CELEBRATING 50 ISSUES

GETTING TO GRIPS WITH THE NDIS IN REMOTE AREAS

Big health reforms underway in regional WA

Good news on binge drinking & smoking rates
GOOD HEALTH AND WELLBEING IN RURAL AND REMOTE AUSTRALIA

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Australia currently has a surplus of young dentists - recent university graduates - who are living in Australian cities and cannot get full-time work as dentists.

At the same time there are hundreds of thousands in Australia who need oral health care but cannot access it. Many of them are in rural and remote areas, where dentists are as scarce as hens’ teeth.

There are also major and growing needs for dental services in aged care, among Aboriginal and Torres Strait Islander people, and for families with low incomes.

This is a classic case of health workforce maldistribution, not under-supply. It is a mal-distribution across population groups as well as between geographic areas.

And not enough is being done about it. The government seems uncertain about the extent of the surplus, partly because ‘the official report’ on dentist numbers has been completed by Health Workforce Australia but not yet published. That report will show that the oversupply of dental professionals will last until 2025.

Surprisingly, the occupation ‘dentist’ remains on the Skilled Occupation List for 2014 which means that dentists with overseas qualifications can still enter Australia and compete directly with dentists graduating from Australian universities. Should ‘dentist’ not be removed from the Skilled Occupation List?

The market won’t look after the Poor Man’s teeth

Editorial
An estimated 200 or more dentists are doing what they can to earn a living without substantive positions as dentists.

Governments and professional bodies should be looking for ways to use the available oral health workforce – dentists, therapists and hygienists - to address the unmet need for oral health services that exists across Australia.

This unmet need results in avoidable pain and cost. Many families in rural and remote areas have no local private practice dentist, and to be served by the public sector they must join a lengthy queue. By definition, not enough is being done to provide incentives for dentists to shift to work in geographic areas of need.

A start has been made. Since late 2013 Rural Health Workforce Australia has been operating a scheme funded by the Commonwealth to encourage private dentists to relocate to rural and remote areas. Dentists moving to a higher Remoteness Area can receive either Relocation Grants, Infrastructure Grants or combined grants under the Dental Relocation and Infrastructure Support Scheme (DRISS). See www.rhwa.org.au

In the first round of DRISS, 36 dentists received grants. This represents a capacity to provide services to over 60,000 patients in rural and remote Australia, but with over 6.7 million people living outside metropolitan areas, much more will be required. A similar number of second round grants is currently being finalised and a third round will open in early September. The vast majority of applicants in the first two rounds were seeking to move from a metropolitan (RA1) location to a more rural or remote one, covering the range from RA2 to RA5.

The Australian Dental Association is calling for a cap to be placed on the number of Commonwealth Supported Places in university dental programs. But the Government believes that, with deregulation of university fees, ‘the market’ will fix this over-supply in university dental graduates.

Perhaps it will - eventually. But in the meantime the market is palpably failing to provide oral health services to many of those in need. The government frequently has recourse to the principle that publicly-funded or subsidised services should not compete with the private sector unless there is market failure.

Many thousands of mouths in rural and remote areas can attest to market failure in oral health services. So what are we waiting for?

National Rural Health Alliance
Dental Health Week 2014 (4-10 August) highlights the oral health of babies and toddlers, with a particular focus on how the ‘Sugar Bandit’ hides in Australian households.

Nearly 50 per cent of Australian children under six suffer from tooth decay, a disease that can result in pain, the removal of teeth, bad breath, loss of sleep and a host of other problems. This is staggering when you consider that tooth decay is preventable.

Children from regional and remote areas of Australia have more decay than those from metropolitan areas.

The Australian Institute of Health and Welfare’s recently released Children’s Headline Indicators outlined the trends in the mean number of decayed, missing or filled teeth (DMFT) of children between 2002 and 2010. The data show children living in inner regional locations presented with the most DMFT (1.4 in 2002 and 1.8 in 2010) compared to other locations. Children in major cities had an average DMFT of 0.9 in 2002 which increased considerably to 1.3 in 2010; while children in outer regional areas had 1.1 DMFT in 2002 compared to 1.3 in 2010. Children in remote and very remote areas had 1.3 DMFT in 2002 compared to 1.4 in 2010.

Since dental services can be more challenging to access in rural and remote areas, it is imperative that parents know how to protect their children from tooth decay. This starts right from birth.

The keys are brushing and flossing, a balanced diet, and teaching one’s children that oral care is not a chore, but a part of life.

Parents need to establish healthy oral hygiene routines for children early in life. Diet plays a major role. A healthy and balanced diet (combined with brushing and flossing of course!) results in healthy teeth for life.

Family and friends can literally spoil kids rotten if sugary treats are given every time they spend time with them. The consumption of sugary foods and drinks on a regular basis is the number one cause of tooth decay.

This isn’t only about limiting the foods and drinks we already know are bad for our teeth like lollies and fizzy drinks. It is about limiting how often we consume sugar, and when we do, ensuring it is consumed in an appropriate timeframe, not over extended periods of time.
Many snacks that are marketed as ‘healthy’ are actually high in sugar and get stuck in kids’ teeth, increasing acid attacks which cause decay. The major ‘healthy’ snack culprits include dried fruit, biscuits (sweet and savoury), fruit juice, muesli bars, children’s cereals, flavoured milk, sweetened yoghurt, fruit bars, flavoured popcorn, canned fruit and banana bread.

When choosing snacks, be aware of how much sugar is in them but, more importantly, reduce the number of times children eat these foods and make sure they are eaten in one go and preferably as part of a meal. Grazing should be avoided. Allow high sugar snacks only in moderation.

The website for Dental Health Week 2014 is www.dentalhealthweek.com.au. All Australians, whether from cities, regional towns or rural and remote communities, can play their part in ensuring that healthy teeth are healthy for life.

The Rural Dentists’ Network of the Australian Dental Association is a Member Body of the National Rural Health Alliance.

Peter Alldritt
Australian Dental Association
It is now one year since the launch of the National Disability Insurance Scheme (NDIS). So it's a good time to consider the challenges the people of rural and remote Australia are likely to encounter as it is rolled out, and how these challenges might be addressed.

On 26 June, the NRHA and the National Disability and Carer Alliance (NDCA) hosted a public forum at the Mount Isa Centre for Rural and Remote Health to explore how the scheme can be made to work well for people in rural and remote Australia.

The forum, *Getting to grips with the NDIS in remote areas*, built on the great work done at a similar forum run by the NRHA and the NDCA at Parliament House, Canberra, in 2013.

Those attending the Mt Isa meeting included carers and people living with a disability, service providers, health professionals, academics, and others with an interest in the rollout of the NDIS in remote areas.

Those present included Ara Creswell, CEO of Carers Australia; Jennifer Cullen, CEO of Synapse; Liz Ruck, Senior Policy Officer with the Mental Health Council of Australia; and Mary Hawkins, Branch Manager in the National Disability Insurance Agency.

Much of the discussion focussed on information exchange, local capacity building, the recruitment and retention of relevant staff, including allied health professionals, transport and accommodation issues, and issues of importance for carers.

There is still considerable uncertainty about what the scheme will mean for people in rural and remote areas and when it will start in particular regions. To prepare communities for a smooth transition between the current arrangements and the new scheme, local consultation and free-flowing communication will be key.

Concern was expressed about how a higher volume of care services would
be provided in rural and remote areas, given the absence of a viable market for service providers and a shortage of care professionals. Given that a commercial or market approach is unlikely to work in sparsely populated areas, there is a need to develop innovative alternative models of care.

Effective workforce initiatives and a culture of interdisciplinary support will be needed to address the chronic shortages of professional staff in rural and remote areas.

The need for greater support for carers through flexible respite arrangements and adequately resourced respite providers was also raised. It is not clear whether informal carers will be eligible for funding under the NDIS and, if so, how this will be managed and delivered under the scheme.

As with any major new system in its infancy, the NDIS is likely to encounter some hiccups along the way. The NRHA and the NDCA will stay the course and look forward to working with people in rural and remote Australia to meet the challenges that await, as we continue to strive for geographic equity in disability care.

The Forum resulted in a Rural and Remote Bulletin on the NDIS which outlines a number of recommendations to guide design and implementation of the Scheme to ensure that it reflects the unique challenges faced by those living with a disability, and their families and carers, in rural areas. The Bulletin is available at www.ruralhealth.org.au/advocacy/current-focus-areas/disability-reforms

You can share your thoughts on the rollout of the NDIS in rural and remote areas by emailing nrha@ruralhealth.org.au

Dane Morling
National Rural Health Alliance
In its landmark report on the need for a national scheme for the long-term care and support for Australians with disability, the Productivity Commission recommended that two schemes be developed.

The National Disability Insurance Scheme (NDIS - see previous story) is designed to provide the disability supports and services Australians with disability require. The second scheme, the National Injury Insurance Scheme or NIIS, is intended to provide a system of no-fault cover for catastrophic injuries sustained in motor vehicle, workplace, sporting and general accidents and assaults, as well as injuries sustained in issues of medical indemnity.

In recommending these two schemes, it was recognised that different reforms would be needed to deliver the supports and services Australians with disability required as distinct from the rehabilitation and other supports needed for those who suffer catastrophic injuries.

Nearly half of all catastrophic injuries suffered by Australians occur as a result of motor vehicle accidents.

State and Federal governments plan to roll out the National Injury Insurance Scheme in stages, starting with alignment of Compulsory Third Party (CTP) motor vehicle schemes. The next injury area to be considered will be workers' compensation schemes, followed by issues of medical indemnity, with sporting and general accidents the last injury groups to be brought into the new scheme.

Despite being construed as a vital complementary scheme to the NDIS, and despite the fact that we are all at risk of suffering a catastrophic injury, the general public knows little about plans for the implementation of the NIIS or the benefits it will deliver.
It appears that anticipation of the NDIS has overwhelmed other important disability reform programs. In addition, there is a lack of public awareness of the need for comprehensive no-fault catastrophic injury insurance and the need to bring all Australia’s CTP schemes to no-fault status.

The benefits of a no-fault scheme are significant. There is no need to prove someone else was at fault and therefore no delay in access to immediate treatment and rehabilitation, and the injured person’s recovery can begin as soon as possible. Early access to critical clinical supports helps maximise recovery and increases the chance of regaining independence. The lack of timely access to rehabilitation and allied health supports is one of the reasons so many severely injured young Australians enter aged care nursing homes and are denied the chance to recover to their capacity.

Of the four remaining Australian states still operating fault-based CTP schemes, South Australia and the ACT moved to no-fault schemes on 1 July 2014. This leaves only the residents of Queensland and Western Australia without the protection of no-fault CTP cover.

A catastrophic injury can happen to anyone, any time and a no fault CTP scheme can maximise their chances of recovery. It is also an important first step to a comprehensive NIIS.

Queenslanders and West Australians should have the same opportunities to recover from catastrophic injuries as people in other states will now have.

**Bronwyn Morkham**
*Young People In Nursing Homes National Alliance*
The call for abstracts closes on 28 November 2014. Abstracts can be submitted via the 13th Conference website at www.ruralhealth.org.au/13nrhc

The possibilities for good health and wellbeing in rural and remote areas are being demonstrated on a daily basis by success stories in many places. However there are still unmet challenges and, overall, the more remote the community, the poorer its health status and access to health services.

Delegates to the 13th National Rural Health Conference will come from around the nation and from a wide range of healthcare settings. They will have different perspectives on how difficulties can best be overcome. Combining experiences and opinions from a range of people will be particularly useful now that there is a greater sense of uncertainty about fiscal circumstances and a hardening of views about State-Commonwealth roles in health care.

Holding the Conference in Darwin provides an opportunity to scrutinise more closely the special needs of people in the Northern Territory and the significant success stories there, and the implications for social infrastructure and health services of the national interest in the development of Northern Australia.

And right across the nation there needs to be continued priority given to the ways in which the health of Aboriginal and Torres Strait Islander people can be improved.

Add your voice by getting onto the program for Darwin. Visit the Conference website for abstract guidelines and more information www.ruralhealth.org.au/13nrhc
The 2014 NSW Knockout Health Challenge saw teams from 27 communities across New South Wales losing weight and embracing a healthy lifestyle.

More than 800 Indigenous men and women in thirty teams registered for the George Rose Challenge, the first of four events in this year’s challenge. The results were announced by Knockout Health Challenge Ambassador and Melbourne Storm player, George Rose. After ten weeks of running, boxing and doing pilates, aqua aerobics and circuit training, the winners were the Menindee Fat Yabs team.

“The Menindee Fat Yabs achieved a total weight loss of eight per cent and collectively lost 178 kilograms, which is a fantastic result for the community,” George Rose said.

The Knockout Health Challenge is an annual partnership between the NSW Ministry of Health and the NSW Rugby League. It is implemented through the Agency for Clinical Innovation and supports the link between Aboriginal culture and individuals’ participation in their own health.

According to Jo Mitchell, Director of the NSW Centre for Population Health, this event is life changing. “It is something the participants can take on for the rest of their lives and teach to their kids, their friends and family.”

“It’s about building healthy families. Mums are getting fitter to keep up with their kids and children are training alongside their parents, aunties and uncles.”

More information about the NSW Knockout Health Challenge can be found at www.facebook.com/nswknockoutchallenge

Participants have been supported by Get Healthy www.gethealthynsw.com.au, a free NSW confidential health coaching telephone service.

Rachael Havrlant
Agency for Clinical Innovation, NSW Health
If measured by reference to psychological distress, the prevalence of mental illness in rural and remote areas may be no greater than in Australia’s major cities.

However such published data measure only the occasions when a person with a mental health condition contacts the health system and the visit is recorded as specifically related to mental health. There are all manner of reasons why people with mental health conditions do not seek or obtain mental health services.

In rural and remote areas the reasons for non-presentation include the fact that no appropriate mental health services may be available. Sometimes serious presentations of mental illness are dealt with through police and law enforcement agencies or through emergency evacuation, and may not be recorded through the health system.

Even if the prevalence of mental illness is no different from that in the major cities, the consequences are greater in rural and remote areas.

There is a quite different cultural approach to the health system and self-care among people in country areas, usually characterised as ‘self-reliance’ or ‘resilience’. In general the people of rural and remote areas are less likely to admit to a mental health problem and to seek assistance for it. They are likely to experience

People in rural and remote areas are disadvantaged in their access to mental health services funded by Medicare, mainly because of the shortage of GPs.
more stigma where the population is sparse and the health service providers few. Even when they do seek help, it is harder for rural people to know about, locate and access relevant services.

Evidence from the Australian Institute of Health and Welfare (AIHW) shows that people in rural and remote areas are disadvantaged in their access to mental health services funded by Medicare, mainly because of the shortage of GPs. This means that one of the standard policy responses to mental health challenges - providing Medicare rebates through item numbers, largely for GPs - does not work as well in more remote areas.

Another of the standard responses is to provide services through the Internet or with telephone answer lines. Given their greater exposure to stigma and privacy concerns, people in rural areas may well find such services to be particularly valuable. But in many rural and remote areas Internet and telephone connectivity is poor.

Several of the risk factors for mental illness and some of the comorbidities associated with it are more common in rural and remote areas. They include smoking, risky use of alcohol and other drugs, levels of disability and ageing, the prevalence of complex and chronic conditions, years of completed education and levels of income.

Efforts must continue to establish more specialised mental health services in rural and remote areas but there is likely to be little change from the current workforce shortages. Much of the initial presentation of mental health conditions and the ongoing care will continue to be managed by GPs, nurses, midwives, psychologists and other allied health professionals, pharmacists and Aboriginal and Torres Strait Island Health workers.

The emphasis must therefore be on education, continuing professional development and support for these health professionals. This task should commence with all health students, particularly those heading for rural and remote areas. Further appropriate use of online and telephone mental health services will be important (see the following story), as will continuation of effective rural mental health programs that are targeted to rural communities.

The National Rural Health Alliance’s submission to the review being conducted by the National Mental Health Commission is at www.ruralhealth.org.au

Susan Magnay
National Rural Health Alliance
Over the last decade there has been much research into and development of internet-based programs to help people manage their emotional and psychological problems. Many such programs have a strong body of evidence to support their use.

This is excellent news for rural practitioners - who face more than their share of the general increase in the prevalence of depression, anxiety and emotional distress.

The suicide figures are frightening, but they represent the tip of the iceberg - one that is growing not shrinking in rural Australia. Mental health problems impact on the community in many ways including decreased productivity, increased drug and alcohol use and related illness, and increased family distress.

Currently available online mental health help ranges from suicide crisis sites to child and adolescent support sites.

There are also evidence based cognitive behaviour therapy (CBT) programs for a range of disorders including anxiety, depression, substance misuse, and eating disorders. These therapy programs are a rich resource for those working with people suffering emotional and psychological distress, especially for those working without much support from other professionals. They provide options for people who will not accept the need for face-to-face therapy as well as for those who are simply unable to access face-to-face therapy for reasons of disability, geography or cost.

People can find many of these websites and therapy programs for themselves, as many of them are open access, available without referral and free of charge. There are also programs that require a referral from a GP and may require a small payment to enrol. The rationale for this is that these programs work better if a mental health professional is also involved.

In order to refer appropriately and guide confidently, health care professionals need to know about the content of the sites and their appropriateness for a particular person.

Over the next three years a federally-funded project, the e-Mental Health in Practice initiative (e-MHPPrac), will roll out a variety of educational programs for mental health professionals and
GPs to help them get to know the e-mental health landscape. It will include webinars, online education programs and some face-to-face training. The first in the series of GP webinars (http://bit.ly/1j5asgP) was launched by Minister Dutton on 17 June.

The goal of the e-MHPrac project is to improve the mental wellbeing of the community by providing more options for care - and to improve the wellbeing of the mental health professionals themselves.

Jan Orman
Black Dog Institute

PHOTO: SHARON ZWI

DIRECTORY

SUICIDE CRISIS SITES
Lifeline 13 11 14
www.lifeline.org.au

CHILD AND ADOLESCENT SUPPORT
Reachout
www.reachout.com

Free Access Sites
OnTrack
www.ontrack.org.au/web/ontrack
(from the Queensland University of Technology; offers programs for depression and depression and alcohol, and a program for family and friends)

myCompass
www.mycompass.org.au
(from the Black Dog Institute, a CBT based monitoring and psycho-education program that works on smartphones as well as personal computers)

Mental Health Online
www.anxietyonline.org.au
(from Swinburne University of Technology)

Centre for Clinical Interventions in Western Australia suite of programs
www.cci.health.wa.gov.au
(includes a helpful online CBT based treatment program for eating disorders)

REQUIRING A GP REFERRAL
This Way Up
thiswayup.org.au
(offers programs for various anxiety disorders and mild to moderate depression)

Note: The list above is a sample of worthwhile websites and is not intended as a complete, exhaustive listing.
Not-for-profit aged care and disability organisation, integratedliving Australia, is breaking new ground with its Staying Strong telehealth project, an Australian Government pilot.

The $2.1 million project is funded under the NBN Enabled Telehealth Pilots Program and addresses chronic disease management in rural and remote communities.

It is helping to deliver a new model of care through telehealth monitoring of vital health signs for 120 older Aboriginal and Torres Strait Islander people across New South Wales and Queensland.

The service is being provided to participants in Armidale, Coffs Harbour, Toowoomba and Goodna. It is delivered both in-home and through telehealth hubs at local Aboriginal Medical Centres which provide a safe and welcome environment for older community members to learn about and use the telehealth service.

Registered nurses employed by integratedliving work with participants and their GP to develop individual health and monitoring plans based on health needs. Using monitoring software and vital sign peripherals, participants monitor their own vital health signs. Data is then transmitted to the triage manager database which prioritises readings for clinical triage. If a reading is outside the monitoring plan range, the triage manager will raise an alert and the nurse will coordinate the appropriate response, in consultation with the participant and their GP or health service.

integratedliving Project Manager, Indra Arunachalam, said the project has shown an increase in timely and accurate diagnosis, as well as a notable increase in patient awareness and self-management.

“Older Indigenous Australians are quite confident using technology. With good internet connection, telehealth monitoring can deliver successful health outcomes for people living in rural and regional Australia,” said Ms Arunachalam.

“When I joined the Staying Strong Project my early telehealth readings identified I was experiencing weekly hypoglycaemic episodes,” said Participant C, living with Type 1 diabetes.

“I now take several readings a day and am able to self-identify potential hypoglycaemic attacks and take steps to prevent them.”
The success of the Staying Strong Project has led integratedliving to proceed with a rollout of telehealth services to 13 regions in Queensland, New South Wales, Tasmania and the ACT. Implementation of this new program has been made possible through funding from the Australian Government’s HACC Program.

A final report for the Staying Strong Telehealth Project will evaluate the enablers and barriers to using telehealth, as well patient health outcomes and improvement to quality of life.

For more information on the Staying Strong telehealth project visit www.integratedliving.org.au or contact the Project Manager, Indra Arunachalam at indra@integratedliving.org.au

For further information on Tunstall telehealth solutions, additional clinical research and trial projects visit www.tunstallhealthcare.com.au

Lisa Capamagian
Tunstall Healthcare
The North Queensland Persistent Pain Management Service at Townsville is a pioneering public pain management hub, providing telehealth, outreach and satellite services across 800,000 square kilometres.

Prior to the release of $39 million for Queensland’s Statewide Persistent Pain Strategy in 2010, Townsville Hospital’s pain unit consisted of a small staff with no local Pain Specialist. It catered only to Townsville, leaving other patients from the north to travel to Brisbane.

With the promise of adequate, recurrent funding came the directive to expand services across North Queensland.

“The main issue in our region is the tyranny of distance, and the model we’ve applied has allowed us to maximise patient access and build primary care capacity,” said Director and Pain Specialist, Dr Matthew Bryant.

With the assistance of key staff, Allied Health Team Leader Alison Beeden and Clinical Nurse Consultant Carol Kanowski, Dr Bryant has expanded his team from eight to 35 (25 full-time equivalents) – including three Pain Specialists – working in three separate locations.

In addition to the large multidisciplinary unit at Townsville, there are now permanent satellite clinics at Cairns and Mackay, which provide psychology and physiotherapy services. A Consultant, Registrar and Clinical Nurse Consultant from the Townsville service travel to Cairns and Mackay every six weeks to provide additional assessment and treatment services.

At Mt Isa, 900 kilometres west of Townsville, a full multidisciplinary team visits every six months, as there are no local specialist pain management allied health services. After the initial assessment, telehealth services are also used.

With a model of care based on self-management and rehabilitation, services closer to home, and a strong emphasis on multidisciplinary care and a patient-centred approach, the aim is to discharge patients to primary care after six to twelve months.

“Patient education is central to our model of care, and we focus on active self-management, holding onto patients while they are on a trajectory to improvement, and then returning them to the care of their GP,” said Dr Bryant, whose background as a GP
has given him insights into how to work effectively with the primary care sector.

Currently the service provides 500 occasions of service to patients each month; on average 15 per cent of these are in Cairns, 15 per cent in Mackay and four per cent in Mt Isa. It sees 550 new patients each year, but hopes to increase that figure to 1,000 over the next 12 to 18 months.

While the main barrier is the lack of adequately skilled and qualified pain specialists, the North Queensland Persistent Pain Management Service has become the first in the state, outside Brisbane, to gain Faculty of Pain Medicine accreditation to train registrars. Their first Registrar, now a qualified Pain Specialist, has continued to work with the service, with a second in training.

Aware that they cannot reach every patient in such a vast area, the team also runs workshops for GPs, nurses and allied health professionals, to build capacity in local communities. Since 2013, four full-day workshops have been run, with about 200 participants and with others participating through video conferencing.

“We’re very proud of what we’ve achieved in North Queensland,” said Dr Bryant. “I’ve never worked harder in my life, but it is fantastic to see the service develop, and it couldn’t have happened without a great team.”

To contact Dr Bryant, email matthew.bryant2@health.qld.gov.au

Linda Baraciolli
Painaustralia
Good news on smoking and binge drinking, but obesity is a growing problem for young rural women

At the 2013 National Rural Health Conference in Adelaide the Australian Longitudinal Study on Women’s Health was recruiting for its newest cohort of 18-23-year-old women. You responded brilliantly! Over 17,000 young women from around Australia answered the Study’s first online health survey in 2013. In line with the 2011 Census, 75 per cent of the women were from major cities, 17 per cent from inner regional areas and eight per cent from outer regional and remote areas.

The survey included questions on health risk factors, physical, mental and sexual health, experience of abuse, and access to health services. This year the Study is asking the same women to complete their second annual survey.

So what did women living in outer regional and remote areas of Australia tell the Study about their health behaviours and lifestyle factors in the first survey? Almost two-thirds of the non-metropolitan women (64 per cent) had never smoked, 18 per cent were ex-smokers and 18 per cent were still smoking. This is positive news. In 1996, 50 per cent of 18-23 year old women in those areas had never smoked, 17 per cent were ex-smokers and 33 per cent were still smoking.

There was less change between 1996 and 2013 in average alcohol consumption. In 1996 eight per cent of 18-23 year old women in regional and remote areas were drinking more than two drinks a day compared with six per cent in 2013. Weekly binge drinking among those women declined from 20 per cent in 1996 to 14 per cent in 2013.

Marijuana use was not as common as alcohol use, with different rates observed among women living in outer regional and remote areas compared with those in major cities and inner regional areas. Forty-eight percent of young rural women had used marijuana compared with 54 per cent of those living in more populated areas.

On the down-side, more women in urban areas as well as outer regional and remote areas were overweight or obese in 2013 than in 1996. In major cities and inner regional areas, overweight and obesity rates rose from 21 per cent in 1996 to 32 per cent in...
2013. In outer regional and remote areas, 26 per cent were overweight or obese in 1996 compared with 41 per cent in 2013.

So inroads are being made into smoking and binge drinking but overweight and obesity are emerging problems which need to be addressed. Given the correlation between all of these factors and heart disease and diabetes, more needs to be done to reduce the prevalence of smoking, excess drinking and excess weight.

For more information about findings from the Australian Longitudinal Study on Women’s Health please visit www.alswh.org.au or contact info@alswh.org.au or (02) 4042 0686

Jennifer Powers
Priority Research Centre for Gender Health & Ageing,
School of Medicine and Public Health, University of Newcastle

Obesity is a risk factor for a late stage of breast cancer at diagnosis

Survival rates from breast cancer, the most prevalent cancer in women, are poorer in rural areas. As early detection of cancer results in a higher chance of survival, delayed diagnosis is a key risk factor that can affect survival.

Using data from the Australian Longitudinal Study on Women’s Health, the School of Population Health at the University of Queensland conducted a study to examine risk factors of a late stage of breast cancer at diagnosis in a population of Australian women.

Results showed that a late stage of breast cancer diagnosis was observed in 36 per cent of women residing in urban areas, compared to 40 per cent of women residing in rural areas.

Adjusting for individual and socio-demographic variables including survey year, menopausal status, country of birth, education, marital status, and urban or rural residence, the study found that obesity was the strongest risk factor for a late stage at diagnosis.

Given that women are becoming increasingly obese, these results provide further evidence for targeting interventions for obesity as a public health priority. And it should be noted that obesity rates in the Australian rural population are higher than in the urban population.

Janni Leung and Deirdre McLaughlin
School of Population Health,
University of Queensland
A shotgun blast shatters the morning. And then another.

In the deep black night, along the river, rustlings and stirrings. Torches flicker, campfires stir into life. Voices carry over water. In the homestead, lights appear, people spill onto verandahs. Braziers come alight. It’s Anzac Day at Kulcurna.

Kulcurna Station, on the Murray River, midway between Renmark and Wentworth, is just one of the thousands of places across the country where people have gathered in increasing numbers over recent years to remember those who have given the ultimate gift of service to their country.

It’s very special, not only because of its location, but also because Paul Hansen, who refers to himself as the ‘custodian’ of Kulcurna, which has been in his family for 150 years, is himself a veteran.

Everyone’s welcome. Luxury houseboats disgorge generations of family members experiencing the river for the first time; swags house those who’ve camped along the reaches for many decades; vehicles of every description make their way along the old Wentworth Road from Renmark or points north; and tinnies appear from camps and stations along the river banks.

As the dawn starts to filter through the ancient red gums, there are a hundred or more assembled on the lawn – standing and sitting in hushed semicircle around the Anzac Memorial – a cross, decorated for today with precious memorabilia of those loved and lost.

Silence. The sky lightens and the river reflects the clouds which scud, glowing, on their way.

Whirrings and sighings and the radio, assisted by an ancient loudspeaker, delivers the Dawn Service from the ABC in Adelaide. Described in solemn tones by the radio announcer,
dignitaries deliver their wreaths one by one to the National War Memorial, 300 kilometres away. And as they do, so we do too. A wreath of bluebush, studded with native daisies and wild orchids is laid at the foot of our simple cross, beside the names of all the locals who are gone. Our flag is lowered, raised again. A gentle breeze ensures its pride.

And then, the radio off, the silence total, our own bugler plays. The Last Post floats hauntingly across the river, reverberates off the scarlet cliffs and comes to rest among the gums. Spine tingling, chilling silence. Honour and tribute given and received in silence, on the River Murray bank.

Last post indeed. A tiny outpost in a massive land. It’s just the beginning though. The day has only just begun. Breakfast is served, tales told, reminiscences shared. Kids, wide eyed, hear stories of campaigns far away, of family members lost for years who did return, and those who didn’t.

This is a scene repeated in a thousand places across the country. A coming together of people from every background and of every faith and none. A shared experience growing more important with the passing years. Old friends, new acquaintances, true community – celebrating, honouring and remembering together. Until we meet again.

Rosemary Young
Party line definition

1. The official policy or opinion of a political party that all its members are expected to support, especially in public. “Toe the party line”

2. A telephone line shared by more than one customer. “If you picked up your phone while somebody else on your party line was talking, you’d overhear their conversation - and could join in.”

3. The official magazine of the National Rural Health Alliance, the peak body working to improve health and wellbeing in rural and remote Australia.

The first issue of Partyline published

Partyline was the name given to the official newsletter of Friends of the Alliance. Over 50 issues and 15 years later, Partyline continues to report on rural and remote health issues.

Feature article on ‘The Bush Budget’

9 May 2000: Health Minister Michael Wooldridge delivers Regional Health Strategy - a $562 million package “to redress the historical imbalance between rural and city health”.

Partyline goes ‘full colour’

As if to celebrate its coming-of-age, the 21st issue is the first to be produced in full colour. Sue McAlpin writes the welcome to this special 8th National Rural Health Conference edition.

Federal Election feature

Rural independents hold the balance of power - and rural health issues help them to decide.

1999

NRHA Chair, Jenny May with the three independents
"Perhaps I should first talk about that ‘rural and remote health community’. We like to believe that there is such a community - a group of people spread across the whole nation who have one thing in common: a desire to improve the status of health in non-metropolitan areas. To the extent that it does exist it includes people in all walks of life: dentists and deer farmers, naturalists and nurses, fisherfolk and physiotherapists, doctors and dancers. And it also includes many people in the major cities. We sometimes make the mistake of thinking that we are on our own in rural and remote health affairs. In fact there are a lot of people in the cities working with us and for us. To the extent that it does not exist, it is nevertheless a fine aspiration for us to have. There is much in common between all of those working in rural and remote health and the communities and individuals served. And there is much to be gained from all of them ‘gangin’ up’ on the common enemies: poor health, incomplete services and high levels of health risk factors.”
In this 50th issue of Partyline we give a special thank you to Friends of the Alliance.

Partyline was initiated in 1999 by the Friends of the Alliance as a newsletter for keeping people connected across rural and remote Australia. From this beginning it has become the Alliance’s flagship publication, circulated to more than 13,000 people and organisations around Australia. And Friends of the Alliance is going from strength to strength too.

In these changing times it is more important than ever that the Alliance remains informed and inspired by its grassroots connections. It is critical to our national influence that we can demonstrate support from a wide range of people and organisations who share our interest in the health and wellbeing of the more than 6.7 million people of rural and remote Australia.

Tim Kelly, Chairperson of the Alliance, offered the organisation’s thanks to its Friends for their ongoing support - especially those whose vision resulted in the establishment of Partyline 50 issues ago.

“I encourage all Partyline readers to consider joining Friends. Your contributions and support will help ensure that the Alliance’s voice remains strong and that its proposals are based on a close and up-to-date understanding of the real situation in rural and remote communities.”

Kellie Sydlarczuk
National Rural Health Alliance
The National Rural Health Alliance has made significant gains for rural and remote Australians through collaboration and a shared vision for “equal health for all Australians by 2020”. The Alliance is more than the sum of its member organisations, and has lead advocacy to improve health outcomes and prioritise access to healthcare for rural and remote Australia.

A succession of whole-of-sector health reviews, each offering shifts in approach and new ways of working, has certainly tested the rural health sector’s resolve. But with each ‘reform’ we’ve ensured our focus has remained on improving health services in rural and remote communities and ensuring access to primary care. We have emphasised the need for funding to be assured and for strategies to be responsive to local and community need.

The shifting policy landscape presents both opportunities and challenges for the Alliance and its member organisations. The combined strength of the member bodies, working through the Alliance, ensures the Government of the day receives the loud, clear message: there must be health equity for rural Australians.

The National Rural Faculty (NRF) of the Royal Australian College of General Practitioners is proud to have been a founding member body of the NRHA. Our involvement since the stirrings in 1991 at the Rural Health Conference in Toowoomba has ensured that NRF members, now over 11,000, enjoy a strong affiliation and involvement with the Alliance’s work. This special 50th edition of Partyline is a time to reflect on the strength of the Alliance, its achievements and future challenges.

The NRF has worked within and alongside the NRHA to ensure that the health disparities in rural and remote Australia are recognised and addressed. Our efforts have focused on improving access to essential healthcare services and ensuring there is an adequate, well supported rural health workforce to address the needs of rural and remote communities.

We look forward to continuing this great work, and congratulate the Alliance for 50 wonderful editions of Partyline.

Katherine Kirkpatrick
RACGP NRF

A time to reflect on our combined strengths

PHOTO: RACGP
Registration is now open for a public symposium in Canberra on 2-3 September that will bring together experienced and early career rural and remote health researchers. The 4th biennial Rural and Remote Health Scientific Symposium will aim to strengthen the value of their work by building a stronger relationship between them and national data agencies and policy makers.

The Symposium will also provide information and practical expertise to help non-traditional rural health researchers undertake research that can shape policy and so improve frontline health services in more remote areas.

The Symposium will involve managers and staff of frontline health services and NGOs in rural and remote areas; representatives of national health data agencies, including the Department of Health, the ABS, AHPRA and the AIHW; rural and remote health researchers; and consumers from rural areas.

Visit the Symposium website at www.ruralhealth.org.au/symposium2014 to see the program and to register.
The inaugural National Regional Eye Health Coordination Forum was held in Melbourne on 23 June. The Forum gave representatives from Aboriginal Community Controlled Health Organisations, universities, research organisations and governments the opportunity to share case stories of different models of care and service delivery, barriers and impediments (especially lack of accessible resources, long-term funding and trained workforce) and successful approaches for eye care coordination.

Discussions and workshops also engaged representatives from Vision 2020 Australia, the Lowitja Institute, Optometry Australia and other experts from various parts of the Indigenous eye care sector.

The Rural Health Continuing Education Stream 2 (RHCE2) program funded the Brien Holden Vision Institute in collaboration with the National Aboriginal Community Controlled Health Organisation (NACCHO), Aboriginal Health College and Vision 2020 Australia to provide scholarships for 21 Regional Eye Health Coordinators and Aboriginal Eye Health Workers to attend the Forum.

The Forum saw eye care as a part of integrated primary health and chronic disease care. It discussed regional eye care service mapping and planning, and innovative but sustainable approaches to eye care in rural and remote areas.

The Melbourne University Indigenous Eye Health Unit reported on the Roadmap to Close the Gap for Vision and progress with the regional implementation. For more information go to iehu.unimelb.edu.au

Recommendations from the Forum were presented to the National Aboriginal Community Controlled Health Organisation (NACCHO) Summit held on 24-25 June 2014. The recommendations covered the urgent need to improve Aboriginal and Torres Strait Islander eye health care and services; provide ongoing, reliable and stable funding; and provide quality training and career pathways for the Aboriginal and Torres Strait Islander people and other eye care health professionals (ophthalmologists, optometrists, eye nurses, allied health professionals, eye health coordinators, General Practitioners).

Wendy Downs
National Rural Health Alliance
Saving sight in the outback

Next to life itself, our ability to see what is around us is valued more than just about anything else. Our eyes are remarkable organs. They focus an image onto the retina, enabling the brain to perceive where we are, who we are with and what’s going on around us. They allow us to watch television, read books, browse the net and see the faces of those we love. It is a tragedy when blindness robs one of us of the gift of sight. It is more of a tragedy when that blindness could have been avoided by early detection and treatment of its cause.

Thanks to good epidemiology research we now know that the conditions which cause vision loss are often treatable, for example by optical appliances, medication or surgery. Simple blurred vision, or ‘refractive error’, is treated with glasses or contact lenses. Of the other blinding conditions, there are four which we know cause the most vision loss in the community: age-related macular degeneration (there are two forms, ‘dry’ and ‘wet’); glaucoma; cataract; and diabetic retinopathy. Of these, only dry macular degeneration has no direct treatment. With the other conditions, early detection and the early initiation of appropriate treatment can slow or stop the progress of the disease and consequent loss of vision.

In all of these conditions, with increasing age comes increased risk. Authorities recommend that diabetics and everyone over 50 years of age (or 40 years of age if there is a family history) should have an eye examination from an optometrist or an ophthalmologist at least once every two years. At that exam, the optometrist or eye specialist will make a full assessment of a person’s risk profile for these conditions, a full examination of the
eye, retina and macula, and if necessary initiate appropriate management or treatment.

There is more to sight preservation than regular eye examinations. Eye protection is essential when handling machinery, repairing equipment or handling chemicals. Make sure you wear safety goggles and/or a face shield when grinding, handling liquid chemicals (especially alkaline chemicals such as degreasers), or operating mowers and brushcutters. If a chemical is spilt into the eye, it should be immediately flushed out with clean running water for at least 20 minutes, making sure to thoroughly flush the spaces between the eyelids and the “white” of the eye. If possible arrange for prompt medical or ambulance assistance, but flushing the eye must come first.

So, to be safe, you should your eyes examined every two years. But what if you live in a small town, community or location where there are no optometrists or ophthalmologists nearby? For many years now, selected optometrists (often but not always based in larger rural towns) have been supported to visit smaller locations to provide regular services. This Visiting Optometrist Scheme operates even to quite remote locations in all parts of Australia. For example, I personally visit Tibooburra, Wanaaring, Menindee and Wilcannia in western New South Wales each year. There are also optometrists in each state who regularly visit all regions. You can find a full map showing service locations at www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/vos-locator or you can phone Rural Health Australia on 1800 020 103 or Optometry Australia on 03 9668 8500.

**Phil Anderton**  
*Rural Optometry Group of Optometry Australia*

*Phil Anderton runs a part-time clinic at Manilla Health Service in northern NSW. He is a pilot and flies himself to visiting optometrist clinics three times each year.*
Cardiovascular disease is a major contributor to the gaps in life expectancy between Indigenous and non-Indigenous Australians (10.6 years for men and 9.5 years for women).

The National Heart Foundation of Australia has published a new framework to improve systems of care for Aboriginal and Torres Strait Islander Australians who experience a heart attack.

The MJA publication, *A framework for overcoming disparities in management of acute coronary syndromes in the Australian Aboriginal and Torres Strait Islander population*, calls for reforms across the health system and outlines measures to help eliminate the differences in diagnosis, cardiac care and outcomes compared with non-Indigenous patients.

Dr Marcus Ilton, lead author and Northern Territory cardiologist, said that every Indigenous patient, regardless of where they live, should be provided with the same level of care as non-Indigenous Australians as outlined in national Acute Coronary Syndrome (ACS) guidelines.

“To be able to investigate a patient’s heart quickly, we need a coordinated approach across the health care system including pre-hospital and hospital services, such as ambulance, emergency and cardiac services,” Dr Ilton said.
Students with Autism Spectrum Disorder (ASD) present unique challenges to school systems. An inclusive approach to education requires teachers to address these challenges and to support the unique needs of such students. Challenging and complex behaviours are more frequent in children with ASD and without appropriate intervention these behaviours tend to persist across an individual's lifespan. One of the biggest challenges faced by educators is ensuring that the high impact social, emotional and behavioural needs some students with ASD experience can be successfully met within educational contexts.

The Australian ASD Educational Needs Analysis (ASD-ENA) project aims to produce the first Australia-wide analysis of the educational needs of students aged 5-18 years with ASD. This is one of the projects of the Cooperative Research Centre for Living with Autism Spectrum Disorders (Autism CRC).

The needs analysis will collect information from school administrators, teachers, specialist and ancillary support staff, parents of students with ASD, and students with ASD. Using a mixed methods approach the needs analysis will obtain information from these stakeholder groups regarding the range of educational needs that students with ASD have within school settings.

The project is looking to gain a comprehensive profile of the educational support needs of students with ASD, including the more individualised support needs of students with ASD who have high impact social, emotional and behavioural needs. It will also identify the needs of educators to manage and support students with ASD and describe the goals identified by parents, students and educators.

Ultimately, the findings from this survey will guide the development of models of support for students with ASD. The findings will inform the development of the Autism CRC's school connectedness study. They will ensure that planning is consistent with consumer needs and also ensure maximum retention, participation and engagement of students with ASD.

(Adapted from Autism CRC eNews, June 2014)
Health workforce distribution and retention around the world

A collection of high-quality research reports that examine how effectively different countries are attracting and retaining skilled health workers has been published in an online international journal.

Health Workforce Australia (HWA) sponsored the series Right Time, Right Place: Improving access to health service through effective retention and distribution of health workers in the free access online journal Human Resources for Health.

The series draws together studies that highlight how different countries are improving access to healthcare through more effective human resource policies and planning and management, with a specific focus on health workforce distribution and retention.

“Improving access to healthcare by attracting and retaining skilled health workers to work in the areas of greatest need is a universal challenge,” said Professor James Buchan, HWA’s Specialist Advisor.

The series consists of ten peer reviewed papers.

The first examines how evidence-based workforce planning by HWA is informing policy developments to retain and distribute health workers. It reports on how HWA developed Health Workforce 2025, Australia’s first major long-term national workforce projections for doctors, nurses and midwives up until 2025, and how this approach can impact on policy.

The paper concludes that Health Workforce 2025 should be an ongoing process which continues to develop and improve health workforce projections to support incremental health workforce changes. There has been a great deal of international interest in the methods and approaches used in that work.

The second paper outlines preliminary findings of HWA’s Rural Health Professionals Program (RHPP), which provides recruitment and retention services to allied health and nursing professionals to work in rural and remote Australia. There is evidence that indicates that case managed recruitment and retention programs can attract health workers to regional and rural areas.

Identifying the lessons learned from implementing large-scale workforce change in Queensland was the focus of another paper. The authors examined Queensland Health’s five year workforce redesign program across 13 allied health professions. The paper identifies strategies associated with successful workforce redesign that could be used to help shape other large workforce projects.

In another paper, the statistical technique of ‘survival analysis’ was used to assess the job turnover patterns of rural and remote family doctors in New South Wales. The
paper found rigorous evidence of the strong association between population size, geographical distribution and the retention of family doctors in rural and remote NSW.


Lauren Djakovac  
*Health Workforce Australia*

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**Knowledge Centre to assist alcohol and other drugs services for Indigenous people**

As a part of the Australian Government’s commitment to preventing harmful substance use among Aboriginal and Torres Strait Islander people and promoting improvements in alcohol and other drug (AOD) and related services, the Department of Health has funded the development of the Australian Indigenous Alcohol and Other Drugs Knowledge Centre.

The Knowledge Centre builds on information relating to AOD and material previously provided on the web resource operated by Edith Cowan University’s (ECU) Australian Indigenous HealthInfoNet. The Knowledge Centre’s responsibilities include workforce and community support and the collation and provision of policy-related advice.

The Knowledge Centre provides information on alcohol, illicit drugs, pharmaceuticals, and volatile substances. In each of these sections you can access reviews, publications, programs and projects, health resources, organisations and courses and training.

The Knowledge Centre also features a dedicated section on Foetal alcohol spectrum disorders (FASD) and a comprehensive alcohol and other drugs policy collection.

There is an AOD yarning place - a free online network that enables people across the country working in the area of Aboriginal and Torres Strait Islander substance use to share information, knowledge and experience. There is also an AOD bibliography and a searchable database of health promotion and health practice resources, providing quick access to guidelines, tools, manuals and other resources.
The composition of the Reference Group reflects the variety of input required to ensure a robust coverage of the field to best support the workforce at the community level, community members working to reduce the harms of drug use, and programs and policy.

A Support Committee comprising membership from Edith Cowan University and the three National Research Centres (National Centre for Education and Training on Addiction, National Drug and Alcohol Research Council and National Drug Research Institute) ensures the capacity of the Knowledge Centre to provide the evidence base to support effective harm minimisation.

Visit the Knowledge Centre: www.aodknowledgecentre.net.au

Michelle Catto
Australian Indigenous HealthInfoNet
New Award for eye health services

Nominations are now open for the Inaugural Fred Hollows Foundation Eye Health Award. The award is open to Aboriginal Community Controlled Health Organisations that are members of NACCHO and are providing eye health services to Aboriginal and Torres Strait Islander people and communities. The award recipient will receive a CentreVue Digital Retinography System (DRS) Camera.

Nominations must be submitted by 15 September 2014 and the Award will be presented at the NACCHO Annual General Meeting in Cairns in October 2014.

For more information contact Gay English, The Fred Hollows Foundation 08 8920 1400 or genglish@hollows.org

Heart attack facts

The Heart Foundation has produced a series of posters specially targeting remote and Indigenous communities.

Heart attacks aren’t always what you think. The warning signs can vary from person to person and they may not always be sudden or severe. The one thing all heart attacks have in common is that the sooner you receive treatment, the less damage will be done. Learn the warning signs and get your heart attack action plan at heartattackfacts.org.au or call 1300 36 27 87. It could save your life or the life of someone you love.

Paige Bolton
Heart Foundation
For the first time, Australia has a Parliamentary Friendship group that will focus on ways to improve allied health provision in rural and remote areas of Australia.

The Parliamentary Friendship Group for Rural and Remote Allied Health is chaired by Independent Member for Denison, Andrew Wilkie, and Liberal Member for Boothby, Dr Andrew Southcott.

Group members first met at Parliament House in March 2014, focusing exclusively on rural and remote provision of allied health services such as audiology, dietetics, occupational therapy, optometry, oral health, pharmacy, physiotherapy, podiatry, psychology, social work and speech pathology.

Rod Wellington, CEO of Services for Rural and Remote Allied Health (SARRAH), addressed the group’s second meeting in May, when he raised key issues that impact on allied health services, especially the ongoing workforce shortages that deny rural Australians access to healthcare taken for granted in the cities.

Mr Wellington spoke to an audience that included North Queensland MP Bob Katter, the member for Indi in

Mr Andrew Wilkie, Independent Member for Denison, addresses the news media after a meeting of the Parliamentary Friends Group of Rural and Remote Allied Health.
north-east Victoria Cathy McGowan, Assistant Shadow Minister for Health
Stephen Jones, Member for Lyne (NSW) Dr David Gillespie, Member for Lyons (Tasmania) Eric Hutchinson and Queensland Senator Claire Moore.

Those present agreed on a number of common goals including addressing service gaps in rural areas, overcoming the accommodation barrier to rural placements and attracting more multidisciplinary health teams to the bush. The group will act as a forum for research, briefings and information affecting the sector and support the health professionals who provide clinical and educational services in rural and remote locations.

Mr Wilkie told the group that he would like to include regional Australia in the group’s sights, as well as rural and remote, as many allied health services were in short supply in his electorate of Denison in Hobart.

Mr Wellington congratulated all group members for volunteering to give their time to a cause that has for so long lacked political focus.

“SARRAH is pleased that all major parties and some independents have taken the time to meet and consider ideas on ways to improve allied health services outside the big cities,” Mr Wellington said.

“All sides of politics should commit to rural health policies and programs that will enable Australia to grow its allied health workforce and achieve equity in the provision of health services to all Australians, regardless of where they live.”

SARRAH will share its resources with the Parliamentary Friendship group members, including the opportunity to talk directly to its members who work at the coalface in delivering health services to rural and remote patients.

Mr Wellington told the Parliamentarians present that they could help by supporting SARRAH’s key ongoing Budget bids, including:

- $500,000 to fund an Australian Allied Health Workforce Study over two years to allow accurate measurement of supply and demand in order to identify gaps in allied health services across Australia; and
- an annual increase of $7.55 million to the allied health streams of the Nursing and Allied Health Scholarship and Support Scheme. This additional funding would result in 430 additional scholarships awarded across Australia. In 2013, only 34.5% of eligible applicants were awarded a scholarship.

Louise Pemble
Services for Australian Rural and Remote Allied Health

SARRAH is a Member Body of the NRHA
Over $560 million is being invested in the Southern Inland Health Initiative (SIHI), funded under the Western Australian State Government’s Royalties for Regions program. The investment is one of the State’s largest ever in regional health, and with the challenges of a geographically dispersed area, scarce workforce and the growing incidence of chronic disease, the project is critical for the sustainability of health services in the region.

Regional and remote communities rely heavily on their local GPs to provide both primary care and emergency medicine at the local hospital. SIHI has developed district hubs with emergency department rosters which support collaboration between doctors in different practices and towns, and enhance flexible work options and work-life balance. This is supported by generous financial incentives which, with those other initiatives, are attracting more GPs to regional WA.

Forty-one new GPs have been attracted to work in the SIHI catchment, with 91 GPs now signed on to receive the SIHI incentive scheme. This has resulted in round-the-clock emergency rosters operating at all the major district hospitals across the SIHI catchment. Emergency Department specialists and nurse practitioners have also been recruited to several of the hospitals.

Technology has been a huge enabler of the SIHI program, with telehealth equipment installed at more than 110 locations since 2012. More than 3,500 telehealth outpatient appointments have been held across a wide-range of specialities, including urology, gastroenterology, respiratory medicine, burns and speech pathology.

“The range of health services that can be accessed via telehealth is ever-increasing, and people are really embracing the technology. We’ve had a lot of positive feedback from patients who have been won-over – with one elderly lady initially worried she would be speaking with a robot, but full of praise once she realised she could speak to a real-life doctor without spending a day travelling to Perth.”

Another exciting use of telehealth has been the Emergency Telehealth Service (ETS), which links specialist emergency physicians in Perth to critically ill and injured patients in rural and remote areas (see the following story). Telehealth video-conferencing units have been installed...
in resuscitation bays at 37 emergency departments across the catchment.

It has saved lives and significantly reduced the volume of patient transfers between small hospitals and larger district centres.

There has been a significant investment in developing and trialling primary health care programs that target chronic health issues, such as diabetes, heart disease and lung conditions.

Other pilot programs are tackling early childhood speech and hearing issues, aged care, and reducing waiting lists for allied health services.

**Kerida Hodge**  
Southern Inland Health Initiative, WA Country Health Service

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**Virtual emergency service short-listed for major award**

A life-saving virtual emergency service which connects patients at regional and remote hospitals with a specialist emergency physician is in the running to receive one of the Western Australian public sector’s most prestigious awards.

The Emergency Telehealth Service (ETS) has been short-listed for the 2014 Premier’s Awards for Excellence in Public Sector Management, in the category of Improving Government. The ETS is part of the Southern Inland Health Initiative.

WA Country Health Service (WACHS) Regional Project Manager, Yvonne Zardins, said it was an honour to be short-listed.

“Providing emergency services in regional Western Australia is extremely challenging, as emergency specialists are a scarce resource, and our emergency departments are so widely dispersed.

“The awards process provides an opportunity to demonstrate the need to embrace technology and new ways of delivering healthcare, and to highlight the excellent work of our clinicians in some tough conditions,” Yvonne said.

When the ETS was introduced as a pilot program in August 2012 it was available at eight sites throughout the Wheatbelt over weekend periods when these sites had very limited access to medical support.

“Since that time it has proven very effective in delivering quality, safe emergency care to patients and is now available at 37 sites across the Wheatbelt, Mid-West, Great Southern, Goldfields, Kimberley and South-West regions,” Yvonne said.

WACHS Executive Director for Primary Health, Melissa Vernon, recognised the work of the original team responsible for implementing the service, including Dr Garth Herrington, Yvonne Zardins, Alan Hamilton and the Statewide Telehealth Service. She also commended the ongoing work of ETS Medical Director Dr Bob Graydon, the emergency physicians and the project team, as they extend the service throughout regional WA.

**Southern Inland Health Initiative**  
**WA Country Health Service**
Phillip Merrdi Wilson was awarded a Des Murray Scholarship to help him attend the 12th National Rural Health Conference in Adelaide in 2013. Great news! Phillip has recently graduated with a Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care Practice.

Phillip lives in Nauiyu-Daly River, a remote community in the Northern Territory. He is a Ngangi speaker, his language is Nangi‘kurunggurr and his traditional homeland is Peppimenarti.

Phillip has worked in a range of jobs since he left school.

“I was a receptionist in the health centre in early 2000 and have done a few clinical activities, but at that time I was not ready to become a health worker so I left and did other types of work in and around the community. I am also an Aboriginal artist.”

In early 2012 Phillip was offered a traineeship with the Department of Health and the Nauiyu Health Centre. He studied the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care Practice through the Batchelor Institute of Indigenous Education and had practical training in the community health centre.

The Des Murray Scholarship supports a young person from a remote area to attend the biennial National Rural Health Conference and is awarded on the basis of commitment to improving the health status of people in the applicant’s region and their ability to be an advocate for young people in their region. Phillip was a most deserving recipient and we congratulate him on the latest step in his career. The Alliance also wishes to thank Janet Fletcher for mentoring Phillip.

**National Rural Health Alliance**
Managing the mother load

Childbirth and pregnancy are two of the major life events associated with urinary incontinence, which is why the Continence Foundation of Australia chose maternity as its major theme for 2014.

One in three women who’ve had a baby will experience urinary incontinence. Moreover, of the 4.2 million Australians (aged 15 and over) affected by urinary incontinence, 80 per cent are women, with problems arising primarily after childbirth and menopause.

The Continence Foundation’s special project for 2014, titled Pelvic floor awareness in pregnancy, childbirth and beyond, targets midwives as well as expectant mothers, and has partnered with the Australian College of Midwives to develop a range of educational resources for midwives.

In the lead-up to World Continence Week (23 – 29 June) the Foundation delivered a series of free national education forums to midwives around Australia on the impact of pregnancy on pelvic floor dysfunction. It continues to deliver educational events for health professionals in a range of subject areas (http://www.continence.org.au/events_calendar.php).

The Foundation and the Australian College of Midwives have also developed an accredited online course for midwives, which was officially launched during World Continence Week.

Expectant mothers are being targeted with an awareness campaign, Managing the mother load, and a number of free resources, including The Pregnancy Guide booklet and the Pregnancy Pelvic Floor Plan smartphone app, available from Google Play and iTunes, have been developed for the project.

Health professionals are able to order multiple copies of any of these and other resources relating to incontinence.

Numerous online videos, online courses, professional development opportunities, scholarships and free resources are available for health professionals from the Continence Foundation - www.continence.org.au/pages/professionals.html

Maria Whitmore
Continence Foundation of Australia
Remarkable outback nurses

In *Nurses of the Outback* (Michael Joseph, 2014) Annabelle Brayley tells the fascinating story of 15 nurses who live and work in outback Australia.

Geri Malone is the Professional Development Manager for CRANAplus, the national body representing remote area nurses and other health professionals. She has also had extensive experience in midwifery and as a Royal Flying Doctor Service flight nurse. In Geri’s opinion, health professionals in the outback are “a unique breed … and the great thing is you meet the most interesting and diverse characters out there, often in adverse conditions, and they tend to be very pragmatic, because they have to be; they show incredible resilience.”

Developing resilience is a necessity for nurses in Australia’s outback because they must deal with the consequences of seemingly endless droughts, such as depression and sometimes suicide, and with many other problems as well - from snake bites to motor vehicle accidents.

*Nurses of the Outback* is filled with examples of such events. While working in the small western Queensland town of Bedourie, Anna Burley saved the lives of four young people critically injured in a car accident over 600 kilometres from the nearest Royal Flying Doctor Service base. As the author points out, in the outback a major motor vehicle accident can be just as catastrophic as a bushfire or cyclone.

Anna Burley had given up a high salary trading in foreign currency options for a nursing degree after becoming dissatisfied with the values of her former career. She talks to the author about the rewarding aspect of using her nursing skills for Frontier Services, which “does smart, practical things, working from the ground up rather than filtering down from on high, and we can make a real difference. If I see a need, I can start addressing it within a month.” Frontier Services does valuable
work in aged care, children’s services, community care and pastoral support in the more remote parts of inland Australia.

The breadth of experiences that outback nurses face makes for riveting reading. June Andrew OAM from Marree in the Northern Territory shared the joys and tragedies of her community, building connections and saving lives. In isolated places the nurse often treats animals; over the years June sutured nearly as many horses and other animals as humans.

After completing a disaster rescue course, Maureen Ker OAM “learnt how to manage rescues from burning buildings, collapsed bridges, derailed trains, gas explosions, mine shafts and major accident sites…”

Another nurse, Aggie Harpham was working in Kununurra Hospital, Western Australia, when a boy brought in his 15 year old girlfriend who had ridden in on the handlebars of his bicycle. They were there for her to have a baby. Aggie quickly discovered that she was already seven centimetres dilated.

Sue Stewart from Bidyadanga, Western Australia, loves the variety of nursing in remote locations: “Every day is different and you never know who or what problem will walk in the door next.”

Jo Appoo is an Indigenous nurse who has worked in a variety of places, including Bathurst Island off the north coast of the Northern Territory, where she managed their first aged care program. She reminds readers: “Nothing happens quickly or easily in remote areas and especially not on remote islands.”

But none of these dedicated people chose this way of life for an easy time of it. These and the eight other nurses in this book all wanted to use their skills and energy to improve the lives of people in rural and remote areas. The adventures they have along the way, in a wide variety of places all over Australia, provide much stimulating reading.

Penny Hanley
National Rural Health Alliance
Academic support for nurses returning to study in a rural area

In recent years, many nurses in rural settings have undertaken certificates of Advanced Practice Nursing. The Certificate allows nurses in rural and remote areas to extend their scope of practice to include administration and supply of Schedule 2, 3, 4 and 8 drugs without the supervision or order of a medical practitioner. This not only brings greater work satisfaction for the endorsed nurses and provides timely treatment for rural patients, it also allows a greater work/life balance for rural medical practitioners.

Returning to study after many years can prove daunting for rural nurses, who often lack the academic support enjoyed by their city counterparts. Four Registered Nurses at Cobram District Health enrolled in the Certificate of Advanced Practice Nursing this year, as external students, which requires completing all the modules online. All four found the task of returning to study difficult, despite continuous up-skilling throughout their long careers. They found it invaluable to have a research academic from the University of Melbourne on-site for advice and academic support. The Rural Health Academic Network provides academic support to all health service staff and students at numerous locations throughout rural Victoria. The initiative is a partnership between the University of Melbourne and the rural health services.

"I could never even have completed the first assignment without the help of the University of Melbourne academic staff," says Genevieve Nielsen, one of the nurses undertaking the study.

This sentiment is echoed by all other three nurses. "To meet and discuss the course content, and have hands-on assistance with requirements such as referencing is invaluable," says Fiona Currie.

"The assistance offered by the University of Melbourne to rural health services means that rural health staff can undertake study confidently. It levels the playing field to what is on offer at metropolitan health services," says the Director of Clinical Services, David Gullick.

Kaye Ervin
Rural Health Academic Network,
University of Melbourne
Department of Rural Health
Rural Health West celebrates 25 years of caring

In 2014 Rural Health West is celebrating its 25 year anniversary.

At a gala dinner earlier this year, Western Australia’s Deputy Premier and Minister for Health, Dr Kim Hames, launched a commemorative book, recording the organisation’s history and achievements.

Originally established as the Western Australian Centre for Rural and Remote Medicine in 1989, the organisation was one of the first of its kind nationally and was appointed as Western Australia’s Rural Workforce Agency in 1998, before changing its trading name to Rural Health West in 2007. At the time of its establishment there were just 282 medical practitioners recorded as working in rural practice across the vast expanse of 2.5 million square kilometres which make up Western Australia. This figure is now 787.

Over the past 25 years the organisation has pioneered a number of initiatives including: helping establish the SPINRPHEX and WAALHIIBE student rural health clubs; launching a comprehensive education and training program for rural GPs; establishing a locum support program for rural general practitioners; and launching Choose Country - The Rural Practice Pathway, a campaign to promote rural careers to the future medical workforce in 2012.

Clare Underdown
Rural Health West

PHOTO: RURAL HEALTH WEST

Rural Health West Chairman Grant Woodhams, Gabrielle Woodhams, Winthrop Professor D’Arcy Holman, Rural Health West Chief Executive Officer Belinda Bailey, The Honourable Kim Hames MLA, Deputy Premier; Minister for Health; Training and Workforce Development and Stephanie Hames.
Sea Lake is a small town in country Victoria with a big heart. For the past 20 years, Dr Michael Lowery, a softly spoken Irishman, has been tending to the needs of local people – treating everything from coughs and colds to farm injuries and road accidents.

“I like the people here,” says Dr Lowery. “They’re the salt of the earth. They’re very honest, they don’t complain, they work hard. They realise that life is cyclical and the world doesn’t owe them a living.”

The community turned out in force recently to celebrate Dr Lowery’s 20th anniversary in the town – an event hosted by the Mallee Track Health and Community Service and described by Dr Lowery with characteristic humour as “an afternoon of what appeared to be continuous eating”.

Victoria’s Rural Workforce Agency, RWAV, which provides Dr Lowery with locum support when he needs a break, was there too, presenting him with a small gift to mark the occasion.

For a man who sees 150 patients a week, it was a nice turnaround to be on the receiving end of some TLC.

Originally from Tuam on the west coast of Ireland, Dr Lowery first came to Australia to work briefly in Melbourne then continued his travels to New York State where he landed a job at the Niagara Falls Hospital.

One day in 1994 a friend called telling him that there was a hospital CEO looking for a doctor in Sea Lake, about four hours from Melbourne on the way to Mildura.

“The initial plan was to come for three years, but things obviously changed and here I am today,” says Dr Lowery, with a hint of pride.

With a town population of 800 and a similar number living in surrounding farming communities, Dr Lowery is usually busy. He sees a variety of farm-related injuries including muscle strains, skin lacerations and eye injuries.

He is also committed to medical teaching, having supervised medical students from Melbourne and Monash
universities as well as a mentoring students through the John Flynn Placement Program and the RAMUS Scheme.

Dr Lowery is a lifelong student of medicine. He has completed a Fellowship of Advanced Rural Practice with the RACGP, a Masters of Medicine in Pain Management at the University of Sydney, a Masters of Sports Medicine at the University of Queensland and a Graduate Diploma in Musculoskeletal Medicine at Flinders University (the university qualifications were achieved through distance learning).

Not surprisingly, his advice to aspiring country doctors is to “concentrate on your training and increasing your competence. The more extensive your expertise, the more you will enjoy country medicine.”

His other tip is to embrace the community.

“If you like people and enjoy getting to know them, then you will enjoy country practice,” says the man who has certainly walked the talk.

There are opportunities throughout Australia for health professionals to connect with towns like Sea Lake. The Government-funded, not-for-profit network of Rural Workforce Agencies attract, recruit and support people like Dr Lowery. Find out more at www.rhwa.org.au

Tony Wells
Rural Health Workforce Australia

Rural Health Workforce Australia is a Member Body of the NRHA
Four university students from country Victoria are the winners of the 2014 Give Them Wings scholarships, provided by Rural Health Workforce Australia and the Royal Flying Doctor Service Victoria. The scholarships, worth $2,500 each, are designed to encourage the next generation of nursing and allied health professionals from rural communities. The scholarship winners will each receive a Royal Flying Doctor experience as well as cash payments to help them cover the costs of first year university.

**Tony Wells**  
*Rural Health Workforce Australia*

*Left (from top): Tasmin Lewis, Drouin East, occupational therapy student at Monash University, Kurt Murphy, Welshmans Reef, physiotherapy student at La Trobe University, Natalie Dowling, Yarrawonga, optometry student at Deakin University and Rhiannan Frusher, Warrnambool, nursing student at Deakin University*
RAMUS Mentors of the Year

Medical students with a Rural Australia Medical Undergraduate Scholarship (RAMUS) are required to have a rural doctor as a mentor. The annual RAMUS Mentor Awards recognise and celebrate outstanding and inspirational mentors.

Jackie Boyd is a GP Registrar based at Coconut Grove in the Northern Territory. She was nominated for a 2013 RAMUS Mentor Award by her RAMUS scholar, Leonie Harold. Jackie dedicated extensive work and time to organising several trips for Leonie to Indigenous communities in the Northern Territory and has been a continual source of support, experience and knowledge since Leonie joined the RAMUS Scheme.

Bob French and Marnie Barrow, of Armidale, NSW, were jointly nominated by the four RAMUS scholars they have mentored: Caitlin Driscoll, Vanessa Lee, Sophie Kerr and Lucinda Donlon. Bob is a general surgeon who has worked in Armidale for over 30 years and been a RAMUS mentor since 2009. Marnie is a retired GP who worked in Armidale NSW across various practices during the same period. Bob and Marnie are heavily involved in the medical school at the University of New England and have a passion for teaching and encouraging the next generation of rural doctors.

Susan Magnay
National Rural Health Alliance
LIFE EXPECTANCY
81 YEARS
LIFE EXPECTANCY
79 YEARS

Fresh air is a weekend treat
You can always smell the roses
Wide range of jobs available
Work for either the Shire or the hospital
29% of adults have a Bachelor degree or above
15% of adults have a Bachelor degree or above
Drought has little impact
Drought is devastating
Wide choice of health services
Narrow range of health services
15% daily smokers
26% daily smokers
Upstairs had a noisy party – I wasn’t invited
Josie’s young fella dropped off a bag of lemons
Rents are prohibitive
Our place has a huge vegie garden
5% higher income
10% lower income

www.ruralhealth.org.au