The Voice of the Rural Health Consumer

Marie Lally

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Good afternoon, everyone. Do we have any politicians here to hear the voice of the consumer? What a shame.

I bring this paper to this great National Rural Health Conference not only from the 44,000 members of the Country Women’s Association which has been active in this country since 1922, but all consumers who seek good health in this good country. These CWA members come from rural and remote country and metropolitan areas and many serve as volunteer members of hospital boards, local councils, governments, NGO organisation instrumentalities, universities and other research investigation advisory committees, senior and aged care organisations, meals on wheels carers and you name it, they are there.

The organisation is non-party political and we guard our reputation most carefully. So, I believe that I speak from a fairly well-informed position. Some of the most important factors to affect our community are poverty and isolation. Poverty, not only financial, but poverty of spirit and lack and loss of communication, loss of support, both family and community, and loss of services, for example, banks and other closures and we have the fear of “what if” happens.

Isolation, distance from support facilities, hospitals, doctors, dentists, psychological support, financial advice, education for their children, separation of family for education, work or health and ageing situations are all contributing factors. Health and the access to health care is of paramount importance. I live in what is classed a remote area of South Australia, although we do not think we are terribly remote. A small farming community of Lock on Eyre Peninsula. We have 500 people in our town and district of a 60-kilometre radius.

It is 100 kilometres to the nearest resident doctor, hospital or pharmacy but we do have a model Community Health and Welfare Centre and we have two registered nurses and two job-share receptionists. A doctor visits one afternoon a week between the hours of 1:30 and 5 pm on Tuesdays, and our bank has gone back to four hours a week so they’re there from ten till two and then you can go on to the doctor. But don’t get sick or wanting money any other day. It works well, if it wasn’t for the politics in the health system.

There needs to be greater communication between health professionals and the perceived needs of senior management and the real needs of the community. Some facilities, like our health centre, are unique and will not fit into a particular category. They are neither ward nor 24-hour service. The geographic location creates a unique environment. For example, senior management from a hospital 250 kilometres away stress that the centre must shut at 5 pm. This makes it illegal for the nurses to be there after that time.
Too bad about the fact that the doctor and the patients are still there at a much later hour and, of course, the nurse has to stay on. The clinical nurse must also now not leave the centre to do house visits — so are the aged and infirm to miss out again? No, nurse finds herself operating her duty of care illegally. How ridiculous is that ruling for our remote situation?

Ambulance volunteers. They are difficult to find because of the exhaustive rules and regulations. It would help if selected volunteers could be brought in to service the vehicle, like fill it up with petrol, check tyres, water, oil and all that and clean it after a call out. But no, no, no. They are not allowed to do that because they’re not in the system and it would help also if someone could go and baby sit and allow those young volunteers to go out on a call out. But no, that’s not allowed either. So, it makes it very, very hard for a small community to keep our volunteer ambulance which is a vital service in our remote area.

But I totally applaud the nurse and doctor working relationships and the co-operation I see in remote areas in this way and I’d like to tell you of a story that’s pretty close to home to me and about an instance of the wonderful co-operation between the sister and the doctor. This twelve-year-old girl who happened to be my grand-daughter was taken to the sister on a Saturday morning and she had a severe headache, poor vision and a high temperature. Sister said, “I don’t want to scare you, but I suspect meningitis.”

The mother got in the car, drove straight to the town south of us with the doctor, and the sister rang, warned him. He came in, it was Saturday morning, let’s face it, and he agreed with the sister and said, “Yes, I suspect meningitis as well.” He rang the Flying Doctor and within two and a half hours of that child seeing the sister in the Lock Health Centre she was in the Royal Adelaide Hospital. Now, I shouldn’t have said Royal Adelaide Hospital because I don’t think it was — it was an Adelaide hospital. And this is where the system fell down.

That child, even though she had “meningitis suspected” written on the end of her barouche, she was let lay for hours and hours without any attention until her mother, who was nearly around the bend at this stage, got somebody to give her painkillers and at 3 o’clock in the morning when the situation was just about desperate a young nurse went above senior management and rang the specialist and that man came in and my daughter said, “Tell them this, mum. He drained six drops of fluid from her brain,” so you probably all know now how sick she was.

And I commend that nurse for going above and putting her job on the line, for the welfare of the patient in an emergency. And there’s a happy ending because my grand-daughter is well and has just passed her matriculation and started at university. But that’s, you know, how it fell down when we got to the big smoke.

The more I talk to people about real life experiences in hospitals, the more I think that if I collapse — and where is he? I was going to collapse in Dr Steve’s arms up here and he’s gone just when I need him. And I thought if I collapse in his arms I want to go to intensive care — straight to intensive care — and I want to stay there until I’m ready to go home. I thought if I just can go unconscious to intensive care I could dodge the paperwork on the way in because really all they seem to want to know is, “Who are you? How many cards have you got? Who’s going to pay?” Nobody ever thinks to ask
you how crook you are. But anyway I want to stay there until I am ready to go home because intensive care is great, spot on.

But please don’t send me to the ward. Oh, no. I’ve heard some shocking stories about the wards, those that haven’t closed down, of course. You really have to be fit to care for yourself in the ward, it seems. I heard of a woman in a car accident and she had to lay flat on her back for two months. Meals were placed at the end of the bed by the kitchen staff, she couldn’t reach it let alone feed herself. Sisters were all too busy with paperwork, and it’s not their job, so it’s thank God if you’ve got someone to visit you, they might keep you from starvation. The wards get dirty. The continual hygiene of yesteryear is not present, I am told. And I heard of the elderly woman who was put in the ward after surgery to find she was in bed next door to a male prisoner who was chained to his bed. Well, I suppose he was safe, wasn’t he, but they had to use shared facilities and, you know, I really think that’s pretty scary and degrading. It’s, you know, not what should be happening and I have heard of medicine mistakes. Not only wrong dose, wrong time but wrong patient. No, it’s definitely intensive care for me.

Whilst I am in awe of the achievements of our doctors and scientists, we lead the world in many fields but I feel in other ways no progress has been made. I think of my own experience 30 odd years ago when I had my last baby. I had to bypass our local hospital because of the fear of golden staph infection. My sister in law had caught it and she was on death’s door for three months so I wasn’t going there. Now, all these years down the track we have test tube babies, transplanting hearts, lungs, kidneys, eyes, you name it, from one human to another, immensely wonderful medicine. But sadly golden staff infection is still haunting us in our hospitals.

The casemix economy has resulted in funding being allotted for a patient for a certain number of days in hospital, for certain procedures, but they don’t know that we’re all different. And so if you go in there with gall bladder, you’re allowed six days, angina 3.2 days, hernia 2.1 days, appendectomy 3 days and hysterectomy 5 days. But if a patient needs to stay longer, and it’s my guess I reckon a fair few of them would, well, then the hospital’s budget is blown out. I am not sure what that means but if Dr Wooldridge had been here I’d have said, “Are you listening?” And then he would have said, “No, it’s State business.”

So, you can’t win. But anyway, obviously the base funding is not high enough. And in Adelaide we have a public hospital crisis with major city hospitals. They are diverting ambulances to other hospitals and this is happening very frequently because of overcrowding and our wards have been closed down due to lack of funding for the staff. Elective emergency surgery has been cancelled for up to two weeks. Some of this surgery is required for cancer sufferers so what a traumatic wait when timing is such an important factor in the survival rate of the patient.

I have been greatly heartened by the launch of the agribility project sponsored by the South Australian College of GPs. This will help injured farm workers with rehabilitation, reassurance and information and I have been equally disillusioned on receiving a letter from a grandmother of a cystic fibrosis sufferer on Eyre Peninsula. Her concerns were the removal of cystic fibrosis from automatic inclusion in the carer’s allowance which includes a review of those already receiving the allowance in 2003.
The way in which pulmozyme is arbitrarily delivered to those who might benefit from it but can’t afford to pay for it, and of huge concern is the fact that remote area hospitals are closing their doors to obstetric patients. This creates great hardships for women and their families especially the Aboriginal and Torres Strait Islander women. There are 150 expectant mothers in Roxby Downs and no obstetrics. I ask you, how many more do you need to make the practice viable? It doesn’t matter how many plans are made, there is the unforeseen emergency. Regionalisation is all right in theory but terribly impractical out there in rural and remote and very remote areas. These women are away from their homes and husbands for at least six weeks. Indemnity insurance is too high for general practitioners practising obstetrics. I realise some Government assistance is given for this but is it enough to make small practices viable? I think not. Another concern is that the number of midwives is seriously depleted in many country hospitals. More encouragement is needed to enable these positions to be filled.

I could speak more on this subject but it is time to assess what is a nurse in today’s society. A nurse is trained for three years in the uni with about twelve weeks practical experience in the hospital actually physically dealing with the patient, I am told. Yes, the patient. The patient who surely is the vital component in the medical profession. There is a huge shortage of young nurses, which is a health crisis in the making. We need different categories of nurses.

We’ve lost the bedside nurse, the one who fluffs your pillows up and smiles at you and knows when you’re uncomfortable without being told; the holistic nurses who have hands-on communication with the patient. Where has Florence Nightingale gone? The lamp’s gone out. We’ve lost her in the mechanism of the modern system. The patient is just a problem in today’s system. Nurses do not receive enough pay. They were ignored in the last Federal budget.

The very remote area nurse, and I speak in particular of nurses who work in places like Halls Creek, Cunnamulla and Cooktown, have on the whole to put up with sub-standard group accommodation with very second-rate shared facilities. We do not expect the doctor or the policeman in the town to have to share accommodation like this. These nurses who are out there in these areas where no end of enticing will get a doctor to live. These nurses are 24 hours a day, seven days a week. They are extremely important people so let’s look after them.

They must be supported and given the training and resources necessary to face with confidence the multitude of situations that they are confronted with. They are first on the scene and have to assess immediately before contacting the doctor for further advice. They are intermediaries, they are the nurses who give holistic care and may God bless every one of them.

Rural and remote people have limited access to routine dental treatment and are often only able to access emergency care and have to travel vast distances to specialist services. Eighty-eight per cent of dental services are provided by private sector through dental surgeries and dental clinics. The school dental service, a public service, is magnificent and we hope this service will stay in place forever. Unfortunately visits have been cut back drastically and students are waiting up to eighteen months between check-ups. This is far too long. Fluoridation of water supply has been one of the most effective health programs in Australia resulting in significantly lowering the number of
dental problems. Sadly, most rural and remote communities do not have fluoridated water supply. Poor dental and oral health is a major public health issue affecting the general health and social well-being of all.

Improved communications between all health professionals will lead to improved health outcomes. Lack of access to the range of allied health professionals in rural and remote communities is now being recognised as a major inhibiting factor to the development of a truly multi-disciplinary approach to primary care in rural and remote areas.

This lack of access to allied health professionals in rural and remote communities contributes to the decrease in the sustainability of health services. Over the past few years the Commonwealth Government has recognised and acknowledges the differences in the level of health and access to health services between people living in metropolitan Australia and people living in rural and remote areas. The Commonwealth Government has therefore made money available to improve access to health services.

I believe mental health area is one to be targeted. Please, we don’t need surveys and paperwork, we need action. Hands-on people are most important to communicate with the distressed young housewife, the child distraught, suicidal husband. We need more than the quick fix of anti-depressants which I believe are being prescribed freely to people from the age of twelve years upwards. In rural Australia businesses are collapsing for a variety of reasons, not necessarily of their own making.

There are increasing incidents of illness, particularly mental health problems and the high suicide rates speak of the seriousness of this problem. The role of the Rural Counsellor is vital in encouraging and guiding and supporting those in trouble and so enabling them to recover and rebuild their activities without recourse to hand-outs and potential family disintegration or self-destruction. The availability of mental health professionals, especially outside metropolitan areas, is a big problem.

Men, in particular, are worried about confidentiality and anonymity and general attitudes of people. They will find numerous reasons why they don’t need medical assistance. This is a big problem in the country. Mental hospitals have been closed and not replaced with enough comparable support in communities. Staff in general, in country hospitals, do not have the expertise to meet the needs of the mentally ill. Much more funding resources are needed to keep people in their own homes successfully.

Aged parents, in many cases, are expected to care for and be responsible for mentally ill adult children. This is totally unfair to all concerned. And youth suicide is the most distressing scourge to hit our country since World War 2. Statistics tell us that suicide rates of young men aged 15 to 24 have trebled since the early 1960s. The rates have not been uniform across geographic locations. In metropolitan areas the rates have doubled whereas in the communities with fewer than 4000 people there was a twelve-fold increase.

This is the impact of the depressed state of the agricultural industry and subsequent collapse of local businesses and the withdrawal of government and other services. Unemployment, poverty, family and inter-personal problems, homelessness and substance abuse are all contributing factors. The young Indigenous male suicide rate is
even higher than the national average. Cultural issues, family dislocation and unemployment are great factors with Indigenous suicide.

Government has poured millions of dollars into funding to support the National Youth Suicide Prevention Strategy to 1999–2000 but it’s all still happening. Have we lost the art of communication with our young? The TV culture of the 60s has been replaced with the computer and the Internet, the www.com culture. Neither are conducive to conversation and communication between families. These young people think that pressing the delete button on their lives is the only way out.

What a tragic situation we’ve got ourselves into. I applaud the Mind Matters Australia-wide program which puts mental health on the agenda in the secondary schools throughout Australia. The core of the program is a resource kit which provides advice to schools on how to adopt a whole school approach to mental health. We need health facilitators in rural and remote areas, someone, especially our young mothers in the bush can turn to for advice, reassurance and information in time of need. Lack of information can cause unnecessary trauma for a family.

Aged care is a major problem in rural and remote areas and the metropolitan area as well. Family members are moved from their homes and community environment into any available bed, be it hundreds of kilometres away. For example, I read of one lady who was moved from Darwin to Perth. This is traumatic and has very adverse effect on the frail aged. They become aggressive, more confused and traumatised and their condition is usually exacerbated by the upheaval in their lives. There have been cases where husbands and wives have been split up.

This is totally unacceptable for people who have contributed to this country for a lifetime. It is shameful. Whilst there are programs being developed to keep people in their own homes, they must be strictly monitored and be ongoing. Something has to be done to keep the aged in their familiar environments. It is estimated that aged care is under-funded by the Government to the tune of $200 million a year. Our small nursing homes around the country need that support. This problem really highlights the fact that we should always stay good friends with our children — because they will choose our nursing home!

This conference, I hope, will discuss and put recommendations forward to find solutions to these issues. It is imperative that the decision makers listen and take notice of the consumers’ point of view and recognise that there is no blanket solution. The solutions vary from place to place and situation to situation. Consumers must have an equitable voice on all health matters for the future well-being of all people of our nation.
AUTHOR

Marie Lally and her husband, Kevin, have pioneered land on Eyre Peninsular and brought it to full agricultural production, producing wheat, barley, peas and canola, while breeding sheep for pure merino wool and prime lamb.

Marie has been a member of the South Australian Country Women’s Association for thirty-five years, serving in all leadership positions, at branch, group, division and State level, including State President from 1996 to 1999. Internationally, Marie has represented the association at four World Conferences of the Associated Country Women of the World (ACWW) as a voting delegate, leading the State delegation to Pretoria in South Africa in 1998. She has also been a delegate at four South Pacific Area conferences of the ACWW, leading the delegation to Suva, Fiji, in 1999. Marie has worked on ACWW resource teams teaching the women of Western Samoa, and the island of Nuie, and Ernabella in South Australia, basic sewing and pattern drafting.

In her community, Marie has served on the SA Country Arts Trust as a board member for the Eyre Peninsula region, and also as a board member for the Lock Health and Welfare Centre. In 1998 Marie was awarded Citizen of the Year for community leadership by the Elliston District Council.