Fly-in, fly-out services: elevating health care levels

Taking junior doctor training to the country

Arts: creating a better health picture

The power of language for Indigenous health

Women's Longitudinal Study reports on rural-urban differences
Untangling rural-urban differences in women’s health

The Australian Longitudinal Study on Women’s Health (ALSWH) is highly regarded for the work it has undertaken over 15 years, for the breadth of its study and the excellence of its scholarship. It is therefore a red letter day when it produces a special report on rural-urban differences, combining the relevant elements from the various projects within the study.

In the report’s executive summary the authors refer to the AIHW’s speculation about the major causes to which rural health disadvantage may be attributed: access, environment, and risk factors. And while many of the general findings about worse health status will not be a surprise to readers of Partyline, what is particularly valuable about this special report is the help it provides with untangling the impacts of these three causes.

Funded by the Department of Health and Ageing, the ALSWH is conducted by the Universities of Newcastle and Queensland. Participants in the study have taken part in five surveys over 15 years and many of them have consented to the study’s use of linked data from Medicare Australia. The data is therefore rich and broad.

The general finding is that, measured objectively, women living in regional and remote areas have poorer health than those in major cities. A higher death rate among women from rural and remote areas in the oldest cohort is possibly explained in part by higher levels of smoking in the past and exposure to smoking by others. This highlights the importance of current changes in rates of smoking and the report notes that the decrease has been slower among young women in remote areas. The Alliance has frequently made the point that if Australia is to meet its medium-term targets for the national smoking rate, something special and especially effective will have to be targeted towards reducing smoking rates in rural and remote areas.

The study found that the prevalence and incidence of both diabetes and hypertension increased with increasing distance from major cities. Differences by area in these two conditions could be explained almost entirely by measured levels of obesity in those areas.

As those associated with the study have previously reported to the National Rural Health Conference, in the period 1996 to 2002 the rate of bulk billing available to women decreased and out-of-pocket costs increased for all age cohorts, but especially for those women in rural areas. On the bright side, however, the study concludes that the 2004 changes to Medicare, which saw additional incentives for GPs to bulk bill health care cardholders and children under 16 in certain regions, improved the situation. The study’s authors should be thanked and congratulated for making this direct link between the empirical study and policy change.

The report continues this useful thrust with the suggestion that the relative equivalence of rates of publicly funded screening services is further evidence that government subsidies for health services can be very effective ways of reducing inter-regional inequities.

As would be expected, the study reports decreasing numbers of visits to specialists with increasing distance from major cities for all age cohorts in all surveys. Perhaps surprisingly, given the findings in the AIHW’s January 2011 report entitled Australian health expenditure by remoteness, the ALSWH report shows little difference in hospital admissions between areas.

Another article in this issue of Partyline deals briefly with the question of the narratives that lie behind particular pieces of data. This report from the ALSWH illustrates some of these narratives. It is suggested that the increasing rates of hysterectomy with distance from major cities seem likely to reflect less access to or less interest in trying alternative treatments by women in country areas. This is in contrast to the reason given for the higher reported incidence of osteoporosis in major cities; in this case the difference is thought to be due to the fact that the diagnosis depends on tests more easily available in the cities. Spelling out these narratives is a useful thing to do.

The study examined several markers of climate change and found no evidence of adverse effects on the mental or physical health of rural women. Such a finding runs counter to other studies and to much anecdotal and media ‘evidence’. The study’s authors suggest that this may point to the resilience and adaptability of country women when dealing with adversity.

This is one issue on which, as the authors say, the apparent contradictions and inconsistencies point to the need for further research to allow deeper understanding and more nuanced responses.
Numbers and narratives

Reports from the Council of Australian Governments (COAG) Reform Council on progress with the National Healthcare Agreement show some substantial differences in cancer incidence rates between major cities and rural/remote areas. And the relationship is not uniform. Rates for lung cancer were higher in regional and remote areas, whereas rates of melanoma were higher in regional than city areas, but lower in very remote areas. Rates for breast cancer were lower in outer regional and remote areas than in the major cities, while rates of cervical and bowel cancer in regional and remote areas were not significantly different from those in major cities.

These figures relate to individuals’ home addresses. But can one be sure they reflect the actual rate of diseases for people living in particular areas, or are there explanatory narratives behind some of the numbers? Is there something about a particular condition that has an impact on an individual’s decisions relating to ‘home address’? For instance, might people with bowel and breast cancer shift in greater number to regional centres or major cities to be closer to treatment and/or family?

In order to know how to mitigate excess (or apparently excess) morbidity and mortality, one needs to know the narratives behind the numbers. And the Alliance’s network is full of people with the clinical, family and localised knowledge required to do this. We will soon publish on our website the 70 performance indicators in the National Healthcare Agreement and would value readers’ comments on them.

For instance, what can you report about the migration of frail elderly people from rural and remote areas to major regional centres or cities – or in the opposite direction? This will help those who interpret and use data on life expectancy. The AIHW reported in 2005 that life expectancy was highest in Major Cities and lowest in Very Remote areas, and the implications of this would be understated if large numbers of the very frail had moved their ‘home address’ to larger centres because of their condition.

Survey responses from Roy Morgan panels show that the reported incidence of high blood pressure is up to 29 per cent higher for rural people than for those in the capital cities. This is a common and therefore significant illness, with over 10 per cent of people affected overall. However it is not clear what proportion of people with that condition receive appropriate treatment.

It would also be valuable to know how the accuracy of self-reported data is affected by the attitudes and cultural characteristics of the subjects. In this matter too there might be some significant rural-urban differences.

The evidence base for identifying health priorities and likely solutions needs to be built of more than just numbers. As Lt Columbo might have said: “We don’t want the numbers. We just want the facts.”

Reaching out but not over

One of the positives for the people of rural and remote Australia from the hung parliament in Canberra has been the establishment of a parliamentary Standing Committee on Regional Australia. Chaired by Tony Windsor, the Committee has completed a report on the impact of the Murray-Darling Basin Plan in Regional Australia (www.aph.gov.au).

The Committee is currently enquiring into the use of ‘fly-in, fly-out’ (FIFO) and ‘drive-in drive-out’ (DIDO) workforce practices in regional Australia. Part of the Committee’s terms of reference is to clarify the importance of FIFO and DIDO practices to particular regions and sectors, so the Alliance’s submission focuses on how important they are in providing more specialised health services to rural and remote areas. In the rural health sector they are more often known as ‘hub and spoke’ and ‘outreach’ services.

Such services should never be seen as adequate or satisfactory replacements for personal healthcare and related services.

Addressing this particular focus of the Committee’s Inquiry led to the Alliance speculating again about where the line is drawn between the health services that an individual in a remote area needs, and what can be sustained or justified financially, ethically and with clinical safety. This part of the Alliance’s submission will be of interest to all those in the health sector who struggle with the balance between ‘access’ and ‘the tyranny of distance’.

There are already numerous situations in which, thanks often to technological developments, individual people can have access to specialised health care in their own small community or home. More and more, justification for the absence from small communities of highly-specialised and publicly-funded facilities such as dialysis will relate to cost or safety issues – not to technical (in)feasibility.
Winning support for arts and health

Three short films from the innovative *Lost Generations* series stood out in the arts and health stream at the Perth National Rural Health Conference.

Presented by Disability in the Arts, Disadvantage in the Arts, Australia (DADAA), each film was a gem! In the first we witnessed the re-union of mother and daughter after more than 30 lost years of separation and institutional living. In the second a retired bakery worker proudly reminisced about his working life, and in the third we watched as loving hands massaged the swollen limbs of a long-time invalid with such care and tenderness it was impossible not to be moved.

What was happening? This was arts and health in action. As art works the films were a credit to their makers for their compassion and production values. An audience of over 1000 health sector practitioners and consumers were drawn into a key experience of how the arts and health can work naturally to deliver messages that promote health and wellbeing.

The arts and health have long been recognised as having great potential to underpin wellbeing and health. The recently published book *seeded* (see box) celebrated 13 great arts and health stories grown in regional Australia but these few only scratched the surface.

While the benefits of arts and health collaborations are well known to the health sector and among artists who regularly deliver projects in the health sector, one of the frequent obstacles is the lack of awareness of the potential benefits of arts and health projects on the part of key government and bureaucratic stakeholders. The Alliance has embarked on an ambitious project to change this.

Partnering with the Arts and Health Foundation and Regional Arts Australia, we have set out to win support for a national arts and health policy. A crucial element of the project is to map current arts and health stories across Australia. The project has established a website on the innovative Place Stories website

In the meantime, fly-in, fly-out and drive-in drive-out services provide access which is relatively cheap, of a high clinical standard and get around the mal-distribution of health professionals. Such services should never be seen as adequate or satisfactory replacements for personal healthcare and related services. Face-to-face interactions provide the best health care, the widest suite of tools to ensure accurate understanding and communication, and some of the human interactions that are fundamental to health and wellbeing.

An important part of the mission of FIFO and DIDO services should be to provide support for those already ‘in the field’.

There is also continuing concern to ensure that outreach health services, such as those provided under MSOAP, do not merely ‘over fly’ the small number of more specialised health service providers who are already in rural and remote areas. An important part of the mission of FIFO and DIDO services should be to provide support, encouragement and perhaps respite for those already ‘in the field’.

Other parts of the Committee’s terms of reference relate to the impacts of fly-in, fly-out services on the communities served (their economic bases, sustainability), the communities from which such workers come, and the workers directly involved and their families. Such issues are significant contributors to the social and economic determinants of health in rural and remote areas, and therefore are of interest to the Alliance. Although much of the evidence on these matters is sketchy or anecdotal, it is certain that there are some adverse effects on individuals, families and communities from the widespread practice of FIFO and DIDO.

However FIFO employment does not always impact negatively on the wellbeing of families. Personal, family, community and workplace factors all influence individual experiences and adaptation. There is evidence of successful adaptation to the FIFO lifestyle for people who have made purposeful and informed choices and have decided that the benefits of such employment outweigh the disadvantages. Health professionals providing outreach or locum services in rural and remote communities can gain life-changing experiences through a broad scope of clinical practice and the delights of country life.

The Alliance’s submission includes recommendations about the continuing need to provide tied support for health service outreach programs; the importance of well-supported locum programs; and the need for better information on the personal and community effects of the practices.

The Alliance expects the Inquiry’s report to reflect the importance of FIFO and DIDO in the context of health services and to endorse the need for continued support for such services from the public purse. Such work practices have been part of the rich fabric of rural and remote Australia for generations, and in the health service sector they still have much to contribute.
to allow anyone involved in an arts and health project to record its details. In this way we will build up a comprehensive map of the extent of contemporary arts and health practice. Participants will also be able to view and comment on a draft national arts and health policy which will be developed for presentation to Commonwealth and State and Territory governments in 2012.

So help us push the arts and health agenda. Register on the Place Stories website! Tell us your arts and health story!! Comment on the draft policy!!

You can still order free copies of seeded: great arts and health stories grown in regional Australia. Visit NRHA website to find out how!

Key arts and health links
NRHA: www.ruralhealth.org.au (select Projects)
Arts and Health Foundation: www.artshealthfoundation.org.au
Place Stories: http://ps3beta.com/community/ArtsAndHealth
Contact: Peter Brown NRHA (02) 6285 4660 (Wednesday – Friday)

Bloom

In May 2012, Canberra’s Gallery of Australian Design (www.gad.org.au) will launch BLOOM, an exhibition curated by Gweneath Leigh in partnership with the Australian Institute of Landscape Architects (AILA).

BLOOM will present case studies from across Australia which demonstrate how our built environment affects our health and wellbeing, addressing topics such as:

• the role of ‘healing’ landscapes within hospitals and aged care facilities;
• how schools are using the outdoors for tackling childhood obesity;
• the value of community gardens; and
• the ability of pocket parks and urban squares to improve mental health.

The goal of BLOOM is to engage people across a range of backgrounds in a discussion which looks at how the built environment can promote healthy and sustainable lifestyles, as well as ask where we need to be investing more creative energy.

It is our hope that BLOOM will tour to rural areas following its launch in May 2012. If your community is keen to learn more about ways in which health can be improved through the design of our built environment, please get in touch.

Information: www.aila.org.au/bloom or Gweneth.leigh@aila.org.au

Gweneth Leigh
BLOOM Curator

Your super fund can make a lifetime of difference

✓ Run only to benefit members
✓ No commissions
✓ Low fees

hesta.com.au/super
Parliamentarians hear nine rural health priorities

The National Rural Health Alliance recently completed the annual 4-day face-to-face meeting of its Council (‘CouncilFest’) in Canberra. This monumental event brings together the staff of the Alliance and delegates from its 32 Member Bodies, each from a different rural profession, agency or consumer group and many from far-flung rural locations.

The first two days were spent identifying the priority themes to be developed and canvassed over the next 12 months. The Alliance policy staff distilled the ideas and discussion into two documents: a summary one-pager, and a more detailed document setting out the nature of the problems to be addressed and suggestions for fixing the problem.

The third day was spent with key decision-makers in Federal Government Departments and non-government agencies, including the Department of Health and Ageing, Health Workforce Australia, Charles Sturt University (a regional university), the National Farmers Federation, the Australian Indigenous Health InfoNet, the COAG Reform Council and the Australian National Preventive Health Agency.

The exhausting fourth day was spent in Parliament House. The Council was split into eight groups, and each was allocated a series of 30-minute interviews with a number of politicians, including rural Senators, rural members of the House of Representatives, as well as Ministers and Shadow Ministers with an interest in health. This was a unique opportunity for the group to lobby for real change in the nine priority areas it had developed in the preceding three days, at the same time gaining physical fitness from many brisk walks along the halls of Parliament House, between politicians’ offices.

The Alliance’s CouncilFest is a fine example of effective and imaginative strategic planning, an absolute necessity for any organisation targeting a key area of obvious socio-economic disadvantage such as rural health.

For 2012, the nine priority areas identified by the Alliance are:

1. **The new Rural Health Agency** – effective interfacing with a new high-level agency to be formed in the Department of Health and Ageing and ensuring that it reports to the public on progress with a national plan for rural and remote health;

2. **Oral health** – to find and fund effective low-cost solutions to address the dire need for dental care in rural Australia and for disadvantaged groups generally;

3. **Broadband solutions in more remote areas** – those in very remote areas are the most in need, and they require high-performance solutions;

4. **Publicly-funded primary health care models for rural communities** – to examine the option of salaried professionals to fill gaps left by the private fee-for-service system;

5. **Improving rural education outcomes** – targeted support for rural and Indigenous places in tertiary health profession programs;

6. **Aged care** – subsidies need to reflect the true cost of providing aged care places in rural locations, recognising increased costs of transport and health service delivery;

7. **Rural placements for students in all health professions** – current programs only support rural placements for students in medicine, nursing and midwifery, but all the professions are key to the network required for rural health delivery;

8. **Mental Health** – increased risk of mental health problems and suicide in rural communities needs to be addressed by resources applied in areas where no clinical services are available;

9. **Integrated Primary Care in Rural Areas** – control and integration of primary care should be local and governed within relatively small areas reflecting a community of interest.

Rural clinical placements in all professions deserve support. Local optometrists, working with local GPs, provide the core of eye health needs in rural towns, and it is clear that, in future, they will be approached to provide placement options. Sadly, there is a looming shortfall in rural eye health professionals.

It is also pleasing that the Alliance recognises the relative disadvantage encountered by students in rural high schools who want to join a health profession. The funding of tertiary health profession programs should be conditional on those programs reserving places for students of rural and Indigenous origin.

Phil Anderton
Rural Optometry Group Convener and delegate to NRHA Council

(Adapted from an article in the November edition of Australian Optometry. More details on the Alliance’s nine priorities are at www.ruralhealth.org.au)
A plan for more doctors in rural and remote Australia

In recent years, considerable investments of money, energy and other resources have been made into increasing the number of medical schools and medical students across the country. At the end of 2011, a greater number of medical students will graduate than in any previous year. This provides an opportunity to achieve a better distribution of doctors across the nation – and, specifically, to secure more of them for rural and remote areas.

The National Rural Health Alliance is promoting a nationally coordinated and expanded system to ensure that all of these graduates can complete the necessary postgraduate training to become competent and confident doctors. The system should ensure that:

- at least 30 per cent of new internships and PGY 2 and 3 positions are established in rural and remote areas (in line with the proportion of the population in these areas);
- a major and growing proportion of these positions incorporate community-based practice supportive of primary care; and
- funds are available to:
  - set up integrated regional and local training networks;
  - accredit additional training positions in rural and remote areas;
  - establish necessary infrastructure (including teaching facilities and accommodation for junior doctors); and
  - train and remunerate increased numbers of clinical supervisors.

Health Workforce Australia (HWA) has been funded “to provide more effective and integrated clinical training for health professionals, support workforce reform and more efficient workforce use, and provide effective, accurate planning of health workforce needs”. HWA is therefore the key body to develop and implement system changes to ensure that the health workforce of the future in rural and remote areas meets the needs of the 32 per cent of the population who live there.

Additional allocations to these various rural training and support measures are justified by the primary care funding deficit in rural and remote areas which amounts to at least $2.1 billion a year. This equates to an annual shortfall of 25 million services, and includes a rural Medicare deficit which has now reached $1 billion a year. Implementation of this plan to ‘ruralise’ internships and junior doctor training would reduce the rural primary care deficit by increasing access to general practitioners and medical specialists.

Other activities that HWA would need to undertake include:

- a national marketing strategy, developed collaboratively with medical students and junior doctors, to capitalise on the benefits of the ‘rural pipeline’ and show a clear rural pathway for junior doctors;
- clarifying indemnity issues for junior doctors in non-traditional training places; (unlike the situation in State or Territory funded situations, in primary care or non-government positions it may not be clear where responsibility for indemnity cover lies);
- identifying successful regional initiatives which have the potential for wider application - and then promoting them broadly.

University Departments of Rural Health and Rural Clinical Schools have demonstrated their success in supporting the education and training of health professionals in rural and remote areas and they must be part of the solution. As Medicare Locals and Local Hospital Networks become operational, they too will have significant roles in addressing rural health workforce shortages.

Creative approaches to challenges have long been a feature of health services in rural and remote Australia, and this augurs well for action to work with the current cohorts of medical students to reduce the shortages of doctors in rural and remote areas. All that is needed now is a little extra resource and the political will of governments and other relevant agencies and organisations.
A web of mental health networks

An ambitious project instituted by the Federal Government to improve collaboration between professionals working in the primary mental health sector is achieving notable success. To date, over 480 networks have been established, with 40 per cent of them in rural, regional and remote locations.

The Mental Health Professionals Network (MHPN) was established in mid-2008 and aims to increase interdisciplinary collaboration by fostering local networks across Australia in which general practitioners, psychiatrists, psychologists, mental health nurses, occupational therapists, social workers, and other professionals working in the mental health sector can regularly meet. In the last year, over 10,000 clinicians have attended one of these network meetings.

The goal is to help them expand their referral networks, broaden their knowledge of local service providers, enhance their professional development, and thereby improve patient outcomes. As one psychologist recently wrote:

“MHPN functions have afforded me the benefits of insights into a variety of practice methodologies and frameworks as well as the invaluable benefits of being able to network with other local providers….The benefits of sharing knowledge and collegiate support are enormous in this industry. This has also enhanced my confidence and understanding of the complexities under which we work.”

For clinicians working in rural and remote communities the networks provide valuable support with the unique challenges they face, including making professional connections. Some remote networks, such as the MHPN Newman Network in WA, whose members service mining communities, and the MHPN West Coast of Tasmania Network, have overcome the challenges of distance by meeting via videoconferencing.

For all its members MHPN also provides a collaborative portal, MHPN Online. This hosts forums as well as enormously popular free webinars and podcasts on topics such as adolescent mental health, psychosis, and grief, trauma and anxiety – this last being a topic of considerable relevance to clinicians given the impact of recent natural disasters and job losses in their communities.

The webinars and forums enable members to view presentations by leading clinicians and to share in discussions with others across the country. For remotely located clinicians it means professional development is now infinitely easier. As one distant member recently wrote: “we in the Far North have been desperate for this for years.”

Happily, it has now been announced that MHPN’s operational contract is to be extended. This will maintain continuity and momentum in consolidating MHPN’s existing networks, and establishing and providing support for new ones.

For more information about MHPN, and to locate a network near you, visit mhpn.org.au

MHPN Network in Ulladulla

A 37-strong Mental Health Professionals Network (MHPN) group in Ulladulla is bounding forward in its quest to improve client outcomes via collaborative interdisciplinary care.

The meeting, held at the Richmond Fellowship of NSW office, saw a host of mental health practitioners as well as community mental health workers and the Member for the South Coast, Shelley Hancock, come together to discuss collaborative care and local issues.

Community support worker Kevin Ramsey opened the meeting with a discussion on this year’s “Mental Health Month” theme of “Good Friends Help Us Bounce Back”, giving examples of how this works in a practical sense on a day to day basis working with clients with a mental illness. Guest speaker Associate Professor Dr Brett Thompson, gave a thoughtful presentation on resilience and how it pertains to patients, clients, community support workers and health professionals.

Service Manager and network coordinator, Karin Robinson, was pleased with the attendance at the multidisciplinary meeting because, while many rural clinicians know each other by name, they often don’t know each other personally.

“Because we’re rural, it’s important for us to actually meet the people we speak to on the phone. It creates a whole network of people who are ready to give each other a hand. It also gives my staff an idea of what services are available,” Ms Robinson explained.

“The meeting has led to better networking between health professionals and that has to lead to better outcomes for clients,” she said. *

Peter Jordaan
News from South West WA Medicare Local

The South West WA Medicare Local is one of the first nineteen established on 1 July 2011.

A nationwide network of Medicare Locals is a key component of the Australian Government’s national health reforms. Medicare Locals are organisations established to coordinate primary care delivery and tackle local health care needs and service gaps. They have been charged with the responsibility of driving improvements in primary care, ensuring that services are tailored to meet the needs of local communities.

The South West WA Medicare Local covers a region that occupies the south west corner of Australia. It covers an area that is 3.2 per cent of Australia’s total land mass and about 1.4 per cent of Australia’s total population. Uniquely, the region covers 73 Local Government Authorities (LGAs), which is more than half the total number of LGAs in Western Australia.

The South West WA Medicare Local is different from others in a number of ways. First of all it is not a service provider. We see our role as working with other providers to address service gaps in the region. Secondly, the South West WA Medicare Local has been designed with community and stakeholder engagement at its core.

One of our first tasks for the Medicare Local will be to develop a population health plan for our region. To do so we will involve all of our stakeholders including consumers of primary care, service providers, clinicians, peak bodies and training, research and education agencies.

Our vision is to have comprehensive, future-proofed and integrated health services that provide the best possible health outcomes for those who reside in the region.

To capture all these individuals and groups we have devised a number of structures that include:

- our membership, which is organisationally based and includes the many agencies that are involved in the delivery of primary care or who support this health sector within our region;
- Local Health Hubs, which we plan to develop within local communities to provide a structure for local clinicians, providers and consumers to be involved in planning for their community;
- Clinical Interest Groups, which we plan to foster to provide support to the clinical workforce at a local level;
- Area Networks, which will bring together the chairpersons of Local Health Hubs and Clinical Interest Groups;
- a Clinical Leaders Group, which is to be established within the region in partnership with the Local Hospital Network;
- Executive Partners, which we plan to establish to operate as steering committees for the various areas of health reform. These groups – selected by our Board from our membership – will guide the planning and developmental work of the Medicare Local; and
- a skills-based Board, which is being formed from individuals residing within our region, who collectively have the range of skills required for governance of our Medicare Local.

The South West WA Medicare Local has established a Strategic Plan that is published on our website. Our vision is for the South West WA Medicare Local Region to have comprehensive, future-proofed and integrated health services that provide the best possible health outcomes for those who reside in the region.

We plan to do this by identifying and linking innovative primary health care solutions to identified need. We will work with others to achieve our goals with integrity, respect, transparency and good humour.

The South West WA Medicare Local gratefully acknowledges the financial and other support from the Australian Government - Department of Health and Ageing.

For further information on Medicare Locals:

- contact us at: communicate@sw-medicarelocal.com.au

Suzanne Leavesley
FAST action on stroke will save lives

Stroke is the second biggest cause of death in Australia and a major cause of disability - and people living outside major cities need better services and support to protect their health, according to National Stroke Foundation CEO, Erin Lalor.

An Australian Social Trends report, Health outside major cities, released by the Australian Bureau of Statistics earlier this year, confirmed that while overall life expectancy in Australia continued to climb, serious inequities existed between people who live in major cities and those who do not.

“The report says that in 2008, people who lived outside major cities were twice as likely as people who lived in major cities to die from a range of illnesses, including high blood pressure,” Dr Lalor said.

“High blood pressure is a major risk factor for stroke – but through lifestyle changes and treatment it can be managed by those people at risk. The issue facing people in rural, regional and remote areas is that they have less access to services. This is compounded by the fact that general knowledge about blood pressure is poor.”

The ABS report revealed that while dying from a stroke was the second most common cause of death both in those who lived in major cities and those who did not, it was 31 per cent more likely to be a cause of death outside major cities.

Every 10 minutes in Australia someone suffers a stroke.

“It’s vital that public education campaigns are funded to help people recognise the warning signs of stroke and to take action without delay - which will ultimately save lives,” Dr Lalor said.

Since 2006 the National Stroke Foundation has been spreading the FAST message - four letters that can save lives.

The National Stroke Foundation’s FAST test contains simple steps to quickly establish if someone around you is having a stroke and understand the urgency of calling triple zero (000).

FAST is an easy way to remember and recognise the signs of stroke:

• Face – Has the person’s mouth drooped?
• Arms – Can they lift both arms?
• Speech – Is their speech slurred? Do they understand you?
• Time – Time is critical. If you see any of these signs, call 000 now.

While this important campaign has raised stroke awareness, we still have a long way to go and we encourage everyone to keep promoting the FAST message.

“Time lost is brain lost,” Dr Lalor said.

“Thinking FAST and acting FAST is critical because early treatment can mean the difference between death or severe disability and a good recovery from stroke.

“Strokes can occur to anyone of any age at any time but every Australian, no matter where they live, has the power to save a life by thinking FAST and acting FAST when they recognise the signs.”

For more information go to www.strokefoundation.com.au

Erin Burton
Literacy – a strong foundation for health

Being able to read and write is a basic human right.

Yet only one in five Indigenous kids in remote communities in Australia can read a book, and many children from refugee and migrant communities are also struggling because of missed schooling and lack of support.

The Australian Literacy and Numeracy Foundation (ALNF) teaches marginalised Australians – including those in Indigenous and refugee communities – how to read and write.

Like all not-for-profits, the ALNF has to raise funds through different avenues to ensure that our valuable services are able to continue. We know we are making a difference to many young lives and, in the long run, their learning will make a difference to the generations that follow. For a closer look at the work and achievements of the ALNF please follow the link - you will be impressed. www.alnf.org

If you wish to support the work of the ALNF, all donations over $2 will receive a tax deductible receipt. ✴

Tom Calma
ALNF Board Member

“...every extra year of education provided to a community of young mothers may add up to four extra years of life expectancy for their first child.”

Jeff McMullen

Language to close the gap

To close the health gap experienced by Aboriginal people requires those people to be empowered to take control of their own lives. For them to be empowered they need access to good information in their own language. This message is simple but it is not being acted on.

Service after service is rolled out to help the people but all these service providers have one thing in common: they cannot communicate with their Aboriginal clients. Why don’t we have a service that closes the gap in communication?

People in Australia today who speak an Original Australian Language receive almost no news and current affairs in their own language from any form of media service. In terms of access to information, they are some of the most marginalised people in the world.

Why Warriors considers Language Centres combined with Media Centres need to be funded as a front line service in advance of all other services to empower and equip Aboriginal people so they can take their future back into their own hands and have the gap closed forever.

In a first for Australian publishing the National Indigenous Times newspaper announced it is expanding and will now publish weekly from Wednesday, September 21. It is the first time a national weekly newspaper has been published for Indigenous Australians. We commend the NIT for this move, while being aware that because many Aboriginal people cannot read English, there is still need for a media service for Aboriginal people in their own languages. www.nit.com.au

The current parliamentary inquiry on Indigenous Languages is examining the benefits of giving recognition to Indigenous languages, and how Indigenous languages can be used in education to improve competency in English. Submissions are still being received and recommendations from the report are expected by the middle of next year.


More info: Phone 1300 501 795; www.whywarriors.com.au; seminars@whywarriors.com.au ✴

Richard Trudgen
Why Warriors
Preventative Health Initiative

An Australian Government program is leading the way in mobilising rural and remote communities to develop local solutions to local health problems.

The $18 million Preventative Health Initiative (PHI) funds 34 community-led projects which address key social and environmental determinants of health, with a focus on chronic disease risk factors.

The PHI uses a community capacity building approach, developing partnerships between a wide range of local organisations and community groups, including local employers. Together, these groups aim to facilitate ongoing community participation and foster local leadership to extend the benefits derived from PHI projects beyond the life of the PHI program. In this way they can equip the community with the skills, resources and momentum to continue running activities to support healthy life choices.

The PHI projects are as diverse as the communities that run them, with a variety of target groups and a vast number of activities, including establishing community gardens, community gyms and community kitchens as well as a range of other health promotion activities.

Active Kyogle is one of the many PHI projects rapidly getting their healthy lifestyle activities off the ground and involving local people of all ages in activities that improve nutrition and increase physical activity.

The Healthy Life Skills program based in Mossman, Queensland, is also running a number of exercise classes and activities, with a Community Cook Book on the way. This project is making significant headway in overcoming some of the cultural barriers for local Indigenous women in participating in physical activity programs and in improving nutrition.

The Pilbara Division of General Practice, in partnership with the local school, the Shire Council, TAFE, local police and mining companies, has established a community and school garden in the town of Onslow in Western Australia. The community garden has now become a venue for community health promotion activities and community functions.

Most projects have developed project resources that could be adapted by any rural health organisation that wants to undertake a preventative health project in their community.

These are a few examples, with many other projects also making good progress in developing local solutions to local health problems. To find out about a PHI project near you, or for the full list of the 34 PHI projects nationally, project officer contact details and a list of project resources, please email Cathy Duncan, Rural Primary Health Section, Department of Health and Ageing: cathy.duncan@health.gov.au.

Consultations have just closed (28 October) for the draft bill to establish the national personally controlled electronic health record (PCEHR) system. This legislation is expected to go before Parliament in late November 2011, once consultation input has been considered.

PCEHR – What it is and what it is not

A personally controlled electronic health record (PCEHR) will be a secure, electronic record of your important health information.

When the system becomes available in July 2012, the PCEHR will bring key elements of your health information together in a unified record. Your information in the PCEHR system will be accessible only by you and your authorised healthcare providers. This information will allow healthcare providers to make better, more efficient decisions about your health and treatment.

The PCEHR will not hold all the information in your healthcare providers’ records, but will detail key and frequently used health care information. As PCEHRs become more widely used and the PCEHR system matures, you will be able to access your own health information online — anytime, anywhere—and so will your authorised healthcare providers. Your health care information will be protected and secure through a combination of governance arrangements, supported by information privacy and system security measures.

You will also be able to nominate which members of your family (or carers) have access to your information. For example, if you are mature-aged or chronically ill, you can nominate your partner (or a trusted person), to have access to your PCEHR.

The national rollout of the PCEHR System will actively seek to register individuals who are likely to receive immediate benefit from having a PCEHR. This includes individuals who have complex and chronic conditions, older Australians, Aboriginal and Torres Strait Islander peoples, mothers and their newborn children, people with mental health conditions, people with disabilities and people living in rural or remote communities.

...continued over page.
My dog has stripes

What do you do when health professionals themselves need care?

This critical topic was played out at a remarkable theatre presentation at the 11th National Rural Health Conference in Perth in March 2011. *My dog has stripes* is a piece of theatre written by Alan Hopgood, well-known Australian actor and playwright, and Tania Nahum. It explores mental illness, with a focus on depression. At the Conference in Perth the performance drew a warm response from an audience comprised largely of health professionals. The play’s light touch and humorous tone encouraged the audience to quickly empathise with the characters and their emerging issues.

Over the years these comedies have proved to be a very good means of imparting information about sensitive subjects.

From a simple starting premise – a familiar staff meeting to review the progress of a number of cases being supported by the team of health workers – the play’s action quickly reveals that one of the team is not coping well with family and work pressures. As the team works through the typical business of a case review meeting, the audience is able to observe and draw lessons from some of the key actions and omissions relating to the situation. The play has clear dramatic integrity that was exploited to its full effect by well-known Melbourne actors Margot Knight, Marcella Russo and Paul English, who joined Alan Hopgood in a memorable performance.

To enhance the learning from the play, immediately following the performance Alan Hopgood moderated a discussion involving a panel of health specialists including Sophie Heathcote, credentialled rural mental health nurse, Dubbo Plains Division of General Practice; Harry Gelber, Senior Social Worker at the Royal Children’s Hospital (Victoria) Integrated Mental Health Program; Dr John Setchell, General Manager, Health Services, with the Royal Flying Doctor Service (South Australia); and Nicole Highet from beyondblue. Comments from the panel and the audience confirmed the positive message inherent in the performance: that the pressures and stigma of mental illness and depression can be reduced not just by talking about it more openly but also by the degree of support available from work groups and family.

Commenting after the performance, Sophie Heathcote said: “An impressive feature of the performance was the way the bigger picture of mental health was brought to the fore, depicting the ease with which issues can be missed – particularly among those closest to us. The play is a very worthwhile reminder of how we need to understand these issues.”

Alan Hopgood has now created seven Healthplays, dealing with topics as diverse as diabetes, Alzheimer’s, widowhood, geriatric sex and palliative care. Over the years these comedies have proved to be a very good means of imparting information about sensitive subjects. The featured presentation in the Perth Conference was a valuable addition to Hopgood’s body of work and a very worthwhile element of the arts and health stream at the Conference.

Healthway plays including *My dog has stripes* are available to tour. Contact Baystreet Productions on 03 9592 5698. [www.healthplay.com.au](http://www.healthplay.com.au)

The performance of *My dog has stripes* was generously supported by beyondblue.
Rural findings from the MABEL project

The Medicine in Australia: Balancing Employment and Life (hereafter MABEL) project is an ongoing longitudinal (annual panel) study of more than 10,000 doctors practising in Australia, recently re-funded by NHMRC for 2012-16. MABEL is being undertaken by researchers from the University of Melbourne’s Institute of Applied Economic and Social Research together with staff from Monash University’s School of Rural Health and Department of Epidemiology and Preventive Medicine. The first cohort (Wave 1) of doctors responded in 2008. The project team is currently conducting the 2011 Wave 4 survey and cleaning data from the 2010 Wave 3 responses.

The MABEL study is unique in Australia in focusing on the dynamics of medical labour supply in Australia. Its longitudinal design has the advantage of enabling research to move from simply measuring associations towards examining causal effects, particularly as the number of annual panels increases. For example, future analysis of rural doctors will be able to focus on observed changes in their geographical location and to measure the influence of changes in job characteristics and job satisfaction.

Several articles have already been published which highlight some key findings in relation to the rural medical workforce. A paper published by McGrail et al in the 2010 Medical Journal of Australia showed that there is little difference in professional satisfaction between metropolitan and rural general practitioners (GPs). Overall satisfaction was above 85 per cent, even after separating respondents into five community size groups ranging from capital cities through to the smallest centres with less than 2,500 residents. This research indicates the need to market more aggressively the benefits of rural practice to prospective doctors, in contrast to sometimes negative perceptions of rural practice.

Two working papers have focused on the earnings of doctors. One by Chang et al showed that rural GPs’ incomes were about 11 per cent higher than those of GPs working in metropolitan areas. However, it also demonstrated the significantly lower earnings of GPs than other specialties, as well as the significantly decreased earnings of female doctors. Another paper by Sivey et al showed that, for junior doctors with an interest in general practice, rural practice is likely to be more attractive, professionally, than metropolitan general practice. It also shows that general practice would be more attractive to junior doctors if earnings or procedural work were increased.

Other MABEL publications have examined the nature of association between rural background and rural practice for both GPs and specialists (BMC Health Services Research) and the association between rural amenity and rural medical workforce shortages (Geographical Research). Current work-in-progress examines the preferred job characteristics of rural GPs, attitudes of rural doctors towards retention strategies, workload and work activities of rural doctors, and the satisfaction of geographically restricted IMGs.

De-identified individual level MABEL data from both Waves 1 and 2 data have been made available for external researchers, and can be linked. More data will be available in the future. Further information is available from the MABEL website at: http://mabel.org.au

Matthew McGrail and John Humphreys (Monash University, School of Rural Health) and Anthony Scott (Melbourne Institute of Applied Economic and Social Research, University of Melbourne).

A great friend to rural health

Dr Bruce Harris, a rural general practitioner from Dubbo, New South Wales, has won the Royal Australian College of General Practitioners’ Brian Williams Award for 2011. The Brian Williams Award is awarded by the RACGP National Rural Faculty to a member of the College who has made a significant contribution to the personal and professional welfare of rural doctors. The Brian Williams Award is the highest accolade awarded by the RACGP National Rural Faculty.
You can help someone with asthma

Asthma Australia is the national voice of Australians with asthma and linked conditions and their carers. Working with people living in rural, regional and remote Australia is a strong focus of our community work.

Data from the Australian Institute of Health and Welfare (Asthma in Australia 2008) shows that adults are more likely to be hospitalised for asthma if they live outside a major city. The rate of hospitalisation increases with remoteness.

For people living in rural areas, these statistics are unlikely to be surprising. With access to doctors or health clinics made more difficult by distance, it is likely to be harder for country people to see a doctor for routine management of their asthma. If someone has an asthma attack, they may have hundreds of kilometres to travel to reach medical aid.

It is vital that everyone can recognise the signs of an asthma attack, has access to equipment, such as an asthma emergency kit, and can provide asthma first aid.

In recognition of this, Asthma Australia runs a range of programs for the general community and staff at schools and pre-schools, showing people how they can help someone with asthma. All education sessions are free and provide information about how to live well with asthma, as well as teaching people asthma first aid.

Learning asthma first aid is one of the most important things we can do to help people with asthma. It is vital that everyone can recognise the signs of an asthma attack, has access to equipment, such as an asthma emergency kit, and can provide asthma first aid. Although the rate has declined, at least one person per day still dies in Australia from an asthma attack.

Asthma Foundations across Australia provide education and training focused on asthma first aid. People living in rural or regional Australia may not have ready access to doctors and hospitals, so knowing asthma first aid can really make a difference and save someone’s life.

Information and support can be accessed through the 1800 telephone help line, or via the website. This is a good starting point for gathering information, if you or someone you care about has been diagnosed with asthma. There are also resources that can help you plan what you need to speak to your doctor about to help make the most of your visit – particularly important if this isn’t just down the road!

Asthma Australia’s school and preschool program educates school staff on managing asthma attacks in the school environment. This can help provide confidence for parents that if their child is at a sports day, for example, and has an asthma attack, the school will be equipped to manage the situation. In facilities to offer asthma education to some of the more remote parts of the country. Positive feedback is always received from people attending web based sessions, who appreciate being able to access asthma education without travelling to a major centre.

An online package for school and pre-school staff will be available in the near future. It is hoped that this initiative will improve access to training for schools in rural and remote Australia where a trainer may not be available.

This work is funded by the Australian Government as part of the Asthma Management Program.

To find out more about asthma, education and training, contact your local foundation on 1800 645 130 or at asthmaaustralia.org.au

Paula Murray

Movember

On average, one in eight men will experience depression in their lifetime - that’s almost one million men who will be affected. Anxiety is even more common. Less than half receive help.

In Movember men are encouraged to grow a moustache to promote the fact that ‘it’s ok’ for men to talk about their health – both physical and mental. At the same time Movember helps to raise money for important research and for men’s health programs throughout Australia.

For more information visit www.movember.com
Medical and midwifery students: learning together in rural South Australia

In 2010 an innovative interprofessional learning activity was implemented in rural South Australia with the support of a grant from the Faculty of Health Sciences at Flinders University. The aim of the activity was to facilitate communication and foster relationships to promote professional collaboration between medical and midwifery students.

Current health workforce developments in Australia include an important emphasis on the range of health professionals working together more collaboratively to improve the patient journey and the quality and safety of care. This South Australian workshop was particularly timely as the Federal Government has moved to give midwives a more autonomous role in caring for women who are considered low risk during their pregnancy and birth.

There were 32 students in the workshop: 16 third year midwifery students and 16 third year medical students. The medical students had had the advantage of working in a rural area on placement, while the midwifery students were all city based but had an opportunity to request a rural placement for their final practicum. It was hoped that this interprofessional activity would provide an incentive for midwifery students to request a rural placement which in turn might lead to them seeking future employment in a rural area. Two midwifery students who participated in this activity have since been employed in a Transition to Professional Practice program in a rural area. Four weekend workshops were held in two rural areas. The first workshop introduced students to normal pregnancy, birthing and post natal care and the second, five months later, focused on complications and emergency care of the pregnant and birthing woman. The activities undertaken included education on the pre-obstetric booking visit which included history taking, assessment and antenatal screening; normal labour and birth including anatomy and physiology; and ‘hands on’ birthing using obstetric models. Third year midwifery students, under the supervision of their midwifery educator, facilitated these sessions using interactive teaching and learning models and role plays which focused on teamwork and collaboration.

Students stated that the workshop increased their awareness of each other’s roles as well as their willingness to collaborate in the future.

One scenario involved a man phoning from home when his partner was in labour. There was much laughter and then seriousness when the responder to the call worked out that the woman was actually pushing and what should happen next! The second and subsequent workshops were student-driven in that they identified what skills they felt needed further development. Skills stations included management of hypertension in pregnancy and labour, estimating blood loss, shoulder dystocia and neonatal resuscitation. These skills were then tested with a final case-based scenario, where students were given roles to play and a situation to manage in a simulation exercise.

The workshop facilitators were a midwifery course coordinator, midwifery lecturer in the Parallel Rural Community Curriculum, rural general practitioners, a rural obstetrician and a University Professor of Obstetrics. Support was provided by administration staff from a rural simulation centre.

The workshops were evaluated using a questionnaire and focus groups. The students were also given the opportunity to write brief notes about their thoughts at different stages of the workshop. They were given a piece of paper with ‘At the moment I am feeling …’. This was a useful exercise as the feelings went from being nervous and excited at the beginning, to learning a lot at the end. The identification of professional boundaries was one of the themes developed in the focus groups. Students stated that the workshop increased their awareness of each other’s roles as well as their willingness to collaborate in the future.

The workshop proved very successful and a new series has been put in place for 2011.

The final words are from a medical student: “It would be fantastic now, as a doctor, to go and be involved in the birth with one of the midwives we have been doing this with. I think the relationship, even now, would be quite different. We just understand each other’s roles a bit more and we are not out to outdo each other. We just want to work together for the best outcome.”

Pauline Glover and Lyn Gum
Listen you women, your breasts are precious

On 9 June, 2011, a new multilingual DVD Resource, *Listen You Women, Your Breasts Are Precious* was launched at the Yeperenye Shopping Centre in Alice Springs.

This was the culmination of four years’ work by the Alice Springs branch of Bosom Buddies, the breast cancer support group, to produce a culturally appropriate resource for Aboriginal women from traditional communities. The DVD aims to raise awareness, encourage attendance at screening, provide a better understanding of breast cancer, and encourage women to detect changes early and seek appropriate treatment.

Some of the founding members of Bosom Buddies had lived in very remote localities in the NT and were aware of the difficulties women face accessing mammography screening. Perceptions and fear that cancer means death can lead to later presentation, later diagnosis and poorer outcomes. As well as barriers of language and distance, other challenges include dealing with unfamiliar medical processes and being away from family and community for extended periods for cancer treatment.

Our vision was to find ways to present information positively. Another purpose was to give hope and support to those diagnosed so they would know they were not alone. DVD resources were available from other jurisdictions but the women from traditional communities did not relate to them.

Our project began when two of our friends, senior women on an Arrernte community in Central Australia, were diagnosed with breast cancer in 2006. One, Mrs Kathleen Wallace, teacher, artist, and foster carer, had lost her mother to cancer at an early age. Mrs Wallace understood the importance of early detection and intervention and was committed to raising awareness and encouraging women to looking after their breasts, significant in traditional culture for ceremony and for nurturing babies. A small working group was formed which also included Mrs Dawn Ross, diagnosed through BreastScreen, and Sandy McElligott, Remote Women’s Health Educator in Central Australia.

Inspired and guided by the strong traditional women who had survived breast cancer and resumed normal life with their families, the project began to take shape. Over time, a number of women agreed to share their deeply personal stories, reflecting a range of age and experience: from a woman in her early 30s diagnosed while still breast feeding her youngest, through to a woman, still active in ceremony, in her 80s.

The traditional elements of passing on knowledge through storytelling, sand drawings, use of leaves and the painting of the Wulatja (breast Story) were used to convey the key messages in a powerful way. To fulfill Mrs Wallace’s instruction that it was necessary “to show what is going on inside” we approached the National Breast and Ovarian Cancer Centre who graciously gave approval to use their animations.

We worked with a structure, not a script, with the only enacted segments taking place in the Radiology and Chemotherapy Departments of Alice Springs Hospital.

With support from a number of Central Australian organisations: the Centrecorp Foundation, CAAMA, Yeperenye Shopping Centre, Rotary Mbantua, and our own fundraising, the project finally got underway in February 2011 when MW Creative – Gaby Mason and Lotte Waters – were engaged for the production. The initial filming of the five women from the Arrernte, Alyawarre, and Anmatjere groups was followed by the post production and translation into other Centralian languages including Warlpiri and Pitjanjatjara.

This multilingual resource was inspired and driven by Aboriginal women survivors throughout, even to the title: *Listen You Women, Your Breasts Are Precious*.

The night of the launch, a cold and wintry one, was exciting for all of us, with an attendance of almost 100 people. The feedback following the private screening was overwhelmingly positive and an opportunity for the storytellers to receive congratulations for their amazing contribution and willingness to reach out to other women who may be diagnosed in the future.

It has been a tremendously rewarding experience for all of us involved in this collaborative project, and we are thankful for all the support given to make it a success.

www.listenyouwomen.com

Lesley Reilly
President, Bosom Buddies NT Inc
Helicopter emergency services

The Snowy Hydro SouthCare Aero Medical and Rescue Helicopter Service is the primary provider of aero-medical and rescue helicopter services in the ACT and Southern NSW. The Canberra based helicopter provides vital Emergency Medical Services with its single Bell 412 rescue helicopter.

Since beginning operation in October 1998, the Snowy Hydro SouthCare Rescue Helicopter has performed over 4,300 missions throughout an area that extends north to Orange, west to Hay, south to the Victorian Border, and up the NSW East Coast. The Service provides the region with the highest standard of aero-medical and rescue helicopter services every day of the year to the community and visitors to the NSW region.

One person who is grateful for the Snowy Hydro SouthCare Rescue Helicopter, and who credits the helicopter with saving his life, is Scott Reardon of Temora, NSW. In 2002 a farming accident on his parents’ property changed his life forever. Scott got his shoe lace caught in a PTO on a tractor; the shoe lace trapped his right leg, amputating it at the knee.

The day of Scott Reardon’s retrieval, Dr Damian McMahon from the Capital Region Retrieval Service was on duty. Dr McMahon is the Director of the Shock Trauma Service at The Canberra Hospital and a Staff Specialist in General Surgery, specialising in Traumatology. His skill set and specialisation with trauma patients made him the ideal person to deal with Scott’s accident.

Each mission is crewed by an Intensive Care Paramedic from the ACT Ambulance Service and a highly skilled doctor from the Capital Region Retrieval Service of The Canberra Hospital. The doctors and intensive care paramedics who crew the Snowy Hydro SouthCare Rescue Helicopter provide care through four main types of helicopter missions.

In **Primary missions**, trained rapid response medical crews fly directly to the scene of an accident. Patients receive treatment as required to be stabilised for flight and are then transported to major hospitals. In Primary missions it is about the fastest delivery of the highest standard of medical care, and often to remote areas.

**Secondary missions** involve the transport of patients who need urgent specialised services from regional hospitals to other major hospitals. In many cases this is a transfer to the Canberra Hospital where patients can receive further care that is not available in their own region. In 2010 Secondary missions made up 66 per cent of all missions.

Scott Reardon’s family property is located outside of town and over 45 minutes by car from the nearest hospital. In response to Scott’s accident a NSW Road Ambulance was dispatched from Temora Hospital. The Snowy Hydro SouthCare Rescue Helicopter was tasked by the regional hospital to retrieve Scott and transport him to the Canberra Hospital where he underwent intensive recovery sessions and physiotherapy.

The helicopter also conducts two types of non medical missions. **Search and rescue (SAR)** missions over land and sea and, in times of **bush fire**, the helicopter utilises a “bambi bucket” to assist ground fire fighter crew.

The SouthCare Helicopter Fund Pty Ltd which trades as Snowy Hydro SouthCare, exists to fund the life-saving efforts of the Snowy Hydro SouthCare Aero Medical and Rescue Helicopter Service. It is committed to encouraging individuals, groups, businesses and organisations in the community to help continue saving lives in the ACT and Southern NSW through financial and in-kind support.

As the fundraising arm of the Service, Snowy Hydro SouthCare is responsible for raising the profile of the service, securing community support, encouraging safety awareness and raising funds to assist the ongoing operation of the helicopter.

Snowy Hydro SouthCare could not exist without the generous and ongoing support from its naming rights partner (Snowy Hydro Ltd), sponsors, community and service clubs, donors, payroll deductees, volunteers, the media and affiliated organisations.

Kate van Haalen
Student network’s national priorities

In 2011, the National Rural Health Students’ Network (NRHSN) Rural High School Visits and Indigenous Festivals programs saw hundreds of university students from the Network’s 29 energetic Rural Health Clubs travel far and wide across the country to promote rural careers and healthy habits.

In August, the NRHSN teamed up with the Australian Medical Students’ Association to host the 2nd National Rural Leadership Development Seminar in Victor Harbor, on South Australia’s Fleurieu Peninsula. This event brought together over 100 hand-picked medical, nursing and allied health students from across the country to talk about rural health and equip them with the skills to become rural health leaders and champions in their communities.

Several successful inter-Rural Health Club events have been run this year, providing NRHSN members with multi-disciplinary networking and professional development opportunities.

At this time of major health reform, the NRHSN continues to demonstrate its commitment to advocating on behalf of its 9,000 members, working hard to ensure the voice of the future of rural health is heard.

The NRHSN welcomes commitment from all sides of politics and levels of government to reform the health system so that it delivers better health for Australian rural and remote communities. As the future workforce for rural health, NRHSN members believe that health initiatives at both national and local levels must consider the particular needs of rural and remote communities. There must also be enquiry into how the future generation of health professionals will want to train and work.

This year, in consultation with its 29 Rural Health Clubs, the NRHSN has developed a National Priorities Paper (NPP) which outlines key issues from the NRHSN student perspective. The NPP outlines five national priority areas on which the Network would like to see policymakers and stakeholders take action now to support efforts to achieve equal health for all Australians.

1. Rural and remote training pathways
2. Aboriginal and Torres Strait Islander health
3. Mental health training for all health students
4. Ensuring Medicare Locals deliver for the rural and remote health sector
5. Regional development and health infrastructure

The NPP provides a number of recommendations to inform the rural, remote and Indigenous health reform agenda and can be found in both summary and extended versions alongside other specific policy documents at www.nrhsn.org.au.

The NPP emphasises the importance of positive rural experiences, such as placements, as integral to recruitment of health practitioners to rural practice. Placements need to be well supported. The NRHSN calls for 33 per cent of health students to be of rural background to match the population distribution of rural and remote areas.

The comprehensive training of health students from all disciplines must provide opportunities that will facilitate the development of clinically and culturally competent professionals. Vertical integration of curriculum and professional development of health students in Aboriginal and Torres Strait Islander health needs to be considered.

The NRHSN seeks additional research into the mental health challenges experienced by health students during tertiary study as well as mental health training for all health students.

The NRHSN is hopeful about what Medicare Locals can deliver for rural and remote areas and highlights the need for scope and appropriate funding to identify local health infrastructure needs in terms of training the future health workforce and delivering improved health services in rural and remote communities.

The NRHSN also recommends the Australian Government develop, fund and implement a targeted program similar to the National Rural and Remote Health Infrastructure Program, or as an extension to the program, to ensure the establishment or maintenance of essential infrastructure in rural and remote communities. Infrastructure for students should promote interdisciplinary learning and interaction through shared facilities.

The NRHSN thrives under the leadership of a dynamic executive team and the support of five enthusiastic Portfolios (Community and Advocacy, Indigenous Health, Allied Health, Medical and Nursing). The NRHSN thanks Rural Health Workforce and the Federal Department of Health and Ageing for their ongoing support. Particular thanks must go to Director of Future Workforce Programs, Helen Murray, and Future Workforce Programs, Program Manager, Kerryn Eccleston, for their assistance and mentoring.

Catherine Ryan
Eleven oral health messages for the Australian public

From a recently released Consensus Paper from the Australian Research Centre for Population Oral Health (ARCPOH)

The messages were developed following a workshop held in Adelaide. Participants were from all over Australia and from a wide range of backgrounds including dentistry, public health, paediatrics, academia and medicine. Topics discussed included diet, tooth cleaning, mouth rinses, chewing gum, safety, age of first oral health visit, frequency of oral health visits and smoking.

Following reviews of the literature, presentations at the workshop and follow up discussions, 11 national oral health messages have been consensually developed:

Diet
(1) Breast milk is best for babies and is not associated with an increased risk of dental caries.
(2) After 6 months of age, infant feeding cups rather than infant feeding bottles are preferred for drinks other than formula or breast milk. Sugary fluids should not be placed in infant feeding bottles. Comfort sucking on a bottle should be discouraged.
(3) Follow the Australian dietary guidelines. Focus on:
- drinking plenty of tap water;
- limiting sugary foods and drinks; and
- choosing healthy snacks, e.g. fruits and vegetables.

Tooth cleaning
(4) Brush teeth and along the gum line twice a day with a soft brush.
(5) People over 18 months of age should use an appropriate fluoride toothpaste.

Mouth rinses
(6) Fluoride mouth rinses can be effective in reducing decay. Speak with your oral health professional about whether fluoride mouth rinsing is appropriate for you.

Chewing gum
(7) Chewing sugar free gum can reduce dental decay.

Safety
(8) Mouthguards should be worn for all sports where there is a reasonable risk of a mouth injury. This includes football, rugby, martial arts, boxing, hockey, basketball, netball, baseball, softball, squash, soccer, BMX bike riding, skateboarding, in-line skating, trampolining, cricket (wicket keeping), water skiing and snow ski racing.

Age of first oral health visit
(9) Children should have an oral health assessment by age 2.

Frequency of oral health visits
(10) Everyone has different oral health needs and risk levels which should be reflected in the frequency of check-ups. Talk with your oral health professional about your risk level and how frequently you need to visit for an oral health check.

Smoking
(11) Quit smoking to improve oral and general health.

The article has been published in the Australian Dental Journal. For more information about the evidence base for these messages, view the article online at: www.ncbi.nlm.nih.gov/pubmed/21884152 or visit the National Oral Health Promotion Clearinghouse: www.adelaide.edu.au/oral-health-promotion/

Getting the message out – and keeping rurally up to date

You can promote your rural health news, resources and events through e-forum which the National Rural Health Alliance distributes fortnightly, by email, to over 2000 subscribers. To contribute or subscribe select ‘eforum’ at www.ruralhealth.org.au
Support for rural nurses, midwives and allied health professionals

The Nursing and Allied Health Rural Locum Scheme (NAHRLS) is a component of the Australian Government’s National Health and Hospital Network Reform agenda and has been established to address some of the challenges and barriers faced by rural and remote health professionals when trying to access professional development activities and training.

The Department of Health and Ageing established the NAHRLS in July 2011 to support nurses, midwives and eligible allied health professionals in rural and regional Australia to get away to do the professional development training they need to continue their vital work.

General Manager Mark Ellis says the NAHRLS team is receiving requests daily. “In the last three months we have assisted with over 100 locum requests from health services and organisations across rural and remote Australia. Our capacity continues to grow and our ability to support nurses and allied health professionals in rural and remote Australia continues to strengthen.”

The NAHRLS provides assistance with locum back-fill to their employers by placing suitably matched locums within the workplace for up to 14 days (per request). The NAHRLS will also cover multiple staff from one organisation who need release for training at the same time.

The NAHRLS is responsible for all administration associated with recruiting and credentialing appropriate locums and will arrange and cover all the costs of the locum’s travel, accommodation, meals and incentive payments during placement. There are no agency fees associated with locum back-fill placements. The hosting organisation is responsible for covering the base locum wage for the period during which the locum is required.

The NAHRLS will benefit urban based health professionals wishing to experience rural and remote practice by undertaking a locum placement and offers great incentives for those health professionals interested in working as a locum in rural Australia.

The NAHRLS supports the ongoing CPD requirements for health professionals in the National Registration and Accreditation Scheme and other relevant workforce regulatory organisations.

To request a locum or to apply to become a locum visit www.nahrls.com.au

AJRH – focus on mental health and drought

The October issue of the Australian Journal of Rural Health (19:5) features editorials and articles on the impact of drought on mental health and social wellbeing.

Tony McMichael’s lead editorial makes the point that rural and Indigenous communities in many regions of the world are bearing the brunt of human-induced climate change. “Property, harvests, incomes, jobs and community vitality are at risk,” he writes.

If there is an upside, it is that the stresses of a tough decade of drought and a dramatic year of floods have brought rural mental health into sharper focus. But according to Russell Roberts, author of the second editorial, this has not as yet been reflected in appropriate mental health reform or investments for rural communities.

Roberts says there is far too little new money directed to mental health, with the proportion of the total health budget spent on that issue rising only to 8 per cent, compared with the 14 per cent of the disease burden that it causes. The bulk of the new effort goes to just two of the 34 agreed priorities in the Fourth National Mental Health Plan: Early Psychosis Prevention Intervention Centres (EPPIC) and Headspace. Being centre-based, these programs are unlikely to reach many of those in need in rural areas.

Roberts acknowledges the laudable elements in the mental health budget package, including new funding for personal helpers and mentors, services to help families with children showing early signs of mental illness, and funding for non-government organisations. However he asserts that most people outside the age range 15-25 years, and most of rural and remote Australia, will miss out under the current arrangements.

Finally, Roberts criticises the national mental health effort for a lack of meaningful consultation with the States and Territories – “the predominant providers of mental health care”.

The four articles that follow these editorials deal with several aspects of these State-delivered services, focusing on NSW. The first deals with rural communities and a successful community development program funded by the NSW Government. The second deals with older farmers, the third with younger people, and the fourth with impacts on the social and emotional wellbeing of Aboriginal communities.

The Editorials and abstracts are freely available and you can access all articles online at: wileyonlinelibrary.com/journal/AJR
Since 1990, women farmers have met at Gatherings held throughout Victoria to share common interests, exchange information, celebrate their contribution to their farms and communities, and regenerate their energies in the face of continuing rural crises. A measure of the significance of these Victorian Gatherings has been the emergence of similar gatherings in other States around Australia, and organisation of the world’s first ‘Women in Agriculture’ conference in Melbourne in 1994. Lorraine Learmonth has written for Partyline about Gathering 2011.

Women on Farms Gathering 2011

The end of March this year saw an influx of 220 rural women into Cohuna, from most ends of Victoria, for a weekend of friendship and sharing ideas, and renewing friendships. The women represented 41 different agricultural enterprises, from truffles, cherries, hazelnuts and flowers, to dairying and cropping.

We were fortunate that we were able to sponsor 16 women from Buloke, Loddon and Gannawarra Shires who had been affected by the floods. This allowed these women not only to attend the Gathering, but to enjoy a break away from the stress, flood damage and the mess at home.

The foresight of the Gippsland ladies who, 21 years ago, began to invite women from all over Victoria to their farm workshops – so starting the Victorian Women on Farms Gathering – must be acknowledged.

Our guest speakers this year were Michelle Wilkinson (a mushroom grower and marketer), Dr Megan Magee, (who spoke about ‘taking care of ourselves’) from Deniliquin, Dr Sharman Stone (about growing up at Pyramid Hill), and Linda Beilharz (about her journey to North and South Poles). Our speakers were inspiring and we hope they have inspired some women to have a go at achieving their own dreams, goals or leadership roles. Our local speakers provided an insight into what can be achieved by pursuing an idea or dream. We did have comments from some women – “that they were proud to be conducting a business which is farming”.

Our Committee had a lot of fun over the past 12 months of planning, and the friendships we made over the weekend will continue – and we hope to see many at the 23nd Gathering at Buchan in 2012. (See http://buchan.vic.au/women-on-farms-gathering)

Further information: www.wofgcollection.org.au/
Being unable to use the phone is hard enough, but it’s even harder in the country

Communication is important for all of us, but when you live in the country, being able to make phone calls effectively is even more important.

Almost a quarter of the Australian population has some form of hearing impairment. Some 40,000 have a speech impairment. Many of these people are unable to use regular phones. A high proportion of these groups experience periods of depression, and mental illness among deaf people is about four times greater than in the general population.

Issues facing those with hearing and speech impairments include: loss of confidence; withdrawal, isolation, and loneliness; exclusion from family and social activities; and frustration and embarrassment.

They often have trouble doing ordinary things, like phoning a friend, contacting the bank or ringing the health worker.

They can sometimes be reluctant to admit to their deafness or the severity of their hearing loss and feel embarrassed about asking friends or family to make calls for them.

The next stage for us is to develop multidisciplinary interactive materials for rural health workers...

The National Relay Service (NRS) is a government initiative that provides a phone service for people who are deaf or have a hearing or speech impairment. The NRS can help hearing or speech impaired people to retain their social and business networks, make new contacts, maintain their independence and self-confidence, and contact health providers.

The NRS also makes it easier for family, friends, support services, businesses and government agencies to keep in touch with people with hearing or speech impairment, with special services tailored to address particular hearing or speech impairments.

As the ‘relay service’ name suggests, the NRS uses a person known as a relay officer who is the central link in each phone call. The relay officer relays – either by typing or re-speaking – all or part of a call between people with hearing or speech impairments and those with whom they are conversing.

Making a relay call is similar to making any phone call. The only difference is that a relay officer is on the line to help the call go smoothly.

The idea of relaying your conversation through a third party can seem a bit daunting at first, but the confidentiality of calls is guaranteed by law and it’s surprising how quickly users find that the relay officers become ‘invisible’.

The NRS works with many intermediary groups to increase awareness of relay calls and their benefits. We attended the National Rural Health Alliance Conference in Perth earlier this year and were again stimulated by our contact with people working on the ground in rural health who provided a lot of feedback about the range of rural health work and the range of professionals working with people with hearing and speech impairments.

NRS has been able to raise awareness through a short video about a rural truck driver called Murph who had a lifetime hearing impairment and discovered the relay service in late middle age (see www.relayservice.com.au/resources/murphs-story). Many delegates at the National Rural Health Conference told NRS staff at the Conference that they had seen this clip on TV. NRS has also developed a learning module for audiologists.

The next stage for us is to develop multidisciplinary interactive materials for rural health workers so that they can introduce their clients to the NRS more easily and feel confident making calls to their clients who use the NRS.

These interactives could be extended into CPD accreditation modules.

While we have lots of ideas for these products we are keen to hear from those of you who could comment on draft materials and work with us in the development process. Please contact our NRS Helpdesk if you want to be kept up-to-date on our new interactive modules or if you want any further information about the NRS.

The NRS can send you more information, links to website resources or arrange for one of our education and information officers to speak at any information session you might be holding.

Phone: 1800 555 660.
Email: helpdesk@relayservice.com.au
Website: www.relayservice.com.au

Ian Close
New help for Aboriginal and Islander people

The Heart Foundation has launched two new resources for Aboriginal and Torres Strait Islander people at risk of coronary heart disease (CHD) or with chronic heart failure (CHF).

1. Hypertension resources

In collaboration with the National Prescribing Service (NPS), National Aboriginal Community Controlled Health Organisation and Aboriginal Health Council of South Australia, the Heart Foundation has developed a suite of resources on hypertension tailored to the needs of Aboriginal and Torres Strait Islander people. It includes a flip chart, patient brochure and five patient flyers.

These resources are designed to help Aboriginal Health Workers and health professionals educate patients and their families about hypertension and support the Good Medicine Better Health hypertension module.

2. Living every day with my heart failure

This practical guide provides culturally and clinically appropriate health information to help Aboriginal and Torres Strait Islander people with chronic heart failure (CHF) better manage their condition.

It follows on from the Heart Foundation’s patient booklet Living well with chronic heart failure and is a companion to the Heart Foundation’s Guidelines for the prevention, detection and management of CHF, 2006.

The resources were successfully launched at the 2nd CSANZ Indigenous Cardiovascular Health Conference in Alice Springs, 16–18 June by the Heart Foundation’s National Leader, National Aboriginal Health Unit, Ms Vicki Wade.

To access the resources, visit www.heartfoundation.org.au/information-for-professionals/aboriginal-health/Pages/resources, or contact the Health Information Service on 1300 36 27 87 or health@heartfoundation.org.au

More places to yarn

The Australian Indigenous HealthInfoNet – a free web resource for anyone working in or studying Indigenous health – has added three more online yarning places to its site. Yarning places are electronic networks that help you keep in touch with people across the country who work in the same health area. Members use the yarning places to stay connected, share information, knowledge and experiences, ask questions, solve problems and network. There are already 12 yarning places available and now there are three more – for eye health, kidney health and physical activity. They are free to join www.yarning.org.au/

Overview of the health of Indigenous people in Western Australia

The 2011 ‘Overview of the health of Indigenous people in Western Australia’ is now available on the Australian Indigenous HealthInfoNet website. It contains information on births and pregnancy outcomes, mortality, hospitalisations, selected health conditions (i.e., cardiovascular disease, kidney health), as well as information on factors contributing to health (i.e., nutrition, physical activity). A PDF version of the report is available at www.yarning.org.au. Although there is evidence that the health status of Indigenous people in WA continues to improve slowly, it is clear from this overview that Indigenous people remain the least healthy sub-population in WA. In terms of specific health conditions in WA, substantial improvements have occurred in the overall impact of many infectious diseases (including improvements due to immunisation programs). It is anticipated that similar information for other States may be available in the future.

Stop Press: Australian Indigenous HealthInfoNet recently won the Diversity Section of the 2011 Australian and New Zealand Internet Awards (the ANZIAs). (Ed.)
Become part of an Australian first

Register4 is Australia’s first online community for volunteer breast cancer research participants.

The initiative was set up in October 2010 by the National Breast Cancer Foundation (NBCF) in response to the growing need for volunteer research participants. It aims to register one million members who will be willing to participate in a range of peer-reviewed, science-based research projects. The level of commitment rests with the participant and could be anything from answering a few questions to something more involved – from once or twice a year, to once every few years.

Breast cancer is still the most common cancer affecting Australian women, and over the last few decades its incidence has been on the rise. There could be something unique about any of us that might hold the answer to one or more of the big questions researchers are asking. By joining Register4, participants have the potential to make a tangible impact on the path of Australian research and the health of women around the world.

It can sometimes take years for researchers to find the right people to participate in their work. Register4 is a way to help fast track this process.

How to get involved

• Sign up at register4.org.au It’s free to join.

• When participants are needed, invitations are sent to Register4 members who meet the project criteria.

• The researcher contacts those members who agree to take part.

RHCE(2) supports Marumali program

One of the recipients of grant funding from the first round of Stream 2 of the Rural Health Continuing Education grants program (RHCE2) was the Centre for Remote Health in Alice Springs.

The grant allowed sixteen employees of the Central Australian Mental Health Service (CAMHS) to attend the Marumali Program, a two day workshop to assist those who provide services to survivors of removal policies.

Specifically the program aims to promote:

• an understanding of the impact of removal policies;

• recognition of the losses and trauma of survivors of removal policies;

• the ability to identify and minimise clinical errors when survivors of removal policies access mental health services;

• insight into the healing journey and the necessary skills to provide appropriate support; and

• clarification of appropriate service provider roles.

Participants evaluated the workshop positively, indicating that the workshop had helped them to be more understanding and respectful in their work with Aboriginal clients and to be better able to assist them in their healing. An unexpected benefit of the workshop was the camaraderie that developed among the professionals present.

Tim Carey
Centre for Remote Health

CANCER IN RURAL AREAS

The burden of cancer in Australia is increasing as our population ages, and there is evidence that people in rural and remote areas will continue to bear a disproportionate part of this burden.

People living with cancer in rural areas have poorer survival rates than those living in major metropolitan centres, and the further from a metropolitan centre patients with cancer live, the more likely they are to die within five years of diagnosis. (MJA 2004)

These lower rates of survival are likely to be due to later diagnosis due largely to poorer access to specialised cancer services.
Centre for Research Excellence in Rural and Remote Primary Health Care

Equitable access to appropriate, timely, high quality health care is the right of all Australians, regardless of where they live. Unfortunately, this is a right not available to a number of people in rural and remote areas.

Given the widely acknowledged poorer health status of many rural and remote communities, it is crucial that rural and remote health policies and programs are guided by rigorous evidence about how best to deliver accessible and effective primary care. At the same time as the Australian Government has strengthened its resolve to ensure that all Australians have access to appropriate health services, rural health researchers across the country have been working together to provide stronger evidence of unmet needs and to define ways in which health care can be better delivered.

In September this year, Mark Butler, Minister for Mental Health and Ageing, launched the Centre of Research Excellence in Rural and Remote Primary Health Care (CRE) in Parliament House, Canberra. This CRE has received $2.5 million from the Australian Government through the Australian Primary Health Care Research Institute.

The CRE will undertake research designed to ensure that rural and remote communities are provided with appropriate primary care services, and to help Australians living outside capital cities overcome problems associated with accessing health care.

“The research will provide a valuable basis to guide health policies for small rural communities that face difficulties in attracting doctors and other health professionals, and maintaining adequate health care services,” said John Humphreys, a Chief Investigator with CRE.

Specifically, researchers will undertake further research designed to:

1. provide better measures of accessibility to guide resource allocation for health services in rural and remote communities;
2. identify the quantum and mix of health services to which all rural and remote Australians can expect access;
3. develop a comprehensive framework for monitoring the impact of health services in improving health outcomes for rural residents; and
4. identify health service models which maximise access to primary care, particularly in relation to mental health, aged care and Indigenous health.

…the CRE will also lead an ambitious program of research capacity building for rural health researchers and practitioners.

“Rural Australia is a great place to live, and we want to ensure it is also a healthy place to live,” said Professor Humphreys.

The Centre of Research Excellence in Rural and Remote Primary Care brings together Australia’s leading rural and remote health researchers from Monash University School of Rural Health in Bendigo (Professor John Humphreys) and Gippsland (Dr Matthew McGrail), the Flinders and Charles Darwin Universities Centre for Remote Health in Alice Springs (Professor John Wakerman), and the University of Sydney Department of Rural Health in Broken Hill (Professors David Lyle and David Perkins).

In addition to the research activity, the CRE will also lead an ambitious program of research capacity building for rural health researchers and practitioners. Funding for PhD and Post-Doctoral positions will provide a great boost. It aims to graduate four PhD students and train three postdoctoral fellows to become accomplished primary healthcare researchers.

The CRE will also work actively to build the research capacity of primary care workers practising in rural and remote Australia through its outreach activities, including seminars, journal clubs, workshops and visits from international experts through the use of interactive technology such as videoconferencing and webinars.

For more information on the Centre of Research Excellence in Rural and Remote Primary Health Care visit www.crerrphec.org.au *
Making new friends

friends of the Alliance is a network of people and organisations helping to improve health and wellbeing in rural and remote Australia by supporting the work of the National Rural Health Alliance. It does this by giving its members a special relationship with the Alliance and facilitating their communication on issues affecting rural affairs.

The activities of friends of the Alliance are overseen by an Advisory Committee and a new one has recently been elected. Committee members come from all over Australia; some are health consumers and others have been working in the health area in various capacities for many years. While the committee members share the same passion for rural life they can each contribute their own varied experiences to the goal of bettering the health of people in rural and remote areas.

The vivacious and energetic Pauline is the Chair of friends. Pauline works in the School of Nursing and Midwifery at Flinders University. She would love more nurses and midwives to reap the rewards of living and working in rural and remote locations.

Marie has lived in rural Australia all her life and has been a member of the South Australian Country Women’s Association for over 40 years. She has represented the Regional Women’s Advisory Council for seven years. Carmel is completing a postgraduate course at the University of Wollongong. Having worked with the Alliance in the past, she takes every opportunity to promote its work.

Janet has been a remote area nurse for 21 years, managing remote health centres in the Northern Territory. She has a Masters in Remote Health and is a mentor with CRANAPlus. Suzanne is a registered nurse as well, with a special interest in the recruitment and retention of health professionals and services in rural communities.

Karen and Amber have also worked as nurses. Like all friends, they feel strongly about ensuring equitable access to health services for people outside the major urban areas. Living in a remote area, Karen understands health challenges from both provider and consumer perspectives. Amber has served on a variety of school councils and club boards and has been a member of a rural medical family network for 15 years.

Angela has worked in health services in the Northern Territory, South Australia and North Queensland and has a strong interest in the work of the Alliance. Irene is a farmer and a passionate advocate of sustainable rural communities. As a hospital board member, she has worked towards the improvement of health and aged care services in small rural communities.

Robin is a strong consumer voice in NSW and has been involved with rural and remote health for over 45 years. Her aim has always been the betterment of health and equity of access for all rural people. As the CEO of the Alcohol and other Drugs Council of Australia, David is passionate about building a more cohesive and collaborative national health policy.

Carolyn and Judi are both generalist psychologists in Echuca. Involved in many local and national groups, both have the opportunity to connect with mental health professionals and to disseminate information to a wide network.

In her former role as National President of the Country Women’s Association of Australia, Lesley developed a vast network and as a member of local government she is involved in many local activities relevant to the Alliance’s goals.

Tim is the Director of the Rural Clinical School at the University of Tasmania. He has an extensive range of national and international networks and focuses on rural health, particularly diabetes. Tim is dedicated to bridging the gap between rural and urban health outcomes.

The broad range of experience and specific expertise of the new friends committee, combined with their shared dedication, can only be good news for the health of people in rural and remote communities of Australia. 

Kellie Sydlarczuk
friends Manager

Membership of friends of the Alliance is open to individuals and organisations. On joining, friends receive a copy of the DVD, Rural and Remote Health Papers 1991-2011, containing twelve years of policy, conference proceedings and research information on rural and remote health.

For more information and to access a membership form: nrha.ruralhealth.org.au/friends
The Rural and Remote Psychology Interest Group of the Australian Psychological Society was admitted to membership of the National Rural Health Alliance in June this year, bringing to 32 the number of national organisations in the Alliance.

At the Council’s face-to-face meeting in Canberra in September, Tim Carey, the newest member’s delegate, affirmed his organisation’s enthusiasm for the place of mental health in the Alliance’s advocacy agenda with this verse:

It’s great to be joined up with the Alliance
Our entry to the stage is overdue
On a healthy mind the healthy body has reliance
And that’s where we can add a thing or two

The outback is the backbone of the nation
But the spine goes all the way up to the brain
The mind and body have no separation
We must serve both for good health to sustain

Wellbeing in the bush will be our calling
With sleeves rolled up we’re keen to join the cause
It’s true that current choice is quite appalling
We’re looking for results and not applause

Efficient services with little waiting
Benefits that empowering patients brings
Psychologists and GPs co-locating
These are a few of my favourite things

Ideas in mental health are really changing
Revising all the concepts that we knew
It’s more than simply deck chair rearranging
A brighter, bolder, patient-centred view

I don’t go fishing or make quilts for pleasure
I like playing squash or going for a run
And times with friends and family are to treasure
Just hanging out and making our own fun

We’re honoured to be welcomed to the table
I think that makes us member 32
We’re keen to help as much as we are able
To get the bush the services it’s due

Rural art competition – for health

Do you live in rural Australia? Do you like to paint? Would you like your artwork to appear on the cover of Australia’s health 2012?

The Australian Institute of Health and Welfare (AIHW), in partnership with the National Rural Health Alliance, is looking to the artists of rural and remote Australia to provide artwork that can be used on the cover of Australia’s health 2012 and other AIHW publications.

The theme for the artwork is the health and wellbeing of Australians.

Prizes of $1,000, $500, $300 and $200 are offered for winning artists. Entries close 5.00 pm (EDST) Friday 6 January 2012.

Please consider entering yourself – or promote this opportunity through arts organisations and networks in your local area.

Details and entry forms are available at www.ruralhealth.org.au

Further information: Tulip Penney, 02 6244 1114, mobile 0419 239 582 or email tulip.penney@aihw.gov.au.
In Parliament you may find it prudent
To consider my plight as a rural student
Working to secure my future wealth
In the burgeoning field of rural health

Off to the city I must go
Wandering about, to and fro
Looking to find some affordable digs
All the while missing my favorite pigs

Mum and Dad cough up the rent for me
While my city friends live at home for free
The answer should be clear to any old fool
We need a decent, high-quality, well-funded, independent, rural health School.

Phil Anderton
Rural Optometry Group of the Optometrists' Association of Australia