Dear Committee Secretary,

Services for Australian Rural and Remote Allied Health (SARRAH) was asked to provide some case examples of people residing in rural and remote Australia having to go to the city or metropolitan centre to get Allied Health Professional services as part of a Palliative Care Service which would have been more appropriately provided in the local community by various means. Two case examples follow:

Case Example 1 (deidentified)

Sally is an Aboriginal woman living on an island in Bass Strait. She is 49 years old and an elder in her community. She has chronic obstructive airways disease and cardiac disease. She is a reformed smoker and has complications such as diabetes and she is morbidly obese. Cardiac and pulmonary rehabilitation programs which are run by Allied Health Professionals have been repeatedly shown to increase the quality and quantity of life for people with the same problems as Sally. Sally received on site medical care via a Commonwealth-funded community controlled health service but to get any Allied Health Professional service she had to go to the mainland. She was resultant to leave her elder and family responsibilities and did not feel able to travel via a small plane and stay in the city centre to get the eight weeks program and as a result was only taken to the tertiary hospital when she was very sick. There is currently the Rural Health Outreach Fund (formerly known as MSOAP) programs available through the Commonwealth (as described in the SARRAH Evidence) that could support such programs to be delivered to remote and rural communities for a fraction of the cost of moving Sally and others like her from the remote community to the metropolitan centre for tertiary treatment.

Case Study 2

Tom was a 76 year old man diagnosed with prostate cancer. Tom lives in Western Queensland on a sheep property. He cared for his wife who has severe diabetes, and related cardiac disease. Part of Tom's story is that he was unable to get appropriate Allied Health Professional support services for his wife so her illness which could have been much better managed with dietetic and physiotherapy involvement was a burden on him as he tried to maintain his farm. Tom could also not get an Occupational Therapist to visit his farm to prescribe some environmental modifications to the family home to help Tom care for his wife. Tom could have benefited from both Physiotherapy intervention to assist him with his incontinence caused by the treatment of his prostate and also a Social Worker to assist him to gain appropriate respite and other community supports. Tom tried to hide his failing health and keep his farm and home in order and only received appropriate care in the provincial centre towards the end of his life away from his wife and farm. Technology such as that developed by Trevor Russell at the Queensland would have enabled Tom and his wife to access Allied Health Professional services From either the private or public sectors.

We hope that these case examples are of benefit to the Senate Community Affairs Reference Committee.

Regards

Rod Wellington I Chief Executive Officer