

Nutritionists where there is no nutrition

Richard Sager

Darwin Dietitians, NT

The involvement of a dietitian as a part of the primary health care team is essential to the health outcomes in urban and remote settings. Previously, individual nutritional care was provided by the remote health clinics, using their own interpretation of public health promotions or the advocacy of local clinic staff that have no training in nutrition and dietetics. This leads to basic recommendations and counselling services being provided from resources electronically distributed from a central NGO office or a supportive government department.

This approach has significant limitations. Achieving appropriate and adequate nutrition services is by far the most significant barrier towards improving the health status of residents in a remote setting.

Clinical dietitians are trained to provide intensive individual dietary advice, however for remote health clinics this service has traditionally only been able to be provided on an irregular basis. The needs of the remote community setting are far greater. This model of service is impractical for a relatively small population spread out over a vast area. Therefore if remote residents are to receive equitable access to services that promote quality nutrition advice to improve and to permanently support lifestyle changes, it is important to develop a service delivery model that meets the clinical demand of the population.

In recent years a Federal Government initiative managed through the Northern Territory Medicare Local known as MOICD, has improved access to clinical Dietetic services within remote clinics. The funding has increased access to the necessary individual dietary advice for sufferers of chronic disease. This paper describes the current model used to provide the increased clinical dietetic services necessary for remote Aboriginal communities. Each community that is serviced has uniquely different needs in attempting to improve the quality of nutrition knowledge and capacity for Indigenous Australians, therefore the model of service is adapted accordingly.

To date this clinical dietetic service has provided more than 800 patient encounters over the past twelve months. This paper will review this model of service delivery, discussing the strengths, including clinical benefits, and limitations of the model. It will also encapsulate the views and experiences of clinical dietitians currently working to provide this service, and their recommendations on how the service can be more cost effective and achieve improved clinical outcomes.