Where rural health is concerned, there were three main contextual issues for the recent Federal Budget. They were the ‘tax cuts versus services’ debate, the lapsing programs in the Regional Health Strategy, and big picture reform of the health system.

Since the previous edition of PARTYline there has been still more evidence that the majority of Australians would have preferred increased Government expenditure on services like health and education to tax cuts. The size of the tax cuts surprised some commentators and it is possible that responses to the ‘Which would you prefer?’ question would have been different had the size of the tax cuts been included.

Never mind the polling. Even without it there is a very good case for increased Government expenditure on key services. The ‘Services First’ Coalition, among others, has made the case clear by focusing on some of the main service inequities and deficiencies, the effects of which are borne disproportionately by those on low incomes and other disadvantaged groups, including the people of country areas.

- The proportion of doctors’ consultations that were bulk-billed fell from 78% in 2000 to 66% in 2003, and average Medicare gap fees rose from $10 to $14.
- Public schools receive one-third of Commonwealth funding to educate 70% of the nation’s students. Many schools are unable to afford basic repairs and are forced to increase class sizes.
- Over 70,000 eligible applicants missed out on first-round university offers for 2004. Over 40,000 applicants to TAFE courses cannot get a place due to a freeze on federal funding.
- There are 174,500 parents on waiting lists for childcare places, and childcare fees have risen by 25% in the past 18 months.
- 298 Aboriginal and Torres Strait Islander communities are located 100km or more from the nearest hospital and 15% of these do not have access to a GP.
- Public housing waiting lists grew by 15% between 1990 and 2001: from 195,000 to 223,290 households.

The second important background matter for rural health was the fact that the twelve programs comprising the Regional Health Strategy were all technically lapsing. They were put in place as part of

in this issue:
- Election 2004 and “PARTYline goes to the polls”
- Local government’s growing role in rural health
- Indigenous oral health
- Supporting transitions for nurses
- Investing in rail trails

continued on page 3
The push for fundamental reform of our health care system will not go away.

People are aware of the savings that could be made and frustrated by aspects of the current system that allow blame and cost to be shifted back and forth between the Commonwealth and the States/Territories. Jurisdictional inefficiencies contribute to the system’s failure to be patient-focused and to provide integrated care. Integrated care is provided by a system with close (‘seamless’?) collaboration between hospital, community and primary care systems.

Morbidity ‘hot spots’ include Indigenous health, mental health and the high rate of dental and oral disease. At the centre of what might be called the policy hot spot are further moves towards a user-pays system in health. There has been insufficient push to secure increased Medicare rebates across the board to meet the doctors’ demand for compensation for the value of their work and cost increases. Instead, MedicarePlus is instituting a two-tiered system which has a limited incentive for doctors to bulk bill some patients but not others.

Australians who believe in a ‘fair go’ want to maintain a health system in which access is determined by health need and for which the majority of costs are paid equitably (because progressively) through the tax system. It is unacceptable that poorer Australians and those with poorer access to services are up to five times more likely to die of a preventable disease than their wealthier compatriots.

The Australian Health Care Reform Alliance, under the leadership of John Dwyer, has been pushing this case and held a second meeting in Canberra in April. Most of the AHRA’s 27 Member Bodies were represented and the agreed priority proposals included:

- a unitary source of funding for health and aged care, through a joint Commonwealth/State Commission;
- allocation of indexed funding for critical groups, such as those with mental illness, dental problems or disability, and including rural, remote and Indigenous populations;
- explicit identification of community values and needs relating to health and health care;
- an integrated workforce strategy (to include national registration for individual professions) and national standards underpinned by data, surveillance, and quality and safety measures;
- a national primary health care framework for all health professionals, to include local primary health care teams;
- a national health information system with a unique patient identifier; and
- tied resourcing for Indigenous health according to need.

John Menadue proposed that a practicable step forward would be to have a joint Commonwealth/State Health Commission established for a particular State jurisdiction. Local government and non-government organisations would be among those tendering to the Commission to provide services. The Commission would hold all monies allocated by the Commonwealth and the State for acute care, aged care and domiciliary services.

Many organisations will need to be convinced before they support the move for reform. There would be some savings just from ending the duplication of government jurisdictions. When one level of government has to pay for a new drug on the PBS while the benefits of its use accrue to hospitals managed by another level of government, the challenges are clear. If one level of government fails to deliver subsidised primary health care in remote areas, the cost is borne by another.

Either we should focus on the preferred way forward or ban rhetorical statements about the deficiencies of the current system. If we opt for the former, the reform will be a challenge. But the bottom line is too important to give up on: no degree of complexity should stand between the Australian people and access to a quality health service in a timely fashion on the basis only of need. ❖
the $562 million made available, mostly to rural general practice, in Budget 2000-01. These programs - badged More Doctors, Better Services - have been the mainstay of the Australian Government’s new initiatives for rural and remote health over the past four years.

The programs were re-funded in the 2004 Budget to the tune of $830 million over the next four years. People in rural and remote areas will be pleased at this re-commitment by the Australian Government. Sue McAlpin, Chairperson of the Alliance, observed that the only new preventive measures in the Budget seemed to be those targeted at rural areas. She was referring to the allocation of a modest amount of money to address some of the prevalent causes of the poorer health in rural and remote areas: obesity, injury, low levels of physical activity and harmful levels of smoking and alcohol consumption.

The measures re-funded include Rural Clinical Schools, University Departments of Rural Health and additional places for GP Registrars in country areas. Also maintained are the expanded Rural Australian Medical Undergraduate Scholarships (RAMUS) scheme, HECS reimbursement for medical graduates in return for time spent working in rural areas, the bonded scholarship for medical students, and assistance for GPs through the Divisions of General Practice. There is new Rural Specialist Support (the previous Medical Specialist Outreach Assistance Program – amended to include assistance for existing regional specialists), support for some private health providers, and capital grants and viability funding for smaller rural and remote aged care facilities. Finally there are three programs now combined: Regional Health Services, the Rural Chronic Disease Initiative and More Allied Health Services.

The Alliance was also pleased to see extra support for the Primary Health Care Access Program, Lifeline, and the Longitudinal Study on Women’s Health – among other things.

The third contextual matter for rural and remote health in the Budget was the broad one of whether and how the Government is going to deal with the need for systemic change in Australia’s health care system. Some of the details are described in the Editorial to this edition of PARTYline. In summary, the case seems to have been made that the current system is ‘broke’ and that alternatives should be considered.

The Prime Minister was promising an audit of the current system when the Commonwealth, States and Territories met last August over the new Health Care Agreements. The Health Minister himself suggested (for a very brief period) that health care in Australia would be better if it was all in the hands of the Australian Government, and later agreed that the current situation is “a dog’s breakfast”.

As well as the PM and the Minister, many others feel that the case for fundamental change has been made: the rhetoric is accepted. What is now required is the action to shift financing agreements, institutional arrangements and operational matters so that we can reap the benefits of a better health care system – perhaps one run by a single level of government, not split between two. However, it is clear that getting to that situation will be a most complex matter in both public policy terms and in terms of the number of interest groups (including vested interests) that need to be involved and to be supportive if the change is to be successful and fairly speedy.

The recent Federal Budget did nothing to push on with this complex process. The best hope still rests with the organisations and individuals who believe that we have to embark now on the very challenging journey towards a different health care system. The Australian Health Reform Alliance and the National Healthcare Alliance are both playing leading roles in setting the directions for this journey and contributing to national momentum towards the final destination.

There is much to be gained for people in rural and remote areas from the proposed changes – in particular for those in more remote areas, for whom the maxim ‘No Doctor = No Medicare’ still holds true far too often. The NRHA will therefore continue to lend its support to the health reform process.

Apology

The Editor wishes to apologise to Dr Kathy Brotchie who appeared in a photograph on page 19 of the February 2004 issue of PARTYline. The headline inferred that Dr Brotchie was an optometrist when in fact she is not. We apologise for the misrepresentation.
Councillor Mike Montgomery, President of the Australian Local Government Association, writes to PARTYline about Good Health to Rural Communities.

Late last year, an unusual alliance of organisations with a significant interest in rural health got together to promote the recruitment and retention of doctors and other health professionals in rural Australia.

The result is a collaborative document, Good Health to Rural Communities, jointly developed by the Rural Doctors’ Association of Australia, the Australian Local Government Association, the National Farmers’ Federation, the Country Women’s Association of Australia and Health Consumers of Rural and Remote Australia.

Good Health to Rural Communities does not have magical answers to persistent workforce problems, but it advances practical measures that have broad community support.

Local government has been an enthusiastic participant in this exercise. Councils in regional Australia have always been closely involved in rural health care, through advocacy and intervention. It is invariably the council that has to step in when services that are the responsibility of federal or state governments dry up and disappear.

The report puts forward a ten point plan. One of the most significant measures for local government is the proposal for a federally-funded scheme to reimburse councils forced to spend scarce dollars on the purchase of medical centres and housing for health professionals.

In at least one case, a council has purchased an entire private hospital to ensure the shire did not lose access to acute care and specialist services.

Occasionally, councils can gain access to some form of federal or state assistance – for example, through the Australian Government’s Regional Solutions Program – to partly offset the cost of purchasing facilities and accommodation. But this is not guaranteed, nor does it fully cover the council resources allocated to the task.

A federally-funded infrastructure scheme would help secure the future of medical services in local communities and recognise the changing nature of rural medical practice. Not unexpectedly, fewer doctors are making long-term commitments to a single rural community, investing in a private practice with perhaps little hope of being able to make a significant return on its eventual sale.

We are now seeing an increasing number of transitory doctors. These doctors, often younger females, are moving in and out of rural and remote locations, often while training. With the much welcome advent of bonded scholarships and bonded medical school places, the changing nature of the medical workforce will become more pronounced.

As a result, these transitory doctors will look for salaried positions with attractive lifestyle packages. As the long term doctors retire, there will be fewer employment positions in group practices owned and run along traditional lines. There will be increasing pressure on councils to step in to purchase and manage medical practices.

While local government is a reluctant player, for many communities there will be no one else. That’s why it is important for state and federal governments to ensure councils are not forced to bear the cost of being the ‘Good Samaritan’.

Councils are tired of being on the receiving end of the cost shifting practices of state and federal governments.

Can we expect the Commonwealth to come to the party? Although it has already invested in significant new rural workforce measures, there are encouraging signs.

The fact that the Deputy Prime Minister, John Anderson, agreed to formally launch the report, is a good start. He committed the government to examining the proposal to reimburse councils for the infrastructure costs, saying it was “on paper, a very sensible proposition because of the changing practice of medicine”. “It is a possibility”, he said.

We hope to see solid responses from the major parties during the course of the year to all ten points detailed in Good Health to Rural Communities.

Changing nature of rural medical practice means increased pressure on Councils
‘Just’ Health

Australia’s Rural and Remote Health. A social justice perspective, by Janie Dade Smith. Thanks to Jane Dixon, Fellow, National Centre of Epidemiology and Population Health, Australian National University, for this special review.

This is a remarkable book. Like its author, who is multi-skilled, disciplined and experienced, Australia’s Rural and Remote Health is multi-dimensional. It is simultaneously plain speaking, learned, policy literate and humane.

For more than thirty years, Janie Smith has worked in rural, remote and Indigenous health and she is currently Associate Professor, Faculty of Medicine, Health and Molecular Sciences at James Cook University.

In the Foreword, Father Frank Brennan of the Jesuit Social Justice Centre summarises the central argument in the “good health in the bush will come only with a better quality of life for all who live there”. This means two things: increasing rural people’s access to services and employment, and other key determinants of health and well-being; and, not assuming that more money for rural health services will remedy the poorer health status of people living outside the cities.

The chapter that follows teases apart the term ‘rural’, and it includes a very important overview of the competing area classification systems used in the health and education arenas. Chapter Five is the final of the scene-setting chapters, providing a brief overview of what are known as the social determinants of health. These are factors that lie upstream of risk behaviours, and there is a description of the WHO determinants including income and social status, social support and early childhood development. Rural and Indigenous Australian perspectives of the social determinants of health are also presented.

Chapters Six to Ten are devoted to the health status of rural Australians and of remote Indigenous Australians, to the various approaches to delivering rural health services and to what is involved in educating a rural workforce. The final chapter enlists the book’s foundational perspectives of social justice, primary health care and the social determinants of health, to nominate the barriers to ‘just’ health services. These are:

1. Health departments maintaining responsibility for health, when portfolios such as education and housing play a greater role in population health;
2. The inadequacy of the current classification systems of what is rural and remote;
3. The education of the health workforce which maintains the dominance of medical practitioners;
4. The false assumptions held by city-based government and other decision-makers about rural life and rural disadvantage; and,
5. The expedient poll-driven policy solutions that emanate from governments.

Dr. Smith concludes that a major initiative is needed for rural and remote Australia, one that preserves the sustaining aspects of rural culture and one that is based on “rural leadership, grassroots approaches and participation by all parties, especially by those whose health is being acted upon”. Let’s see if we at last have the maturity and wisdom to create a ‘circuit breaker’ initiative that builds upon a socially just vision for all Australians.

Jane Dixon
Community Health target Koori Tobacco

The Bairnsdale Regional Health Service in Victoria is running a Koori Tobacco Program. Chris Shoemaker reports.

It was inspiring for me to hear recommendations from delegates at the 6th and 7th National Rural Health Conferences that artistic and creative methods of disseminating health information should be promoted and funded equally by arts and health departments.

The Victorian Department of Human Services has responded to this call, funding five community health programs that incorporate an arts component. Bairnsdale Regional Health Service was awarded funding for 12 months for innovative and creative health promotion work. The work addresses one of the ten priorities in the Koori Alcohol and Drug Plan 2003–2004.

The overall aim of the Plan is to respond to the high smoking rates in Koori communities (over half their people are smokers), increasing awareness and decreasing the impact and use of tobacco.

The project was designed and implemented from the outset through a committee comprising Koori Educators, Aboriginal Health Workers and other interested people from the Koori community. It has begun to produce some positive outcomes.

Taking up smoking, as with many other unhealthy or risk taking behaviours, happens for a myriad of reasons. The project has used a number of activities for encouraging healthy options, a greater sense of pride in the traditional cultures and skills of the region.

The project also affirms the choice of a healthy lifestyle and coping strategies that may be adapted on a broader scale.

During the planning and organisation of the community or school-focused activities, support is provided to Aboriginal Health Workers or Educators, adding to their skills and confidence. The people they come into contact with are given choices that will enable them to change behaviour and so enhance their health and well-being.

Information is shared and disseminated in the project within the bounds of cultural respect and permission. One of the project’s aims is to produce a book and health promotion posters using a collection of photographs and literature (poetry, stories and research findings) collected in the project.

Organising work days with key stakeholders from a number of different organisations can be challenging, but the benefits outweigh the difficulties. Projects of this kind can augment the skills of people in the multidisciplinary team. Collaboration in a multi-sectoral team also increases the human and financial resources available to the project. Collaboration between health and education services and professionals can empower young people.

We’d love to hear about community programs happening in your area. Contact the Editor on 02 6285 4660 or email michele@ruralhealth.org.au
**Indigenous oral health under the spotlight**

Nicola Johnston is Health Promotion/Education Officer with the Centre for Rural & Remote Oral Health at the University of Western Australia. Dr Helen Milroy is at the Centre for Aboriginal Medical and Dental Health at UWA. Contact CRROH at crroh@uwa.edu.au

Aboriginal and Torres Strait Islander people have more decay and gum disease than non-Indigenous Australians. Their children have nearly twice the decay rate in their baby teeth as non-Aboriginal and Torres Strait Islander children. These decay rates are increasing in Aboriginal and Torres Strait Islander children who live in remote areas. These statistics are especially alarming considering the state of oral health of our Indigenous people before colonisation, when they experienced good oral health and minimal oral disease.

**The issues**

Aboriginal and Torres Strait Islander people have significantly poorer health due to a number of factors including displacement from their homes, land and lifestyle. Family structures and communities have been traumatised and fragmented over generations and this has had a significant impact on their health and well-being.

They have had to adjust to new customs, laws and diets while trying to retain a sense of cultural integrity. The substantial changes in diet have had negative impacts on oral health.

This historical legacy has left them with many unresolved issues including native title, reconciliation and cultural security. Against this backdrop, it is not surprising that preventive oral health behaviours have been a relatively low priority.

**Where do we go from here?**

In theory, dental decay is a preventable disease. The two standard oral health messages for the prevention of decay are:

1. brush daily using standard toothpaste, i.e. containing fluoride; and
2. limit the frequency of sugar intake.

These messages are not new, but how do they fit with the lifestyles of Aboriginal and Torres Strait Islander people who may be mobile, have lowered self-esteem and feel disempowered? Where, for instance, would a child who sleeps in a different household each night leave a toothbrush? If they did own a toothbrush, how sterile would it be? Do they have access to toothpaste or the means to replace a toothbrush regularly?

One of the important challenges we face is to identify and develop messages and health care practices that are appropriate for Aboriginal and Torres Strait Islander people. Collaboration between health organisations, services and Aboriginal and Torres Strait Islander groups is required in order to deliver and promote holistic, achievable and effective oral health care and prevention.

The Centre for Rural and Remote Oral Health (CRROH) is one of several organisations working to develop strategies for long-term improvement in oral health. As part of this, CRROH has collaborated with various Aboriginal groups to develop Solid Smiles, an oral health resource kit designed for health professionals, childcare workers, and other groups to use. The kit includes information suitable for adults and special interest groups, and activities or games for children of all ages.

Smiles Ahead is an adaptation of Solid Smiles and contains information specifically for children under six and their parents and carers. Solid Smiles and Smiles Ahead are available for download from the CRROH website.

Marc Tennant, Director of CRROH, has confirmed that the Centre continues to look for new and innovative collaborative solutions to facilitate improving the oral health of Indigenous people.

Developing the Solid Smiles resource kit required extensive consultation and collaboration with various Aboriginal organisations. The end result is a user-friendly kit which people can utilise for either one-off lessons or workshops or as part of an ongoing oral health program within their community.

For more information on oral health contact the Centre for Rural and Remote Oral Health at crroh@uwa.edu.au, phone (08) 9346 7322, or visit www.crroh.uwa.edu.au
Rail Trails: physical networks for community health

A network of rail trails in Victoria is providing safe recreational opportunities, linking communities and having other economic and social benefits. Chris Shoemaker reports.

Rail trails are win-win-win developments – and Victoria is showing the way. The concept of linking people with open spaces may not be new to those familiar with the bike paths of Melbourne or Canberra, but it is a most welcome development for those wanting safer riding experiences in country areas. Rail trails run along disused railway lines or abandoned forest tramways, and are providing safe and accessible pathways for walking, cycling and horse riding enthusiasts.

The Victorian Government has been encouraged to assist by Railtrails Australia, a non-profit community association (www.railtrails.org.au). The Government has provided some much-needed funds for capital and further works, and also resources to assist Committees of Management to manage complex issues related to land ownership, leases and other legal matters associated with establishing management structures for trails.

There are approximately 30 operational trails in Victoria - more than the rest of the country combined - often with local government as a keystone of the legal management structure.

In East Gippsland, the original 30 km trail became the dream of a dedicated group of volunteers, working with designated employees and under the governance of the Department of Natural Resources and Environment. With 38 km nearing completion, there will soon be 95 km of continuous rail trail in East Gippsland, with an additional network of trails through adjoining State forests, linking at least six rural and remote communities.

As local communities and governments realise the potential value of trails, more are being developed in other States, under varying funding and management models. Recent studies have shown rail trails to be a catalyst to economic growth in surrounding rural communities. The benefits are evident through business, employment and tourism ventures, with the new visitors to the region said to be spending in excess of $100 a day. The trails can become green linear parks and wildlife corridors, with the development offering an administrative structure to ensure that the rail reserve is managed for its historical, cultural and ecological values.

The recent call for expressions of interest to join the Friends of the East Gippsland Rail Trail saw more than 100 people show their commitment to this valuable community recreational resource. The Friends committee will support the Committee of Management with tasks varying from writing submissions for grants to clearance of trail-overgrowth. The rail trail has become a vehicle for social and community networks, and will also provide opportunities for the development of new skills.

With gradients no steeper than 1 in 30, these trails are suitable for all who can ride a bike or enjoy walking. This allows opportunities for young children and older people to gain or maintain physical confidence and strength in safe and financially affordable activities.

Successful rail trail ventures grow from foundations of strong local partnerships, with a strong sense of ownership and pride.

As well as the health and well-being I personally have gained from this resource, I have also been able to see the strength that comes from community consultation and action, intersectoral collaboration, capacity building and the strengthening of social connectedness. These things have led to healthier people, environments and communities.

Over 50,000 kilometres of railway line have been abandoned throughout Australia since the 1930s. Why not consider rail trails as an additional way to develop community and health opportunities near your own town?

For more information visit www.railtrails.org.au

Chris Shoemaker

National Rural Health Alliance, Number 18, May 2004
Supporting transition to a new clinical setting

Healthcare professionals, whether registered, enrolled or accredited, are required to demonstrate a predetermined level of generic competency (knowledge, skill, attitude) as a prerequisite to joining their community of practice. This competency is a starting point and signifies that the individual is a safe beginning practitioner. However, when this newly-qualified practitioner begins practice in an unfamiliar clinical setting, he or she enters a period of transition. ‘Transition’ has recently been described as the period of learning, adjustment and socialisation, when the practitioner applies, consolidates and increases their existing knowledge, gaining competence that is applicable to the context in which they are expected to perform.

The anxiety and stress associated with this transition period are described in the nursing workforce literature. Given the increased mobility of the workforce and the trend towards specialisation and technological approaches to healthcare, the nurse may experience many such ‘starting points’ through her/his career. Any employee who is unfamiliar with the role expected of them, the clinical setting, clinical tools, patient population, or the underpinning social and cultural context of the workforce they are entering, is an employee likely to experience ‘uncertainty’ in their functional capacity. This uncertainty is likely to be compounded by an expectation that they should ‘hit the deck running’.

So how do we facilitate transition? The health professional has the ‘blueprint’, having met the essential criteria for the position. However, from their colleagues, managers and the wider healthcare community, they require a safe and supported environment in which to consolidate their previous learning experiences. They do not need extensive retraining for their new role – only time to transfer their training to meet its requirements.

To provide a safe and supportive environment, it is necessary first to acknowledge the new employee as an adult health professional who understands accountability and is motivated. Next, the workplace has to be a place in which learning is valued. Thirdly, clear and detailed descriptions of the workplace routine, expectations, standards and core competencies are required. Opportunities for self-assessment, goal development, critical feedback and reflection will also help the professional to function safely and effectively.

The Department of Nursing at the University of Wollongong and Illawarra Health have created a joint appointment to improve the transition support available to nurses in the Illawarra Region. The Nursing Workforce Transition Co-ordinator will build partnerships between Illawarra Health and the University of Wollongong, and enhance opportunities for nurses to practise and reflect on their profession in a supportive clinical environment.

Karen Patterson, Nursing Workforce Transition Coordinator, Illawarra Health/University of Wollongong

pattersonk@iahs.nsw.gov.au ➔
PART Yline goes to the Polls

Rural health continues to be an important issue for rural, regional and remote communities. But will it be important for the parties who seek the votes of rural Australians? PART Yline went searching for some answers. We brought Ralph McLean out of ‘retirement’ to talk to some rural voters in the warm-up for this year’s federal election. Ralph worked in government and rural health from 1993–95 and 1998–2000.

Bruce Walker, Alice Springs

Bruce Walker works as Project Leader at the Centre for Appropriate Technology in Alice Springs.

In the rangelands, where populations are sparse and difficult to service, there are few politicians. “Because of our small numbers we don’t have a lot of ‘pull’ with governments – we must use logical arguments,” he says. “We have to look at a range of angles, not purely the economic ones. Out here, with our desert focus, sustaining wealth is about understanding what we’ve got and how to use it. Out here we don’t tend to factor in the politicians… the politicians follow.”

Bruce says that the present government has recognised the importance of rural and remote health, following the greater recognition of the mid 1990s by both sides of politics that things weren’t equitable in health outside the big cities and regional centres. He points to the continuing need to improve primary care and to train and retain more practitioners. “It’s hard to convince practitioners to come to our neck of the woods where they can be missing their lattes!”

Gary Misan, Whyalla

Gary Misan works with the University Department of Rural Health and the Rural Clinical School in Whyalla at the University of South Australia.

He thinks rural health issues “should be important – but the way the political landscape is shaped for now they don’t look like showing up strongly in the election platforms”. He believes that the election will more likely “focus around issues of national security and terrorism and general issues [like] education, equity and access – and health”.

“Issues around Medicare will be where the focus lies. There doesn’t seem to be a strong undercurrent [for rural health to be dealt with]”. With his “pragmatist’s hat on”, Gary recognises that improvements have been marked in some areas, but the issues around rural, regional and Aboriginal health remain.

“The rural politicians will have their hands tied… by Party lines,” says Gary. “This is despite the work done to lobby both State and Commonwealth politicians.”

Bruce Robertson, Wangaratta

Bruce Robertson practises as a pharmacist in Wangaratta.

“There needs to be a very clear and unashamed commitment to the non-medical workforce” in the platforms of the Parties at the election, Bruce begins. “At present almost all the emphasis has been on medicine… money [has been] spent and programs established for GPs and their families”. Whilst recognising the benefits of the current programs, Bruce points to “the rest of the health professions [being] very poor cousins by comparison. The politicians need to look beyond medicine and they have to put some serious money into allied, nursing, pharmacy and the other health professions. It’s a great model, but there’s more to the health workforce than just doctors”.

He doesn’t stop at the general problems of the health professions and rural communities. “There needs to be a serious...”

Bruce Robertson: “The politicians need to look beyond medicine and they have to put some serious money into allied, nursing, pharmacy and the other health professions.”
commitment to the issue of Indigenous health. It’s a matter of shame for Australians – the issue needs to be depoliticised. Political points shouldn’t be scored on the basis of Indigenous health. There needs to be a politically bipartisan Indigenous health policy … and one which crosses the State and Commonwealth divide.” Bruce emphasises the importance of asking the Aboriginal communities what can help. “There is no one-size-fits-all solution for it. It needs real partnerships.”

“I’d like to see [rural and Indigenous health] higher up the political agenda. There have been some gains but we shouldn’t rest on past successes… we need to agree that there are still lots things to be done … money and political will are essential”.

Damien Niven, Chinchilla

Dr Damien Niven’s medical practice is in Chinchilla in Queensland’s southern heartland.

He thinks the “Federal Government has demonstrated an understanding [of rural health]. I think they’ve listened to the Rural Doctors’ Association of Australia, who have spent years working on solutions … They’ve been astute. They’ve taken initiatives.”

Asked how important rural, regional and remote health issues will be in the election, Dr Niven says he doesn’t think they will be significant in every community and electorate. “There is a looming threat of suffering in some areas without doctors. Although we complain about lack of doctors, many communities are able to meet local needs.”

He points to the many initiatives taken in medical services by the current government where the “fruits [of our labour] have paid off”. He thinks the “present government will maintain their stronghold. A lot of people pooh pooh local government area [for] … some youth service provision – national programs don’t cover every geographic area, and we need blanket coverage”.

When asked whether she thinks rural health and rural communities will vote for the current government or the Opposition, there’s the hint of a smile in her voice as she says “I think John will have a bit of a run for his money …”

Rowena Allen, Shepparton

Rowena Allen is the CEO of Uniting Care’s Cutting Edge Youth Service, based in Shepparton but working in towns large and small along the NSW/Victoria border.

“We’ve had droughts and other local and regional problems. There aren’t as many new services going into regional areas as have been promised.”

“In some communities, we’ve got new arrivals who aren’t being supported. In our region, there are a lot of [newcomer] Albanians and Iraqis … [needing] a bigger range of services”.

“Population growth also needs to be met. Services are being dismantled in the smaller centres. Regional centres are thriving in numbers, but new services are not necessarily established”.

Getting down to the political choices faced, she says, “country people give the government of the day a good chance. They don’t change their votes for the sake of it.” In her area of youth services, Rowena points to the need “within every

Rural health and the election

It’s clear that rural health issues are still important for bush residents. Although they are satisfied that many rural health issues have been addressed by the current government and its predecessors, there are still many to be dealt with. Medical programs and programs in the universities have been put in place and in most cases are up and running, but broad-based primary care and other community solutions are yet to be given the emphasis they deserve. Only the Election, and the new government – whatever its political shade – will tell if those other solutions are to be pursued.

Ralph McLean
MENTAL HEALTH

Beyondblue: working for better mental health

Depression is a major risk factor for suicide, particularly in regional Australia where primary health care services are often limited. Tragically some 2500 people die from suicide each year in Australia – considerably more than the national road toll.1

Getting help for depression in rural Australia is not easy - but the situation is improving, according to Leonie Young, CEO of beyondblue: the national depression initiative.

Changes in MedicarePlus mean that Medicare will pay for a limited number of interventions by allied health professionals, as long as the work is done through a doctor. There will be additional mental health payments for GPs in rural areas, providing increased services and enabling more of those with symptoms of depression to get help.

The main reasons for people in country areas not getting help with depression are limited access to services, limited choice, and cost. The inclusion in Medicare of psychologists, mental health workers, Aboriginal Health Workers and occupational therapists, in association with general practitioners, will provide extra health care options for rural people with depression and related disorders.

beyondblue’s clinical adviser, Professor Ian Hickie, says that depression and anxiety can be every bit as serious and debilitating as physical illness.

One in five people experience depression in their life - more than one million people in Australia in any one year. Of these, less than half receive medical care. beyondblue is working to raise community awareness and reduce stigma and discrimination associated with depression, anxiety and related disorders.

beyondblue is independent of Government, and brings together the expertise and experiences of health services, schools, workplaces, universities, media and community organisations – as well as people living with depression. Its extensive research partnerships include those on the prevention of post-natal depression, depression in the workplace, within the education system, among young people and Indigenous Australians, and in regional Australia. Important work remains to be done on the further development of preventative programs and their dissemination to individuals and community groups throughout Australia - including to rural and remote areas.

beyondblue’s rural, regional and remote health programs are being strengthened through a new research partnership with the University of Sydney’s Northern Rivers Department of Rural Health at Lismore. Dr Kim Webber is working at beyondblue until the end of the year.

Dr Webber is leading a team of rural health researchers from across Australia working with local communities and service providers to investigate the relationship between rural general practitioners and regional hospitals.

Related research programs funded by beyondblue include a comparison of depression prevalence in rural and urban Australia, and issues relating to promoting mental health in the bush.

For more information on beyondblue, including on early intervention in depression, visit www.beyondblue.org.au or contact Brian Peck, beyondblue Communications Manager on (03) 9810 6108 or Professor Ian Hickie, beyondblue Clinical Adviser.

1. 1,627 people were killed on Australia’s roads in the year to September 2003 – down 112 on the corresponding period for the previous year.
www.itsallright.org - a new SANE website for young people with family or friends affected by mental illness.

It is estimated that 85 per cent of us will be affected by mental illness at some time in our lives - either directly or through family or friends. One in four young people aged between 18 and 24 will develop a mental disorder. Thirty thousand young people in Australia have a parent with a mental illness - and many of them have a primary care role.

www.itsallright.org provides young people with a fun way to learn about mental illness, in a language they can understand. The website helps 13 to 17 year-olds with information, advice and referral to support agencies, through a friendly story-based website.

SANE Australia is a national charity helping people affected by mental illness. Its Executive Director, Barbara Hocking, says there is a growing recognition of the need to educate young people about mental illness. Better understanding of the conditions can make all the difference to health outcomes.

The website is designed to appeal to teens and has a funky interface. The story of four fictional characters is told through entries in their online diaries (blogs), as they meet at a group for young people with families affected by mental illness. The blogs are updated weekly.

The site was developed in consultation with young people who have a family member with a mental illness. Helplessness, confusion, guilt, anger, sadness, embarrassment, fear and conflicting emotions of love and resentment are some of the feelings young people have when someone they care about is mentally ill.

Sixteen year-old Dan Halloran says there have been some very hard times with his mother in and out of hospital: “Mum’s schizophrenia has robbed me of a lot of time other kids have with their mums. Young people need help to understand what’s going on because they still love the person with the illness and the person loves them.”

Professor Fiona Stanley, Board Member of the Telstra Foundation, which gave a grant to develop the website, said: “I’m very pleased that the Telstra Foundation has supported the site’s development as it’s so important we make sure this type of information is presented positively and in a way that is accessible to young people”.

“I think this website is a wonderful initiative by SANE. It’s a great site for young people to learn about mental illness and to start to understand and support those who are dealing with its challenges every day,” she said.

Australian Journal of Rural Health

Telling your story

Do you have a rural health story to tell? Have you learnt something in your rural health experiences that might be valuable to others?

The AJRH is brightening its look with a new full-colour cover and also increasing the scope of its content. In addition to the original research articles for which it is highly regarded, the AJRH is now seeking letters to the Editor and contributions of shorter articles with the same relevance to rural, multi-disciplinary health provision.

“Grazings” is a new column for short reflections, humorous or philosophical pieces. Obituaries, practice pointers or clinical tips will also be accepted. Just keep in mind that the Journal has a multi-professional readership with a rural interest.

If you have a good idea but have never written before, the AJRH Editorial team is happy to provide help and advice. Articles should run between 250 and 600 words, and should be sent to the Editor at AJRH@newcastle.edu.au

Complete author guidelines are at www.blackwellpublishing.com/ajr

For a one month free trial go to freetrial@blackwellpublishasia.com
Empowering Communities

Julian Krieg is a Project Officer with the Central Wheatbelt Division of General Practice in WA. Julian describes the ‘Alive and Well’ men’s health program.

The ‘Wheatbelt Support Services’ program was born of a desperate need to find an alternative solution to prescribing anti-depressant drugs to the large number of patients with problems of a non-physical kind. We have a team of six counsellors funded through the More Allied Health Services and Regional Health Services initiatives. In addition, a Community Educator is funded under the National Suicide Prevention Strategy to focus on keeping people ‘Alive and Well’.

‘Alive and Well’ is based on the philosophy that members of the community can do much to help themselves in the reduction of mental illness. A key strategy is to talk to men and women in places where they regularly meet and using these opportunities to raise awareness of mental health issues.

The project focuses on giving lay people the skills – and therefore the confidence – to intervene and care for others around them who are experiencing a mental health challenge. Even in rural areas, people have never before had such good access to health professionals. Unfortunately this has led to the mistaken belief that professionals will solve all the local health problems – whether it is an emotional issue, a physical health problem, or inadequate health education for their kids. If communities continue to leave it all to health professionals, there will never be enough of them to do the job.

‘Alive and Well’ has been running for about two years and is producing some positive results. There have been numerous instances in which people have expressed concern about the well-being of others and referred them to our service. We have provided advice and support on a wide range of matters: financial issues, family breakdowns, dismissal from work, and the loss of a colleague to suicide.

The number of participants and observers in the ‘Alive and Well’ scheme continues to grow. Our aim is to help more and more people to help each other. If we continue to develop programs to empower people in the community, this will take the load off health professionals and give them more time to care for those in most need.

Rural Women and Drought

Judy Swann, Executive Officer for the National Rural Women’s Coalition, outlines the Coalition’s work on drought.

The social impact of drought in Australia has been severe. Income levels for farm families have continued to decrease in comparison to our urban counterparts. The social impact of these changes has resulted in increased rural poverty, reduction in access to health, education and welfare services and increased stress in farm families and communities.

Services that are offered on an ad hoc or inconsistent basis are causing further stress to farm families. Services through a welfare provider are not appropriate in the rural sector due to the stigma associated with ‘poverty’, inadequate staff training and the equity issues surrounding rural income testing.

The reluctance of farmers to access this type of support impacts on the welfare of the family.

The NRWC believes that supporting rural communities and developing policies that enhance capacity building is the key to long-term success. Community capacity building is a whole-of-community responsibility and should incorporate a collaborative approach by the three tiers of government, non-government organisations and community stakeholders.

The National Rural Women’s Coalition (NRWC) has released a Policy Paper outlining key recommendations made by rural women regarding climatic variability. Managing Drought – Managing Solutions is available at www.ruralwomen.org.au For more information contact Mrs Judy Swann, on 02 6162 0430 or judy.swann@ruralwomen.org.au
Use of computers and the internet in rural, regional and remote Australia

Leanne Coleman is Office Manager at the Alliance. Leanne is interested in how many of you actually get her emails – and browse the Alliance’s website.

According to the Australian Bureau of Statistics, 61% of Australian households had access to a computer at home in 2002 (up from 44% of households in 1998) and 46% of Australian households had home internet access (up from 16% in 1998). The ABS data also show that households with children, higher incomes and located in metropolitan areas were more likely to have computer and internet access than – respectively – those without children, on lower incomes and located in non-metropolitan areas.

In 2001, non-metropolitan Australia had a population of 16.9 million people, 36.6% of all Australians and growing at a rate of 0.8% per annum. In 2000, of Australia’s 19.1 million people, there were 3.9 million registered internet subscribers.

The Bureau of Rural Sciences recently produced a report, ‘Country Matters, Social Atlas of Rural and Regional Australia’ which provides data on social and demographic issues and trends in rural and regional Australia.

The Social Atlas describes the similarities and differences between Metropolitan and Non-metropolitan Australia. It gives details for a range of population, employment, household, income and education factors. More importantly, the Social Atlas highlights the rich and diverse nature of Non-metropolitan Australia and some stark contrasts across Non-metropolitan regions.

According to the report, 44% of Australians reported that they had used a computer at home in the week prior to the Census in 2001 (46% in metropolitan areas and 39% in non-metropolitan areas). Internet use was also lower in non-metropolitan areas with 43.6% of people in the major cities accessing the internet and only 32.4% in non-metropolitan areas.

The figures above focus on computer and internet use in the home. The use of computers in the workplace is another issue. Many workplaces have sophisticated IT facilities but accessing them is another issue. Some workplaces have limited internet access with restrictions on certain websites. In other workplaces not everyone has a computer on their desk and staff have to take time out to access one of the public computers with internet access. Many people in the health sector are busy tending to patients and do not work in front of a computer all day.

Many of us have learned that it is all very well to email important information – but you can never be sure the person at the other end has the technical capacity, the time and the permissions to receive it.

Even if they have all three, they may be affected by trojan horses, viruses, worms, spoofing, spam filters, broadband, bits, bugs, bots, bytes, crawlers and nibbles – Keep in touch please – by whatever means you can!

1. ABS Household Use of Information Technology, Australia (cat. no. 8146.0).

IT Needs of Rural and Remote Nurses

Lack of access to information technology (IT) has been identified as a priority issue for nurses in rural and remote areas. There is little evidence of what IT is currently available, how widely it is used, or how IT could be brought into more routine use for the benefit of rural and remote area nurses. The nursing project partners, led by AARN, the ANF and CRANA, are undertaking a pilot to collect information to identify the extent of these issues, with a view to finding ways to address them more systematically.

- What are the key IT issues for rural and remote nurses in your area?
- What would make a difference?
- What are the main needs – data line access, hardware, education, motivation?
- What assistance would work – and what benefits would result?

Visit ‘Special Projects’ at www.ruralhealth.org.au for background and working papers from the Project and contact Chris Moorhouse at the National Rural Health Alliance (chris@ruralhealth.org.au).
GAPP: multidisciplinary support for new rural health graduates

Simone Bartrop is Project Officer for the Australian Rural Health Education Network (ARHEN) and for the Graduate Assistance & Partnerships Program (GAPP).

The Graduate Assistance & Partnerships Program (GAPP) provides support to health graduates who are in transition from training to a career in a rural or remote area.

GAPP began in January 2004 and is managed by the Australian Rural Health Education Network (ARHEN). It is funded by the Department of Health and Ageing until the end of December 2005 and is an initiative of the National Rural Health Network (NRHN), building upon the Network’s achievements at undergraduate level.

It helps to overcome the isolation that may be experienced by new graduates practising in rural and remote areas by providing a forum for support, information dissemination and advocacy. The program aims to fill the ‘gap’ between being a student with rural or remote aspirations and an established rural or remote professional.

GAPP builds partnerships and a communication network that facilitates discussion, peer-support and access to information and resources. The network helps graduates to pursue rural careers; it promotes awareness of various training and career pathways, addresses problems of social and professional isolation, and provides a national voice for new health professionals with an interest in rural and remote health.

In the long term GAPP hopes to provide a means for health graduates to act as mentors and advisors to student Rural Health Club members, and it will track the progress and activity of graduates through the creation and maintenance of a longitudinal database.

The Graduate Assistance and Partnerships Program has won widespread support from both professional organisations and government and is a very exciting initiative that will forge opportunities and vital links for new health professionals in rural and remote areas.

If you would like more information about GAPP please contact Simone Bartrop on 02 6282 2166, email: projects@arhen.org.au or visit the website at www.gapp.org.au.

8th National Rural Health Conference

Central to health: sustaining well-being in remote and rural Australia

10–13 March 2005 Alice Springs, NT

Interested in submitting a Paper?

Deadline for abstracts: 15 July, 2004
For more information go to www.ruralhealth.org.au
Email: conference@ruralhealth.org.au
Phone: 02 6285 4660 Fax: 02 6285 4670
Useful Websites

Blackwell Publishing: Australian Journal of Rural Health: the AJRH is a multidisciplinary refereed journal contributing to the accumulation of knowledge of rural health in Australia. www.blackwellpublishing.com/ajr

Volunteering Australia: the national peak body working to advance volunteering in the Australian community. www.volunteeringaustralia.org

Rural Doctors Association of Australia: Good Health To Rural Communities – Ten Point Plan, 24 March 2004 www.rdaa.com.au

The Matagouri Club: is an undergraduate health science student club with a rural flavour at the University of Otago. www.otago.ac.nz/matagouri


HealthInsite: Through this site you will find a wide range of up-to-date and quality assessed information on important health topics such as diabetes, cancer, mental health and asthma. www.healthinsite.gov.au

Volunteers for Isolated Students’ Education: VISE volunteers provide assistance to support the distance education of students in rural Australia, and domestic and personal support in the case of emergencies or when respite is necessary. www.vise.org.au

Pfizer Australia Health Report www.healthreport.com.au

Issue 1: Depression, February 2004
Issue 2: Parkinsons, February 2004
Issue 3: Healthy Lungs, March 2004
Issue 4: Healthy Kidneys, April 2004

Australian Organ Donor Register: www.hic.gov.au/yourhealth

Australian Alcohol Guidelines: interactive quiz www.alcoholguidelines.gov.au


Anti-Poverty Week: In 2004, Anti-Poverty Week begins on Sunday 17 October and finishes on Friday 22 October. www.antipovertyweek.org.au


Aged Care Standards and Accreditation Agency is the independent body responsible for managing the accreditation and ongoing supervision of Commonwealth-funded aged care homes. www.accreditation.aust.com

Australian Transport Safety Bureau, Fatal Road Crash Database is presented by ATSB for public use and provides basic details of the road transport crash fatalities in Australia as reported by the police each month to the State and Territory road safety authorities. tssu.atsb.gov.au


Rural Realities

The Bureau of Rural Sciences has shed some light on rural and regional Australia in Country Matters: Social Atlas of Rural and Regional Australia. See www.brs.gov.au

Overall, Australia’s non-metropolitan population grew by 0.8% per annum between 1996–2001, compared with the average national growth rate of 1.1% per annum.

Unemployment rates in 2001 averaged 8.4% in non-metropolitan and 6.8% in metropolitan areas. The national average was 7.4%. Rates well above average were recorded in Mount Morgan (23.4%), Tiaro (20.3%) and Bilinga (18.7%).

Youth unemployment was higher in non-metropolitan areas (15.9%) than metropolitan areas (12.8%). It was higher in populated coastal areas (18.1%) and Regional Cities (17.3%) than in populated inland areas (14.3%) and remote areas (9.9%).

Between 1996 and 2001 the number of people with a university qualification increased at a higher rate in non-metropolitan than metropolitan areas (33.5% compared to 31.9%). There were some marked variations. Above average growth occurred in Regional Cities (38.7%) and populated coastal areas (34.8%). Growth was below average in populated inland (29.8%) and in the remote region (26.2%).

In 2001, there was a higher proportion of families receiving a weekly income of less than $300 in non-metropolitan (16.3%) compared to metropolitan areas (12.3%). The national average was 13.9%. ☑
Movement at the station

Robert Fitzgerald is now a Commissioner with the Productivity Commission. He was previously the Community and Disability Services Commissioner with the NSW Ombudsman.

Joy Burch has been appointed the Executive Officer of the Australian Rural Health Education Network (ARHEN) based in Canberra. Her predecessor in the position, Kathy Bell, is now CEO of the NT Remote Health Workforce Agency and General Practice Divisions.

Natasha Cole has left Rural Health for a position in the Overseas Trained Doctor Taskforce. Maria Jolly will temporarily fill Natasha’s previous position, with Alison Sewell taking over in early June.

Lesley Seigloff has taken a new position as the Director of Nursing at the Kingston Soldiers Memorial Hospital in Kingston, South Australia. Lesley, who was a long-standing member of the Alliance Council representing AARN, was previously Director of Nursing at Waranga Memorial Hospital and Hostel in Rushworth, Victoria.

Steve Clark will leave his position as CEO of the Australian Divisions of General Practice in July. Steve will head up the Australian Rural Leadership Foundation.

Lynne Sheehan (pictured above) has been appointed to the position of Deputy Chairperson of the National Rural Health Alliance. The position became vacant when Shelagh Lowe took on her new role as the Executive Officer of Services for Australian Rural and Remote Allied Health (SARRAH).
Rural, Regional and Remote Health: A Guide To Remoteness Classifications

Ever wanted to know the strengths and weaknesses of RRMA, ARIA and ASGC?

Ever wanted to know just what the initials stand for?! This recent publication from the Australian Institute of Health and Welfare, reviews the methodology behind the three major classification systems used to describe remoteness: RRMA (Rural, Remote and Metropolitan Areas), the ARIA (Accessibility/Remoteness Index of Australia), and ASGC (Australian Standard Geographical Classification) system. It also summarises how the classifications are applied to administrative and survey data.

See www.aihw.gov.au/publications

Water for rural industries and communities

There seems to be another stoush over Australia’s water resources - and the Murray-Darling basin in particular. The interim report from the House of Representatives Standing Committee (www.aph.gov.au/house/committee/primind/watering/index.htm) begins: “In light of the Committee’s severe reservations about the science, [it] recommends that the Australian Government urge the Murray-Darling Basin Ministerial Council to postpone plans to commit an additional 500 gigalitres in increased river flows to the River Murray...” The brief report makes interesting reading - and all rural people must be interested in the future of water supplies. (Dick Adams, Member for Lyons, wrote a dissenting report.)

Innovation in rural Queensland: Why some towns prosper while others languish

What are the characteristics that make some towns prosper while others, facing similar social, economic and environmental pressures, still decline? A report commissioned by the Queensland Department of Primary Industries and Fisheries has the findings from a survey of eight small towns in the State. Innovative towns were more likely to have residents who were tolerant of others, who have been educated and traveled overseas, and have the managerial and administrative capacity to organise whatever needs to be done.


Treating kids with asthma-getting it right is available online at www.NationalAsthma.org.au/roadshow

Falls Prevention

The Australian Council for Safety and Quality in Health Care, in association with Queensland Health, is holding consultation workshops to inform the Australian Falls Prevention Project. Consultations will be held in each capital city, Mildura and Dubbo and some specific Indigenous and Culturally and Linguistically Diverse sites. Rural and Remote Teleconference will also be held to complement consultation workshops. Registration is essential. For further information contact Michael Bourke, Principal Project Officer (07) 3275 6542 or email australianfallsprevention@health.qld.gov.au

Church + Football = Sex?

First it was sexual abuse in the church - treated as if it is a church issue rather than one related to sexuality. (But at least we were discussing it.) Then it was football and sex - treated as a cultural issue for football. One day we'll be bold enough to discuss sexuality itself as an issue: what it is, what are its manifestations, how it is related to power in various settings, and how it is used and abused. After that we can discuss its particular rural aspects, like stigma and transparency.
Health calendar

JULY 2004
ACRRM Scientific Forum on Rural and Remote Medicine
‘Recognising Rural and Remote Medicine’
8–11 July 2004
Alice Springs
www.acrrm.org.au

ACHSE National Congress – The Leading Edge
20–22 July 2004
Darwin
www.achse.org.au/frameset.html

AUGUST 2004
2004 Federal Conference
Isolated Children’s Parents’ Association
5–6 August 2004
Perth

General Practice Education and Training Ltd (GPET) Annual Convention
11–14 August 2004
Brisbane
www.gpet.com.au

The National SARRAH Conference
26–28 August 2004
‘Walking together side by side’
Alice Springs
www.sarrah.org.au

SEPTEMBER 2004
CATSIN Annual Conference
1–3 September 2004
Coffs Harbour

8th Biennial International Paediatric and Child Health Nurses Conference
‘Bringing it together for kids and families’
1–3 September 2004
Adelaide

Catholic Health Aust Conference 2004
‘Just Care’
6–8 September 2004
Adelaide
www.cha.org.au

SEGRA 2004
‘Sustainable Economic Growth for Regional Australia’
6–8 September
Alice Springs
www.segra.com.au

8th National Undergraduate Rural Health Conference
28 September – 2 October 2004
Tanunda, SA
www.nrhn.org.au

RACGP 47th Annual Scientific Convention and AGM
30 September – 3 October 2004
Melbourne

Divisions of General Practice Network Forum 2004
‘Taking Action’
23–26 September 2004
Adelaide Convention Centre

Council of Remote Area Nurses of Australia 22nd Annual Conference
‘Remote Isolated Community Experience’
24–27 September 2004
Fremantle WA
www.cranau.org.au

Aged and Community Services Australia – 17th National Conference
‘Mummy, what’s going to happen to Grandma?’
3–6 October 2004
Hobart
www.agedcare.org.au

MARCH 2005
8th National Rural Health Conference March 2005
‘Central to Health: sustaining well-being in remote and rural Australia’.
Alice Springs
www.ruralhealth.org.au