Arts in the heart of the country

Dentist puts smiles into Nhulunbuy

Integrated pain management service at Mildura

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Teena receives University of Wollongong Young Alumni award

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Scholarships for rural medical students
The Alliance will be monitoring the forthcoming transition from 61 Medicare Locals (MLs) to 30 Primary Health Networks (PHNs). The change, to be effected by 1 July 2015, poses some threats and some opportunities to health patients and services in rural and remote areas.

As was the case with Medicare Locals, there will be just one PHN in the Northern Territory and Tasmania. In WA the area covered by the three non-metropolitan Medicare Locals will be in just one PHN. And there will be a single PHN for the whole of country South Australia.

Opinions vary about the likely effectiveness of the new PHNs. Managers and clinicians in country South Australia may see some potential benefits in the fact that all parts of the State outside Adelaide will be covered by one Local Health/Hospital Network and one PHN. This should make close collaboration between the hospital and primary care sectors easier.

At the other extreme of opinion is the view that size matters a great deal and that the larger geographic scope of the PHNs has merely compounded what was already a huge challenge for the Medicare Locals in terms of the number of communities and distances to be covered. This view is premised on the belief that the integration of primary care has to be largely a local matter, making whole-of-State organisations almost irrelevant.

It will be important that in setting key performance indicators for the PHNs the diversity within the larger ones is recognised.

At least three things are probably agreed by everyone. First, if the new
entities provide a more integrated primary care system with a better or simpler patient pathway, that will be very beneficial. Australia needs to grow the strength of its primary care health sector in order, among other things, to reduce avoidable hospitalisations.

Secondly, in rural areas especially, the PHNs need to work with and through local healthcare consumers and all members of the local primary care team, which might well include one or more broad-based general practices.

The third point of likely agreement is that there should now be some stability in the architecture of rural and remote (as well as metropolitan) health services. The regularity with which health service structures have cycled through large regions, small regions and even smaller districts has been a longstanding and exasperating cause of scepticism among those who are involved directly in the provision of health services.

There is much still to be sorted through and put into practice about the governance, structure and operations of the PHNs. Some of the principles are clear, such as the fact that there will be ‘GP led’ Clinical Councils and Community Advisory Committees. However, in this as in many other things, what will matter in the field is the way it is implemented.

PHNs are not to be direct service providers except where there is ‘market failure’ - which is the case in much of rural and remote Australia. Here again one waits to see what spillage there is twixt cup and lip.

The critical next step is to see which entities win the tenders for the 30 PHNs to be established. The NRHA is on the record as arguing that it is essential that the tenders for the rural and remote PHNs be won by organisations that have demonstrated experience in rural and remote health matters, credibility with rural clinicians and patients, and a strong commitment to multi-disciplinary care.
There’s something special in the walls and corridors at the Royal Far West (RFW) health and education campus at Sydney’s famous Manly beach. Everybody who visits can feel it – and it is reflective of the love, care and commitment given by the 130 staff and volunteers who look after the country kids and families visiting Manly for specialist health care.

With a medical centre, a school and a guesthouse co-located in one seaside campus, RFW delivers truly integrated care to support the health and wellbeing of rural children.

90 YEARS OF CHARITABLE SERVICE

RFW was established in 1924 as a charity to help children and families who lived in the harsh NSW outback and had no access to health services. In those days conditions were grim. Babies were born with no midwives available, diseases were rife, congenital abnormalities went unattended and families in the bush relied on the charitable services of the RFW Children’s Health Service. The polio epidemic of the 1960s put further pressure on country families who could not access the critical healthcare they needed and so the services of RFW further expanded.

In the 21st century RFW is once again the organisation to which country children and families turn for advice and support. Multi-disciplinary assessment, diagnosis and treatment of complex developmental, learning, behavioural and mental health concerns and learning disorders, together with other child health and dental problems, are the core of RFW’s services today.

In 2014 there are 29 RFW programs being delivered into communities, schools, homes (via telehealth), and from the Manly campus. Through these programs, children with complex and multiple conditions such as attention deficit hyperactivity disorder (ADHD), anxiety, oppositional defiant disorder (ODD), autism spectrum disorder (ASD), intellectual disability and speech and language difficulties are assessed and supported by expert clinicians in a systematic and timely fashion.
Over the last year, RFW has provided support to more than 1,300 rural families and delivered 27,060 individual occasions of service – and the work keeps growing. Clients from 229 different NSW towns received over 17,250 occasions of service as part of the Manly Paediatric Developmental Program - an intensive, multidisciplinary health and development program including paediatrics, speech therapy, psychology, social work, eye health, occupational therapy, oral health, diet and nutrition, and psychiatry.

RFW’s telehealth services are also on the rise and being delivered to homes and schools across the state and, in 2014, RFW piloted its first technology-based therapy in Queensland.

“It’s all about relationships”, says RFW’s CEO Lindsay Cane. “The NSW Government, schools partnerships, support from the Ronald McDonald House Charities, Rotary and our other wonderful corporate and community partners – they all help us deliver services for people from isolated rural and remote communities.”

SEASIDE CARE FOR KIDS AND FAMILIES

As part of its care, RFW provides supported accommodation for children and families from rural and remote NSW, allowing them to receive the intensive and complex care they need while benefiting from the health-giving seaside environment. For many families living in country NSW, health support is often simply not available. The shortage of child health care experts in rural and remote NSW makes it very difficult for a child with complex disorders to get the comprehensive care they need. This is why RFW is such a fundamental part of country NSW.

For more information visit www.royalfarwest.org.au

Gabby Phillips
Royal Far West
An innovative holistic health care program in Townsville has been successful in helping Aboriginal and Torres Strait Islander women with the transition back to their community after time in the Women’s Correctional Centre.

Led by Townsville-Mackay Medicare Local (TMML), the program delivers a culturally safe health and wellbeing reintegration model of care.

Townsville Women’s Correctional Centre had 154 inmates when the RHCCC program started. One hundred and twenty six of them joined the program and received 495 episodes of care between November 2013 and July 2014.

One of the things that set the RHCCC apart from similar programs was that it provided opportunities for continuous learning through ongoing self-reflection, research, implementation and evaluation.

Not only did the program help women to link up with services for support in managing their chronic disease or battle with substance abuse after their release from prison. It also addressed how they could confront and overcome the underlying issues in their lives that led to them being in custody.

Planning for the program was based upon the community needs and systemic environment of correctional care. This consultative collaboration across various sectors aimed to ensure a holistic model of care was developed and maintained. It also identified the need to introduce the Women’s Leadership Program of the Bindal Sharks United’s Sport and Recreation Aboriginal Corporation as part of the RHCCC.

Coordinator Joanne Bourne and Project Officer Bianca Brackenridge ensured participants were the focus of coordinated and integrated case management. They also committed themselves to a personal journey.

“We were very grateful to the Townsville Women’s Correctional Centre, our partners Bindal Sharks who delivered the Leadership Program component and, most
importantly, the women involved who gave us their consent to participate,” Mrs Bourne said.

“It’s not something that anyone can participate in. This is a journey in which women share really personal stories of tragedy and crisis in their lives and it’s not something that they necessarily want people to hear.”

Central to the RHCCC program’s success was that both the Coordinator and Project Officer were Indigenous women. This enabled them to work closely with clients and key stakeholders to develop individual pre- and post-release transition plans and coordinate referral pathways to Aboriginal medical, mental health and social and emotional wellbeing services, to social work, cultural officers, Offender Reintegration Support Services and Pathways to Employment.

TMML’s General Manager of Indigenous Programs, Carl Grant, puts it simply.

“Murris talk to Murris … black fellas talk to black fellas. When Bianca and Joanne went out there to the prison they could yarn with the women,” he said. “If it had been a white fella, the women would have been thinking: ‘I don’t know about this’.”

The RHCCC program included one-on-one interviews and group Yarning Circles, regular face-to-face reviews, acknowledging and celebrating personal achievement and the development of a DVD which allowed clients and key stakeholders to share their journey and the personal benefits the program provided for their reintegration into life outside prison.

Evaluation of the RHCCC program by the University of New South Wales Muru Marri Team determined that the TMML-RHCCC team and supporting agencies had implemented a highly complex program that provided women with effective support in their health journeys home from custodial care. It also strongly recommended that funding be made available to re-establish the TMML-RHCCC program in the future.

**Joanne Bourne**

*RHCCC program, Townsville-Mackay Medicare Local*
Rural Engaging Communities in Oral Health (ECOH) is a three-year project to connect local people with health professionals and service planners to work out what services rural communities need to improve oral health outcomes. The project is funded by the National Health and Medical Research Council and is currently underway in six rural communities: Bowen, Ingham and Hughenden in Queensland and Kyabram, Swan Hill and Gannawarra Shire in Victoria. These locations were selected because they were identified as rural communities with many risk indicators for poor oral health. We are interested in finding out whether the oral health of rural communities can be improved when rural people participate in developing oral health plans.

The project used ‘Remote Services Futures’ (RSF), an evidence-based method of community participation that was developed in Scotland. Using oral health as a focus, we hoped that local people would actively engage in discussions about what their community needed and we could develop fully-costed, evidence-based strategies to address oral health challenges.

We have completed the first part of the project, which involved interested community members, health professionals and community leaders coming together in four structured workshops in each community. At the end of the workshops, each community had designed their local oral health plan. The workshops covered:

1. community health aspirations and the role of oral health;
2. what works to improve community oral health;
3. example initiatives from other rural communities; and
4. planning and developing an oral health service model.
In Queensland, the three communities focused on making sure that community members and health professionals were aware of the services that are available. Some of the other ideas from the Queensland workshops were:

- to produce infographics that clearly describe the oral health pathways in each community;
- training for health professionals to integrate oral health screening (for example, *Lift the Lip* early childhood screening program) and education as part of normal child health checks and the Year 8 vaccination program; and
- oral health education that provides information to individuals, parents, carers and health professionals about good oral health behaviours and the correct way to look after teeth and gums.

In Victoria, the three communities were also interested in developing an information brochure that outlines options for oral health treatment in the local community as well as how to make an appointment with the service. The Victorian communities were very focused on strategies to improve oral health in early childhood and looked at the *Smiles 4 Miles* and *Lift the Lip* screening programs. They were also interested in exploring oral health screening as part of vaccination programs and finding out more about education for good oral health behaviours. In Cohuna, the community was interested in finding out more about water fluoridation.

The Rural ECOH project provides a unique opportunity for collaboration between partner organisations: James Cook University, La Trobe University, Royal Flying Doctor Service, Dental Health Services Victoria, and Loddon Mallee Murray and Townsville-Mackay Medicare Locals. The next stage of the project involves implementing the oral health plans that have been developed. The Medicare Locals will take the primary responsibility for managing this part of the project.

More information is available at the project blog [http://ruralecoh.com](http://ruralecoh.com) or you can contact Dr Virginia Dickson-Swift, Senior Researcher, La Trobe University, on (03) 5444 7852 or email [V.Dickson-Swift@latrobe.edu.au](mailto:V.Dickson-Swift@latrobe.edu.au) or Dr Karen Carlisle at Townsville-Mackay Medicare Local on (07) 4421 7789 or email [kcarlisle@tmml.com.au](mailto:kcarlisle@tmml.com.au)

**Jane Farmer**  
La Trobe University

**Sarah Larkins**  
James Cook University
The Physiotherapists’ code of conduct requires practitioners to base their practice on the current and accepted evidence base of the profession. As stated by the National Health and Medical Research Council, it takes ‘skill, determination, time, money and planning’ to transfer evidence into clinical practice, but there are additional challenges for rural practitioners.

Some challenges will be unique to each rural location; for example, a small town may have a hydrotherapy pool, but not the staff to operate it. Other challenges are found across many rural areas, such as difficulty recruiting and retaining allied health professionals and limited access to appropriate medical and diagnostic services.

When it comes to the practice of paediatric physiotherapy, there are even more and greater challenges in rural and remote areas. It is unlikely that all members of the interdisciplinary team will be available locally, and there may be poor access to paediatric medical and diagnostic services.

For example, one of the difficulties in applying the new ‘Physical Therapy Management of Congenital Muscular Torticollis’ guideline in rural practice is the recommendation for routine referral to paediatricians of infants with asymmetries. Difficulties are caused by limited access to paediatricians, and sometimes it may be difficult to convince a GP of the need for referral.

This raises two key issues for rural paediatric physiotherapists acting as primary contact practitioners. We need to be confident of our ability to screen infants and identify any red flags, and we need to work to educate other professionals about these guidelines.

Many of the challenges of rural practice in paediatric physiotherapy are open to creative solutions.
Create your own interdisciplinary team. In Young we created an informal early intervention team, comprising early childhood educators from the disability service, physiotherapist and occupational therapist from the hospital, and a speech pathologist from community health. Although we had different employers, with commitment we were able to function as a team.

Think laterally about service provision. In smaller rural communities the options for crossing traditional boundaries can be greater. It may be possible to work with existing community groups, with minimal red tape, allowing increased scope for informal but effective inter-professional teamwork and more efficient use of resources.

Consider a trans-disciplinary approach to continuing education that is appropriate to your scope of practice. For instance, the paediatric physiotherapist could consider post graduate training in a different but complementary field such as education or psychology.

Acknowledge and promote your own expertise. In WA Health, for example, the mandatory prerequisites for employment as an advanced scope physiotherapist are a high degree of clinical expertise and a formal postgraduate qualification in a relevant area. In my experience, there are many allied health professionals in rural areas who are working, unacknowledged, at the advanced scope level. Whether it’s formally recognised or not, promoting your expertise provides opportunities to deal more directly with specialist services, to negotiate new and more appropriate ways to provide services to rural paediatric clients, and to work for change.

Find others and use their expertise. Join networks such as the Paediatric Physiotherapist Network (operating in Central West NSW) or the Rural Paediatric Physiotherapists Facebook page and group (www.facebook.com/#!/Ruralpaedsphysios) set up to facilitate networking, support and continuing education for rural physiotherapists treating children. And if there aren’t appropriate networks, start your own.

Make links with rural universities. These relationships can help you access current guidelines for best practice, provide feedback into the training of new graduates and highlight areas for change. Becoming a clinical educator is an effective way to maintain your own currency and also work towards improving rural recruitment and retention.

Kay Skinner
Charles Sturt University

Kay Skinner lectures in physiotherapy at Charles Sturt University in Orange. She previously worked for two decades as a paediatric physiotherapist in Young, NSW.
Between Tennant Creek in the centre of Australia and Darwin, Australia’s northernmost capital city, is approximately 1,000 kilometres of highway slicing north through the Barkly Shire - a local authority larger than the United Kingdom. Despite its vast size, Barkly Shire is home to just 8,137 inhabitants: one person per 40 square kilometres.

For the majority of Australians clustered along the coastline in the metropolitan centres, such remote conditions might be understood in the abstract. But the reality of life in a town like Tennant Creek is a world away from Sydney, Melbourne, Canberra and Perth.

Tennant Creek, the regional centre of Barkly, is home to approximately 3,500 of the Shire’s residents. It has had a challenging history but there are things happening in the area that are joyous, surprising and deserving of great celebration.

A number of these very positive activities can be attributed to Barkly Regional Arts (BRA). BRA is a grassroots organisation that currently provides 50 annual programs or projects to over 800 artists throughout the Barkly region. They are visual artists, musicians, traditional Indigenous dancers, writers, weavers and potters. They are young and not-so-young. They are in town and out bush - up to four hours away from Tennant Creek.

The Winanjjikari Music Centre, Artists of the Barkly, Media Mob and LADY
BEATS are just some of the programs BRA runs that help nurture, support and maintain the rich culture of the Barkly and its people.

Anti-Poverty Week provided an opportunity to showcase some of the inspirational work of BRA. Through a live web cast on 16 October, Kathy Burns, Artistic Director of BRA, led us on a virtual tour of the organisation and allowed us to see up close the challenges and rewards of working in such remote conditions and the importance of maintaining the strong cultural traditions of the region.

BRA is an exceptional example of the power of arts and community to change the lives of individuals through training, support and creative expression.

The NRHA has been a long-standing advocate of connecting arts and health, and it was an honour for it to partner with BRA to have a glimpse inside the lives of some of the women and men of the Barkly through song, dance and video.

If you were unable to watch the web cast live, it is now available on the NRHA website at www.ruralhealth.org.au

Alice Sisley
National Rural Health Alliance
There is a clear relationship between the characteristics of particular places and health outcomes for the people who live there. The ways we shape and interact with the environments in which we live - our homes, neighbourhoods, towns, cities and regions - have profound implications for our health.

Where settlements are located, and how they are connected, influences access to water and food, healthcare, housing, employment and educational opportunities – all of which are crucial to good health outcomes.

Our perceptions of how we belong in our local neighbourhood or region, and the nature of social relationships that occur within different places and localities, also have major impacts on our health. For many Indigenous people, a connection with ‘country’ – a place of ancestry, identity, language, livelihood and community – is inextricably entwined with individual and community health.

Yet humans are not passive agents when it comes to our living environments. Those places we call ‘home’ are in fact highly modified or constructed environments. They are the product of many years of accrued impacts of human activity within and upon the natural environment.

In addition, particularly in rural and remote areas, towns and settlements have typically grown and evolved without any overarching design strategy or guiding framework for long-term sustainability (including improved public health) – with predictably mixed results.

Recognition that the size, location and natural asset base of a place are key influences on the social determinants of health raises questions of what to do about communities that are located in places that currently do not support good health outcomes. Moving beyond simplistic propositions such as potentially relocating communities away from undesirable environments, might it be possible to manipulate the social determinants of health in particular places to give their populations the prospect of a healthy and enjoyable life?

Could we begin to discuss the potential for ‘designed’ intervention, specifically targeted to improve health outcomes? What would be needed to enable this to happen? What kinds of health targets and priorities should inform the design process? Who might need to be involved?

Urban design and planning is not just the concern of cities. Urban designers and related professionals have the capacity to transform the conditions...
in which people live and work, their access to facilities and services, their lifestyles and their ability to develop and maintain strong social networks - wherever they are located.

Research is increasingly pointing to the role of urban design interventions in alleviating crime and anti-social behaviour, increasing social cohesiveness and participation, improving mental health and supporting and encouraging more active lifestyles.

In response to the challenges posed by population growth, resource depletion, urbanisation and climate change, many planners and decision-makers are looking towards new ways of designing urban areas to integrate transport, housing and economic development objectives, including design goals for improved public health, employment and educational outcomes.

Many of the projects which demonstrate greatest human health benefits also incorporate broader sustainability objectives - such as climate adaptation, water sensitive design, local employment growth via community-led nature-based tourism, and the development of alternative energy and niche agricultural and land management/rehabilitation initiatives.

While much of the focus to date has been in metropolitan areas, similar strategies have potential to improve the conditions and quality of life for people living in rural and remote areas - especially as these communities already suffer disproportionate health disadvantage.

Healthy urban planning and design means putting the needs of people, communities and their environments at the heart of planning and considering the implications of decisions for human health and wellbeing.

To achieve its vision the NRHA should play a part in determining how the primary living environments of rural and remote Australians are shaped and function.

Catherine Neilson
National Rural Health Alliance
Many years ago, I was shocked by reports from the Cancer Council Queensland, stating that the further someone lives from a metropolitan city, the more likely they are to die from cancer. I designed my doctoral research with a focus on the information and support available to women with breast cancer in urban compared to rural and remote areas.

A review of the literature revealed there had been few, large scale, quantitative studies of the role of the Australian breast care nurse. Therefore, it was clear that more research in this area was necessary.

Phase One of the research, a geographical comparison of the information and support needs of Australian women following treatment for breast cancer, found the internet to be the most commonly used source of information regardless of geographical location. However, satisfaction with information found using this source was lower compared with face-to-face sources of information such as the breast care nurse, surgeon or cancer specialist. This reliance on online information sources reinforces a need to educate patients about the use of credible internet information and to provide them with details of high-quality websites for health related information.

A comparison of sources of support used by women with breast cancer showed that those in outer regional, remote and very remote areas were statistically significantly more likely to use the breast care nurse for support. This supports the important work of the breast care nurse, particularly for patients in geographically isolated areas.

Phase Two of the research, a study of the role of breast care nurses Australia-wide, was the first such national investigation. This study of 50 breast care nurses, spanning all parts of Australia, has provided useful data about the differences in work depending on geographic location. It was found that breast care nurses from outer regional, remote and very remote areas were less likely to be involved in multi-disciplinary team meetings compared with their peers in major cities and inner regional areas. Given the fact that breast care nurses are recommended as a core member of the multi-disciplinary team in Australia, improving access to multi-disciplinary team meetings for those...
working in outer regional, remote and very remote areas is an area recommended for improvement.

In the third and final stage of the research, over 800 women with breast cancer participated in a study to examine the unmet needs and self-efficacy of those with access to a breast care nurse, compared to those without access to a breast care nurse. Analysis of the results of this study is currently underway.

Assistance to recruit appropriate participants for this research was received through the use of Register4 and the Breast Cancer Network Australia Review and Survey Group and I thank these two organisations for their support of the project.

Overall, this research has explored the perspectives of both breast care nurses and those living with and beyond breast cancer. The results will serve as a knowledge base to expand theory and inform research and practice. Comparisons between those living in urban and rural/remote areas have shown important differences which I hope will be able to be used to improve services for cancer patients living in rural and remote areas.

**Tracey Ahern**

*Tracey Ahern is a Registered Nurse from rural Queensland and is a PhD candidate at the Australian Catholic University. She is researching the differences encountered by women with breast cancer living in urban areas and those living in rural and remote areas.*
New integrated pain management service at Mildura

Chronic pain is the most common reason people seek medical help. It causes distress and disability for millions of Australians. Up to 80 per cent of people living with the condition are missing out on treatment that could improve their health and quality of life (National Pain Strategy 2010).

Australia has a serious shortage of pain services and specialists, and people living in regional and remote Australia are more disadvantaged than others when it comes to timely, affordable access.

Until recently, the lack of such services in the Lower Murray Medicare Local (LMML) region was typical of this neglect.

The LMML region, which covers 75,000 square kilometres in parts of the Riverina, western New South Wales and north-west Victoria, had only a Palliative Care Pain Specialist visit Mildura Base Hospital twice a month.

The nearest public pain clinic was in Bendigo - a round trip of 900 kilometres, which was prohibitive for many. Others faced a wait of up to two years for appointments at clinics in Melbourne or Adelaide.

Now, with the launch of the Integrated Pain Management Service in Mildura, people in the region have much better access.

“People can now access care locally. From every point in our region, the return trip to Mildura can be made in one day,” said LMML Regional Care Coordinator Bertilla Campbell.

There have been 141 referrals from throughout the region since the service opened, 25 per cent of cases have been handled, and there is already a waiting list of six months.

Operating as a multidisciplinary clinic since June 2014, the service includes a Melbourne-based pain specialist who visits monthly and a nurse practitioner who specialises in wound care and visits three times a month; as well as a locally-based oncologist, psychologist, physiotherapist, podiatrist, pharmacist, yoga therapist and two occupational therapists.

Another Melbourne-based pain specialist is setting up telehealth. The first clinic was held from the Royal Melbourne Hospital in October.

The service also provides access to complementary therapies, and fast-tracking of surgical intervention if required.

The clinic is being supported by fourth year medical students from Monash University, who assist the Regional Care Coordinator with initial patient assessments.
Outreach pain management services will be offered as needed to other towns in the region: Robinvale, Ouyen, Sea Lake, Wentworth and Dareton. Dr Michael Lowery, from Sea Lake, will assist with this service.

Plans are underway for an outpatient pain management education program, based on a model used by Tasmania Medicare Local.

With feelings of isolation and loneliness part of the chronic pain experience, patient support groups are seen as important. Currently there are two groups catering to people with Fibromyalgia and Parkinson’s Disease.

“Having a local chronic pain service has given people an opportunity to get to know others in the same boat, which has really boosted their confidence and self-esteem,” said Ms Campbell.

LMML CEO Lydia Senior says the vast region has required a strategic response.

“We cover a vast area and some of it is remote, so we’ve had to focus on the skills and resources we already have on the ground, and then build on them by providing education in pain management,” she said.

“I am delighted about what we’ve achieved for the people of our region. They think it’s fantastic and are happy they don’t have to travel long distances to get the treatment they need. Many have said to me they can see a light at the end of the tunnel.”

To find out more about the project, contact Lydia Senior on 03 5023 8633 or lsenior@lowermurrayml.com.au

Linda Baraciolli
Painaustralia
The Australian Cooperative Research Centre for Living with Autism Spectrum Disorders (Autism CRC) has become the new home of the Secret Agent Society (SAS) Program.

SAS is an evidence-based, social-emotional skills training program for 8 to 12 year-old children with Autism Spectrum Disorders. SAS captivates children with its espionage-themed games and eye-catching resources, including an animated computer game, Helpful Thought Missile action game, Challenger board game and Secret Message Transmission Device game. Kids learn how to recognise and manage their own feelings, cope with change, detect other people’s emotions, talk and play with others and deal with bullying. Parents and schools are an integral part of the group program and receive resources and support to help young ‘secret agents’ develop and practise new skills at home and school.

Practitioner training courses for the program are being run throughout Australia in October and November 2014. Caregivers are also able to purchase program materials to use at home with their children.

Research evaluating a rural/remote delivery variant of the program is currently underway.

Families interested in joining the study are encouraged to contact Hugh Walker (Provisional Psychologist and Doctor of Clinical Psychology Candidate, the University of Queensland) on 0439 428 284 or at hugh.walker@uqconnect.edu.au for further details.

For more information visit [www.autismcrc.com.au](http://www.autismcrc.com.au)

**Tess Cosgrove**

*Autism CRC*

*The NRHA is an Autism CRC Participant*
Ninety seven per cent of women report that they would like to discuss the issue of alcohol consumption during pregnancy. Visits to a health professional present an ideal opportunity for this and to reinforce the message that not drinking alcohol during pregnancy is the safest option.

However, some medical professionals are reluctant to discuss alcohol with women, either because they are concerned that women may feel uncomfortable, or they are unsure of what advice to provide. The new national campaign, Women Want to Know, aims to overcome these barriers by educating health professionals on the effects of alcohol consumption during pregnancy and helping them to provide the correct advice to women.

Conversations about alcohol with women who are pregnant or planning pregnancy are important. These can assist women to stop or reduce their alcohol use and prevent adverse consequences from alcohol consumption during pregnancy which can include miscarriage, premature birth, low birth weight and Fetal Alcohol Spectrum Disorders (FASD).

For health professionals in rural or remote locations, attending training or accessing resources can be difficult. Women Want to Know has developed a range of free online and printed materials and resources. These include videos providing demonstrations of health professionals having conversations with women about alcohol, and brochures for women on the risks of alcohol consumption and pregnancy.

In developing the campaign, the Foundation for Alcohol Research and Education worked with leading health professional bodies to develop accredited online CPD training on alcohol and pregnancy. These online courses are available through the Royal College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the Australian College of Midwives.

For more information about Women Want to Know or to order the free resources visit www.alcohol.gov.au

Sarah Ward
Foundation for Alcohol Research and Education
Years of completed education are a key determinant of the health of an individual. On this measure there is a significant gap between the people of rural Australia and the major cities. In 2011 31 per cent of people aged 25-64 living in major cities held a Bachelor degree or above, compared with 18 per cent in Inner regional areas, 15 per cent in Outer regional areas and 12 per cent in remote areas.

The Australian Council for Educational Research (ACER) reports that 63 per cent of young people in metropolitan areas intended to enrol in higher education, compared with 39 per cent in regional and 32 per cent in remote areas.

Only 12 per cent of tertiary education is provided in rural and regional areas, and over half of the rural and remote students undertaking tertiary study have to live away from home.

Cost is therefore a major inhibitor for people from rural areas seeking further
education, especially for those in lower socioeconomic groups. Despite lower incomes on average, rural families already have to pay some $25,000 a year extra for a child to relocate to attend university or TAFE education.

The tertiary education sector plays the pivotal role in educating and training people for the professions and regional universities are a critical part of the sector. They provide access to tertiary education relatively close at hand for people living in rural and remote areas, and the training they provide has particular relevance for rural areas because of its setting.

Universities in regional centres are well patronised by students from the local region and, because students from regional areas are more likely to end up working in those areas, the regional unis contribute significantly to the local availability of professionals. They play a critical role in providing a pipeline for students from rural areas to go through all stages of education and training until they end up practising back in rural areas.

This is as true for health professionals as it is for any others and in recent years there has been a welcome increase in health courses offered by regional universities or regional campuses. Some universities also provide special entry schemes for rural students to selected courses.

Professionals working in rural areas and the students they teach in regional institutions are important as role models for local students considering their future options.

For all of these reasons it is important that regional universities are not disadvantaged by changes to the funding of Higher Education and can remain as strong institutions for skills and learning for rural and remote Australia.

The proposal to charge interest on the HECS loan at the long-term bond rate will be regressive - penalising those who fail to secure high wages quickly after graduation. Such a change would have a disproportionate impact on women, because many of them will choose to take time out from their paid jobs to start a family.

Whatever arrangements are agreed for student fees, the provisions currently in place to maintain quota systems to ensure fair representation of rural students in health professional courses and additional support for Aboriginal and Torres Strait Islander health students must be preserved.

The Commonwealth Scholarship Scheme, which provides support for students who are disadvantaged by location and/or socio-economic status, should deem students who have to relocate from a more remote area as a separate disadvantaged group.

Regional universities are critical parts of the social and economic fabric of rural and regional communities, with a unique role to play in securing a better distribution of the professional workforce. Their vitality and sustainability must not be put at risk.

**Gordon Gregory**

*National Rural Health Alliance*
Due to a range of demographic, occupational and lifestyle factors, people living in rural areas are more likely to have arthritis than their city counterparts. Limited access to appropriate treatment, especially specialist care, means that they often fare worse with the condition.

Recent research has highlighted the critical importance of early diagnosis and specialist treatment of arthritis, especially inflammatory forms such as rheumatoid arthritis. Early treatment, ideally within weeks of the onset of symptoms, provides a much better result for people with these conditions and can result in virtual remission.

Limited rheumatology services in most rural and regional areas mean that people in the bush often experience delays in diagnosis and appropriate treatment. People from rural areas also face significant travel times and lengthy waiting periods to see a specialist.

Arthritis Australia and the Australian Rheumatology Association are rolling out a Rural Outreach Education Project with the support of Arthritis & Osteoporosis NSW. It is designed to support the management and treatment of arthritis in rural and regional communities by providing outreach specialist services and information for the community and health professionals.

Ms Ainslie Cahill, CEO of Arthritis Australia, said that the program was
Arthritis is often referred to as a single disease. In fact, there are over 100 different types of arthritis affecting people of all ages, including children. The most common types are osteoarthritis and rheumatoid arthritis.

Osteoarthritis is a degenerative joint disease that affects nearly two million Australians. Although often referred to as ‘wear and tear’ arthritis, osteoarthritis is a disease and not an inevitable part of ageing. Although there is no cure for osteoarthritis, it can be managed by weight loss, exercise and pain medication or, in advanced cases, joint replacement surgery.

Rheumatoid arthritis, the second most common type of arthritis, is a serious autoimmune condition that can occur at any age, characterised by hot, swollen joints and prolonged early morning stiffness. Early diagnosis and treatment is critical to prevent much of the joint damage associated with rheumatoid arthritis and improve the chances of achieving disease remission.

Don’t dismiss sore or swollen joints as a natural part of everyday life. If you are experiencing joint pain, no matter what your age, you should seek medical advice as soon as possible.

For further information on arthritis and how to live well with the condition call 1800 011 041 or see www.arthritisaustralia.com.au

Franca Marine
Arthritis Australia
PART ONE: YEAR-IN

The NRHA is a collective of 37 national organisations. Passionately rural and remote, with loads of lived experience of the large and small communities beyond the metropolitan fringes. From Tumbarumba to the Top End. From Manjimup to Mt Isa.

The closest we get to a meeting of all members of all member bodies is our annual CouncilFest. Every year, forty people travel from various parts of rural or remote Australia to share, over five days, their particular views on our common cause: improving the health and wellbeing of the people outside Australia’s capital cities.

CouncilFest brings together health service managers, carers, graziers, students, rural and remote health clinicians (all professions!), researchers and teachers. Some of them have met face-to-face before. Some of them have not.

Here’s the tale of one who had not - but was determined not to be fazed...
Preparing to attend my first CouncilFest, I was filled with trepidation. This was not only my first CouncilFest but also the first time that a representative for Speech Pathology Australia’s Rural and Remote Member Community had attended. It was then a recently-admitted new member of the NRHA.

I was going in blind!

A review of the agenda did not calm my nerves: ‘Councillor’s musical reflections’; ‘physical activity’ and ‘morning tea, coffee, tablets, blackberries etc.’. Oh dear ... What had I got myself into?

I’d like to say that these things didn’t happen, but they did. And more: morning group dancing, group singing, and a breathless piper.

Who are these people? I spent five days with the most dedicated, inspiring, interesting and intelligent people. All working together to promote and improve the health of people in rural and remote Australia. I learnt so much in five days and it has really helped me understand how the National Rural Health Alliance ‘works’.

Knowing that 37 organisations can agree on five key issues to take to Parliament House emphasised to me that we are all fighting the same good fight. Thanks so much to everyone who contributes to organising this amazing CouncilFest, particularly our staff in Canberra who really know how to pull a group of people together!

I am looking forward to next year already. I will be less nervous and have so much more to contribute.
The culture of the NRHA is characterised by collaboration, cooperation, common purpose and community, and along with all the hard work that goes into developing the collective messages, practising the art of the political conversation, and other business of the Alliance, the culture is enhanced by multiple opportunities for fun, song and communal exercise.

The ‘branding’ of the group #loverural on distinctive T-shirts meant that everyone in Canberra knew that rural issues were being highlighted over this time, although on Parliament Day we were almost overshadowed by Tony Abbott’s ‘Terrorism Speech’ which almost had us locked out of a locked down Parliament building.

The NRHA has been influential in the development of RHAANZ, in particular the advice we have had from past chairs Dr Jenny May and Professor Lesley Barclay.

THE #LOVERURAL CAMPAIGN WAS CONCEIVED FOR (AND BIRTHED AT) COUNCILFEST 2014, BUT IT IS EXPECTED TO HAVE A LONG LIFE.

Why do you #loverural?

Tell the world in any way you like why you love rural and remote Australia: with a tweet, a selfie, a photo of your favourite place, a short video… Contributions can be tweeted, posted on Facebook, Instagram or whatever social media platform you desire. Or email your contribution to conference@ruralhealth.org.au and we will promote your contribution for you.

Some of the best #loverural contributions will be displayed at the 13th National Rural Health Conference. It is one way to celebrate the things that make rural Australia so special for the more than 6.7 million people who live and work there.

And if you #loverural, you’ll also want to attend the 13th National Rural Health Conference in Darwin.
Part Two: Year-Out

Pack your bag and make your booking for some accommodation in Darwin for the third week of May 2015. Or phone a friend in the Top End you haven’t seen for years and see whether you can camp on their floor.

People of the Larrakia Nation are preparing to give representatives of Australia’s rural and remote health sector a warm welcome to their Country.

The plenary sessions will be chaired by Conference MC, Charlie King, well-loved local ABC radio sports commentator. (Check out the campaign against domestic violence that Charlie leads: nomore.org.au). One of the plenary sessions will focus on health and health services in the region to Australia’s north, including PNG and Timor-Leste.

There will be the usual number of concurrent sessions. If you want to present a paper in one of them you will have to join the last-minute rush of abstracts we expect before the online portal closes on 28 November. There is a reduced Conference registration fee for paper-givers - as well as for students and Friends of the Alliance.

Your company, professional body or interest group may want to book an exhibition booth. A booking form, along with a list of those we already know will be exhibiting can be found on the Conference website, or you can contact the Conference team on 02 6285 4660.

We are also still seeking sponsors for the Conference. For a full range of options available, visit the website.
Friends of the Alliance will be out in force in Darwin - partly because they will be paying a reduced registration fee. There will be fantastic opportunities for Friends to meet and connect with professionals and individuals with similar interests and passions from across the nation.

PHOTO AND POETRY COMPETITION

This year we are encouraging entries that relate to the Conference theme: People, Places, and Possibilities and highlight the best of life in rural and remote Australia.

Cash prizes are on offer and the work of the finalists will be on display at the Conference. Winners will also announced at the event. Entries close 3 April 2015.

For the entry form, visit www.ruralhealth.org.au/friends

UNSUNG HERO AWARD

This award celebrated those people who work tirelessly for their community and make enormous contributions on local issues. These ‘Unsung Heroes’ are the quiet local achievers – the volunteers or paid workers who constantly go above and beyond what is normally expected.

Nominations must be made by a Friend but the nominee does not need to be a Friend. The winner of the Award will be announced at the Conference Dinner. Nominations close 6 March 2015.

MEET A FRIEND AT THE ALLIANCE BOOTH

The Alliance’s Exhibition booth will be the epicentre of activity. Members of the Alliance Council and of the Friends Advisory Committee will be on hand. Come along and introduce yourself.

For more information about Friends and its activities, visit www.ruralhealth.org.au/friends
In May 2014, a Roundtable on regional health industry pathways, held in the Wheatbelt region of Western Australia, brought together a broad range of health industry and regional education and training stakeholders, to respond to concerns about the lack of regional opportunities for young people and others in Wheatbelt communities.

The WA Wheatbelt covers an area of over 150,000 square kilometres with a population of 72,000 people. This dispersed population distribution leads to the usual challenges of coordination of healthcare and access faced by other rural and remote regions, as well as specific difficulties in developing and selling a consistent region-wide strategy for youth transition into employment and the health sector locally. Recent labour market reports have noted a significant rise in Wheatbelt youth unemployment rates over a ten year period, from seven to 23 per cent, currently the highest in the State.

The Roundtable’s recommendations focused on developing strategies for engaging regional youth and others in the health industry. It recommended that the health sector and its stakeholders embrace the concept of ‘grow your own’, commit to fostering a culture of learning within their organisations, and look for increased opportunities for local participation in the delivery of local health services.

In response to these recommendations the Roundtable partners decided to develop a Wheatbelt Health Workforce Plan, which would encompass all sectors across the region. The Plan would focus on addressing skill shortages through the engagement of regional young people and others in a career exploration, education and training framework, supported by all regional health industry stakeholders.

Importantly, this strategy would enable all the objectives of the Roundtable to be addressed and would be likely to generate greater capacity for the regional health industry to respond effectively to emerging regional workforce needs. This approach also takes into account the State Government’s existing, overarching Wheatbelt Workforce Development Plan.

The partners plan to engage a consultant to develop the regional Health Workforce Plan. They are also working on addressing existing needs, for example by finding ways for greater engagement between the WA Country Health Services and regional schools.

Overall, the Roundtable partners are optimistic that this collaborative, strategic approach will generate more and more varied local career pathways for the region’s young people and others, thus strengthening regional communities.

Trevor Saunders
School Business Community Partnership Broker, Sorcit Ltd
Volunteering in health care used to be largely limited to aged care facilities. Now volunteers are contributing to health services in rural areas across all domains and disciplines.

Cobram District Health Service in Victoria had been fortunate to have the volunteer time of Audrey Birchall in the aged care facility for 20 years. But just three years ago, Audrey approached the health service with a project she had read about at Bega Health Service, which implemented volunteer services to assist with patients admitted to the acute ward with dementia or memory loss.

With the assistance of a University of Melbourne research fellow, the program was launched in early 2013. Audrey leads a group of eight volunteers, who each donate three to four hours of their time when there is a need. The volunteers support acutely ill patients with dementia, engaging them in their interests during their hospital stay.

Audrey also continues to volunteer in the aged care facility, as well as having many other community volunteering roles - despite being 79 years of age herself. She actively supports carers in the community, having great empathy after everything she has done herself as a carer for so many years. She also hosts students from University of Melbourne, who come to the area as part of the Chancellor’s Scholars Program.

When asked for permission to write about her volunteer work, Audrey replied “I don’t mind as long as it helps the cause of more people volunteering and maybe commencing programs in their areas that bring comfort to those in need.”

Director of Clinical Services at Cobram District Health, David Gullick, recognises the contribution volunteers make to the service. “Volunteers such as Audrey make an enormous difference to the lives of patients and residents. Our volunteers are a mainstay, providing much-needed services for our patients.”

Kaye Ervin
Rural Health Academic Network, University of Melbourne
Department of Rural Health

Audrey Birchall
A round a hundred people met for two days in September to consider ways in which the rural and remote health research sector can further improve its performance. There was strong collaboration between researchers and academics; representatives of the holders and analysts of some of the national health data sets; policy advisers, health service managers and practitioners; and representatives of the community and private sectors.

The panel discussions on clarifying the research questions and on the rural health research interests of Government, the National Health and Medical Research Council and the private health sector were particularly well received, as was the keynote address from David Hansen, CEO of the Australian eHealth Research Centre, on research and innovation in rural and remote health services.

Other stand-out sessions included one from Martin Laverty (CEO of the Royal Flying Doctor Service) on cardiovascular health and social determinants in rural populations, the panel on national data sets (involving the Australian Bureau of Statistics, Australian Institute of Health and Welfare and Medicare), and the address on data linkage work at the AIHW by Phil Anderson.

The 4-minute video *Making the most of the national data sets* gives just a few of the highlights from Day 2. We are reminded in that video that what’s really important are the next steps.


Our thanks to the Primary Health Care Research & Information Service for helping with that streaming.

There were interactive displays of rural data analyses and presentations that provided opportunities for people to talk more specifically about some of the ways of analysing the data and displaying the results.

There was so much energy and commitment at the Symposium that even at the dinner - formally addressed by the Shiny Bum Singers - the bulk of the time was spent debating new ways of tackling challenges in the analysis of rural/remote health issues.

**Helen Hopkins**  
National Rural Health Alliance
A landmark biomedical health survey released in September showed Aboriginal and Torres Strait Islander people have high rates of risk factors for heart disease; including diabetes, kidney disease and high cholesterol.

The results, from the Australian Bureau of Statistics Australian Aboriginal and Torres Strait Islander Health Survey: Biomedical Results, 2012–13 revealed:

- two in three had at least one risk factor for cardiovascular disease (CVD), that is, they were taking cholesterol-lowering medication or had one or more of high total cholesterol, lower than normal levels of HDL (good) cholesterol, high LDL (bad) cholesterol or high triglycerides;
- a quarter had high cholesterol, but only around one in ten of this group were aware they had it; and
- Aboriginal and Torres Strait Islander people were nearly twice as likely to have high triglycerides.

The survey showed the risk factors for heart disease are greater for Aboriginal and Torres Strait Islander people and far worse in remote areas. Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander people are three times more likely to have a heart attack and nearly twice as likely to die from heart disease.

The Heart Foundation has released a geographical snapshot of cardiovascular disease (including heart disease and stroke) which shows one in four people living in regional and rural areas are suffering from the disease compared to one in five in metropolitan areas.

Australians living outside capital cities are at significantly greater risk (26 per cent) of the nation’s biggest killer, CVD, according to national data analysed and mapped by the Heart Foundation.

You can view the CVD Prevalence Maps for all states and territories at www.heartfoundation.org.au/information-for-professionals/data-and-statistics/Pages/default.aspx

**Heart Foundation**

Prevalence of Cardiovascular Disease (CVD) in Australia

![Prevalence of Cardiovascular Disease (CVD) in Australia](attachment:image.png)

Data: ABS, Australian Health Survey, 2011-12
Maps: ABS, Census of Population and Housing, 2011
The dentistry is different at Nhulunbuy in East Arnhem Land, where one of Australia’s most remote dentists plies his trade.

Members of the 3,000 strong community are happy to see a dentist. The fact that Nhulunbuy was without private dental services for six months before Dr Nhalila Valappil’s arrival from Brisbane may partly explain this warm welcome.

He is one of the first dentists to be funded under the new Dental Relocation and Infrastructure Support Scheme (DRISS) which encourages private dentists to consider a career in rural and remote Australia.

Dr Nhalila Valappil works two to three days each week treating mine workers, teachers, hospital staff and people employed in local Indigenous communities.

“The tropical environment is beautiful here,” he says. “Everyone knows each other and you feel very connected to the community.”

Since establishing the ‘Gentle Gove Dentist’ practice, Dr Nhalila Valappil has also generated employment for two dental nurses who had previously only been working part-time at the local supermarket. The nurses, Kayla Honnery and Renee McConnell, are well-known in the community and now take the occasional dental appointment from people they see in the street or at the checkout.

DRISS is an Australian Government initiative managed by Rural Health Workforce Australia. It provides grants for relocation and infrastructure to individual private dentists moving to rural areas.

In its first year, DRISS grants have been awarded to 68 dentists to make the move to rural and remote Australia.

The DRISS steering committee includes representatives from the Department of Health, the National Rural Health Alliance, the Australian Dental Association, the Australasian Council of Dental Schools, and Services for Australian Rural and Remote Allied Health.

The next funding round is open from 23 February to 27 March 2015. For further details, go to www.rhwa.org.au/DRISS.

Tony Wells
Rural Health Workforce Australia
Where does Brisbane end - and the need for travel assistance begin?

Recent research, funded by the Leukaemia Foundation of Queensland and conducted at Griffith University, explored the financial and psychosocial impact of relocation for specialist treatment for patients diagnosed with a haematological malignancy.

The findings documented the many hardships faced by regional, rural and remote patients who have to leave the comfort of their home to travel to metropolitan hospitals for specialist treatment.

However, the findings also identified a group who live within Queensland’s Patient Travel Subsidy Scheme’s (PTSS) definition of metropolitan (that is, within a 50 kilometres radius of the specialist treating hospital) who shared many of these problems but who were not eligible for the government travel and accommodation subsidy.

Some, who were living on the islands adjacent to Brisbane, had to travel by water transport to the mainland before connecting with a bus or train to the city. As one participant said about the lack of PTSS funding for their travel, “I think water doesn’t count the same”.

Others were travelling many hours; for example, up to a four hours’ round trip per day on public transport. Depending on the location, the travel could involve...
connections with different types of public transport such as buses and trains. Travelling on public transport was described as difficult during times when the patient was suffering from side effects of the illness and treatment, such as fatigue, nausea and low white cell counts which can make the individual more susceptible to infection. At times, patients were dependent on family members to drive them to and from the hospital.

The costs of public transport were described as considerable. In addition, patients were often in financially strained situations because of a loss of employment caused by ill health. As one patient explained:

“Almost $11 per day, yes. If you are not working what are you going to do? You have to go to the hospital, it is not a choice.”

The 50 kilometres definition of metropolitan was seen as arbitrary and as not providing flexibility to cover the variety of patient circumstances. One young person who was dealing with treatment on a government pension summed it up like this:

“But people like myself who have to go in every day, I don’t think a lot of people realise the expense of that. Just because you live in the metropolitan area doesn’t mean it is all easy or that there can be no big expenses. There are major expenses with driving, parking, the cost of fuel, all the things that go with it. It makes you wonder about that divide of the 50 kilometres from the hospital. If you live 50 kilometres you get assistance but if you live 49 kilometres you don’t get any help at all.”

Treatments for haematological malignancies (including leukaemia, myeloma, and lymphoma) can be lengthy and many of these chronic conditions will require ongoing routine monitoring. Thus, travel to and from hospital will be a continuing requirement.

PTSS is an excellent government scheme that has been shown to be ameliorating the serious financial impact of relocation for specialist care for regional, rural and remote patients. However, the findings from the study indicate that there is an unrecognised group whose inclusion in the scheme would be of merit.

For further information contact: pmcgrathgu@gmail.com

Pam McGrath
Griffith Health Institute,
Griffith University
Osteopath Barbara Rouch recently moved from a busy and crowded Melbourne to calm and peaceful Broken Hill. While living in Melbourne during her early years Barbara says she was spoilt with the health choices available.

“It contrasts greatly with the lack of services available in regional areas. The people who were growing, packing and putting food in our supermarket aisles were being denied access to quality health care, and it concerned me a lot.”

Barbara returned to RMIT to study osteopathy. Each holiday she returned to the outback horizons around Broken Hill, where the bluebush dances in the moonlight, and to the changing colours of the landscape, where flora and fauna open the heart with such vibrancies.

“I truly believe in the advantages of living in the rural area. My house is close to work, and all the offices, shops, sport and recreational centres are nearby and easily accessible. I live close to the great national parks and the Darling River. As I don’t spend two hours of travel to and from work now, I can decide how to spend my time.”

Barbara works part-time these days. She chooses to start work late, have her lunch at home and then work a little
bit later than the office workers. “It is very flexible and I love that it takes me six minutes to get to work – this is amazing, it helps to keep the work-life balance that is incredibly important in modern life.”

The clinical issues of the locals in Broken Hill are not quite the same as the problems of people living in the big city. Many locals work hard in occupations that are inherently dangerous, therefore more occupational injuries are seen. Manual work may involve heavy and awkward lifting, overstretching, and periods of prolonged bending causing back and disc injuries, sciatica, and muscle strains. Osteopathy can be very beneficial to these patients.

Barbara enjoys the honesty and openness of the local community in Broken Hill. “I love the jokes, life stories and the laid back attitude of our broad multicultural community. It is such a delight to watch families growing, moving away and moving back from their adventures.”

“There’s literally time to breathe, to become a part of the community that I observe. I enjoy treating growing families, becoming a part of each generation’s life.”

Of course there are certain difficulties in Barbara’s rural life: “Certainly I miss my family, but I still love to travel around the country. It is very important to attract young doctors and practitioners to rural practice as despite the fact that the Royal Flying Doctor Service works really well, we still live far away from major city hospitals. It is 300 kilometres to the next osteopath!”

“Broken Hill is a great place to bring up a family. Becoming friends with somebody here means you will be friends for life. In Broken Hill you are part of a genuine community. To be greeted down the street on a regular basis is such a contrast to numbly walking through the masses in the cities and having time there only for a superficial lifestyle.”

Irina Aristova
Osteopathy Australia
The Abbott Government has a clear and purposeful commitment to the development of Northern Australia. (Only those of a cynical disposition plus others who watched ABC TV’s *Utopia* might point out that this is a return to the natural *Order*.)

The Alliance’s submissions and links to other documents relating to the Government’s policy development in this area can be found at www.ruralhealth.org.au

The Government intends to “set out a clear, well-defined and timely policy platform for realising the full economic potential of the north, including a plan for implementing these policies over the next two, five, 10 and 20 years.”

For the purposes of this work, ‘Northern Australia’ is defined as the parts of Australia north of the Tropic of Capricorn, spanning Western Australia, Northern Territory and Queensland. It is an area of approximately 3 million square kilometres with a population of around one million people. The Government has identified six focus areas: delivering economic infrastructure; improving land use and access; improving water access and management; promoting trade and investment, strengthening the business environment; fostering education, research and innovation; and enhancing governance.

The Alliance is vitally interested in the directions in which the initiative develops. It has interests on several fronts. What would substantial new development of Northern Australia mean for the distribution of the nation’s population and industries? How would it impact on the health and sustainability of communities in the region? What would be the intersections between Northern development and climate change, including as they impact the rest of Australia? Given the substantial levels of economic and social disadvantage that already exist in Northern Australia, can it be assumed that its planned development will improve the health and wellbeing of people who already live there?

The Government speculates about the region becoming ‘a food bowl’ that...
could double Australia’s agricultural output, and a $150 million energy export industry. It also wants to increase tourism and lift restrictions to allow Indigenous landholders to “use their land to create economic opportunities and jobs”.

The Alliance is a supporter of stronger economies in rural, regional and remote areas. It is on the record as suggesting that significantly enhanced remote zone tax allowances be considered as one means of effectively decentralising Australia’s population. However there can be no further development of the North without proper consideration of access to health services for those who are already there and those who would be there after growth. And there should be no further development of the North without due consideration of the ecological and cultural implications.

The Alliance has identified the health sector as a key industry in Northern Australia, with cross-sectoral and cross-jurisdictional aspects to it and considerable potential for growth. A strong sustainable health sector in Northern Australia is a key part of the economic base of the region, as well as a prerequisite for human rights and service equity.

However, health is not a stand-alone sector. There are particular synergies to be gained in rural and remote areas through effective investment in the people who serve across the health, disability care and aged care sectors. Local education and training have an important role to play.

The Alliance has long believed that the best medium-term investment in better health for the people of rural and remote areas is action to enhance the economic vitality and sustainability of as many rural communities as possible.

All of these matters will be one of the focuses of the 13th National Rural Health Conference in Darwin, 24-27 May 2015. For information about the Conference, visit www.ruralhealth.org.au/13nrhc

Dane Morling
National Rural Health Alliance
The South Australian End of Life Care Choices (EOLC) Program has successfully helped patients in rural areas to fulfil their wishes to die at home while also providing significant cost savings in care and hospitalisation.

The EOLC program was initially rolled out by Country Health South Australia (CHSA) in July 2009, followed by its May 2010 start in metropolitan Adelaide. Between July 2010 and June 2013, 702 - almost half of the 1,500 palliative home care packages provided under the program - went to country patients with complex end of life care needs and their families. This rural/metropolitan split has continued since the formal evaluation phase of the first three years of EOLC’s operation.

Kevin Hardy, the Nurse Management Facilitator for EOLC in CHSA, told the 2014 Palliative Care Victoria Conference that the program had provided country patients and families with complex need access to terminal phase care in the last week of life; stabilisation care for an escalation of an existing or new symptom; caregiver respite care; and complex continuing care for longer periods.

“This care was on top of existing palliative care, and has helped to avoid hospital admissions as well as earlier hospital discharges than would ordinarily be possible,” Kevin said.

“The key to the EOLC program is flexibility - in the type of services delivered, the time and place where services are provided - and topping up existing services,” he said.
Explaining these figures, Kevin said that EOLC was not as expensive as first thought despite being provided for up to three months. “A lot of the care (such as daily showers) is delivered by paramedical staff, not always Registered Nurses, which helps to reduce costs,” he said.

**TWO EOLC PATIENT EXPERIENCES**

A 63-year-old female had pancreatic cancer, liver and lung metastases. Her main carer had a physical disability restricting mobility and was unable to provide adequate support as the patient’s health deteriorated. Additional paramedical aid and nursing support was provided for 31 days, enabling the client to die at home as she wished.

For a 50-year-old female with breast cancer and cerebral metastases, daily hygiene assistance was provided along with weekly input from a Palliative Care Community Nurse for symptom management. The EOLC complex continuous care option assisted in keeping the client out of hospital for 43 days, allowing her husband to return to part-time work. The client was admitted to hospital with uncontrollable nausea/vomiting and died five days later (she had indicated preference to die in hospital at start of home care). The family reported a significant benefit to all in having her at home prior to death.

Both these cases reflect situations that would have resulted in long hospital admissions prior to death if access to the additional level of support provided by EOLC options had been unavailable.

“These and other patient and care experiences also demonstrate the significant cost advantages of EOLC over inpatient hospital care.”

For more information, contact Kevin Hardy, End of Life Choices Program, Country Health SA, email: kevin.hardy@health.sa.gov.au

**Megan Stoyles**

*Consultant writer*
No-interest loans help disadvantaged rural women

No Interest Loans (NILS) is a national, community led initiative providing no-interest loans to financially disadvantaged Australians. Across Australia, over 250 community providers are accredited with the national auspice body, Good Shepherd Microfinance, to provide small, no-interest loans for those experiencing social and economic disadvantage. These loans are used to purchase essential household goods and services. The National Australia Bank provides the loan capital and the Federal Government provides some funding for operational costs. Nationally 75 per cent of NILS users are women.

Women’s Health Goulburn North East (WHGNE), based in Wangaratta, has been an accredited NILS provider since 2007. WHGNE has written over 300 loans for more than $400,000 and was the first women’s health service in Australia to develop a specific NILS for women exiting family violence. Women have used these loans for a wide range of purposes, including essential white-goods and furniture, training/employment costs, cataract operations, breast prostheses, dental costs and vehicle repairs.

In 2012 a mature aged woman applied for a WHGNE NILS loan for cataract operations. She needed cataract surgery on both eyes. She stated that if she remained on the public hospital’s waiting list for the surgery she would have to wait for at least twelve months. Her specialist had told her that by then she would have lost her sight completely. Living in a rural town, with very little public transport, she relied on her ability to drive for a number of reasons, including taking her son to and from work. She could not afford the cost of this operation herself but fortunately she had heard about NILS. Her loan was approved and the operations were successful.
More recently a woman applied for a WHGNE NILS loan to purchase breast prostheses and good fitted bras. As a result of breast cancer, she had both breasts removed and, having lost her job as a result of the illness, had not been able to afford good quality breast prostheses. She was using cheap alternatives which were ill-fitting, hot and uncomfortable. By borrowing just over $1000 and with affordable repayments of $25 per fortnight via Centrepay, she was able to purchase good quality prostheses and comfortable bras which greatly improved her self-esteem and sense of wellbeing.

As part of the application process, NILS recipients receive financial literacy information. Many financially disadvantaged women who were previously unaware of the free financial counselling service go on to engage with financial counsellors for extra assistance. For some, just to be alerted to their rights can be empowering and, for others, the support to make an initial phone call can mean addressing financial issues that they may otherwise have put off, leading to more serious financial stress in the future.

“NILS has a proven track record in providing safe and equitable credit for disadvantaged Australians. NILS is a vital tool for early intervention and financial capacity building for people experiencing social and economic disadvantage. For some on low incomes, applying for a NILS loan can be the first opportunity to address their financial situation with assistance,” said Susie Reid, Executive Officer of WHGNE.

NILS is not charity. NILS is a hand-up, not a hand-out.

Karen O’Connor
Women’s Health Goulburn North East
Rural and remote communities need a stronger voice on climate change and health policy, as well as a better spread of allied health providers, according to key speakers at the recent Services for Australian Rural and Remote Allied Health (SARRAH) national conference.

The conference, held in the New South Wales regional town of Kingscliff, opened on 18 September with a video message from Prime Minister Tony Abbott and an address by NSW Labor Senator Deborah O’Neill.

Senator O’Neill, who is Chair of a Senate Select Committee on Health, acknowledged the need to address the well-documented shortage of allied health services in rural Australia.

“Good health does not equal good medicine alone – evidence-based, economically sensible interventions by allied health professionals are key,” she told delegates.

Commenting that the proposed $7 co-payment for GP visits risked the creation of a two-tiered health system, Senator O’Neill said: “Rural Australians could argue we already have a two-tiered health system – metro and rural.”

Senator O’Neill said “local knowledge is gold” in effective rural health delivery, as every community has different needs. She urged delegates, who included physiotherapists, podiatrists, social workers and psychologists, to become politically involved in moves to improve services in the bush.

Another speaker, Fiona Armstrong of the Climate and Health Alliance, warned that we are on track for a temperature rise of four degrees by the end of the century, which would significantly impact on rural communities.

“Given the vulnerability of rural and remote communities, there is a striking lack of rural sector representation in the climate change research - just 3 per cent,” she said.

Other highlights of conference included news of a highly successful eight-week research project into the use of performance, improvisation and comedy therapy for people with dementia, presented by stand-up comedian Many Nolan and Associate Professor John Stevens.

SARRAH Board member and physiotherapist Daniel Mahoney gave tips for attracting more young health professionals to rural settings by mentoring young graduates and embedding them in communities.

The conference attracted more than 200 delegates from across Australia. Other program highlights included presentations on:

• how a physiotherapist and occupational therapist in a new job-share role reduced re-admissions of patients at a Toowoomba hospital;
• how a vision screening program for Year One students in rural Victoria found 30 per cent had common eye conditions such as amblyopia (lazy eye) and refractive errors that impair reading and learning;

• how remote Kangaroo Island now has a reliable flow of foot care by introducing a system of brokering of podiatrists from other sites in the region with spare capacity; and

• how an innovative screening test successfully identified the suitability of allied health professionals to work in remote areas of Australia.

Other presenters shared models that break the service deficit, such as the dental Sun Smiles program that now has 1,000 children enrolled across rural Victoria and New South Wales. Research shows that prior to the project more than 80 per cent of enrolled children missed out on preventive dental care.

SARRAH CEO Rod Wellington said the conference was unique in Australia because of its focus on allied health in rural settings.

“We bring together the leading minds in rural allied health research and practice to shine a light on the allied health providers who work outside the cities,” he said.

“Without them, many Australians would have worse health outcomes, more hospital admissions and disability – as the presentations at this year’s conference so clearly demonstrate.”

Mr Wellington said a set of conference recommendations would be released shortly to inform delegates, other stakeholders and Parliamentarians.

Louise Pemble
SARRAH
Dr Geoff King died at home in Naas, Ireland, on 29 August 2014. Four nurses who worked with him pay tribute to a remarkable colleague.

May Smith (former Director of Nursing, Mossman Hospital, North Queensland) remembers Geoff as a young Medical Superintendent there from 1986 to 1991 after he returned from Africa. From the challenges they faced together in setting up the health structure for the Indigenous communities of Wujal Wujal and Hopevale was borne a lifelong friendship and mutual respect.

From 1991 to 2003, as Medical Superintendent of the Royal Flying Doctor Service (RFDS) (Qld), Geoff transformed the RFDS, unifying fragmented bases into the dynamic cohesive service it is today. Suzanne Hood, RFDS Director of Nursing during those years, experienced firsthand a master strategist at work.

Geoff’s early Mossman experiences and his work with the RFDS sowed the seeds of great understanding of and insight into the risks associated with rural and remote area care for both doctors and nurses.

This insight was to result in the development of the Primary Clinical Care Manual (PCCM), Drug Therapy Protocols (DTP) and changes to rural and remote health care practices. Geoff found a kindred soul in Lyn Overton who, like him, had long abhorred the risky practices and fractured care delivered in many remote and rural communities. The changes to the Health Drugs and Poisons Regulation in 1996 was the catalyst for the work which Geoff and Lyn and many others then drove to see the introduction of the PCCM and the first isolated practice course and then the rural and isolated practice course for nurses and Indigenous health workers.

The instruction from the Queensland Director General of Health (1998) that “…Queensland Health staff working in remote and rural location are to adopt the Manual as their guide to best practice and to actively contribute to its ongoing review and revision” is an indication and vindication of the importance of this manual.

Catherine Miedecke, speaking at the memorial service for Geoff, matched his beliefs and commitment to his colleagues and those under his care to the definition of collaborative practice in the 2nd edition of the PCCM “… a belief that the best health outcomes are achieved when well prepared health professionals work in collaboration and partnership in both practice and educational settings.”

At the time of his death, Geoff was the Director, Pre Hospital Emergency Care Council, Ireland.

Dr Geoff King, 4 May 1956 – 29 August 2014, a true hero of the bush.

Catherine Miedecke, Lyn Overton, May Smith and Suzanne Hood
Good connectivity, including through high speed broadband, is essential for households and businesses, for commerce, recreation and communications.

The health sector in rural and remote areas stands to be a major beneficiary of high speed broadband. It offers a range of opportunities for continuing professional development, online education, mentoring, clinical decisions and other support for the current and next generation of rural and remote health professionals – as well as for health service delivery and management.

Despite the fact that those communities with limited or no current access to broadband have been given priority in its rollout, there are still many that are struggling to connect or are going without altogether.

The National Broadband Network (NBN) will consist of fibre-optic cable to 93 per cent of premises. The remaining seven per cent of premises, mostly in rural and remote areas, will be connected by fixed wireless or satellite - which may not be sufficient to deliver all of the potential benefits of broadband.

Mobile communications also offer some exciting opportunities for people in rural and remote areas, but this potential is hindered by patchy, unreliable coverage or the absence of it all together. Mobile phone coverage currently extends to only 25 per cent of the Australian landmass.

The Broadband for the Bush Alliance (B4BA) is one of those leading the charge for improvements on these matters. It brings together organisations that seek to advance the digital capacity and capability of remote Australians. B4BA seeks the best possible communication outcomes for the seven per cent of Australians not currently scheduled to receive fibre to the premise through the NBN, and is promoting the adoption of the means by which these unmet telephony needs can be met.

The NRHA has adopted as one of its key priorities for the year the ‘last mile connectivity’ strategy put forward by the B4BA. This strategy proposes that many of the more challenging places could be provided with broadband through a program focused on ‘last mile solutions’. The program would give priority to connection for premises or communities close to fibre; and to connections to a community node for individual premises in communities where there is fibre to that node.

See the B4BA’s communiqué at www.broadbandforthebush.com.au

Dane Morling
National Rural Health Alliance
For several years the Rural Doctors Association of Australia (RDAA) has promoted a ‘rural training pipeline’ as an effective mechanism to attract more of the increasing numbers of medical school graduates to rural practice.

The pipeline concept is based on a growing body of evidence showing that students who have positive rural training experiences and who complete a significant component of their studies and training in a rural setting are more likely to become rural doctors.

The pipeline starts in medical school, providing students with the opportunity to complete a significant amount of their course from a Rural Clinical School, or to undertake rural placements during their studies. After graduation from medical school, it continues with their work as interns and junior doctors in regional hospitals, which is hopefully then followed by general practice fellowship training in a rural practice, and eventually work as a fully trained rural GP.
The Prevocational General Practice Placement Program (PGPPP) formed an integral part of this pipeline. Its abolition, which was announced as part of the Federal health budget, will cause a significant and concerning blockage.

The PGPPP gave interns and junior doctors the opportunity to spend a three-month rotation in a general practice environment - away from the full-time work in metropolitan or larger regional hospitals which is required at this stage of their career. It provided these doctors with what was often their only opportunity to experience general practice work during a time when they were making decisions about their future training and the general direction of their medical careers. The rotations also created additional intern places at hospitals, relieving some of the pressure on an already overstretched system.

RDAA has received overwhelmingly positive feedback from rural doctors and training administrators about the benefits of the PGPPP. Everyone strongly believed that it was having a significant impact in attracting junior doctors to a career in rural general practice and there have been loud protests about its abolition. Rural doctors appreciated having these bright and enthusiastic doctors working in their practice, and many of the participants actually returned to their rural hosts to complete their GP registrar training.

In short, the PGPPP was a great way to give young doctors a chance to experience rural general practice and to attract them to rural medicine. These doctors would never have had this opportunity without the program, and it succeeded in attracting many of them to the bush. Scrapping it puts an end to any junior doctor exposure to general practice at a time when they are deciding on the direction their medical career will take.

The budget allocation for the PGPPP has been used to fund an additional 300 GP Registrar places, with 60 per cent of these to be in rural areas. However these additional places do not motivate or encourage junior doctors into rural practice in the first place, nor do they come with any indication that Registrars who sign up for rural training under these requirements are genuinely interested in a career in rural practice.

RDAA continues to call for the reinstatement of the PGPPP or a program with similar aims and outcomes, and we have stressed the importance of consultation with relevant stakeholders before changes such as these are made in future. This is important if we are to achieve a sustainable robust health care system that recognises and rewards quality care and provides mechanisms and incentives to achieve a highly-skilled, home-grown rural medical workforce.

That is the key aim of the rural training pipeline. Some remedial plumbing is needed.

**Jenny Johnson**  
*Rural Doctors Association of Australia*
SW pharmacist Lindy Swain has been named the Pharmaceutical Society of Australia’s 2014 Pharmacist of the Year for her work as a clinician, innovator, teacher and researcher in rural areas, and in particular for improving the health outcomes of Indigenous Australians. As a clinical pharmacist at Bullinah Aboriginal Health Service, Ms Swain provides patient counselling and medication reviews, Nurse and Aboriginal health work training and pharmacy liaison. Lindy represents the Rural Special Interest Group of the PSA on the NRHA Council.

Shannon Hallatt has received the 2014 Telstra Young Business Women’s Award for the Northern Territory. Shannon began her occupational therapy career in government agencies before creating OT for Kids NT in 2010. Her business provides occupational therapy services to children with learning disorders, including diagnosis and therapy for children with Autism and a range of other challenges.

OT for Kids NT provides outreach services, with regular visits to centres outside Darwin, as well as running training programs with schools and educational organisations.

Dr Teena Downton has received a 2014 Young Alumni of the Year award from the University of Wollongong. Teena graduated in medicine in 2012 and is now working as a Junior Medical Officer in Tamworth NSW. Teena has a passion for rural and remote health. She is active in the Rural Doctors’ Association of Australia and, as a student, was heavily involved in her university’s rural health club, SHARP, and in the National Rural Health Students’ Network which she represented on the NRHA Council.

In 2015, Teena will be moving to Orange Hospital in central NSW to do a year of obstetrics as part of the NSW Rural Generalist Program.
The Graduate Certificate in Global Point-of-Care Testing (POCT) offered by Flinders University International Centre for Point-of-Care Testing is a fully online one-year, part-time course, which provides advanced knowledge and specialist skills in POCT.

The course covers how to set up and manage a POCT service and how to perform POCT for acute, chronic and infectious disease. Students also study two elective topics such as emergency and disaster management, chronic disease management, and rural and Indigenous primary health care.

Douglas Chiwara, a medical scientist working for the National Institute of Pathology in Namibia, recently became the first international student to undertake the Graduate Certificate course.

Namibia has a high disease burden and generally poor access to health services for people living in its rural and remote areas. The Namibia Institute of Pathology is responsible for providing medical diagnostic testing throughout the country.

As Douglas explains:

“Point-of-Care Testing was identified as one strategy that would bring diagnostic services closer to people, especially those in isolated locations. The National Institute of Pathology was set the task of validating and implementing POCT. I came across the Graduate Certificate offered by Flinders and was convinced that this course would assist with the implementation of POCT in Namibia.”

With financial support from the Australian Rotary Foundation, Douglas was able to undertake the course while continuing to work full time in Namibia.

“POCT will help deliver safe, accurate and timely clinical diagnosis and management to patients thus helping to provide safe, reliable and quality health services to all communities in Namibia,” he said.

To learn more about the Graduate Certificate in Global Point-of-Care Testing, email Heather.Halls@flinders.edu.au or visit www.flinders.edu.au/courses

Bridgit McAteer
Flinders University International Centre for Point-of-Care Testing
You may not know this but the Alliance is registered with the Australian Tax Office as a tax deductible health promotion charity.

That means you can provide financial support to our work in fighting for the health and wellbeing of the more than 6.7 million people of rural and remote Australia.

Best of all, you can claim it as tax deduction.

Where will your money go?
Your donation will support the Alliance’s policy development and advocacy for better rural and remote health services, health outcomes and wellbeing.

Help us keep rural and remote health front-of-mind with the decision-makers and people of influence.

Together we can make a difference. There is still much more to be done. No donation is too big or too small.

**Donating is easy.**

Donate online at ruralhealth.org.au/donate
or call us on 02 6285 4660
The 2015 application round for the Rural Australia Medical Undergraduate Scholarship Scheme is now open. Applications will close on 12 January 2015. You can apply online at ramus.ruralhealth.org.au

The RAMUS Scheme is aimed at attracting more doctors to rural and remote Australia. It assists selected students with a rural background to study medicine at university. In addition to their rural background, RAMUS scholarship holders are selected on the basis of financial need and demonstrated commitment to working in rural Australia in the future.

Approximately 150 new scholarships will be awarded in 2015 through a competitive application round.

RAMUS is an Australian Government initiative, administered by the National Rural Health Alliance.
Oi,
EARLY BIRD REGISTRATION NOW OPEN!

Register online at ruralhealth.org.auconference

13TH NATIONAL RURAL HEALTH CONFERENCE
24-27 May 2015, Darwin Convention Centre, NT

www.ruralhealth.org.au/conference
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