Working for Good Health and Well-being in Rural and Remote Australia

PARTYline

SEPTEMBER 2003

Newsletter of the National Rural Health Alliance

BEHIND THE WIRE: Children In Immigration Detention

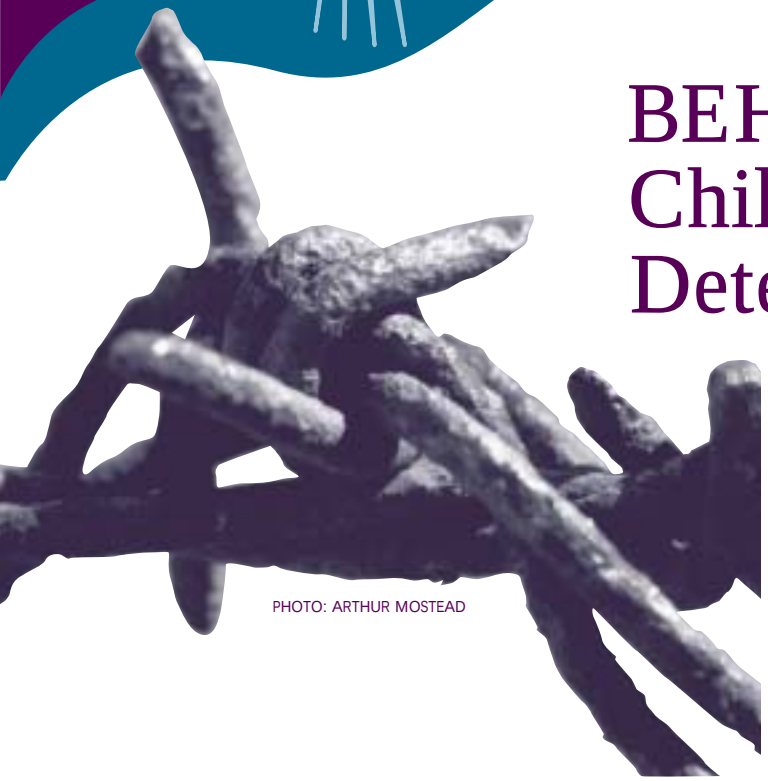

PHOTO: ARTHUR MOSTEAD

Movements such as Rural Australians for Refugees have given an important lead in refugee activism, indicating that many rural Australians favour a 'fair go' for refugees, and indicating their willingness to support them. This is an important issue for clinicians in rural and remote areas as well as for rural and remote people more generally. Most immigration detention centres are in rural and remote areas. They exacerbate detainees' other difficulties by being situated in physically harsh, climatically extreme and isolated environments, far from family, services and scrutiny.

In recent years, and especially since September 11, 2001, many Western governments have introduced policies aiming to deter asylum-seekers and to ensure that they do not trigger protection obligations under the Refugee Convention. Australia began indefinite mandatory detention of asylum-seekers in 1992 and, from 1997, it has toughened refugee review and appeal processes, abolished family reunion and restricted access to work, education, social security and health services for asylum-seekers. In October 1999 it created temporary protection visas, a category that ensures impermanence and appears to compound pre-existing psychological trauma.

Since its inception, the policy of indefinite mandatory detention (IMD) has been plagued by controversy, with riots, damage to property, hunger strikes, and acts of self-harm and attempted suicides (the rates for which are many times the national rates). Children and their parents are held behind razor wire indefinitely, pending 'processing' or 'removal'. Australasian Correctional Management (ACM), a subsidiary of US Wackenhut Corporation, runs immigration detention centres (IDCs) for the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA). A culture of profit, lack of transparent accountability, conflict of interest (the source of the distress provides the service that purports to treat it) and resulting compromises of professional ethics, affect all health treatment decisions. No appropriate psychiatric treatment can be given, as the environment itself causes the problem.

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in this issue:

editorial

We have a good health system in Australia compared with many nations, but there is widespread belief that it needs to be re-shaped. An important *ad hoc* alliance, led by Professor John Dwyer, ran a Health Reform Summit in Canberra in August. The Summit focused public and political attention on some of the deficiencies of the current system. They include problems at the interface between acute care and aged care – including in smaller hospitals; continuity of care through life stages and through the stages of an illness; access to emergency care; how best to deal with chronic illness; the urgent challenge of Indigenous health; the supply and distribution of nurses, allied heath professionals, specialists and GPs; and access to bulk billing.

Once the Commonwealth had made the decision not to support the Health Reform Summit (not even through having its officers attend) it was possible for the event to be falsely portrayed as "a State plot". This disappointed those who were there only because of a passionate belief in the urgent need for change and the good sense of using the Australian Health Care Agreement process as a vehicle for change.

Once the dust settles, it will not be possible for this initiative to be written off as a political stunt. The strength of feeling for change will remain – and the only means for effecting real change is through the political process. People will therefore not be cowed by accusations that the debate "is being politicised". It needs to be; it has to be.

In fact in the September 2002 edition of *PARTYline* we celebrated the value of politics, calling it "the important bit in the middle" between the catalyst for change (the evidence) and the change itself (to policies or programs). This view sees politics as the bridge between community opinion and government action.

However for this to work, people need to have confidence in the political processes and in their governments.

Political process has been devalued the world over; by lawlessness in some countries and by 'spin doctors' in others, including our own. People have lost confidence in the ability of their politicians to exercise policy leadership in the national interest on difficult or contentious issues. The public is unimpressed by poll-driven policy making that – by definition – hopes to please the majority. The spin doctors (who include media gurus as well as politicians and their minders) ration the information and shape the stories. The public ends up discussing 'proxy issues' after the main event has been determined. These proxies are smaller than the real issue, later than the real issue, and only partially related to the real issue.

The real issues in the Australian health and aged care system include the structure and quantity of its funding (Federal v State, public v private), its accessibility (especially to people in more remote areas), and the relationship of its parts (acute v aged care; chronic illness v end-of-life interventions). We must keep to grips with these and not be diverted into policy backwaters.

The majority of copy for this edition of *PARTYline* has been submitted from readers – and this is as it should be. Please keep your pieces coming! ❖

Editorial details

PARTYline is the Newsletter of the National Rural Health Alliance, the peak body working to improve health and well-being in rural and remote Australia. The Editorial Group for this PARTYline was Michele Foley (Editor), Shelagh Lowe, Gordon Gregory and Irene Mills. PARTYline is distributed free. Articles, letters to the Editor, and any other contributions are very welcome. Please send these to:

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Children in Detention Centres

Continued from page 1

Australian health professionals confront the health and mental health consequences of IMD. Strong evidence exists that IMD harms asylum-seekers, and especially children. IDCs have been universally criticised for this by multiple independent enquiries (the UN High Commissioner for Refugees, UN High Commissioner for Human Rights, Australian Human Rights and Equal Opportunity Commission (HREOC), Australian Commonwealth Ombudsman, the Joint Standing Committee on Foreign Affairs, Defence and Trade), by human rights organisations (Amnesty, Human Rights Watch), and by health, welfare, legal, educational and other refugee advocate groups. Research studies uniformly find extraordinarily high rates of mental illness amongst detained populations. Recent research using internationally validated diagnostic instruments, finds unprecedented rates of mental illness amongst a cohort of children who had spent in excess of two years in detention. Severe attachment disorder has been documented in young children and those born in detention.

Our mental health professionals have very limited access to IDCs. Offers from medical and psychiatric bodies to assess need and to provide services have met with inconclusive responses. Child protection agreements between DIMIA and state government departments of community services are absent or fail to recognise the systemic, state-sponsored trauma and child abuse involved. Medical advice is not heeded, clinical care is compromised, and what is left to clinicians is independent testimony and advocacy, often through medico-legal reports. Cases of medical negligence are currently being brought before health bodies.

The situation faced by IDCs thus represents a convergence of health and human rights concerns. In this situation, basic human rights apparently only apply to those with Australian citizenship, while "others" (currently identified under Immigration Law as "illegal non-citizens") have fewer rights and are therefore less worthy of concern and professional services. Prevention and early intervention, adequate and timely management of mental health problems and advocacy are the core business of mental health professionals. In the current political climate, concerned clinicians cannot avoid the evidence, its potential consequences for the futures of those affected, and its implications for Australia's response to other vulnerable groups. Historical evidence of the dire consequences of medical and psychiatric failure to resist inhumane and brutal government policies adds weight to this task.

The Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of Physicians with the Committee of Presidents of Combined Medical Colleges, the AMA and the Australian Psychological Society, currently participate in a broad alliance which opposes the policy of indefinite mandatory detention. As concerned clinicians we do not choose to play politics. Rather, we believe there is no ethically tenable position other than continuing to actively advocate for a change in government policy and practice on this issue. ❖

Dr Michael Dudley
Dr Sarah Mares
Dr Louise Newman
Mr Zachary Steel
Dr Bijou Blick
Dr Konya Roy
Dr Fran Gale

Just a comment on the photo on page 2 of the last edition of *PARTYline* – beautiful though it is, it is unmistakably a profile of people climbing Uluru, an activity which the traditional owners find deeply offensive. Lack of respect for their traditional beliefs is one of the many factors contributing to their ill-health today, and I just don't think it is appropriate for the official newsletter of the NRHA to include photos which are disrespectful to their beliefs. I hope the comment is received in the spirit in which it is intended.

Yours sincerely,

Dr Sarah Laurie (rural GP)

The National Rural Health Alliance wishes to apologise to readers who may have been offended by the photo in the last edition. We had no intention of being disrespectful.


PHOTO: IRENE MILLS

Drought response

PARTYline readers will recall a moving article from the Walkers from Quilpie, Queensland, who articulated their community's struggle with the drought. We received a great response from readers offering their support. Here is one letter which may help others in the same situation.

I was deeply moved by the letter in *PARTYline* from the Walkers, and wanted to respond by outlining what is done in Western Australia for people in similar circumstances.

Here in the Central Wheatbelt Division of General Practice, we have secured Federal Government funding through the Department of Health and Ageing to develop what we call the Wheatbelt Support Service (Counselling and Personal Support). It comprises five tertiary qualified and highly experienced counsellors (four of whom are men), mobile over 110,00 square kilometres (probably a small area by Queensland (suicide prevention) project officer – again, a very senior, mature, experienced and skilled man. All our services are free. We provide one-to-one counselling sessions, group sessions, talks, seminars and workshops. We tailor training to area or group needs, men's health checks (holistic health including emotional and spiritual) at farm field days and work collaboratively with Shire Councils in their provision of crisis response strategies. We believe wholeheartedly in assisting communities to better care for themselves rather than call in the so-called 'experts' when some traumatic event occurs in their communities.

We have anecdotal and hard research evidence to show that our services are reducing stress and moving people back from the edge to which they were driven by conditions. Men are talking to each other and going to doctors about a range of health issues more than ever before. Men are talking to their spouses and children about their inner struggles. Hope is increasing. One of our programs carries the focus, "Before it all gets too much, talk to a mate". There is a growing focus on being 'in-it-together' and looking at people as our greatest resource. Men, in particular, are hungrily engaging with these 'new' ways of being men. They are engaging with matters of the heart and spirit in a non-religious, non-doctrinal way. We are finding that the hunger is universal and, when there is an opportunity to engage deeply with what it means to be human, it is embraced eagerly.

We would be happy to provide any support we can for anyone in your region to set up something similar if there is interest. There certainly is need all over our country. Many of our farmers have experienced 3 or 4 drought years. For many, the drought has broken and this season is looking promising. But, as you know, it will take years to overcome the trauma and difficulty that has been experienced through no fault of anyone.

I don't know what else to say other than come back to us if you think there is any value for you.

I wish you well in all you do for the people you represent. We belong together on this planet and only together and by mutually supporting each other can we really live. ❖

John White
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The National Rural Women's Coalition (NRWC) hosted a national drought forum entitled "Managing Drought – Managing Solutions" in Dubbo in September. The forum was attended by a diverse range of community, government and industry representatives.

The forum focused on rural women's solutions for managing drought and on the social, economic, cultural and environmental consequences of the climatic extremes and hardships being faced in rural, regional and remote Australia.

The solutions and policy initiatives identified at the forum will provide the basis of a report to the Office of the Status of Women. Preliminary meetings with representatives for Ministers Anderson and Truss and Senator Troeth have been positive and all have indicated a keen interest in the outcomes of the Forum.

For more information call Judy Swann, Executive Officer, NRWC, on 02 6162 0430.

The rural workforce… some opportunities…

PHOTO: SOUTH AUSTRALIAN CENTRE FOR RURAL & REMOTE HEALTH

Gary Misan

There is no doubt that recruitment and retention of health professionals to small communities in rural, regional and remote Australia is a major challenge. Shrinking rural community populations, an ageing workforce, increasing gender mix of the professions, changes in lifestyle goals and workforce expectations and other factors all contribute to the difficulty.

But despite recent concerns in the popular press, not all is bleak. The Commonwealth Government has funded a number of major initiatives to assist this process, not the least being establishing a network of University Departments of Rural Health as well as Rural Clinical Schools around Australia. The objectives of these organisations, although different in several important aspects, are similar in that they exist to provide training and support for existing rural practitioners as well as to train a proportion of the next generation of health professionals in the country. The hope is that many students will opt to live and work in the country after they graduate.

The Commonwealth has also provided funding for more student places in medical and nursing schools and a range of scholarships for medical, pharmacy and nursing students to help defray the costs of study. Some of the medical scholarships bond students to work in the country following specialist training. Scholarships for nursing and pharmacy students are not bonded but provide support for rural students to attend university in the knowledge that country students are more likely to return to the country to practice after they finish University. In some cases the State Governments have supplemented these schemes or provided similar initiatives. However, these are long-term strategies, which will take several years yet to produce results and the success of which probably cannot be properly evaluated until the end of the decade.

What of short-term initiatives? There has been funding to Divisions of General Practice directed at recruiting more allied health professionals to areas of need and for Rural Doctors Workforce Agencies to undertake direct recruitment initiatives for doctors in each State and Territory. There has also been funding for changes to GP training programs to allow more GPs to be trained in the country thereby filling a workforce gap. There is also funding for vertical integration programs which see young doctors, including interns, now afforded the opportunity to undertake rural placements before they enter vocational training programs, for example the Rural and Remote Area Placement Program (RRAPP) of the Australian College of Rural and Remote Medicine. There has also been a major push, particularly from medicine and nursing, to recruit trained, work-ready personnel from overseas. These latter programs, particularly those that have attracted heavy government support, have drawn significant and probably valid criticism from various quarters about the ethics of recruiting health professionals from poorer countries.

Remaining sensitive to the ethical issues, South Australia has taken a softer approach and yet still achieved significant successes in addressing short-term recruitment needs for country SA, primarily for medical practitioners. There has been no active recruitment strategy in the sense that there is no overseas advertising or direct soliciting for doctors by SA agencies. Rather SA has developed efficient and effective systems for processing the passive enquiries that come from overseas about the possibility of work in Australia. The University sector, through the South Australian Centre for Rural and Remote Health together with the Rural Doctors Workforce Agency, developed an integrated and coordinated approach to recruiting doctors with support from the Commonwealth Department of Health and Aging and the South Australian Department of Human Services. The key elements of the strategy were robust evaluation of applicants, efforts to match the skills base of the applicants with the service needs of local communities, integration of the elements of immigration and medical registration, orientation upon arrival and support once working. Local communities have supported doctors in a range of practice models, from salaried arrangements to profit sharing and/or facilitating the establishment of medical practices. There are even viable and sustainable models of service delivery that maintain bulk-billing arrangements for all patients. Each

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"It all comes back to hot water and racism"

Liz Mattock, the newly appointed Council of Remote Area Nurses of Australia representative to Council of the NRHA, writes to *PARTYline* about her thoughts on child health in her experience as a remote area nurse.

Remote Area Nurses work and live in many different situations in Australia and overseas: Indigenous communities, mines, tourism, education. My experience is in remote Australian Indigenous communities and I offer some comments surrounding my experience with regard to child health.

For children, better access to health services is paramount, including visits out bush by the paediatrician. This happened from Derby to the Kutjungka Region when I was there in the past 2–3 years. The paediatrician was extremely supportive and got to know the families well.

Health resources in the broadest sense also start with provision of hot running water to homes, access to reasonably-priced, nutritious fresh food in the community shop and adequate facilities in the local school.

As an example, at my last posting a baby had continuous nappy rash because there was no hot water at the house, despite repeated requests. Provision of hot water and a proper toilet is basic. Nganampa Health has well shown this. Food at local community shops tends to be expensive, poor and old. Some have made decisions where they do not sell disposable nappies. Others do not sell baby formula. These are community decisions and are generally helpful.

The school at one community did not have enough chairs for the pupils. This was suddenly rectified when the story got on the 7.30 Report. Some schools have regular teeth cleaning, ear treatment and shower times but often the teachers do not see this as their domain, although they do see the importance and benefit of the results. "Send in the Aboriginal Health Worker (AHW)" of course; – well AHWs are a bit like hen's teeth in lots of places. What we need is a retention scheme for AHWs. Swimming pools at schools are of enormous benefit; clean skin, hair and ears equals better health.

More frequent dentist visits are very important, and also the dental hygienist in-between times.

Many years ago, not long after I finished my nurse training, I went to visit my aunt and uncle in Kenya. One afternoon I was lent the car and went off exploring. I came across a hotel called the Blue Posts near a lovely waterfall. I decided to stop for a cool drink. The hotel had a garden with lawns and spreading trees (the jacarandas were probably in bloom) and I took my beer out under the shade. I sat down and looked around at the tables with weekend family groups and couples enjoying themselves.

No one took any notice of me, and why would they? I suddenly realised that I was the only white person there. It was the first time this had happened to me. It was quite shocking. I was horrified. Since then it happens all the time and I do not give it a second thought.

Fast forward to Australia. I was in the bank sitting waiting for something and a middle-aged Aboriginal woman walked in. She had her head down and people looked at her. The tellers glanced at each other and raised their eyebrows. I got the distinct feeling they were expecting some problem. I have noticed similar occurrences in many other places: the supermarket, petrol station, bottle shop, hospitals. Some Aboriginal people tell me they feel it too.

What does this have to do with child health? Well, if Aboriginal mothers get this sort of treatment it is no wonder they feel reluctant to visit clinics, hospitals etc. I was shocked at my experience because it was new, but I was not being discriminated against. Aboriginal people are. It would be good to hear from some remote Aboriginal people to see if I am being simplistic.

Self esteem, self worth, unemployment, alcoholism, domestic violence, poor health.

I think it all comes back to hot water and racism.

And if that is being simplistic, well sometimes simple ideas are the best. ❖

Liz Mattock

Time to say Sorry

PHOTO: LEANNE COLEMAN

Stewart Roper

Contributed...

"I originally left Adelaide to work in a remote Aboriginal community because I found it strange that I had never met or talked with any of the original inhabitants of Australia during my entire life here. I envisaged that I might stay for six months to a year. I ended up staying for nine and a half years and still regularly work there as a locum nurse, drawn back by the rugged beauty of the country and the wild spirit of the people.

When I first started work in the community I was close to forty years old. Ten years later most of the Aboriginal men of my own age are dead. Unemployment, poverty and hopelessness wreak havoc on health; manifested through diabetes, heart disease, alcoholism and violence. Even to this day it is a common occurrence to be called out at night to enter a home with no furniture and children crowded for warmth on bare strips of dirty foam.

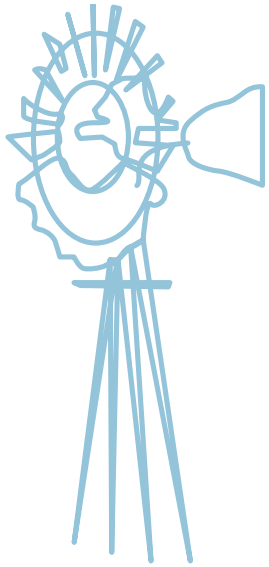
The school is a series of dilapidated buildings that would not be tolerated anywhere else. The skills of the children, especially evident in sports and arts, will never be recognised or nurtured. The laughter and fire in their young eyes gradually dulls as they grow older, realise their lot in life and drift aimlessly until boredom and desperation drive them to petrol sniffing, alcoholism and even taking their own lives.

Despite these devastating realities of community life I also see packs of smiling faces on the back of trucks, piled high with blankets on a freezing morning, roaring with laughter as they set out on a journey of perhaps hundreds of kilometres over rutted roads to a football match. At night in the tiny community I hear animated laughter and discussion of a vibrancy that is all but absent in the neighbourhoods of our larger towns and cities.

Meanwhile, outside the communities, Aboriginal culture brings hundreds of millions of dollars, mostly to non-Aboriginals, through tourism and art. Many others (myself included) earn a living, directly or indirectly, through service delivery to Aboriginal communities. In addition, we live in one of the most beautiful countries in the world.

And yet, in the midst of all our wealth, we are so mean spirited that we quibble over the degree of suffering and which generation did what, allowing governments to hide behind morally bankrupt terms like 'practical reconciliation'. Let's have the courage to acknowledge our good fortune, apologise to Aborigines for the injustices they have obviously suffered and get on with the real process of reconciliation." ❖

Stewart Roper



The rural workforce… some opportunities…

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situation is different and tailored to the needs of the communities.

This approach has resulted in the recruitment of approximately 70 highly skilled overseas trained doctors into rural, regional and remote South Australia over the last 3-4 years. Several agencies working across State Government, Regional Health Services and the University sector are now exploring similar opportunities for other professions while at the same time looking at measures to make rural practice, even short-term, more attractive to Australian graduates.

Through a balanced and ethically sustainable strategy, it is possible to maintain the rural health workforce while awaiting the Australian graduates from the longer-term educational initiatives. ❖

Gary Misan
Associate Professor
Spencer Gulf Rural Health School and
Head, South Australian Centre for Rural & Remote Health (SACRRH)

"My Nana didn't care too much for Instant Pudding"

Leann Wilson, the Indigenous representative on the National Rural Women's Coalition, gave a moving speech about *Lifelong Learning* at the Coalition's inaugural Roundtable held in Canberra in June. Here is an extract of what she had to say…

PHOTO: STEWART ROPER

I am of Australian Aboriginal and South Sea Island descent. I am a descendant of the Bidjara and Kara-Kara nations, with my traditional lands being in Central and Central West Queensland. My South Sea Islander heritage is from the Tanner Islands and a small Island called Malata in the Solomon Islands.

I have been asked to speak about *Lifelong Learning* and I am excited to do so, as it gives me a chance to share a story about my Nana and how she didn't care too much for Instant Puddings.

The most vivid memory I have of my Nana cooking was when she was preparing to cook the famous *Sponge Cake.* The preparation began the afternoon before the actual cake baking took place. This time was equally important as was the actual blending of the ingredients and the cooking process.

The afternoon prior, my Nana would yell out to my Grand Pop who was always outside doing *men's stuff* to please chop up some gidyea logs and bring them in for the fire. As any Sponge Cake cook knows, gidyea is the best wood to cook sponges, it's slow burning and produces great coals, just what's needed.

Grand Pop would bring the gidyea in and place it beside the stove, some of the logs would be split and some left whole. Nana would put a split log on the fire and leave the door open as she and the grandkids would gather around to have a warm milk and a story before she tucked us into bed.

Once in bed, as I learnt years later, Nana would continue with the preparation. The eggs would be left out so that they would be at room temperature. The mixing bowl and the utensils placed on the table to also reach room temperature. All the ingredients strategically placed on the table ready for the ceremony the next day.

In the morning on rising the fire was a rich orange colour of hot gidyea coals, just the right temperature for cooking. After all the grandkids had breakfast, Nana would begin cooking the *Sponge Cake.*

Now begins the blending of ingredients, all at room temperature remember. The mixture is then poured into the cake tin for baking and placed gently in the oven, for some 35–40 minutes. I don't know what temperature – there was no gadget on the stove, it was hot with gidyea coals though.

The next 35–40 minutes was absolutely critical. One had to walk gently – if allowed to walk at all – and you also had to lower your voice so as not to interfere with the cooking of the *Sponge Cake.*

PHOTO: STEWART ROPER

PHOTO: STEWART ROPER

So for the next 35–40 minutes my Nana, my Aunties and me would drink tea and I would get to listen to these wonderful lifelong learners share their rich beautiful stories – some sad and some happy, but always filled with romance, intrigue and excitement.

As I reflect on the lessons of my earlier years right up until my grandmother's passing, and the learnings that have allowed Australian Aboriginals to live in harmony for many thousands of years, I recall what my Nana taught me about the 4 Rs:

1. Respect – for our Mother Earth and for each other;
2. Responsibility – towards Mother Earth and towards each other;
3. Relationships – With Mother Earth and with each other; and
4. Reality – Our life's purpose, our legacy and returning to Mother Earth.

My Nana always spoke with great vision, compassion and forgiveness. She spoke of the good of humanity, which she entrusted me to continue with.

As you can see this is more than the Instant Pudding recipe, this will take the real deal, this is about preparing and baking the Sponge Cake. This takes effort, energy and commitment.

So how can we transition my Nana Mallee's teaching into global strategies that will allow us to better understand each other? As leaders we are all in positions of privilege and are ideally situated to effect positive change.

How then do we learn from each other, how do we accept and embrace diversity? I think the answer lies in the ceremony around baking the *Sponge Cake*. I think that symbolically it is about each of us taking this piece of playdough and building bridges. The building of bridges will allow us to cross over and onto the other side, but of equal importance it also allows us to return. For me as an Aboriginal Australian returning across the bridge allows me to maintain my history, my heritage/culture and my integrity as an Aboriginal Australian.

Our challenge as Australians is to develop and operate in relational frames where we need to be listening with open minds, trying new things, and reflecting honestly. The great thing is that this doesn't require a high IQ, a degree or a privileged background. Lifelong learners take risks, there are bigger results and successes and also bigger failures, but there in lies the greater learning.

I don't need to tell you about the challenges of Aboriginal Australia – we see and hear about this everyday but what I do need to bring to your immediate attention is that we can't do this alone.

To test whether one is on the life long journey, let me make this statement: 'Native Title:' Do you know the facts around the terminology or are your thoughts based on assumptions? Native Title in fact is a western construct and if one cares to peel back the layers of bureaucracy and legislation one will come to understand Native Title is about Me the person, the human being. One comes to understand that it is about the 4Rs and one begins to understand that it is about the heart and soul of Aboriginal Australians.

Here's your piece of playdough; I am inviting you to build return bridges with Aboriginal Australia. If during our journey, we're not suffering a little discomfort and anxiety at times, the possibilities are that we're not operating in a relational frame.

Lifelong learning is about two choices: Instant Puddings or Nana Mallee's Sponge Cake.

Today in our lifelong journey, if we want to experience and taste Nana Mallee's Sponge Cake, the challenge for each of us is to find ways to effect the intent of Reconciliation. ❖

PHOTO: STEWART ROPER

PHOTO: ARTHUR MOSTEAD

Contributed...

Many smaller country towns are faced with the reality of reduced populations and agonising decisions about whether to defend existing local services from change or to move to new models of service delivery and care. This choice can be particularly difficult when it concerns birthing services. Just how agonising this can be is demonstrated in this article submitted by a South Australian country general practitioner.

More years ago than I can remember, I was born in a country hospital. This was a particularly unique hospital, because three of the babies born in it that year trained to become doctors. All three of us went to practise in rural South Australia, one doctor working in Woomera (then Tailem Bend), another at Narracoote, and myself in Blyth and then Clare in the Mid-North.

Two of us remain in rural SA, providing procedural services to our patients. It hasn't been easy for any of us.

Personally, I accepted the long hours and many nights of broken sleep. I accepted being awake all night and then working the next day. I accepted being unwell and still having to see other sick people. I accepted being constantly on call, being called away from school concerts and my children's sporting events. I also accepted that I was unable to visit friends that live in Telecom 'black holes'. I accepted meals well and truly desiccated in the oven and I accepted not saying goodnight to my children.

I asked my wife to accept living away from her family and social supports with young children. I made my wife and children compete with my commitment to rural medicine. This ranged from being unable to take family holidays due to severe lack of locums, to sleep deprivation, as when the phone rings it wakes my wife as well. It included sending our son away to school at age 13, and perhaps soon my daughter at the same age. "I miss you daddy" is a standard phrase heard in our household.

This reflection was prompted by recent events. A friend with whom I trained in Medicine was researching his family history and found a clipping from a local paper from 1966. It showed a much younger doctor Holmes and his family arriving in Blyth to start a career in rural medicine.

All of the above negatives I accepted – as the rewards of rural medicine outweighed these things. The personal caring role of a country doctor – looking at individuals and knowing that your commitment and skills keep these people safe, seemed to make sense. The returning looks from my patients expressing a deep and sincere gratitude for this care are an immense payment in terms of personal satisfaction.

But what I cannot accept is the lack of help from the State government. It approved removal of obstetrics from and then closed Blyth Hospital. I moved to Clare to continue providing a service to my patients. In the last 10 years, four other surrounding hospitals have undergone 'role change', losing obstetric care. Doctors in those surrounding hospitals no longer deliver babies at Clare Hospital.

Why is this? It is because of governments' profound inaction in addressing the true needs of rural communities. Medical indemnity changes forced me to give up obstetrics on July 30, 2003. It was probably the most public and shortest retirement in rural obstetrics history. I returned two weeks later. The reason for resumption was being informed by another doctor in town I could only share care with city specialists. I consider this the last straw. I contacted the indemnity organisation that provides public cover for obstetrics, paid an extra $2500 on top of other medical insurance and notified Clare Hospital and the Regional Health CEO that I was restarting public patient obstetric care. This was greeted with great enthusiasm (and tears of joy from one obstetric patient) from patients, midwives, and the CEO of the local hospital.

That is until the CEO realised that it was going to cost the local hospital money. Not a lot of money, and in fact costing the taxpayer no more. What it would do is shift the funding from Federal (ie: Medicare) to State through the Department of Human Services. So the bottom line is that the State Government does not want to support the attendance of pregnant ladies at the Clare Hospital as public antenatal outpatients. This service is taken for granted by our city cousins and I believe that the State Government has an obligation under the Federal Medicare Agreement to provide these services.

It is a great disappointment to me that the Clare Hospital Board has not unequivocally supported the provision of sustainable rural obstetrics now and into the future.

It all comes down to equity and access. It comes down to supporting country doctors who are trying to stay in the bush looking after communities.

Just in case the State Government has not noticed, there are no busloads of doctors heading for rural and remote areas. Why? I guess it has to do with what I have accepted in the past, and what I can no longer accept now.

If we do not take a stand on this issue the future of country medicine is in great peril. ❖

Dr Stephen Holmes

Rural is not shorthand for 'everyone is in the same boat'!

John Halsey, the Executive Director of the Rural Education Foundation Australia (REFA), delivered a comprehensive report on the state of education in rural, remote and isolated areas to the Country Areas Program (CAP) National Forum in July. Here is some of what he had to say.

The overall impact of rural or remote location is not a good news story in education. Reliable data show that rural and/or remote students are less likely to participate in schooling, more likely to be absent, less likely to complete the compulsory school years, less likely to complete Year 12, and less likely to participate in tertiary education and training.

Despite this there are many rural schools with outstanding programs and results in some of the newer vocational pathways like aquaculture, as well as the traditional academic areas. Many rural schools have a well-earned reputation for innovation and best practice.

Students from lower socio-economic backgrounds who live in rural areas are more likely to experience the powerful discouraging effects on participation in higher education. A comparison of metropolitan and rural schools shows that students have lower participation rates in Year 12 (82% compared to 69%), and are less likely to participate in higher education (35% compared to 23%). These figures get worse with increased rurality.

Rural students comprise 30% of the national student cohort but only 19% of tertiary students. Isolated students are about 4.5% of the population but only 1.8% of the tertiary enrolments.

Young people in rural and remote areas have less access to part-time work that provides financial support, self-esteem building and an opportunity to become known in the workplace. Many of them grow up with the knowledge that they will leave town and home when they leave school. While many feel confident about this, it is nevertheless an emotional hurdle. As one young person in NSW said, "This is my home. I love living here. But you can't be a checkout chick all your life."

The economic plight of rural areas is accentuated by a growing elite of privileged urban workers in secure and profitable positions who experience a working life that is far removed from that of many of their rural counterparts and urban workers in less secure positions.

Family-friendly policies are essential for rural Australia, including to support parenting. The early years of a child's life are crucial for developing a confident and competent student and member of society. Small and dispersed populations require access to a full range of child care and pre-school experiences.

Some ways forward

Implement the National Framework for Rural and Remote Education as developed in response to the Human Rights and Equal Opportunity Commission Enquiry into Rural and Remote Education and approved by the Ministerial Council.

Develop a modern and appropriately resourced approach to country teaching practicums as part of a comprehensive strategy to ensure that the best qualified teachers and leaders opt for country postings as a matter of preference.

Consideration should be given to developing a major national city-to-country education program as a way of:

- reversing the perception that country education is only for country students but city-based education is for everyone!
- extending the range of choice of metropolitan families especially in terms of primary industry based vocational pathways and country lifestyle experiences.
- improving the viability of some curriculum offerings and programs thereby maintaining breadth and choice for local students and families.
- utilising education as a contributing vehicle to improving county-metropolitan understandings and relationships.

Ensure that the resourcing levels for country education match costs and that they are seen as investments in nation building – not merely as costs.

Ensure that all students have access to affordable high quality information communication technology. ❖

Allied Health Scholarships

Rural and remote communities will benefit when more than 130 health professionals complete postgraduate studies funded under scholarships announced recently by the Minister for Health and Ageing, Senator Kay Patterson.

"These scholarships, worth $600,000 in total, have been provided under the Commonwealth Allied Health Rural and Remote Scholarships Postgraduate Scheme," Senator Patterson said.

Scholarship recipients include physiotherapists, occupational therapists, social workers, speech pathologists, podiatrists, audiologists, optometrists, chiropractors, radiographers and clinical psychologists.

PHOTO: ARTHUR MOSTEAD

The scholarships were awarded for a range of educational activities including obtaining postgraduate studies, short courses, clinical placements and attendance at conferences.

"Specific scholarships include assistance for occupational therapists undertaking training in driver assessment and rehabilitation, radiographers in ultrasonography, and dieticians working with diabetes management and education," Senator Patterson said.

The scholarship scheme is managed by the Services for Australian Rural and Remote Allied Health (SARRAH). SARRAH President, Robyn Adams, endorsed the Minister's comments. "We were particularly pleased with the response to our first application round. Over 480 applications showed that there is great interest from among health professionals in improving their qualifications and capacity to serve their communities," Robyn said.

The next round of applications opened on Saturday 30 August 2003 and closes on Friday 26 September 2003.

◗ *For more information* about these rural and remote health scholarships please visit the SARRAH website www.sarrah.org.au

Action on Nursing in Rural and Remote Areas

Despite a number of important developments, there is an emerging crisis in the nursing workforce in Australia. The worst of this crisis is being experienced in rural and remote areas of the nation. (See the project papers at www.ruralhealth.org.au)

Among the efforts to address this important rural health issue is the collaborative project established and supported by the organisations listed above to identify and deal with key related issues. Recently, concerns have focused largely on current nursing shortages and ageing of the nursing workforce in rural and remote areas with resultant escalation in shortages over the next ten years. It is clear that the problems are many-faceted and will only be resolved by a strategic long-term approach involving all relevant parties.

Against that background, the project has been established to address the priorities identified by participating bodies. Chris Moorhouse, a current CRANA member who has considerable experience in rural and remote health practice, education, research and policy roles, was recently appointed to the project. Based part-time at the NRHA Office in Canberra, he will take this project to its implementation phase. He will summarize the project and its next stages at the joint AARN/ CRANA Conference in Katoomba 21–24 September.

◗ *For further details* on how to contribute to this project, contact Chris Moorhouse at the National Rural Health Alliance on 02 62854660 or email chris@ruralhealth.org.au

The Australian Nursing Federation (ANF), Association for Australian Rural Nurses Inc. (AARN), Council of Remote Area Nurses of Australia Inc. (CRANA), Australian Council of Deans of Nursing (ACDN), the Australian Nursing Council Inc. (ANC), the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN), the National Rural Health Network (NRHN) and the Royal College of Nursing Australia (RCNA). ❖

Confused about the Acronyms?

The Allied Health postgraduate scholarship scheme has undergone a name change. Once called the Commonwealth Allied Health Rural and Remote Scholarship Scheme (CAHRRS), the scheme will now be known as Australian Government Rural and Remote Health Professional Scholarship Scheme (AGRRHPSS) – just to make it simple!!!!

Future of the PBS

There are two issues of concern about the future of the Pharmaceutical Benefits Scheme. One concern is the potential for its cost to blow out further. This is driving the Government's information campaign on 'better use' of the PBS and its proposal (so far resisted in the Senate) to increase patient co-payments. The other is the possibility that the PBS may be a 'bargaining chip' in negotiations with the US on a Free Trade Agreement. Trade Minister Mark Vaile has assured the Alliance that "the FTA negotiations will not impair Australia's ability to provide universal access to pharmaceuticals through the PBS". Some parties are still concerned about the ability of the PBS to set prices that ensure universal access. ❖

Management of Stroke

The National Stroke Foundation has developed acute clinical stroke guidelines. Guidelines are available at www.strokefoundation.com.au
◗ *Further information* contact Lucinda Bilney on 03 9670 1000. ❖

Telstra and Privatisation

There have been major improvements in telecommunications in rural and remote areas. The Government's proposal to fully privatise Telstra should raise concerns about the future level of services. Judgements about current 'adequacy' are irrelevant in this respect. It is doubtful whether cross-subsidies that underpin equivalent services to rural areas would remain if Telstra was privatised and driven by commercial imperatives like profitability and share price.
See the discussion paper at www.ruralhealth.org.au ❖

Rural Health Services Reviews

There are current reviews of the Regional Health Strategy (More Doctors – Better Services), the Regional Health Services Program (that took over from the MPS program), the University Departments of Rural Health and the Regional Clinical Schools. Between them, these comprise much of the Australian Government's effort in rural and remote health so we will be interested in the results. All of the individual programs in *More Doctors – Better Services* were funded for four years and so are up for renewal in Budget 2004. ❖

Anti-poverty Week

Anti-poverty Week will be 13–17 October 2003 and the UN's International Anti-poverty Day is Friday 17 October.
Its work in Australia is described at www.anti-povertyweek.org.au Local committees are encouraged to hold an event to help raise awareness of the impacts of poverty, including on health. ❖

Health Reform Summit

Over 25 health organisations came together in the Australian Health Reform Alliance to organise the Summit in Canberra 17–19 August. There is very strong agreement that Australia's health system could deal better with continuity of care, the interface with aged care, workforce, funding issues, etc.
The Summit Communiqué is at www.healthsummit.org.au ❖

Ageing and health in rural areas

Aged Care Services Australia (ACSA) and the Alliance are working on a joint paper to ensure that policies and programs relating to older Australians have appropriate rural content. The National Strategy for an Ageing Australia is one of the key documents and has very few references to rural issues. ◗ *Contact* ACSA at psparrow@agedcare.org.au or phone 03-9686 3460 or the NRHA at 02-6285 4660. ❖

PHOTO: ARTHUR MOSTEAD

Water

Water is in the news, and not just because of the drought. There are major changes in the way water rights are distributed and how much individual water users have to pay. Water storages are at historically low levels. The challenges of the Murray-Darling Basin are receiving some current attention. A new national agreement was signed off by the Commonwealth, States and Territories at the latest Council of Australian Governments meeting – see the Communique at www.dpmc.gov.au/pdfs/coag290803.pdf ❖

The Commonwealth Government is continuing to work in partnership with rural and regional communities around Australia to improve access to quality health and aged care services. Since the announcement of the *Regional Health Strategy* in the 2000–01 Federal Budget, a number of programs have been introduced to strengthen the regional health workforce, improve rural health education and training opportunities and deliver improved health services for country Australia.

Part of the Strategy is the *Multipurpose Services* (MPS) program that assists small rural communities to develop a more coordinated and cost effective approach to service delivery.

"Our MPS is not just a hospital. An MPS can be everything a community needs, health-wise. You need to be flexible and you need to be very open minded and lateral thinking. And you can make it how you want it – to suit your local community."

Another integral part of the Regional Health Strategy is the *Regional Health Services Program* which enables communities to tailor local health services to better suit their needs by expanding their local primary health care services.

In rural Victoria, the Drummer Program supplies the Mallacoota and Cann River communities with a mix of services, including primary health care professionals and equipment, health education, a youth worker, and a bus to take those without transport to visit specialists in the surrounding area.

Neil Switzer, the administrator of the program in Cann River, said: "The program has been magnificent – we've been able to gain many services we otherwise couldn't afford."

The Australian Government's Rural Chronic Disease Initiative provides small rural communities with populations under 10,000 with the opportunity to take a hands-on approach to primary health care and to address local health issues taking either a whole-of-population or a targeted population approach.

The WellingTONNE Challenge, being run by the Wellington Health Service in Wellington, central NSW, is one of 19 pilot projects funded under this initiative.

"The WellingTONNE challenge is really part of a bid to reduce the levels of obesity and associated health risks in the Wellington community and generally improve people's sense of health and wellbeing," said Karen Lloyd who has been the Health Promotions Officer with the Wellington Health Service for the past six years.

"We are only four weeks into the 12 week program and the results are fantastic! Already we have lost 480kg – that's already half way to losing our tonne!" said Karen Lloyd.

Another program funded is the *More Allied Health Services* program. It facilitates greater access to a range of additional allied health professionals to rural and remote communities. Tania Greaves is an audiologist based in Perth who travels out to the Pilbara, remote WA.

"Having grown up in Kalgoorlie, I can appreciate the limited access to health services that some of the smaller communities have," she said. "It is very satisfying being able to provide a service that can make a significant difference to someone's quality of life."

The *Rural Women's GP Service* provides rural communities with visits from female GPs. Dr Stephanie Partridge, based in Adelaide, travels out to Pinaroo and Lameroo, in rural SA.

"Generally, I am seeing women who are well overdue for their pap smears," Stephanie said. "In this way, I feel we are having a great impact in providing preventative care, rather than having to deal with conditions as bigger issues further down the track."

PHOTO: EUROBODALLA SHIRE COUNCIL

The *Emergency Locum Service* is another initiative of the *Rural and Remote Pharmacy Workforce Development Program*, which is fully funded by the Commonwealth Government.

Ross Myers and his wife Michelle, who run the community pharmacy in Baradine, west of Tamworth NSW, found that even the best-laid plans could go awry when it came to babies and births.

"Three days before I was due to stop work, the doctor decided that the baby would have to be born by Caesarean section," said Ross. "We needed a locum fast. I called the *Emergency Locum Service* and within two hours they had located a locum. In 24 hours the locum was in Baradine picking up the reins."

There are also a variety of scholarships for rural medical, nursing, pharmacy, allied health and Indigenous health professionals.

These are just some of the projects improving the range of health care services and strengthening the health workforce in rural communities. Since 1996, around $2 billion has been spent on targeted rural health and aged care initiatives nationally.

Find out more information about the Commonwealth Government rural health initiatives by visiting www.ruralhealth.gov.au or freecall 1800 020 787. ❖

Who's gone Where?

NRHA Council Member Judi Walker has taken up a new position as Chief Executive of the North West Rural Clinical School. Judy was previously Head of the Tasmanian University Department of Rural Health based in Launceston.

Elaine Duffy has been appointed Professor and Dean of the Faculty of Nursing, University of Windsor in Southern Ontario, Canada.

Karen Francis will take up the position left vacant by Elaine as the Associate Professor for the Rural Clinical School at Monash University. Karen was previously at the School of Health and Human Services at Charles Sturt University.

Jack Beach has succeeded Megan McNicholl as president of the Isolated Children's Parents' Association (ICPA). Bernadette Devenish-Batzloff will now represent the ICPA on the Council of the National Rural Health Alliance.

Myra Pincott is the newly appointed National President of the Country Women's Association of Australia. Myra is also the CWAA representative on the Executive of the National Rural Women's Coalition (NRWC).

The National Association of Rural Health Education and Research Organisations (NARHERO) is being wound up due to difficulty in finding volunteers for the Executive. Lesley Fitzpatrick, previously Convenor of NARHERO, has left Toowoomba and accepted a job with General Practice Education and Training (GPET) in Canberra.

Carmen Hinkley, Senior Policy Officer with the Mental Health Council of Australia, has taken a position with the Mental Health Branch in the Department of Health and Ageing.

PHOTO: EUROBODALLA SHIRE COUNCIL

The newly constructed Narooma Library and Community Health Centre

New Narooma Library and Community Health Centre

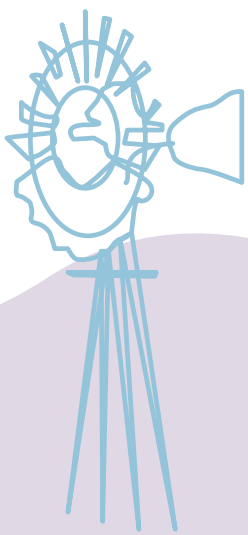
The community of Narooma and surrounds on the South Coast of NSW have benefited from the close working relationship of the State and local governments with the recent opening of the Narooma Library and Community Health Centre.

The $1.8 million establishment is effectively owned by the Eurobodalla Shire Council with the Southern Area Health Service paying a capital contribution, in effect, as rent. Rather than erecting separate buildings on separate sites, the two organisations agreed on the benefits of sharing resources with the minimum of red tape.

Chairperson of the Southern Area Health Service, Gratton Wilson, says the facility will be a great asset to the community. "By being under the one roof, the community can access a range of library and information services and a variety of community health and drug and alcohol services. Visitors to one service are encouraged to use the other. Reading and information services are seen as major contributors to better health for all age groups and families."

The model has been such a success that a similar arrangement is proposed for Jindabyne where the Snowy River Shire and Southern Health are looking into the possibility of a shared facility to improve service delivery.

◗ *For more information* about the model contact the Southern Area Health Service media relations on 02 61249853. ❖



October 2003

5th Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)
1–3 October, 2003
Rydges Plaza Cairns
Contact: Sally Gould
Phone: 07 3410 7236
Fax: 07 3410 7235
Email: catsin@bigpond.net.au
Web: www.indiginet.com.au/catsin

National Anti-Poverty Week
13–17 October 2003
www.antipovertyweek.org.au

Carers Week
19–25 October 2003
www.carersweek.org/CW2003.asp

6th International Conference on the Regulation of Nursing and Midwifery
26–28 October
Carlton Crest Hotel Melbourne
Phone:02 6257 7960
Fax: 02 6257 7955
Email: conference@anc.org.au
Web: www.anc.org.au

November 2003

ACOSS Congress 2003
Piecing it Together: equity, empowerment and change
12–14 November, 2003
Rydges Lakeside,
Canberra

Mid March 2005

8th National Rural Health Conference
Alice Springs Convention Centre

Alice Springs
◗ *Contact:* Lyn Eiszele

Phone: 02 6285 4660
www.ruralhealth.org.au ❖