PARTYline

newsletter of friends of the Alliance
Number 1 March 1999

"Kulini, kulini" (listen, understand)

friends of the Alliance was conceived several years ago, but only in the last eighteen months has the concept grown and been developed. Our typing may look askew, but *friends* has a small "f" to help indicate grass roots involvement in the program, rather than a formality led by heavy-weight associations or by those known as 'the rural health mafia'. **The Alliance has regular contact with nearly 2,000 people through distribution of information** by phone, mail, fax and email. *friends* is intended to make this more of a two way process, by using information from the field to influence the direction of policy or research.

John Lawrence

In my lifetime I don't think rural and remote health issues have ever had a greater political profile than at present. *friends* is intended to build on this exposure and have a real impact on decisions that affect those living in rural and remote areas. I am still involved with the consequences of the drought and then the floods and storms in East Gippsland last year. The impact will be felt for many years. Some people will leave the area, others already have, and some will soldier on in the face of extreme adversity. Some small rural communities may fail as will many businesses, and some relationships.

Farming practices will change, the environment may continue to be compromised, and problems such as gaming and youth unemployment will need new approaches. Too many decisions on transport, telecommunications, hospitals and schools will be made with city life in mind, even though governments say they are listening to rural people.

friends will be another voice for rural people – many of whom feel that 'enough is enough', and that they are every bit as deserving as their urban cousins. We all want it to be known that working in the bush is not second rate. We want city people and governments to listen to us, consider the evidence and make decisions that improve the lifestyle of those in the bush. We want to be sure that they don't make decisions that challenge the very nature of our existence. The bush has a beauty, a camaraderie, a history, a spirituality and a stoicism that must be continued, not in legend, but in the real life equity of health outcomes.

John Lawrence Chair, NRHA Council ❖

Dear friends

I am honoured to have been asked to make a few remarks on the introduction of this new 'branch' of the National Rural Health Alliance.

Some of those associated with the Alliance have thought for years that it would be valuable to involve more people in its activities. My time on Council was extremely rewarding and fulfilling. The Alliance is very different from many other organisations – it has become a positive and friendly body, despite what some believed about putting a large mob of health professionals and consumers together to make decisions about rural and remote health!

The success of the Alliance shows that these fears were unfounded. It is now widely called upon for comments, appraisals and recommendations for improvements in all avenues in the rural and remote health arena. *friends of the Alliance* should be proud of this – it is one of the main reasons that *friends* was formed.

The present Council has kept this tradition alive and *friends* has been established to continue and extend the work begun by others. **Your active participation and involvement will ensure that the high esteem in which the Alliance is held, is even increased.**

I thank all the members of the Interim *friends* Advisory Committee for their hard and diligent work over the past year and may I say it has been an honour to be their Chair for that period. I look forward to many happy years as a *friend*.

John Ward

Chair - Interim *friends* Advisory Committee ❖

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friends wishes to acknowledge the valued support of the following FOUNDING MEMBERS who have assisted considerably as friends during our formative period.

Ailsa Bond	Launceston
Michael Bishop	Toowoomba
Steve Clark	Townsville
Leanne Coleman	Queanbeyan
Bruce Chater	Theodore
Bruce Cullen	Kaleen
Elaine Duffy	Traralgon
Gordon Gregory	Hughes
Margaret Hansford	Balmain
Desley Hegney	Toowoomba
Bill Humes	Yarralumla
John Kerin	Garran
John Lawrence	Lakes Entrance
Joan Lipscombe	Campbell
Jenny McLellan	Brewarrina
Patrick Mahony	Manilla
Kris Malko-Nyhan	Palmwoods
Dennis Pashen	Mt Isa
David Petty	Curtin
Anita Phillips	Higgins
Mandy Pusmucans	Lakes Entrance
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Christine Simpson	Walgett
Margaret Smith	Wallendbeen
Fiona Tito	Wanniassa
Maria Vincent	Nichols
Storry Walton	Ryde
Chris Ward	Bathurst
John Ward	Bathurst

Partyline is the Newsletter of *friends of the Alliance*, a network of people and organisations working to improve health and well-being in rural and remote Australia by supporting the National Rural Health Alliance.

The Editorial Group for this issue of **Partyline** was Mandy Pusmucans, Shanthi Ramanathan, Storry Walton, Gordon Gregory and Anita Phillips. **Partyline** will be distributed free to all members. Articles, letters to the editor, and any other contributions are very welcome. Please send these to:

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The opinions expressed in **Partyline** are those of contributors and not necessarily of the National Rural Health Alliance, or its individual Member Bodies.

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The Acronym Puzzle

(Storry Walton, *friend*)

At first glance the Member Bodies of the National Rural Health Alliance (NRHA) are bewildering – such long titles, so many acronyms, so many members. Acronyms, or the insistence on them, are a recent arrival in the English language. ANZAC was one of the first. Strictly speaking, an acronym should be a word in itself, or at least sound like a word. Otherwise all you have are initials, or a rubric.

Care must be taken when choosing an organisational name. When radio was added to the Australian Film and Television School, it was nearly named the **F**ilm **A**nd **R**adio **T**elevision **S**chool. *friends* may be interested to know that thought was given to naming the NRHA the **N**ational **U**nion of **T**hink **T**anks for **E**very **R**ural **S**ervice, until someone woke up.

To help *friends* cope with the acronym puzzle, we have provided below our **C**oncise **L**ist of **A**cronyms, **R**ubrics and **I**nitials for the **F**irst **Y**ear. *friends* may be also intrigued to know that all the acronyms of Member Bodies of the NRHA are, in fact, proper words, deriving from a little remembered early bush dialect. This is well illustrated below in the ballad by the deservedly little known bush versifier of the early nineteenth century, *Barman Soake*.

The Pretty Crook Stockrider

Ah! The sounds of the ranges and all the broad *achas*
Bring tears to my eyes as I wait the grim *rpa*,
For I'm *atsic* at heart; I've drunk all from life's *aarn*,
And my ship's lost its *rdaa*, (much use it was here).

Oh the *cwaa* of the crow and the *acrrm*'s sweet trill,
And the ring of the *achse* on the ironbark hill,
And the cries of the *narhtu* – "narhtu work, narhtu bed",
And the swamp *crana*'s splash and the hot *naccho*'s scream.

Hark! deep in the scrub where the shy *icpa* are
Marsupial *arrahts* sing *sarrah* que sarrah
While *ahas*, red *rfds* and the tiny green *anfs*
Sing glorious anthems to wing me to rest.

And here as I lie with my billy and bong
I'm ready to go with a smile and a song
To the Claypan on high and the Mystery where
I'll surrender my soul to the Great *Rf of Racgp*

For I've seen earth's horizons, these visions of splendour;
Ridden through the mirage to the promise beyond
Where I've fed on the *hcrra* dew at the moon's rise
And drunk the sweet *nrhn* of the bush paradise.

ACHA	Rural Interest Group of the Australian Community Health Association
RPA	Rural Pharmacists Australia – Rural Interest Group of the PGA & PSA
ATSIC	Aboriginal and Torres Strait Islander Commission
AARN	Association for Australian Rural Nurses
RDAA	Rural Doctors Association of Australia
CWAA	Country Womens Association of Australia
ACRRM	Australian College of Rural and Remote Medicine
ACHSE	Australian College of Health Service Executives
NARHTU	National Association of Rural Health Training Units
CRANA	Council of Remote Area Nurses of Australia
NACCHO	National Aboriginal Community Controlled Health Organisation
ICPA	Isolated Children's Parents' Association.
ARRAHT	Australian Rural and Remote Allied Health Taskforce of the HPCA
SARRAH	Services for Australian Rural and Remote Allied Health
AHA	Australian Healthcare Association
RFDS	Royal Flying Doctor Service
ANF	Australian Nursing Federation (Rural Members)
RF of RACGP	Rural Faculty of the Royal Australian College of General Practioners
HCRRA	Health Consumers of Rural and Remote Australia
NRHN	National Rural Health Network ❖

featuring

Two Member Bodies of the National Rural Health Alliance (NRHA)

Isolated Children's Parents' Association of Australia Inc. ICPA (AUST)

ICPA has two urgent concerns on its hands at present. It is negotiating with government so that isolated families will be able to give their children better access to tertiary education, and to quality communication services for phone, fax and internet, to support their education.

"I'm looking forward to meeting Ministers" says President Jenny McLellan. "I think the government is sympathetic and we have a long record of fair and successful negotiation for the education of our children."

3000 Families

ICPA was born in 1971 at Bourke NSW when parents rallied after the closure of the school hostel. Today ICPA is an influential national body of some 3000 families with very broad interests. ICPA represents all systems of education – public, private and denominational. It covers all stages of education – pre-school, primary, secondary and tertiary; and among its member families are pastoralists, miners, local government employees, fisherfolk, business people, and itinerant show folk.

Goal

ICPA's goal is to achieve equality of access to educational opportunities for isolated children – including cultural experiences, social contacts, participation in sport and other activities which enrich young lives.

Benefits of Tertiary Education

Remote and rural areas have the lowest participation rate in tertiary education in Australia. "Apart from achieving their right to opportunities for tertiary education, there is another benefit when more outback kids get higher education," says Jenny McLellan "There's a reasonable chance that bush-bred kids will return to practise in rural and remote areas – where they are badly needed – as doctors, allied health professionals, lawyers, and so on."

Capital rich, cash poor

ICPA's main concern is to have the criteria of the assets test for the Youth Allowance varied so that many more bush families can qualify for assistance – the expensive business of higher education is most often conducted in distant towns and cities. "We've made it clear we are not against the means test" says Jenny, "But many country families are cashed out after putting their kids through secondary education. The Youth Allowance Means Test includes farm capital, which knocks them out of the running. Capital rich, cash poor. Farm capital is just the tools of trade – like a surgeon's hands – but two surgeon's hands are not assessable criteria."

Digital Communications

As for communication, ICPA is arguing strongly (along with other Member Bodies of the Alliance) that remote and rural Australians must be treated equally with city Australians as the analogue system quickly gives way to the digital. "Our kids who are being educated at home or in regional towns need equal access to quality phone, fax and internet services".

Action!

Action is being taken! On the 6th – 10th March 1999 the Federal Council of ICPA meets in Canberra with Ministers and government officers to discuss these concerns.

Contact: Mrs Jenny McLellan
President ICPA
"Waratah"
BREWARRINA NSW 2839

Services for Australian Rural and Remote Allied Health (SARRAH)

One of the great contributions which SARRAH makes to the network of the Alliance is the extraordinary diversity of its membership. It includes audiologists, dietitians, nutritionists, social workers, psychologists, physiotherapists, speech pathologists, occupational therapists, podiatrists, radiographers, optometrists and others. The most obvious common problem of so many professional disciplines is of course the isolation. President, Kathryn Fitzgerald of Geraldton WA, explains further – "Our rural and remote members are often sole practitioners – professional isolation within geographic isolation, and many these days are recent graduates, who need support, orientation and further training and education, all harder to access in the bush than in town".

Purpose

SARRAH's overall purpose is to develop services to help its members in their professional practice and help them achieve the best possible health outcomes in the communities they serve. Although a young organisation, it has already set up networks for sole practitioners across all States and the Territory, initiated newsletters and conferences, and with RHSET funding is undertaking research into education and training needs of allied health professionals in rural and remote areas. SARRAH also seeks to co-ordinate and voice the political views of its membership – and encourage national standards of competence.

Current Issues

Two issues which SARRAH is actively pursuing are the recruitment to and retention in the bush of allied health professionals, and the development of relevant education and training. "You only need to glance at the professional disciplines in allied health to see how inequitable it is for bush people to be denied their services". SARRAH aims to achieve support at all levels of government. "It is critical that programs, to ensure the recruitment and retention of allied health professionals in country areas, are established".

'Rural Ready'

SARRAH believes there are significant opportunities for programs within the newly established University Departments of Rural Health. "It's about making graduates rural-ready, and ensuring that practitioners have access to relevant on-going education" says Kathryn.

Sole Practice

Within the many allied health course curricula, SARRAH would like to see new skills and awareness based units which will better prepare graduates for sole practice. Sole practitioners are expected to acquire a wide range of skills to work across various program areas. This requires not only strong clinical expertise, but also in management.

Continued on page 7

contributions from *friends*

To start the ball rolling, we are introducing a long-term friend, Dennis Pashen

Dennis Pashen has been Associate Professor, Director of the Mt Isa Centre for Rural and Remote Health, since August 1997. Dennis was born in Cloncurry and educated in Charters Towers, Alpha, Port Moresby and Brisbane. He graduated from the University of Queensland Medical School in 1973. He completed internship years in Brisbane and Mackay before entering the Family Medicine Program in Ingham, 110kms north of Townsville, where he spent the next 20 years in rural general practice.

"When I first heard about the concept of a University Department of Rural and Remote Health (UDRRH), I was a member of the local Regional Health Authority responsible for the North and West of Queensland. I was completing my Masters Degree in Public Health, a task my daughter attributed to a mid-life crisis much less fun than other less cerebral pursuits in which many males in their forty-somethings indulge. I also was involved with the Northern Queensland Rural Division of General Practice, so I was interested in ways to deal with health issues in this region. For many years the historical imperative had left the north and west largely ignored. The falling prices in minerals, beef and other primary industries had led to a number of "recession-producing" decisions. The first issue to impact upon me was the lack of health providers, medical practitioners especially, but also the high turnover rates in all staff."

"In 1995, I heard Dr Jack Best address a meeting at the Anton Brienl Centre for Public Health and Tropical Medicine, in Townsville. He described the setting up of a Rural Health Training Unit in Broken Hill, and then a University Department of General Practice that had evolved from a mixture of red wine, pizza, Jack Best, Sue Morey, Michael Wooldridge and Carlton, the suburb not the beer, but may in fact have involved that as well. Which only goes to prove that red wine not only reduces cholesterol but pizza stimulates great ideas! The Italians have always been ahead of the Anglo-Saxons in their understanding of this.

Dennis Pashen

The parallels between Broken Hill and Mt Isa were immediately apparent to Jack and myself, even without the influence of red wine. Apart from the prevailing winds dictating the siting of the mines downwind of the town and the historical precedence of Broken Hill, there was little difference between the two centres, although the model eventually employed for developing the Mt Isa UDRRH was slightly different (it is often stated that everything in Queensland is different)."

"The Mt Isa Centre focus has evolved over the past 18 months. The focus is very much upon Community Ownership and the relationship with rural and remote communities, whether under the guise of community development, capacity building, or whatever is the current vogue term for the process of talking to people in rural towns. Community ownership doesn't mean 28 bureaucrats in a room in a metropolitan or provincial centre, with token community and indigenous representation. It is basic stuff. Talking to people within rural and remote communities on their level, in their environment, understanding their perspective and discussing the options that they may explore. This is a time consuming process that can't be rushed. But we have seen the failure of rapid externally imposed processes, disguised as community consultation, which have had little or no attributable positive and sustainable impact on the health of rural and remote people over the past 30 years. The relationship and support of the community for health providers cannot be ignored if there is to be redress of the current health inequities. If the figures for rural health providers are to continue to improve, and the latest statistics for rural doctor numbers have shown a reversal in the decline of the past 30 years, then new ideas and models of care need to be developed. How does the old saying go? "*Give a man a fish and he'll have a meal. Teach him how to fish and he'll need a deodorant forever*". I'm not sure that's exactly how it goes, but we shouldn't underestimate the strength of rural and remote communities.

I have driven 10,000 kilometres through outback Australia over the past 4 months and have been struck by the revitalized communities I have visited. The new paint upon the buildings, the resurgence of promotion of the history of the towns, the obvious pride in their communities.
If this drive and spirit is transferred to health, if the vested interests are brought on side and incorporated into the process, then I feel that we have every reason to be optimistic". ❖

friends out there!

In future issues of Partyline, we hope to be able to print lots of letters and other contributions from *friends*. Help to make this your page!!

We welcome articles, reports of events, comments and lots of photos. Remember that the aim of *friends* is to provide a network of people and organisations working to improve health and well-being in rural and remote Australia. The Newsletter is a critical vehicle in facilitating this communication. It is very important that we hear from you out there, and that *friends* are able to use this as a medium to talk to each other.

In future issues, this page will have a column of issues/ideas/comments to assist you in networking, and in identifying common and relevant issues. This may lead to action in solving or otherwise dealing with such concerns. This can only work if we hear from YOU!!

Drop a line to:
PO Box 280, Deakin West ACT 2600;
or fax to: (02) 6285 4670;
or Email us at: friends@ruralhealth.com.au

Anita Phillips
Manager, *friends* ❖

‘Geographic Provider Numbers’ – Defined and Discussed

‘Geographic Provider Numbers’ for doctors have been in the news again lately. They are considered by some to be the answer to the shortage of GPs in rural and remote areas. Parts of an information paper produced by staff of the Alliance are reprinted here. This is an important and complex issue and we would appreciate your views on it.

Extracts from Alliance Information Paper

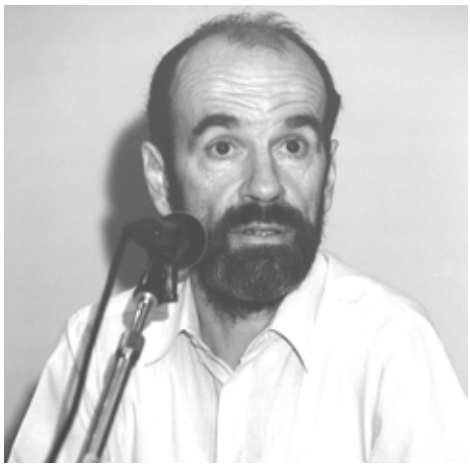
“The idea of restricting Provider Numbers was supported in a paper prepared by Dr Bob Birrell in 1998 for the NSW Farmers’ Association. Unless greater reliance is placed on recruiting Temporary Visa Doctors to fill the gaps in rural practice, the only alternative, Birrell argues, is “to restrict the allocation of rights to bill on Medicare in metropolitan areas which are clearly ‘over-doctored’. (Furthermore), while the under-servicing of rural areas continues, the Government could refuse to allocate Medicare billing rights to newly accredited GPs unless they practise for a time in under-serviced areas.” (**Birrell** 1998)

Dr Wooldridge has to date indicated the Government’s opposition to the geographic restriction of Medicare PNs. However some in the National Party favour the idea as do the Australian Democrats. The Democrats argue that the idea could be implemented without real fear of a ‘conscription’ tag if the regulations determined areas in which no additional GPs would receive a Number, as distinct from fixing areas to which they would be allocated. Others have observed that such a scheme would have budgetary appeal to the government as a means of containing overall health costs.

The recent report on ***Medical Workforce Supply & Demand in Australia*** pointed out that the GP workforce in capital cities “moved from a position of over-supply in 1985 to far greater over-supply in 1997” with the number of GPs increasing from 7039 FTE (1984-85) to 11,383 FTE (1996-97).

> “Because the (Medicare) rebate prevents the price falling further with increasing workforce supply, and because volume of services can be expanded by both patients and suppliers at zero cost to the patient, supplier incomes can be maintained in an over-supplied workforce.” (**AMWAC** 1998:8 p. 5)

Despite this analysis the report did not support the option of geographic restrictions.



Gordon Gregory

Some of the arguments put forward in support of the geographic restriction of Medicare Provider Numbers are highly emotive. For example, it has been suggested that because doctors are “living off the taxpayer through Medicare”, they should go “where they are needed – the bush”.

The assertion that there is only one solution to the rural doctor shortage and that that is to “allocate more Medicare Provider Numbers to the bush” is not only simplistic, but presents a misleading representation of the issue. Medicare Provider Numbers are not allocated to a location but to a doctor in a particular location. Simply restricting access to Numbers will not address the significant disincentives perceived by many GPs and new graduates to be inherent in rural practice, when they have access to other medical work eg. in hospitals. Integrated policies, which embrace a combination of short, medium and long term strategies, are required to address the chronic shortage of rural GPs.

By the same token, some of the arguments from the medical profession have also been emotive, with claims that the geographic restriction of Medicare Provider Numbers is a form of “conscription”, or “unconstitutional”.
As pointed out by Dr Wooldridge, there is nothing to stop State Governments, through their Medical Registration Boards, limiting the registration of new doctors to particular geographical or regional areas.

The geographic restriction of PNs could produce a number of unintended consequences that would not be in the best interest of rural medical practice or rural communities. According to the Rural Doctors’ Association of Australia (RDAA), these include the possible exodus through early retirement of current rural GPs who do not want to work with inexperienced recruits; the loss of medical graduates overseas to avoid going to rural areas; the loss of interest in General Practice as a specialty by medical graduates; the placement of doctors in rural areas who are not adequately trained and supervised; increased difficulties attracting locums and greater levels of dissatisfaction by doctors which have adverse implications for health consumers. How doctors would actually respond would be determined by a range of professional, family and business factors.

Other strategies to complement current initiatives and improve the image and status of rural practice also need to be considered. Logic suggests that, if geographic Provider Numbers did become a reality, those schemes designed to give incentives to rural practice over city practice would work better assuming that many doctors still preferred family practice over salaried work.

There is the potential for real benefits to flow on to rural general practice from the review of current Medicare items and schedule fees paid to GPs and specialists by the Medicare Schedule Review Task Force. The new item structure it proposes aims to address many of the perverse incentives that exist in the current Medicare schedule which benefit “high volume low intensity” practices in metropolitan areas.

Other options that require further consideration include:

- differential Medicare rebates;
- salaried GP positions in rural and remote locations eg Multi Purpose Services;
- a clear definition of geographic ‘area of need’ that ensures Temporary Visa Doctors with temporary visa, registration and Provider Numbers remain in under-serviced rural areas and cannot be poached by other health administrations; and
- specific incentives to attract more women GPs to rural and remote locations.

Patrick Mahony lives in Manilla NSW and presides over 140 members of **the Remote and Isolated Pharmacists Association of Australia** Inc. (RIPAA)

Patrick spends about half a day a week on RIPAA business and a day a week on Pharmacy Board of N.S.W. work. Community service is in his blood. His great grandfather, grandparents and parents all did civic and charitable service. But why does he do so much? "To be the pharmacist in a country town is an important responsibility – and an enjoyable life" says Patrick. "But you can easily sit back and let the world go by. I've seen the national picture in the bush and I know there's a lot to be done for rural pharmacists".

RIPAA, in line with other organisations representing health professionals, is also concerned about succession viability, (recruitment and retention of staff). "We want to show that although the value of a rural practice might be less than a suburban one, there are great lifestyle and professional compensations in the bush. For instance, most people don't realise how much professional innovation comes out of bush practices. It's a fact". Patrick can cite many instances, including Colin Trevena's computerised patient profile system that came out of Boorowa. (**Partyline** challenges *friends* to locate it for themselves!). Patrick says "Rural practice is not backward practice".

Contact Patrick via the RIPAA Secretariat Email at nrha@ruralhealth.com.au ❖

ICPA delegation meeting the Minister. Left to right. Jenny McLellan (Federal President), Senator the Honourable Richard Alston, Jenny Sheaffe (Federal Publicity Officer)

For **Merle Fullarton**, the worst part of her early struggle with Chronic Fatigue Syndrome (Myalgic Encephalopathy, or ME), was the belief she was the only one suffering from it. In Lismore NSW where she lives, no-one seemed to know about it. But when she put an ad in the local paper in 1986 twelve people responded immediately.

Now Merle presides over the **M.E/FMS Country Network Australia**, an organisation of 850 members throughout rural and remote Australia. With miniscule funds and Merle's voluntary effort, it has conducted surveys, run a number of conferences and established an important network of advice and support, for both ME and FMS (Fibromyalgia Syndrome).

Now she is preparing to take part in the world ME awareness week in May 1999 The Network is the representative in Australia of the international body BRAME. "Our network is very important especially at its basic level" says Merle. "When they ring us, people feel they have found a lifeline. Just to talk is good – to know that you're not going crazy."

Contact Merle via the ME/FMS Email at nrmecfs@nrg.com.au ❖

Noela, Sally, Gordon, Pat, Leanne, Colleen from N.R.H.A. National Office

Lesley Siegloff, Mandy Pusmucans, Sue Wade and friends

friends in action

As if **Nan Gurner** isn't busy enough, she's currently looking for new office accommodation before the premises at Shenton Park, Perth are bulldozed. Busy? Nan is president of **Carers' Helpline**, and has recently participated in a Neurological Expo – raising awareness of carer members to the nature of many disorders, and to better understand the people they are caring for. Nan visits country centres regularly to meet carers. It's a tough schedule. Her current itinerary includes Esperance, Carnarvon, Kalgoorlie, Geraldton, Albany, Port Hedland and Newman.

Carers' Helpline has recently initiated a new 'early warning' program – an orientation for younger people to prepare them to be cared for, or to be carer. Nan says, "One of the main elements to come out of our first forum was that carers don't always want to face up to the fact that they are a carer. There is often a 'head-in-the-sand' kind of attitude." Nan says that we all need to know where to go for help if we become carers – and there is help at hand. But she warns "Often help with the physical side is taken care of with home care services such as Silver Chain and other such organisations. However help for the emotional side for carers is harder to find." That's what Carers' Helpline is addressing. Nan thinks that children of school age would be receptive to study of carer/caree roles in units of health curriculum. "After all, children are often already living in a family with a cared for person and carer, and educators should be aware of this as it could often reflect on their behaviours, and capacity to cope with school life in general."

Contact Carers' Helpline via Nan on 08 9381 5541 or Email: nan@highway1.com.au ❖

Mt Isa Centre for Rural and Remote Health students and staff abseilling near Lake Moondarah.

Left to right. Patrick Mahony, John Ward, Sue Wade, Bruce Harris, Margaret Hansford

5th NATIONAL RURAL HEALTH CONFERENCE

14 –17 MARCH 1999

ADELAIDE CONVENTION CENTRE

HIGHLIGHTS

Keynote: Hon. Dr M. Woolridge MP
Launch of Healthy Horizons
International Satellite Hook-up
Speakers: Prof. J. Humphreys, Prof. F. Baum, Prof. G. Andrews,
Dr D. Weller, Ms M Murnane, Mr P Pholeros,
Dr W. Walsh, Ms S. Knight, Mr P Hunter.

Further Details: Phone 02 6285 4660
Email: nrha@ruralhealth.com.au

Come and visit the *friends* Stand at the Trade Show, first on the left, inside Hall.

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Services for Australian Rural and Remote Allied Health (SARRAH)

Co-operative Health

Kathryn says "As a multi-disciplinary organisation, SARRAH has a strong philosophy of health professionals working together as a team. SARRAH is actively pursuing opportunities to work together to the further development of multi-disciplinary solutions for the improved health of rural communities ".

Contact:

Ms Kathryn Fitzgerald
President SARRAH
PO Box 467
GERALDTON WA 6531
Email: fitz@wn.com.au ❖

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'Geographic Provider Numbers' – Defined and Discussed

The *General Practice Strategy Review Group* considered the issue of the geographic restriction of Medicare Provider Numbers and recommended against them in the following terms:

Rec. 30: The Review Group recommends against the introduction of geographic controls on provider numbers, but the majority recommends that the issue and other mechanisms to achieve this intent be further explored through the proposed consultative structure for general practice.

Rec. 31: In the further exploration of geographical provider numbers, that the specific concerns and future career needs of medical students and prospective and current GP registrars be formally recognised."

Gordon Gregory Executive Director N.R.H.A. ❖

New Programs in Rural and Remote Heatlth

So many good programs are happening around rural and remote Australia. Following are snapshots of a few innovations that have been sourced from abstracts of papers submitted to the **5th National Rural Health Conference**. Others have come from nominations for the inaugural achievement awards for innovative rural mental health programs to be awarded at the **7th Rural Mental Health Conference – Crossing the Borders Towards the New Millenium** (hosted by the Greater Murray Area Health Service and Charles Sturt University in NSW) from March 17 – 19, 1999 in Albury.

Paediatric Telepsychiatry Project

Damien Eggleton – Achievement Award Nominee

Macquarie Area Mental Health Services (Dubbo) participated in the Paediatric Telepsychiatry Project funded through NSW Health. This initiative sought to decentralise expertise from metropolitan to rural areas, thus increasing accessibility for those resident in the bush.

Through the Department of Psychological Medicine at the New Children's Hospital in Westmead, consultations are conducted via video conferencing every three weeks. Local mental health personnel in Dubbo attend the consultation and then act as the ongoing liaison. Additionally a medical officer is nominated.

The target population are children and adolescents in the Macquarie area with a disabling mental illness that requires tertiary level support.

The success of this pilot project has demonstrated that Telepsychiatry is a cost effective, efficient and sustainable means of accessing tertiary psychiatric consultations that complement and support rural mental health services.

Rural Carers Project

Cate Bourke – Achievement Award Nominee

The Rural Carers Project assists rural carers and families in Victoria to access services and support available in the mental health system. Through dynamic collaboration with carers and workers in this region the project is implementing a number of initiatives that serve to better meet the needs of rural families and carers. Additionally, there has been employment of peer support workers in the Adult inpatient unit. These initiatives all serve to better meet the needs of rural families and carers.

- The **Carer Network** promotes collaborative working relationships, through ongoing consultation with carers and carer support groups, and enhanced support and advocacy avenues for carers.
- The **Rural Carers Kit** is a resource and education package that shows a partner, family or friend where to get appropriate support and information.
- A **Training module** is part of the Rural Carers Kit that is available to mental health and community services staff, that provides additional support for workers.

The greatest challenge is incorporating the successful aspects of the project into the core practice of workers, so that carers and family needs are addressed as a matter of course and not just as a bonus, when time permits. A time-limited project can be a bit like a blip on a radar, but by incorporating those useful aspects of the project into everyday clinical work, the blip becomes a strong signal that services are meeting a need. In the project team's experience this is the hardest thing to achieve.

To find out more about the 7th Rural Mental Health Conference, contact Kevin Bourke on 02 6023 0110 or email albwodltd@albury.net.au.

Overcoming the 3Ms! Marks! Money! Motivation! How Can More Secondary Students From Rural And Remote Areas Be Encouraged To Choose A Career In Rural And Remote Health Care?

Sandra Heaney *(Abstract of paper for 5th National Rural health Conference)*

This study was designed to seek information from secondary school students about what they consider to be the barriers to pursuing tertiary level health care courses, and to explore their thoughts on possible solutions that might assist in overcoming such barriers.

The survey highlighted the relatively low level of interest shown by rural and remote secondary students, in undertaking careers in health care. It has confirmed previous data regarding the disadvantages, perceived and real, that students experience when considering health care careers. Of the 2205 students surveyed, 308 indicated the health care field as their first career preference.

Students and teaching staff perceive the main barriers to entry into health care careers is the prerequisite Tertiary Education Rating (TER) score, and the lack of financial resources of many families.

Suggestions for overcoming the TER marks barrier included more holistic assessment of students' abilities and aptitude for particular careers, in order to compensate for the possible lower marks rural students are awarded.

To overcome the money barrier, teaching staff posed the notion of some form of bonding scheme, which gives students financial support while studying, with the aim of postgraduate service in a rural or remote area. Students reacted positively to this idea but with some reservations.

The issue of motivation is more difficult to address but increased careers promotion at an earlier stage in secondary school, plus introduction of positive role models, would be encouraging. Parental involvement would be useful. Parents were acknowledged as the most influential in the career choice process. The ability to assure students that marks and money issues will be addressed, will be the greatest incentive and motivator for rural and remote students.

The Development Of A Sustainable Health Service In A Small Rural Community - Every Cloud Has A Silver Lining

Peter Lorraine *(Abstract of paper for 5th National Rural Health Conference)*

In 1998, a new sole nurse practitioner health service model in two small West Australian rural communities was established. These communities had traditional nursing posts with occasional support from visiting medical and other health professionals. The service was threatened in 1997. In addition to declining funding sources, it was becoming increasingly difficult to recruit experienced nurse practitioners to go bush. The communities concerned were passionate about the value of the emergency and acute services provided by their resident nurse, however, still had a fairly high level of dependence on the nurse, and often had unrealistic expectations of the service.

Silver Chain, in consultation with communities, is piloting a new model of service delivery which will focus on primary health care objectives, whilst retaining the acute and emergency response capacity. New technology has been embraced to enhance the service, and will particularly assist in the provision of acute and emergency health services. The model includes significant improvements to infrastructure and employment conditions, as well as better health outcomes for clients.

The goal is a seamless service provision model which can respond along a continuum of care to client needs, and is capable of meeting changing community demands. A case management approach, which links funding to demand, has also been developed for palliative care clients. Nursing staff will have an opportunity to move beyond the traditional boundaries of a "bush nurse".

The outcome is a more responsive and appropriate health service that enjoys a high level of community support, and decreases the risk of "burn out" in nursing staff, and dependency in clients. This model will be much more sustainable in the longer term, as the fiscal environment tightens yet further. The optimism of staff and the two communities involved in the changes to their respective health services has enabled a silver service to evolve from the storm cloud. ❖

New Rural Health Branch in the Federal Department

The Commonwealth Department of Health and Aged Care has identified rural health as a priority outcome in its 1998/99 Corporate Plan. A new Rural Health Branch has been created within the Department's Health Services Division. The Branch, which is headed by Nicholas Blazow, will have responsibility for rural health support, education and training. It will also be responsible for initiatives relating to Regional Health Service Centres and Multipurpose Services. A new function will be responsibility for coordination of Departmental responses on rural health issues generally. ❖

Emphasis on Services for Regional Australia

The new Department of Transport and Regional Services (formerly Transport and Regional Development) incorporates a deliberate shift in the Federal Government's emphasis on "service delivery" for regional and rural Australia.

Both Ministers within the portfolio — Minister for Transport and Regional Services, John Anderson, and the Minister for Regional Services, Territories and Local Government, Ian Macdonald — are keen to ensure rural and regional communities have the services they need and the economic, environmental and social conditions necessary to realise their potential.

The structure of the new Department (announced after last year's Federal election) incorporates programs including:

The **Rural Transaction Centre program** aimed at providing rural Australians with improved access to a range of private and government transaction services including personal banking, post, Medicare Easyclaim, telephone and fax. The Government has committed $70m over five years (from the next Telstra sale) to help establish up to 500 **Rural Transaction Centres** initially in towns with populations between 500 and 3000. Applications from local communities to fund the set-up and operational costs of the centres will be assessed on the basis of need. The Government envisages that each centre will be run either by the local community itself, or by a small business in the community, with the aggregation of services in a single centre.

The Rural Plan provides funding assistance to groups to develop a strategic planning approach to the growth of regional communities and industries. The objective of the **Rural Plan** is to develop the capacity for rural communities and industries in a region, to work together to develop and implement strategic plans, and on-going planning processes. Total funding of up to $200,000 may be provided to groups representing local industries and regional communities. Typically, **Rural Plan** funds may be used for: economic studies; business planning processes; seminars and workshops; leadership development opportunities; networking and consultation; facilitation; and in some cases, coordination of implementation.

Rural Communities Program assists small rural communities to identify and address their needs and plan for their future.

Non-profit community groups in rural areas are encouraged to apply for grants to fund measures including community planning, financial counselling, information services technology and information provision.

COUNTRYLINK is the Commonwealth Government's information access service for country people. This program provides people living away from capital cities with information about government programs and services, and up-to-date information about their entitlements. *COUNTRYLINK* offers five major services:

1. 1800 026 222 free telephone answer line
2. the Rural Book, an up-to-date guide to Commonwealth services and programs
3. a shopfront display which visits country shows and field days
4. community information stands located with community groups as a local source of information and pamphlets, and
5. a video lending library.

For *more information on any of these programs,*

Australian Journal of Rural Health

The first issue of the 'new-look' *Australian Journal of Rural Health* (*AJRH*) was launched in early March 1999 by the Minister for Health and Aged Care, Dr Michael Wooldridge, during morning tea in Parliament House, Canberra. The morning tea was held to mark the significant occasion in the history of publishing rural and remote health research and practice when the *AJRH* became the official journal of the National Rural Health Alliance. Housed with the Alliance, the Journal will gain wider access to people with an interest in this area. As part of the move, the Alliance negotiated a special discounted subscription rate for *friends* and members of the NRHA's Member Bodies.

Highlights from articles in the first issue include:-

Breast cancer concerns for women living in rural and remote Queensland

This two-part article by researchers from the Queensland University of Technology and the Queensland Institute of Medical Research examines personal concerns of, and support issues for, women in rural and remote Australia diagnosed with breast cancer. Existing research suggests that women with breast cancer and their families face many special difficulties, and these difficulties can be compounded by the unique challenges of living in a rural or remote area.

Researchers interviewed 24 women and found that personal concerns included the fear of recurring cancer, psychological or emotional concerns such as changes in body image, worry about family, work-related concerns, pain and physical distress, financial worries, relationship problems, loss of roles, and uncertainty.

Partners were reported to have a major role in supporting women through the experience of breast cancer - as were families, friends, neighbours, the church community, and self-support strategies to increase self-esteem and to maintain a positive mental attitude. For the majority of women interviewed, work was not seen as a place to provide support.

While the study group had contact with a wide range of health professionals, satisfaction with the care they received was variable. Most women saw the medical team as having an important role in supporting them. Positive support was identified as having confidence in the knowledge or expertise of health professionals, when they received adequate information, when sensitivity for their concerns was demonstrated, and when there was follow-up and attention to their needs.

Positive indications of the study were that rural communities operate on strong, informal networks of support and that both patients and health professionals are aware of these and use them. Views of service providers to women with breast cancer are also discussed.

For further details contact Dr Pam McGrath, Centre for Public Health, Queensland University of Technology, Victoria Park Road, Red Hill, QLD 4059. Email p.mcgrath@qut.edu.au

Post-acute care for older Aboriginal people

This article discusses the findings of a qualitative study from the perspectives of eight Aboriginal health workers and focussed on post-acute care for older Indigenous Australians. Although the health workers indicated an improvement in available services for post-acute care, they felt that there is still insufficient support for older Aboriginal people discharged from hospital, and that follow-up care frequently does not occur. For some older Aboriginal people, post-acute care needs can be complicated because they tend to discharge themselves early, which increases their need for adequate post-acute care.

Most of the health workers involved in the study felt that increasing Aboriginal use of existing mainstream services, would complement Aboriginal-specific services and improve care in the post-acute phase of illness. Some health workers indicated that there are plans in their areas to introduce mainstream workers into local Indigenous communities, to encourage Aboriginal people to access mainstream services.

Evidence from the study indicates that there is a need for proactive health policies to increase equity and accessibility of existing services for Aboriginal people. Researchers from several NSW institutions conducted this study. For further details contact Debra Jackson, Faculty of Health, University of Western Sydney, Macarthur, PO Box 55, Campbelltown, NSW 2560. Email DE.Jackson@uws.edu.au

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THE AUSTRALIAN JOURNAL OF RURAL HEALTH

Australian Journal of Rural Health

The *AJRH* is a multidisciplinary refereed quarterly journal, and since its inception in 1993 the *AJRH* has contributed to the accumulation of knowledge of rural and remote health in Australia.

This year it became the official journal of the National Rural Health Alliance. It is also the official journal of the Association for Australian Rural Nurses, the Australian College of Rural and Remote Medicine, and Services for Australian Rural and Remote Allied Health.

The *AJRH* publishes articles that highlight issues specific to health care in rural and remote areas of Australia. It includes a policy article in each issue and contributes to rural and remote health policy and practice in Australia, as well as informing readers about these issues.

The Editor is Professor Desley Hegney, Chair of Rural Nursing, University of Southern Queensland and Toowoomba Health Services. It is published by Blackwell-Science Asia in Melbourne.

For further details contact *AJRH* Journal Manager, Colleen Sheen. Ph: 02 6285 4660, or

Further Reports, Readings

Health in rural and remote Australia
Kathleen Strong, Phil Tricket, Ian Titulaer, Kuldeep Bhatia
Summary: This, the first report from the AIHW on rural and remote health, provides quantitative evidence about the poorer health status of rural and remote people. It details life expectancy, health risk factors, available health resources and the impact of indigenous health on rural/metropolitan health differentials. The basis of the report is the seven category Rural, Remote and Metropolitan Area classification. (RRMA).
1998, Australian Institute of Health and Welfare, phone: 02 6244 1000.

Australian Children: their health and wellbeing
Lynell Moon, Naila Raham, Bhatia Kuldeep
Summary: The report deals with Australians under 15 years of age. It provides mortality data and information on hospitalisation, illnesses and health services used .by this age group Information is provided using the RRMA classification system, which shows that 33% of children in 1996 were in rural or remote zones.
1998, Australian Institute of Health and Welfare, phone: 02 6244 1000.

Medical workforce supply and demand in Australia: a discussion paper
Australian Medical Workforce Advisory Committee
Summary: The Australian medical workforce more than doubled between 1976 and 1996 while the population grew by 30%. Despite this, there is still a major shortage of doctors in rural areas. This confirms that "market forces (economy, lifestyle and family) … act as a disincentive to new entrants and existing practitioners to move to under-supplied rural areas". It also confirms that the incentive schemes in place by the three tiers of Government "have had limited success in countering the market forces attracting and retaining doctors in the capital cities".
1998, Australian Medical Workforce Advisory Committee, phone: 02 9391 9933.

Influences on participation in Australian medical workforce
The Australian Medical Workforce Advisory Committee
Summary: The report of a study of 296 medical practitioners who graduated between 1967 and 1992, 42% of them as general practitioners. *Females in the study* worked an average of 38 hours per week and males 53.8. The females in the sample were almost twice as likely as the males to have a 'professional' as a partner. The report provides useful information that could assist in designing incentive schemes to attract GPs to rural and remote areas.
1998, Australian Medical Workforce Advisory Committee, phone: 02 9391 9933.

A blueprint for rural development
National Rural Health Alliance
Summary: The blueprint discusses some of the 'policy levers' available to Governments, if they want to intervene in a strategic fashion to revitalise rural communities and businesses (rather than responding in a piecemeal fashion to rural difficulties on a case by case basis). It proposes that a Rural Development Commission be charged with the job of evaluating a range of proposals for employment and services in rural areas.
August 1998, NRHA, phone: 02 6285 4660, price: $20.

Fighting rural decay-dental health in rural communities
National Rural Health Alliance
Summary: There is a serious need for a low cost oral and dental health service for people on low incomes. The Commonwealth Dental Health Program, now abolished, provided valuable care for those in greatest need, many of whom reside in rural and remote areas. The paper proposes that the Commonwealth and the States put in place a replacement program as a matter of urgency.
1998, NRHA, phone: 02 6285 4660, price: $10.

Drugs and alcohol in rural Australia
National Rural Health Alliance
Summary: Young men between 15 and 29 are most at risk of injury and it is worst in remote areas. The death rates from injury in 'large rural centres' and 'remote centres' were 22% and 69% higher than in capital cities in 1993. The death rates for men from road traffic accidents are also significantly higher. Alcohol plays a major role in these injuries and deaths and polydrug use is increasing and is a very significant risk factor.
August 1998, NRHA, phone: 02 6285 4660, price: $10.

National Rural Health Alliance Annual Report
National Rural Health Alliance
Summary: Describes some of the Alliance's work, including Healthy Horizons, the National Rural Public Health Forum and the work of a range of advisory committees.
1998, NRHA, phone: 02 6285 4660, price: free.

Economics and Australian health policy
Gavin Mooney and Richard Scotton
Summary: Australia's health system now absorbs 19% of all government tax revenue. This book seeks to provide readers, those with and without formal economic training, with an understanding of issues such as how to assess health outcomes, how to assign resources efficiently and what financial arrangements will promote equity as well as efficiency. Its authors include Anna Howe, Jeff Richardson Steven Duckett, and the two editors.
1999, Allen and Unwin, phone: 02 8425 0100. ❖

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Australian Journal of Rural Health

Educating rural community-based health workers about violence against women

According to researchers from the School of Nursing at the Queensland University of Technology there are no reported education programs that cover the spectrum of violence against women and address the needs of rural health workers.

Based on a needs analysis of 52 rural community-based health workers a self-paced educational package was developed. It included the role of the community worker, strategies to empower women, enhancing and developing supportive networks, building community development action, violence against women as a public health concern, and future directions for community health workers. The package has been refined to incorporate evaluation findings.

For further details contact Heather McCosker, School of Nursing, Locked Bag 2, Red Hill, QLD 4059. Email h.mccosker@qut.edu.au ❖

Have You become a *friend* of the Alliance?

friends of the Alliance has been established to promote and facilitate communication on rural and remote health issues among the rural community, people working in the field, relevant government agencies and the National Rural Health Alliance.

The Goals of *friends of the Alliance* are to:
provide a means to improve communication among the community of people interested in rural and remote health issues and the NRHA; increase awareness of the issues to be addressed and the actions that need to be taken to improve health outcomes for people living in rural and remote communities; and
assist in raising funds for the NRHA which can be used to address specific issues, either through research or undertaking targeted projects, such as awareness programs.

The Benefits of becoming a *friend of the Alliance* include:

- becoming part of an information sharing network of people and organisations working to improve health and well-being in rural and remote Australia, by supporting the NRHA;
- receiving a **CD-Rom** containing eight years of conference and research information on rural and remote health;
- receiving a regular **friends of the Alliance Newsletter;**
- being entitled to a discounted subscription to the **Australian Journal of Rural Health**;
- having an opportunity to **help identify priority areas** for rural and remote health policy, programs and research;
- receiving a **Certificate of Membership**, acknowledging support.

The Categories of membership are:

❑	Individual	$40 per year
❑	Concession *(not in paid workforce)*	$25 per year
❑	Small organisation *(less than 50 staff)*	$150 per year
❑	Large Organisation *(over 50 staff)*	$300 per year
❑	Organisation Associate member *(limited benefits apply)*	$40 per year

Application form for *friends* of the Alliance

I wish to become a member of *friends of the Alliance*

Name: _____

Address: _____

_____ State: _____ Pcode: _____

Telephone: (w) _____ (h) _____ E-Mail: _____

Photocopy this Application Form
Attach Cheque/postal note payable to *friends of the Alliance*.

Post to: PO Box 280, Deakin West ACT 2600 Phone: 02 6285 4660

If undeliverable return to:
NRHA
PO Box 280
Deakin West ACT 2600

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