The three blokes who helped me gentle and tender  
An old woman off bush to die in her sand  
Family around her, touching her hands

Her daughter a fighter with a handicap in life  
Her daughter-in-law, come from far to help  
A granddaughter walking two worlds with her mum  
They made the journey to take lady home

A battered troopy along bitumen and dirt  
The dust in the back smelt of home to them all  
One off to her fate, but with love and support  
Bumping along with love and concern

Back home for this lady, back in the bush  
Just breathing now, comfort and love  
No tubes to extend what was on the cards now  
Family to soothe an oft furrowed brow

Bush medicine and healers helping with passing  
Nurses from clinic checking in when can  
Family can do this, honour a matriarch  
Rubbing and blowing and grinding of bark

True to her country, true to her family  
Last breaths in country, spirit released  
Following her people on up ahead  
Home in her dreaming, no longer dread

I honour this family for staying true  
Call from the clinic letting me know  
Family had done it, help though she was weak  
I loaded an old lady into a troopy earlier this week

Fred Miegel