Dr Amy Coopes reported on the 16th National Rural Health Conference, held in Meeanjin/Brisbane, for the Croakey Conference News Service.

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We pay our respects to the Traditional Custodians of the country where we live, work and travel upon, and to Elders, past, present and future.
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Innovation, collaboration and bridge-making: national conference to put a timely focus on rural health

The 16th National Rural Health Conference was held in Meeanjin/Brisbane with the theme, *Bridging social distance; Rural health innovating and collaborating*.

Dr Amy Coopes, who covered the conference on 3 August for the Croakey Conference News Service, previews the #16nrhc discussions below.

Amy Coopes writes:

A crisis in rural healthcare – driven by funding and training models that are no longer fit for purpose and driven to breaking point by a looming exodus of medical professionals amid the pressures of the COVID-19 pandemic – will take centre stage at the National Rural Health Conference in Brisbane.

The three-day event, which is convened by the National Rural Health Alliance, will be the first such meeting since early 2019 – with some 700 delegates – and comes at a pivotal time for rural, regional and remote health.
Some seven million Australians, roughly one-third of the populace, live in rural and remote areas, and they experience higher rates of hospitalisation, injury and early mortality compared to their urban counterparts, according to the Australian Institute of Health and Welfare.

They are typically a younger population with lower levels of educational attainment and employment, poorer income and higher costs of living, and less frequent use of and access to GP services. This demographic is more likely to smoke, drink alcohol and suffer chronic conditions such as diabetes, arthritis and asthma.

The total burden of disease is 1.4 times higher in rural and remote areas than in metropolitan areas, the average life expectancy is reduced by up to three years and rural residents experience lower rates of health screening.

Lung cancer, chronic obstructive pulmonary disease and suicide, along with land transport accidents feature more prominently in mortality data from rural and remote areas.

Rural and remote areas have the lowest five-year survival rates for cancer, and the highest incidence of uterine, cervical, liver and head and neck cancers, as well as malignancies of unknown primary.

While spared the worst in the pandemic’s first few years by virtue of geographic isolation – with the exception of very remote areas, where the AIHW says a high proportion of residents were affected – rural and regional health services are now under significant strain.

The combined burdens of resignation and burnout, an influx of deferred and delayed treatment back into the health system, and resurgent Omicron, influenza and other infections as public health measures are rolled back, are all taking a toll.

Ramping, bed block, and staffing woes are being seen across Australia, but being felt more acutely outside of metropolitan centres, because many rural services were already underserviced long before the global outbreak of SARS-CoV-2, explained NRHA CEO Gabrielle O’Kane.

“All we are hearing now is much more about exhaustion, in the general sense,” said O’Kane. “It’s not necessarily even about the (COVID) numbers, it is just that there is not people to take up the slack.”

**Compounding crises**

Compounding these pressures are the rolling impacts of climate crisis-driven fire and flooding disasters on Australia’s rural communities, who now increasingly find themselves on the frontlines of the climate crisis, and without adequate readiness or time to cover.

“How are we preparing for and responding to natural disasters?” O’Kane told Croakey in an interview. “How are we adapting to things like heat stress, smoke inhalation? What preparations are we making in the health system to deal with all of these things? And what can we do in terms of mitigation and health infrastructure?”

The climate emergency will be a key focus for the National Rural Health Conference, with an afternoon plenary on its second day featuring keynotes from Professor Mark Howden, who is director of the **Institute for Climate, Energy and Disaster Solutions** at the Australian National University, and Roland Sapsford, who is the new head of the **Climate and Health Alliance**.
Workforce issues, including what new Federal Health and Aged Care Minister Mark Butler recently described as a “crisis” in Australian primary care, will feature prominently, as will models of care, with the NRHA lobbying the new Albanese Labor government to fund a trial of its RACCHO initiative.

Rural Area Community Controlled Health Organisations, or RACCHOs, are inspired by and based on the world-leading and renowned ACCHO model in Aboriginal and Torres Strait Islander health and comprise “place-based health and wellbeing networks” owned and controlled by local communities.

“We know that the NACCHO model with wraparound services is a good one, and we know that it is supported by this block funding that allows them to be sustainable over time, and to remain flexible to local need, because no two towns are the same,” explained O’Kane.

Indigenous health, cultural safety, and innovative solutions in this space will be highlighted, with a much-anticipated keynote by high profile Wiradjuri and Kamilaroi journalist Stan Grant to kick off the summit’s second day.

Grant, who was recently appointed host of the ABC’s flagship Q and A program, delivered an acclaimed address on racism and health at this year’s annual congress of the Royal Australasian College of Psychiatrists. You can read our coverage here.

The Federal Government will hold a roundtable on Aboriginal and Torres Strait Islander health later this year in Alice Springs, with a focus on workforce and social determinants including housing, justice, education and social services.

**Alarm sounding**

The need for urgent structural reform has been cast into sharp relief in recent weeks, with the Rural Doctors Association of Australia sounding the alarm on a mass exodus of overseas-trained doctors from rural areas following changes to the Distribution Priority Area (DPA) scheme.

Under these changes, large regional towns and outer metropolitan areas will now be considered priority areas for the purposes of recruiting doctors, alongside the more rural and remote zones already covered by the scheme. The DPA allows international medical graduates to work in Australia on the proviso they practise in a defined area of workforce shortage.

RDAA President Dr Megan Belot said the expansion of the DPA to include anywhere classified as Modified Monash Model 2 or above – a policy of the previous LNP government but waved through by the new ALP administration – would “wreak havoc in the bush”.

Though it “wasn’t a perfect system”, Belot said many rural and remote towns relied on the DPA to attract staff and “it did make a difference to the care of many rural patients”. Practices across the country were already reporting resignations and withdrawn job applications since the changes, which came into effect this month.

“We are already desperately short of rural doctors, and the DPA expansion will pull the rug out from under many rural medical practices,” said Belot.

Rural medical workforce concerns were also on the agenda of the AMA’s recent National Conference.
Innovation, collaboration and bridge-making: national conference to put a timely focus on rural health

#16NRHC

Urgent action needed

Townsville-based Dr Michael Clements, who is rural chair of the Royal Australian College of General Practitioners, said without additional incentives to draw or retain doctors remotely, or measures that made it easier for foreign medical graduates to get visas, rural practices would be forced to shut their doors.

“I certainly feel that unless we do something dramatic and new, we are going to see more rural practice closures, because people just won’t be able to recruit,” he said.

Belot agreed urgent action was needed to address the “immediate drain of doctors from the bush”, including expedited rollout of the National Rural Generalist Pathway and recognition of Rural Generalism as a discrete and essential medical specialty.

More broadly, Belot said there needed to be systemic reform to encourage, support, incentivise and train doctors to work rurally.
This was echoed by O’Kane, who said workforce remained a perennially wicked problem in rural health, driven to a large extent by metro-centric training models, and the chronic underfunding of the MBS.

“If you’ve gone from having 50 percent of your graduates that used to go on and do general practice to now 15 percent, what does that tell you straight away? You’re then having to look at a pool of 15 percent across the country, and you have got to get a portion of them to go rural. What are your chances?”

Instead of basing medical training in the cities, with short rotations to rural sites, O’Kane said training time should be mandated to at least 50:50, and there should be greater emphasis on drawing early career doctors away from metropolitan sites for their pre-vocational years.

Allowing junior doctors to carry over their pay and conditions including leave and loading from the hospital system into primary care – underwritten by block government funding – would also make a material difference to the recruitment of graduates into general practice. This needed to be accompanied by a rethink of the fee-for-service model rurally, she added.

“I think we just have to do a lot of this differently,” O’Kane said.

**Taskforce priorities**

The Federal Government recently announced the appointment of a Strengthening Medicare Taskforce to address stresses on the hospital system, with priorities to include after-hours access to health care, affordability, and chronic disease management.

The Taskforce includes a number of rural representatives including Dr Sarah Chalmers from the Australian College of Rural and Remote Medicine, National Rural Health Commissioner Adjunct Professor Ruth Stewart, and NACCHO chief Dr Dawn Casey.

The NRHA conference, which is themed ‘Bridging social distance: rural health innovating & collaborating’, is pushing a focus on solutions, with delegates being asked to consider three key questions:

- What motivates you to keep working rural?
- Is there a local solution to improving rural health delivery that has worked for you?
- If you had one recommendation for the federal Minister for Health, what would it be?
Presentations will canvas a broad range of topics including digital health, mental health, family and domestic violence and women’s health, health and the arts, prevention and determinants, research, aged and palliative care, chronic disease, and oral health.

From Twitter

Sabina Knight @nwgran · 2h
Hi ho - it’s off the the 16th National Rural Health Conference we go. Looking forward to hearing of the innovation that’s occurred and meeting colleagues old and new #16NRHC Brisbane

Broken Hill University Department of Rural Health @BHUDRH · 2h
#LiveWorkStudyResearchRural #16nrhc

Australian Rural Health Education Network (AR... @ARHE_ · 2h
Best wishes to all the speakers from our University Departments of Rural Health who will be sharing their research and learnings this week at the #16nrhc. A great conference ahead. See you in Brisbane! @NRHAlliance @C_Quilliam

V Dickson-Swift @VDSswift · Jul 28
Looking forward to being a part of the #16nrhc #ruralhealthconf by @NRHAlliance being held in Brisbane next week. Lots of @LaTrobeRHS colleagues presenting their research.
You can view Croakey's coverage of the conference here.

Innovation, collaboration and bridge-making: national conference to put a timely focus on rural health
#16NRHC

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Croakey
“Conference News Service”
The climate crisis is on the health agenda, from Federal Parliament to the National Rural Health Conference

From Parliament House in Canberra to the 16th National Rural Health Conference in Queensland, the climate crisis and its devastating health impacts have been in the spotlight, reports Croakey editor Dr Amy Coopes. Finally, some progress is being made.

Amy Coopes writes:

The climate wars were declared “in retreat” yesterday after the Greens indicated they would pass Labor’s climate bill, locking in a 43 percent emissions reduction target, and Liberal MP Bridget Archer indicated she would cross the floor to support the legislation.

In a momentous parliamentary session signalling an end to years of deadlock on climate policy, new independent MP Dr Sophie Scamps used her first Question Time allocation to press Health Minister Mark Butler on the Government’s climate and health strategy.
Scamps, previously a GP from Sydney’s Northern Beaches, called on Butler to outline the substance and timeline for delivery of the strategy, telling the chamber her specialist college and the Australian Medical Association had both declared climate change a health emergency requiring urgent action.

Acknowledging Scamps for her “important question”, Butler echoed the World Health Organization’s characterisation of climate change as the “greatest threat to public health in the 21st Century”.

“They estimate that between 2030 and 2050, 250,000 people every year will lose their lives as a direct result of a warming planet. And the impact in Australia will be profound. In a continent that already pushes us right up against the limits of human tolerance, heat-related deaths will increase,” Butler told the House.

He said Australia would see the health impacts of climate extremes intensify, with substantial growth in devastating weather events and the slow creep of tropical disease further southward.

Butler said dengue fever would be seen as far south as Rockhampton by mid-century and move into northern NSW by 2100, and he noted that apart from the direct toll of megafires like Black Saturday, such events were also already accompanied by an order of magnitude more heat stress deaths.

“Australia lags the rest of the world in climate and health after nine long years of denial and inaction,” said Butler, describing “good climate policy as good public health policy”.

Butler said he had advanced talks with his state and territory counterparts on reducing emissions from the health sector, which was itself a major contributor to the problem, accounting for about seven percent of the nation’s greenhouse gas output. The Health Minister said greater action also needed to be taken to shore up healthcare’s readiness for and resilience to climate shocks.

On the climate and health strategy alluded to by Dr Scamps, Butler said he had commissioned advice from his Department about its implementation and “we are getting on with the job of making that plan”.

He described the introduction of Labor’s climate legislation this week – “real action on climate” – as the “first and most important step”.

The bill received a significant boost on Wednesday when Greens leader Adam Bandt told the National Press Club his party stood ready to support its passage through both houses of parliament, and Liberal MP Bridget MP told her colleagues she would be crossing the floor in endorsement.

Archer, who is member for the Tasmanian seat of Bass, encompassing the island state’s rural north-east, said she had reached the conclusion that “it is important we act now and not delay until the next election”, describing the climate crisis as an issue that “transcends age, gender, political beliefs and socioeconomic circumstances”.
Prime Minister Anthony Albanese said it was a “pretty significant” development after a decade of inertia, while Climate Change Minister Chris Bowen described it as a “good day for Australia. It’s a good day for our economy. It’s a good day for our future.”

“The climate wars may or may not be over, but they are certainly in retreat,” Bowen said.

Rural health focus

While events played out Canberra, climate and health was also in sharp focus at the 16th National Rural Health Conference in Brisbane, where the implications of the climate crisis for rural communities took centre stage.

Rural communities were uniquely vulnerable to the impacts of the climate crisis and, as a “wealth of lived experience in this room” could attest, they already found themselves on the frontlines, piling pressure upon services under strain, conference delegates heard.

Some 700 delegates have gathered in Brisbane for the renowned rural health event, which is being held for the first time since the global outbreak of COVID-19, and has an emphasis on rural readiness for the climate emergency.

Professor Mark Howden, who is director of the Institute for Climate, Energy and Disaster Solutions at the Australian National University, described the accelerating and converging impacts of global warming and the need for systemic understandings and responses to the crisis.

“Climate change is a real and present danger when it comes to rural health concerns,” Howden said in an interview with Croakey on the sidelines of the conference. “It’s bad and it’s getting worse, and we need to take more action than we thought was perhaps needed at this point in the climate change trajectory.”

Rather than understanding extreme events purely in health terms, Howden said it was essential to appreciate the flow-on effects for agriculture, water, energy, food preparation, labour productivity – all of which either directly or indirectly also influenced health.

“There’s systemic impacts of climate on rural health and so we need to be thinking in systemic responses,” he said, also highlighting the aggregation of risks, as seen in Australia over summer with the overlap of flooding disasters and COVID-19.
While Australia was largely a “representative microcosm of global change” tracking in line with averages in terms of accelerating impacts like storm intensity, extreme flooding and cyclone strength, Howden said we were leading the world in terms of fire risk. Along with drought and heat stress, rural communities were particularly vulnerable to fires.

Focusing on the issue of heat, Howden said there was a direct observable impact on mortality due to the physiological stress, particularly for people with chronic conditions, though he said we failed to capture this in our data collection and reporting.

“If someone dies from a heart attack associated with higher heat levels it’s actually just recorded as a heart attack, there is no mention of the fact that it might actually have been triggered by high temperatures,” Howden said. “I think we need to be thinking about how we more effectively record this information so that we can actually have a handle on how this is impacting, and how treatment effectiveness is propagating.”

But there were also downstream impacts, some of which were hidden, with a domino effect on water and crops flowing through to livelihoods and labour productivity, mental health and the ability to take preventative action. Heat events were also associated with spikes in suicide, domestic violence and violence more generally, as well as criminal activity, and with accumulation of future chronic disease burden via decreased physical activity.

Howden said rural communities were also uniquely placed to build climate resilience, with the Sendai Framework recognising that “localised action and localised capability building is actually really critical to dealing with effective disaster risk responses”.

Lived experience

Roland Sapsford, the new chair of the Climate and Health Alliance, paid tribute to the “wealth of lived experience in this room around the immediate impacts of climate change in rural health care in Australia” following years of historic bushfires and flooding in his Conference keynote.

Sapsford said climate instability “adds yet another pressure to how care is delivered, and to the chronic staffing and recruitment challenges and lack of investment” in rural health.

“People in rural Australia know all too well the impact of droughts, extreme heat, floods, fires. You also know first-hand the way the burden of these often falls most heavily on those already burdened by low incomes, racism and economic insecurity,” he said.
“Rural Australia is often the first hit by the impacts of a climate disaster. This means rural Australia has a vested interest in being part of the solutions.”

Even as delegates were meeting in Brisbane, Sapsford said rural communities continued picking up the pieces following the summer’s catastrophic floods, with real questions about their wellbeing and prospects for the future – perhaps Australia’s “first domestic climate refugees unable to go back to their homes.”

“What will happen to them if, as the Bureau of Meteorology is forecasting, there is a 50:50 chance of another La Nina cycle this spring or summer bringing more heavy downpours fueled by climate change?” he asked.

He said much rural health infrastructure was old, outdated and not fit for purpose in an era of extreme heat, severe storms, floods and fires, medical supply chains were vulnerable to disruption as were power and water supplies, and staff access to their workplaces.

“Rural health workforce need support and training to deal with heat exhaustion, mental health, increased domestic violence, vector-borne or zoonotic illnesses, as well as preparing for and managing a climate disaster event.”

Sapsford described the election of the Albanese Government as a “sea change” for climate change engagement, representing a “real opportunity to shift the political discourse to a genuine discussion about how we tackle climate change,” including listening to Traditional Owners on environmental stewardship.

Sapsford called on delegates to hold onto a sense of “both urgency and hope”, saying rural health care workers had an opportunity, ability and responsibility to “join up a narrative about the personal and the immediate with the planetary and enduring”.

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Published on Thursday, August 4, 2022
Regional Australians at the frontline of the climate emergency and health workforce crisis

Introduction by Croakey: Last week, Independent Federal Member for Indi Helen Haines moved to amend the Government’s Climate Change Bill to ensure rural and regional Australians would benefit from actions on climate change, highlighting her commitment to rural health.

Her commitment stems from witnessing first hand the increasing impacts of climate emergencies and the wide gaps in health outcomes for rural and regional Australians, Haines told delegates in a pre-recorded speech at the 16th National Rural Health Conference.

“Climate change is a health crisis, and regional Australians are at the frontline of it all”, she said.

In her speech, Haines also discussed the urgent need for increased funding and commitment to improving rural health infrastructure, including a single-site hospital at Albury-Wodonga, and the rural health workforce.

Haines highlighted that the Murray Darling Medical Schools Network Program produced only 15 new doctors each year out of hundreds of applications.
Helen Haines writes:

I’d like to start by acknowledging the Traditional Owners of the lands from which I’m coming to you today – the Ngunnawal and Ngambri people of the Canberra district – I’m in Parliament House.

I wish to pay my respects to those Elders past and present and to acknowledge 60,000-plus years of continuous First Nations culture in this land of ours, the longest continuous culture in the world.

I’d also like to assert my sincere and passionate support for the Uluru Statement from the Heart and my very dear hope that in the term of this Parliament the nation delivers a resounding yes to the referendum on a constitutionally-enshrined Voice to Parliament. As the Parliament opened last week the Prime Minister reiterated strongly his intention to make this a reality.

Sadly I can’t be with you in person but it’s an honour to be invited to address this, the 16th National Rural Health Conference. I’ve attended many such conferences in the past and I know how wonderful it is to catch up with friends and colleagues and to learn of the latest research programs, the wonderful work that’s happening in rural health right across Australia.

Rural health is my life’s work. As some of you may know, prior to being elected to Parliament in 2019 I spent over 29 years working as a nurse, a midwife and a rural health researcher. In fact one of my first jobs in the country was as the matron of the Chiltern Bush Nursing Hospital, a tiny hospital in North East Victoria with a close-knit team and a vibrant local community, a place where I had the opportunity to utilise my full scope of practice as a nurse and a midwife, a place where I had the opportunity to work with an inter-disciplinary team which was just crucial to addressing the complex needs of our community.

I’ve had many jobs since, but the lessons I learned then have served me well everywhere I have gone since. A career in rural health should be something everything health professional should be absolutely desperate to have.

Of course it’s not all a bed of roses, there are many hills to climb to achieve health equity in rural health. There are many hills to climb when it comes to moving government policy along a continuum that recognises and funds models of care that are contextually right and effective in a rural environment.

In fact, one of the reasons I ran for Parliament in the first place was to try to make a difference on issues relating to rural health, to bring my professional experience into the federal debate. The argument that successive Australian governments have let down rural and regional Australians on health is pretty clear.

It’s a stark fact, as illustrated by the Mitchell Institute, that for every Medicare dollar spent in the city, 94 cents is spent in regional areas, 75 cents in remote areas and 56 cents in very remote areas. Interestingly, inner regional Australians do a bit better, with a spend of a dollar and four cents.
There are countless examples of models of care that work for rural Australia, but it still remains true that regional Australians have higher rates of chronic disease, we die younger and have less access to healthcare than our metropolitan cousins. And we can never forget that Indigenous Australians are disproportionately affected by these health challenges.

My community in the electorate of Indi knows these challenges well. The survival rate for cancer is four percent lower for regional Victorians than those Victorians that live in the metropolitan area of Melbourne. Benalla, a small town in my electorate, has double the state average of mental health conditions, and the suicide rate in the Murray region, where I represent, is four percent above the rest of the state.

While we’re seeing access to improvements to care, the availability of mental health professionals to meet the need remains abysmally low. And it remains true that it is a sorry fact that one-third of all chronic disease is in fact preventable, you all know that, and yet 1.3 percent of the health care budget is spent on disease prevention.

It’s one of the reasons that I am a co-chair of the Parliamentary Friends of Health Promotion. We know there is a problem, many of us in the Parliament are health professionals and we know there is a problem and we’ve continued to try to lobby successive governments to make a difference on the health spend in the preventative space.

**Climate change**

Regional Australians are also at the frontline of the health impacts of climate change. A few summers ago my region in North East Victoria was one of many places blanketed in heavy bushfire smoke for many, many months. Beautiful Alpine towns like Bright, like Walwa, Harrietville edged out the world’s megacities like Beijing and Delhi for the sad record of having the planet’s most toxic air. For months our kids, our pregnant women, our elderly breathed in this toxic mix of carbon monoxide, sulphur dioxide and nitrogen dioxide.

Across Australia the Black Summer bushfire smoke resulted in over 1,100 hospitalisations for cardiovascular problems, and over 2,000 hospitalisations for respiratory problems, and over 1,300 asthma presentations in emergency departments. On top of this, 445 deaths can be directly attributed to the deadly smoke – 445.

A **2019 study** by Abdo and colleagues of 535,895 pregnant women in Colorado who were exposed to wildfire smoke in their second trimester found a significantly increased risk of preterm birth. That large study concluded that as climate change is expected to increase, the frequency and intensity of wildfires will increase the health burden on expectant mothers and their babies.

We know from research out of Melbourne University that five years after the Black Saturday fires, 22 percent of people in highly affected communities were reporting symptoms of mental health disorders. After the most recent Black Summer fires I visited a bushfire-affected community in Indi where the school principal told me 60 percent of kindergarten children at their school had been assessed by a psychologist as showing signs of trauma from summer bushfires – 60 percent of those little children.

The devastating floods that we have seen in the last year also take their toll. And when drought comes again, as it surely will, that too will leave scars.

Climate change is a health crisis, and regional Australians are at the frontline of it all.

Because of these reasons, because of the glaring gap in health outcomes for regional Australians, and because climate change will present many new challenges – indeed challenges already (being seen) – I have made rural health a focus of my time as the member for Indi.
Because I take my role as an Independent member of Parliament very, very seriously I took to the election a comprehensive and fully costed suite of policies on rural health, mental health and aged care to the election. I don’t want to be a politician who only points out all the problems, I want to use my time in Parliament to work closely with my community, to develop together the solutions that we need, and to fight for the government to take action.

**Community priorities**

The priorities that my community put to me are these. First, they say, we need to fund rural hospitals. The fundamental infrastructure in rural health services is lagging behind the needs of the community. Many of our health services are ageing and no longer fit for purpose and there’s little transparency in how government decides to fund infrastructure in health care.

Albury-Wodonga is one of the many communities in desperate need of a new hospital. Albury-Wodonga Health runs one of the busiest regional health services in the state of Victoria. It’s the only cross-border health service in the nation. In 15 years the population in this cross-border community will grow by one-third.

Regionalisation is happening in front of our very eyes. For years we said, build it and they will come. Well here’s the thing: on the border, they have come, but we haven’t built it. By 2040 we are going to need a hospital capable of handling 150,000 emergency presentations, 4,000 surgeries and 1,900 births every year. Yet the current hospital has been in and out of Code Yellows for the past 12 months.

We desperately need a new single-site hospital, and we need it now. The stories of why include problems with a workforce split across the state border, across multiple sites, and the very, very familiar stories to all of you of rural people having to travel vast distances to the city for specialist care, when in fact the population now warrants that specialist care being available close to home.

I have campaigned hard for the Federal Government to provide a $300 million contribution to a new hospital, and I reiterate that call today. And the community and staff, they are very active campaigners alongside me too, as are the local media outlets. People power has worked in the past to get specialist cancer services on the border and we are activating similar campaigning now to get this world class single-site hospital.

But so many smaller hospitals are in a similar position. In my electorate, in small towns from Mansfield to Bright and Benalla, we have small rural health services who barely get a look in when it comes to Federal and State funding for hospital infrastructure and equipment. It’s a story that gets repeated across regional Australia – small rural health services are left under-resourced.

The Federal Government has taken leadership and set up a dedicated funding scheme for rural hospitals before; well it is time it did it again. It really needs to come to the table again. So I’m fighting to establish a dedicated $1 billion fund for rural hospitals, to upgrade infrastructure and equipment, and to have transparent guidelines and a pathway to apply.

**Rural health workforce**

But buildings of course are only part of the picture, you all know that. We need people to staff our healthcare services. In my time as a rural health researcher I spent a decade studying the best ways to grow and retain a strong regional health workforce, and we’ve got to start by nurturing the talent that we already have locally, the evidence backs this up.
Young people have enormous potential but we often lose them to universities and hospitals in the cities because we don’t have enough opportunities locally for education and training in health careers. We need to build better and more successful models like the Murray Darling Medical Schools Network Program – that’s at La Trobe University in Wodonga in my electorate.

It’s a great success but it only produces 15 new doctors each year, and 15 is nowhere near enough. This is a school that had hundreds of applications for just 15 places. I spent many many years working in the University Department of Rural health program and I’m sure there are many of my former colleagues in the audience today.

I’ve seen how transformational these programs are and we need our Federal Government to stump up and continue these, and to expand them. I’m campaigning for the new government to triple the amount of places at the Murray Darling Medical School and to look at expanding it to allied health too.

I am committed to building a pipeline of health workers who stay in my region, in the North East of Victoria, for generations to come. But I want that for every rural, remote and regional area across the nation.

I also think we need to triple the funding for mid-career regional health workers so that they can upskill. Our health workers have been stretched to the limit because of the pandemic, and because of the work they carried before this.

We shouldn’t be playing catch-up, we should be investing in health workers so that they have the skills they need to deliver the health care that we require. I want to see every health worker have access to $20,000 in funding to upskill. It doesn’t matter if it’s for course fees, childcare costs, supplementary income – whatever it takes to support our health workforce to grow professionally.

Right now, federal funding for this is oversubscribed and it excludes major regional towns such as Wodonga, in my electorate, for no clear reason. We’ve got to fix that. This means health workers will not have to move to big cities to advance their careers; it means that our health workers, particularly mid-career, can get the specialist training that we need to provide the specialist care right where people live.

If we create opportunities for long-term, fulfilling health careers in our region, in our rural areas, in our remote areas, we all benefit.

We need to do better in building mental health workforce in our regions too. Rural, regional and remote Australia has about 28 percent of the population, but just 13 percent of psychiatrists, 17 percent of all psychologists and 23 percent of mental health nurses. And of course, the more remote you are, the lower those numbers are.

One of the best things the previous government did was to forgive the university debt of any medical doctor or nurse practitioner who worked in remote or regional Australia. I think we should expand this scheme to mental health workers, to bring more psychologists, psychiatrists, mental health nurses and social workers out into the regions.

Finally, we need to invest more in developing specialised mental health services for complex conditions like eating disorders. Eating disorders affect around one million Australians at any one time, that’s around four percent of our population. But accessing the support needed for recovery is nigh on impossible in many parts of rural and regional Australia.
The previous Government did, perhaps, more than any other government ever on eating disorders, but still I have spoken to dozens of families in my electorate who have to travel to Melbourne or Sydney to access eating disorder supports because there simply is not anything available closer to home, and when they return there is no support available to back in the care they have just had.

One specialist psychologist in Albury-Wodonga told me she had to turn away 43 patients from her practice last year alone.

Finally, and in conclusion, I would say the pandemic has seen scores of people appreciating the benefits of rural and regional Australia, but what is clear is that rural and regional Australia needs a substantial investment in healthcare.

We all know we are operating in a time of substantial economic challenge, a trillion dollars of debt and a government determined to return the budget to surplus. It will be challenging to make the case to invest further in rural health, but it’s a case we simply must make.

As an Independent member of the Federal Parliament I have a platform, and I intend to use it to prosecute some of the issues I have spoken about today. I have the ability to develop and table private members’ bills to advance important legislative priorities in this place, and I’m determined to be a sensible and rational voice; a voice of the regions, a voice of rural and remote Australia to this Government.

That is the benefit of being an Independent – no matter who is in power, I can work with them. And I want to work with all of you too. Together we can make a change.

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**From Twitter**

Jessica Harris @wordsbyjess · Aug 4
Priorities for rural health, Helen Haines. Fund hospitals including Albury Wodonga and small rural services. Expand rural clinical schools and invest in locals to expand workforce. More funding for upskilling and mental health. #16nrhc

Dr. Kristen Glenister (views expressed are ... @kristengle ... Aug 4 ...
#16nrhc @helenhainesind Helen Haines calls out health inequities in rural areas and celebrates contextually appropriate models of care

National Rural Health Alliance @NRHAlliance
Dr. Helen Haines, Independent Federal Member for Indi stresses that climate change is a health crisis and regional Australians are at risk. Highlights the importance of investment in healthcare infrastructure and services.
#16nrhc #ruralhealthconf #ruralhealthoz
You can view Croakey's coverage of the conference here.

Helen Haines, Indi, has covid so Rebekha Sharkie, Mayo, is reading her amendments on her behalf.

Nationals showing their hand. Choosing to vote AGAINST Regional Australia benefitting from Climate Policy. Beggars belief @D_LittleproudMP #auspol

Next amendment from @helenhainessndl (moved by @MakeMayoMatter) ensuring the transition explicitly benefits regional Australia.

What will the Nationals do? (Yes, that’s a rhetorical question). Still, watching ..#auspol @AmyRemeikis

The government will support @helenhainessndl amendments. @D_LittleproudMP says The Nationals won’t #auspol

The Parliament of the
Commonwealth of Australia

HOUSE OF REPRESENTATIVES

Climate Change Bill 2022

(De Haines)

(1) Clause 12, page 7 (line 18), at the end of subclause (1), add:

; and (e) the impact of the Commonwealth’s climate change policies to achieve Australia’s greenhouse gas emissions reduction targets on rural and regional Australia, including the social, employment and economic benefits being delivered by those policies in rural and regional Australia.

[annual climate change statement]

(2) Clause 15, page 9 (after line 34), after subclause (1), insert:

(1A) The advice given under subsection (1) must include advice on:

(a) the social, employment and economic benefits of any new or adjusted greenhouse gas emissions reduction targets and associated policies, including for rural and regional Australia; and

(b) the physical impacts of climate change on Australia, including on rural and regional Australia.

[advice on emissions reduction targets]
Wrapping some of the tweets and news from the 16th National Rural Health Conference

Introduction by Croakey: A vibrant record of the 16th National Rural Health Conference can be found on Twitter at #16nrhc. The National Rural Health Alliance contributed to the conference coverage via Croakey’s rotated Twitter account, @WePublicHealth.

The summary below includes presentations on the health and wellbeing of Aboriginal and Torres Strait Islander people, the social determinants of health, public health, workforce matters, and research, as well as celebrating an auspicious birthday for The Australian Journal of Rural Health.

Also, don’t miss the selfies, and thanks to all who contributed to the conference hashtag trending on Twitter. To stay in touch with presenters and participants, follow the #16nrhc Twitter list – a handy resource for news about the health of rural, regional and remote communities.
You can view Croakey’s coverage of the conference here.

Wrapping some of the tweets and news from the 16th National Rural Health Conference

#16NRHC

Tweets and retweets by National Rural Health Alliance

Vicki Flood @FloodVicki - Aug 2
Compelling opening address from human rights lawyer Rabia Siddique, challenging us to speak up, out of our comfort zone, protect hope, challenge our perspectives #16NRHC.

Dr Sonia Alhoh @soniaalhoh - Aug 3
Calling out chronic service disconnection in Indigenous eye health #16NRHC

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Wrapping some of the tweets and news from the 16th National Rural Health Conference #16NRHC

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RFDS SA/NT Aeromedical & Emergency... @RFDS_CO_EC... Aug 2

Rural representation on state, national & other committees matters. How do you hear the voice of both Rural and Remote patients and practitioners in your strategic & operational planning? #16nrhc

Susan Trevillian (nee Parry) @TrevillianSusan Aug 2 #16NRHC #ruralhealthconf

A/Prof @kinfielding on the BRACsurgeryRuralHealth Equity Strategy, describing extensive rural representation on RACS committees, with a standing item on all agendas to focus efforts on addressing rural inequity.

#SHPRuralRemote @the_shpa
Show this thread

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WRAPPING SOME OF THE TWEETS AND NEWS FROM THE 16TH NATIONAL RURAL HEALTH CONFERENCE #16NRHC

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River Flooding

Likely to increase in frequency & severity with climate change
Negatively impacts mental health
Exposes & exacerbates existing inequalities

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RFDS SA/NT Aeromedical & Emergency... @RFDS_CO_EC... Aug 2

Being willing to deconstruct metro-based, bricks-and-mortar institution-based education as the legacy gold standard takes incredible persistence - as well as innovation. And successful innovation includes a lot of failures - are we willing to try and fail? #16nrhc

Dr. Kristen Gilnster (@kristangie...) Aug 2 #16nrhc- Carol McKinstey's recommendations for health training in MMM2-F

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Suicide Prevention Australia @SuicidePrevAU Aug 2

We’re at the 16th National Rural Health Conference this week in Brisbane talking about the Suicide Prevention Accreditation Program and the Suicide Prevention Competency Framework. If you’re around, come say hi.

#16NRHC #ruralhealthconf @NRHAlliance

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We Public Health Retweeted

Vicki Flood @FloodVicki Aug 2

Great to hear from Sharnie Roberts and Dave Edwards @UCRNHRNC presenting today on WellMob wellmob.org.au, #16NRHC. Great presentation, culturally relevant resources.

---

We Public Health Retweeted

Vicki Flood @FloodVicki Aug 2 @JodieBaliff presenting on challenges for people with disability in floods, 4x more likely to have inadequate housing 6 months after floods, #16NRHC. We need to do more, system level change needed.

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You can view Croakey’s coverage of the conference here.

Wrapping some of the tweets and news from the 16th National Rural Health Conference

#16NRHC

1. We Public Health Retweeted
Susan Trevillian (nee Parry) @TrevillianSusan - Aug 2
@doggrumpy describing 10 years of delivering #telehealth services across WA Country Health Service from the WACHS Command Centre. “We’re not trying to replace, but to support.”

2. We Public Health Retweeted
V Dickson-Swift @VDSSwift - Aug 2
Thanks for the photo of today’s presentation @profjenmills at #16nrhc #ruralhealthconf! Great energy and support in the room for better access to fluoridated water in rural areas #Croakey #LaTrobeRHS

3. We Public Health Retweeted
#16nrhc Ruth Warr talks about the impacts of the telehealth stroke rehab model in Geraldton

4. We Public Health Retweeted
Australian Stroke Alliance @AusStroke - Aug 2
Jessica Carew describing how digital health solutions are leading modern health care. @AusStroke recognizes this & are developing #telehealth tools to increase pre-hospital #stroke management. But digital health literacy is needed @NRHAustralia #16NRHC

5. We Public Health Retweeted
National Rural Health Alliance @NRHAAlliance - Aug 3
Dr. Gabrielle O’Kane, CEO of the National Rural Health Alliance spoke about the two key policy platforms from the Alliance: a new National Rural Health Strategy and the Rural Area Community Controlled Health Organisation (RACCHO) model of care #16nrhc
You can view Croakey's coverage of the conference here.

Wrapping some of the tweets and news from the 16th National Rural Health Conference #16NRHC

Jodie Bailie @JodieBailie - Aug 3

“Principles not rules” outlined by @okane_gabrielle from @NRHAlliance for the Rural Area Community Controlled Health Organisations (RACCHO) model. #16nrhc #ruralhealth

Susan Trevillian (nee Parry) @TrevillianSusan - Aug 2

#16NRHC #ruralhealthconf

Celebrating 30 years of @AustRuralHealth.

Notably in the first edition Roger Strasser asked “How can we attract more doctors to the country?”

#workforce #ruralhealth

Melissa Stoneham @DMissStoneham - Aug 3

The Lost Art- a social enterprise for unemployed people in #Blackfell- a place & space that makes a significant contribution to the social, economic and healthy welfare of the community, changing people’s lives & making a creative difference #artsandhealth at #16NRHC in #brisbane

NSW Rural Doctors Network @NSWRDN - Aug 3

The rapid expansion of digital technology has opened new opportunities to build capability for those who are working in rural and remote areas. RDN has developed a framework to support this and is excited to share this with delegates at #16nrhc today. bddy.me/5PY4Xltc

Croakey "Conference News Service"
You can view Croakey’s coverage of the conference here.

Wrapping some of the tweets and news from the 16th National Rural Health Conference

Selfies

27
You can view Croakey's coverage of the conference here.

Wrapping some of the tweets and news from the 16th National Rural Health Conference #16NRHC

Grogeous Geoff @ArgusGeoff Aug 3
Great to catch up with my good friend and fellow Qld UDRH Director Prof Sabina Knight @nwqran at the National Rural Health Conference #16nrhc

Reunion of friends & colleagues from across outback Australia sharing a passion for rural health & a bright future for our communities #16NRHC @JCUCQQRIRH @CIRRH_JCU @IRHAustralia

Very excited to have been representing @The_NRHSN today at the #16NationalRuralHealthConference in Brisbane #16NRHC #ruralhealthconf

28
And thanks

Wrapping some of the tweets and news from the 16th National Rural Health Conference

Published on Wednesday, August 10, 2022
Governments urged to address inequities in access to abortion services in rural, regional and remote areas

Australian women should be able to access abortion care no matter where they live. Photo taken on Narungga Country by Alison Barrett

Governments at all levels have been urged to take systemic actions to address “chilling” inequities in access to abortion services in rural, regional and remote areas.

Dr Amy Coopes reports from the 16th National Rural Health Conference for the Croakey Conference News Service.

Amy Coopes writes:

One in three Australian women lives in a region where there is no access to medical abortion and states like New South Wales remain a “vacuum” of information about where to access care for an unwanted pregnancy via “underground” networks relying on word of mouth.

These were some of the messages delivered at the National Rural Health Conference in Brisbane, bringing together 700 delegates from across rural, regional and remote Australia for the first time since the beginning of the COVID-19 pandemic.

The focus on women’s reproductive health at the conference – with a number of presentations on abortion care in rural, regional and remote areas – was timely given the recent US Supreme Court’s controversial Roe vs Wade decision. The move, which effectively set the clock back decades on abortion rights in the United States, made headlines and sparked protests in countries including Australia.
Abortion is legal in all Australian states and territories, although still under the criminal code in Western Australia, and the conditions under which termination can take place varies widely. South Australia was the most recent party in the Federation to decriminalise abortion.

Between one quarter and one third of Australian women experience an abortion in their lifetime, with estimates suggesting half of all pregnancies are unplanned and, that of these, one in two are terminated.

As with many aspects of health service provision, access to abortion care varies widely by geographic location, with providers concentrated in metropolitan areas and rural women facing significant barriers, the conference heard.

Geographical variations

Dr Samantha Chakraborty, from the NHMRC-funded SPHERE Centre for Research Excellence in Sexual and Reproductive Health for Women in Primary Care, presented the findings of a study looking at GP provision of abortion care by statistical area.

About 10 percent or 3,000 of Australia’s 35,000 GPs are estimated to have completed medical termination training, using the dual-drug combination mifepristone and misoprostol (MS-2 Step), but those figures don’t represent the number who are actually, in practice, offering this service.

Using PBS data on MS 2-Step prescribing and dispensing, and disaggregating it by location, the SPHERE team was able to map where, exactly, GPs were offering medical abortion services. Centre director Dr Danielle Mazza described the findings as “chilling.”

“What we found was that 30 percent of women in Australia live in a statistical area where no GP is actually providing this service, and that this rate goes up even higher in rural areas,” Mazza told Croakey on the sidelines of the conference of the “shocking” data. The data was collected in 2019, before the introduction of specific MBS item numbers for telehealth abortion services.

“Women are very much disadvantaged because they can’t get local access,” Mazza said.

The SPHERE team found significant variation in the age-standardised rates of MS 2-Step dispensing by remoteness area per 1,000 women. In major cities, MS 2-step was dispensed to 3.3 per 1000 women compared with 6.53 in outer regional areas – significantly above the national average 3.79.

Average rates of dispensing were highest in the ACT, at 3.15 per 1,000, and lowest in the Northern Territory, at 7.16. Tasmania and the NT scored the worst overall, with outer regional areas in those jurisdictions offering a bleak picture to access (8.43 and 9.75 per 1,000, respectively).

Barriers to access

Sydney University researcher Anna Noonan is examining abortion care experiences of rural women and health care providers in western NSW. Her findings, which remain under embargo as part of her PhD studies, were presented in preliminary format at last week’s conference.

In the main, Noonan said the work “confirms what we already know, which is that access is hard, travel is costly, it’s complicated, and there are compounding factors that make accessing services really tricky.”
Despite decriminalisation, Noonan said the system remained opaque for people wanting to access an abortion – a category that she noted did not exclusively apply to cisgendered women – and NSW stood in stark contrast to jurisdictions like Victoria and Queensland in terms of transparency and accessibility.

Both states had interactive online directories and maps detailing “all the different ways and places you can access abortion care”. In NSW, there remained “a vacuum, there’s just no publicly available information at all,” Noonan said.

“It’s this really strange and kind of fragmented environment in which rural NSW woman are living,” Noonan told Croakey after her talk.

“And the frustrating thing is that it’s not that there aren’t service providers, because we know that there are – we have talked to them… [It’s] that they don’t advertise their service publicly, for lots of reasons, and finding them is really hard.”

Participants interviewed for Noonan’s research described a “weird underground kind of potluck, this kind of antiquated process” where they had to rely on word of mouth and local connections to find someone locally to provide abortion care, or to even access information to help them make a decision in “a very time-critical three or four weeks”, she said.

For local providers, Noonan said a variety of factors played into the reticence promoting their credentials in this space, including a concern that they themselves would be stigmatised as the ‘abortion doctor’ in town, and that demand would be such it would crowd out their other work.

Noonan said there was also a concern for some doctors that, while they were themselves strongly supportive of abortion service provision, they operated in settings where – were a medical termination to not succeed – options were limited locally for escalating care.

“There is a nervousness among providers that if they do provide this service but they know that the hospital is antagonistic towards abortion care, then they are setting that person up to potentially end up in an environment where it’s out of their ambit and they’re unlikely to receive non-judgmental care,” said Noonan.

**International comparisons**

Mazza has just returned from Churchill Fellowship travels through Europe and North America, examining models of abortion integration into primary care. On international comparisons, she said Australia compared “pretty poorly”.

In countries like the UK, Ireland and Sweden, Mazza said governments assumed “full responsibility for ensuring that women have access to abortion in their publicly-funded health services”, while in Australia it remained – in large measure – a private sector issue.

Lack of standardised, uniform education and training about abortion care from medical school right through to GP training was a significant part of the issue, Mazza said, also echoing Noonan’s sentiments around the lack of local and regional specialist support for primary care doctors in this space.

“GPs need to feel confident that, in the rare case that there is a complication they can rapidly access support for their patient in the local hospital,” she said.

Mazza also highlighted stigma as an issue for rural GPs.
“They are fearful that they might become known, might face discrimination or retaliation or goodness knows what from people who are anti-abortion in their region,” she said.

**Policy**

At a policy level, Mazza said there was plenty state and federal governments could do to address this issue, including tasking primary health networks (PHNs) to conduct a needs assessment of and commission service provision for abortion care in their region.

Both Mazza and Noonan agreed there was a place for telehealth to augment offerings in the telehealth space – in fact, Noonan’s research had found that some women preferred a “transactional experience” that was separate from and not delivered by their usual provider.

But Mazza said it was only part of the solution, arguing that abortion care should be seen as just one element of “comprehensive women’s health services” offered in primary care.

“GPs know their patients, they know their social circumstances, they know their families and they can assist women with other ongoing issues around, for instance, the need for ongoing contraception,” Mazza said. “You can’t put in an IUD remotely, or give a Depo injection remotely, if that’s what the woman wants.”

The overarching message was that “rural women do want to have agency over the care that they receive,” added Noonan.

“It’s just healthcare. You turn up to your GP, you want them to be able to help you,” she said. “Please, just get the information you need to be able to give rural women choice, and not stuff them around so they are not wasting really critical time.”

She called for NSW to follow the lead of Victoria, Queensland and Tasmania and establish a public directory of services, “or better still” roll out such an offering at a national level, pointing to the “problematic” example of the United States where, following the Roe v Wade decision abortion had defaulted from a federal to a state-based issue.

Mazza said the “appalling” developments in the US had shown both how far Australia still had to go but also sparked an openness to change that should be seized upon.

“I think it has also galvanised people to realise that unless we really address these issues, abortions can become very precarious indeed.”
Governments urged to address inequities in access to abortion services in rural, regional and remote areas

#16NRHC

Croakey “Conference News Service”
Profiling Dr Brad Murphy and a vision for more equitable healthcare

Amy Coopes writes:

Growing up in a rural hotel as the son of a nurse, a young Kamilaroi boy called Brad Murphy spent his Saturday nights patching up patrons after brawls and tending to weary travellers as they spun him a yarn.

In those formative years, he discovered both an aptitude for providing care and a love of stories that would cement his future.

"I am a storyteller," said Murphy, who works as a GP in the regional Queensland city of Bundaberg and is making an historic tilt at the presidency of the Royal Australian College of General Practitioners (RACGP). If elected, Murphy will be the first Indigenous person to hold the role and the first Indigenous president of an Australian medical college.
“I talk and I write too much because I’ve got a lot to get out. And I have an opportunity to make a difference, which is why I am doing what I do,” he told Croakey during a recent interview.

Gunnedah-born Murphy will be the first to admit he took the road less travelled into medicine, a circuitous journey subverted by racism and the tyranny of low expectations, and fuelled by a love for Country and community.

He credits his maternal grandmother, a proud Kamilaroi woman, with instilling in him a fierce community spirit that set him on a path of service to others, and a drive towards the greater good.

At a time when so many Aboriginal children were being taken from their families, Murphy said his family escaped being taken by falsifying documents to erase their Aboriginal heritage, many fleeing to the stock routes to drove cattle and avoid undue attention from the authorities.

“I’ve got no extended family, because we don’t know who they are, they were so good at protecting us from that,” Murphy told Croakey on the sidelines of the recent National Rural Health Conference in Brisbane. “They were such strong people, they lived at a very different time.”

Murphy recalls his “strong, passionate” grandmother scrimping and saving every penny the government sent her while her husband was away at war, and supplementing her income by cleaning the local bank and solicitors’ offices in Gunnedah to save for a house deposit.

When his Pop deployed overseas, Murphy said he left a spartan dwelling with dirt floors and walls made from pressed kerosene tins; he returned to the comforts of their first family home.

“I get a bit teary at times about it,” he said.

**Career pathways**

Even as a boy, Murphy was always more likely to be found in the St John’s Ambulance tent than on the sports field, out with the State Emergency Service, or in uniform with the Naval cadets, where he found his niche as the corps medic.

He dreamed of being a doctor, but left school in Year 10 after a maths teacher told him he “wouldn’t amount to anything” and should pursue an apprenticeship. Instead, he decided to continue with the Navy.

“You could join at 15 years, 9 months. I joined at 15 years, 9 months and three days,” he said. “I jumped on a plane for the first time ever, went from Newcastle to Fremantle, and it was the best thing that ever happened to me.”

During his Navy service Murphy took a ride with NSW Ambulance in Sydney and, by the end of the shift, realised he had found his calling. He got out of Defence and reinvented himself as an intensive care paramedic, working across rural and remote NSW and responding to critical incidents including the 1989 Newcastle earthquake and 1991 Strathfield massacre.

He did six months at Uluru with the Royal Flying Doctor Service and had transferred to Canberra to work with ACT Ambulance when he got Ross River Fever and had to take two years off work.

It was during this recovery period that Murphy found himself flicking through the university guide, contemplating a switch to multimedia, when he opened on a page advertising the first new medical school in Australia for 20 years at James Cook University.

“I saw that as a sign, put in an application, and here we are,” he said.
**Workforce safety matters**

That inaugural JCU cohort had five Aboriginal students. Murphy was among the two that graduated, relishing the course’s focus on rural, remote, Indigenous and tropical health.

His studies took him from Doomadgee to Mount Isa and Proserpine to Longreach, and he trained under the stewardship of some foundational figures including former AMA president Dr Bill Glasson, RDAA and NRHA founder and ex-ACRRM president Professor Bruce Chater and Professor John Murtagh, a globally-recognised giant of primary care.

After internship in Townsville, Murphy followed Chater to the tiny town of Theodore, then struck out on his own as a Remote Vocational Training Scheme registrar to Eidsvold, where for four years he was the locality’s solo doctor – a challenge, in retrospect, he isn’t sure he would repeat.

“I worked myself into the ground. I was getting by on sort of two to four hours sleep a day, and after three weeks you just couldn’t string a sentence together,” said Murphy of the “terribly unsafe” working conditions, which culminated in him running off the road and narrowly missing a tree.

“Small country town medicine, it’s so hard when the system doesn’t support you.”

As someone who has lived the challenges of a remote posting, Murphy is passionate about doctors in training – many of them international medical graduates – who are sent to rural areas to fulfil their clinical obligations.

Too often, they are expected to juggle the competing and often confusing demands of practice administration, accreditation and studying for exams, isolated from their families and communities, Murphy said.

“We need to find ways to advocate so that these people are safe, they’re looked after,” he said. “We’ve got to find ways to increase staffing so that people don’t burn out.”
Vision for equity

Murphy presented at the 16th National Rural Health Conference on models of care in Aboriginal and Torres Strait Islander communities and lessons for mainstream health service provision.

Where the latter valued throughput, Murphy said the former placed a premium on spending time with the patient. “We’ve got to find ways to bring those lessons back into general practice”, he said, so that people appreciated, anew, the value of primary and preventative care.

“If we do the same thing the same way we will get the same result,” he said.

Murphy stressed that the shift away from bulk-billing, which has received a lot of political and media attention in recent weeks, would disproportionately impact the most vulnerable – including, but not limited to Indigenous peoples – and stood to erase “all the tremendous work we have done around Closing the Gap”.

Rather than a status quo where Aboriginal and Torres Strait Islander health strived for parity with non-Indigenous benchmarks, Murphy – who, as a registrar, was founding chair of the RACGP’s Aboriginal Faculty – outlined a vision where true equity flourished.

“If we do Aboriginal health really well, Closing the Gap becomes an impossibility to a degree, because it’s Aboriginal health that ends up driving the healthcare of our whole nation,” said Murphy. “I would be really proud of that, it’s one of the tenets I want to push for and I want to hold the government accountable to.”

Murphy reflected on a “mesmerising” keynote address at the National Rural Health Conference from Wiradjuri and Kamilaroi journalist, Stan Grant, which he said was both topical and confronting, and resonated deeply with his own experiences as a Kamilaroi man.

It spoke to the challenges of racism and division for health, and the critical role of GPs as brokers for peace and unity.

“Everything is very volatile, and I think if we don’t find ways to unite and make sure we build resilience in our communities, we are in strife,” said Murphy. “GPs are the cornerstone of that.”
Short and longer term perspectives

Murphy called for a diversity of voices and perspectives to address access and workforce issues, and for doctors to get “out of our silo mentality and start to work together” with approaches that were GP-led not GP-centric.

He applauded the new Labor Government for “saying the right things” but warned that they needed to be held to account and match their words with action – including adequate resourcing for initiatives like the Strengthening Medicare Taskforce to ensure it wasn’t “just another talkfest”.

Longer-term strategic action was welcome and well overdue, but Murphy said there was also a need for an immediate crisis response.

“We need change today, we need something to happen right now, and I think whatever that happens to be, it should be a rescue package,” he said.

“We did it for the nation when people were quarantining and couldn’t work. Now, we need to save our GP workforce. If we falter, it’s not just about us.”

Circling back to his own story, Murphy said his Kamilaroi grandmother would be “very proud of the man I have become” – a story that he hoped would inspire others.

“I want to tell our mob that, if you have got a big enough dream and you believe in yourself – not without sacrifice and not without investment – but if you really do believe in it, you can do whatever you want.”

"My inspiration" says Dr Brad Murphy – his grandmother, Hazel Jane Tailby.
With photos of him and his daughter Kiah and with Uncle Jimmy Little and Suzie O’Neill.

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