Past Conferences, Future Strategies

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Chairperson, Distinguished Guests, Ladies and Gentlemen. I am delighted to have the opportunity to be here today to speak to you at this very important gathering. This is the 5th biennial National Rural Health Conference and I have been fortunate to be a participant at each of them. This Conference comes at a critical time, foreshadowing an agenda for rural health to take us into the new millennium.

Rural health has been a matter of major concern for many years now. Yet it has only been in the last decade that any concerted effort has been made to address rural health issues. This National Rural Health Conference provides the opportunity to reflect on progress over the past decade, to identify what progress has been achieved and to ascertain those factors that have contributed most to the implementation of policies designed to address the health needs of rural and remote Australians.

Two factors above all others underpin all the significant advances and achievements that have brought about improvements in the health status of people living in rural and remote Australia - first, the involvement and collaboration of all key rural health stakeholders, and secondly, a strong base of evidence from which to formulate appropriate action.

Given the importance of these factors, it is appropriate that the theme for this conference is “Leaping the boundary fence - Using evidence and collaboration to build healthier rural communities”. Let me illustrate the role of these two factors both historically and into the future.

THE HISTORY OF THE NATIONAL RURAL HEALTH CONFERENCE

I shall begin with a couple of recent quotations. The first extract is taken from the Australian Institute of Health and Welfare’s 1998 report Health in rural and remote Australia:

Australia’s rural and remote populations have poorer health than their metropolitan counterparts with respect to several health outcomes … People living in rural and remote Australia have many health disadvantages compared with their urban counterparts.

My second quotation comes from The Best of Health - the Federal Coalition Government’s 1998 election manifesto for rural and regional health:

Australians living in rural, regional and remote areas do not access the same level of services as the majority of Australians living in the cities.
Clearly the state of health in rural Australia today is less than optimal. Moreover one might be forgiven for thinking that not much has been achieved in the past decade in relation to rural health since it was these very same issues that underpinned the Prime Minister’s Rural Health Care Task Force that was convened ten years ago to address the problem with rural health services. At that time that Task Force stated that:

…rural health services in Australia are in crisis and that all levels of Government and other interested bodies should be involved in urgent moves to address the situation. (Chater, 1992:4).

The Task Force’s preliminary report was the forerunner to the 1st National Rural Health Conference held in Toowoomba. The title of the 1991 Toowoomba National Rural Health Conference - A Fair Go for Rural Health - revealed much about the status of rural health. Despite the importance of the rural community in terms of its contributions to the comfort and wellbeing of the nation as a whole, for too long, rural health, indeed rural Australia, had been neglected. In the words of the Chair of the Toowoomba Conference Organising Committee “rural health became the forgotten country cousin” (Chater, 1992:2).

The Toowoomba National Rural Health Conference agenda focused on the major problems confronting rural health. The conference themes included:

- the health needs of rural and remote communities and particular groups,
- issues of education and training,
- overcoming disincentives to rural practice,
- resource allocation and infrastructure,
- Aboriginal and Torres Strait Islander health, and
- distance education technology.

Interestingly these issues were not new and had been highlighted many years before by health workers, rural communities, and health professions. In 1976 a report published by the Hospital and Health Services Commission entitled Rural Health in Australia identified major problems with respect to inappropriate service delivery and the rationalisation of hospital services, shortages of staff and services in many rural regions, inadequate access to services, and the state of Aboriginal health. In 1978 the Country Towns, Country Doctors Conference highlighted the many significant problems and disincentives facing the medical workforce in rural and remote Australia.

From the 1st National Rural Health Conference in Toowoomba an agreed strategy A Fair Go For Rural Health (Department of Community Services & Health, 1991) emerged for submission to Australian Health Ministers’ Advisory Council and subsequently for endorsement at the Australian Health Ministers Conference.

As more knowledge was acquired about rural health issues, so the themes of subsequent biennial National Rural Health Conferences changed in direction and emphasis. The access and equity theme of the Toowoomba Conference was enhanced by a focus on collaboration in the 2nd National Rural Health Conference held in Armidale, New South Wales in 1993 with the theme “A FAIR
GO FOR RURAL HEALTH-FORWARD TOGETHER”. The 3rd National Rural Health Conference held in Mt. Beauty, Victoria in 1995 sought to take stock of progress with its theme “THE POLITICS OF RURAL HEALTH-HOW FAR HAVE WE COME”. Two years ago in Perth, the 4th National Rural Health Conference looked forward to “HEALTH FOR ALL BY THE YEAR 2000”.

Today the problems associated with rural and remote health are widely recognised and the goal of optimal health for all Australians remains unchanged. This 5th National Rural Health Conference brings together an alliance of interested people and representatives from governments and a wide variety of stakeholder organisations that are dedicated to bringing about improvements in the health status of rural and remote Australians. Attention must now focus more on reviewing the impact of health care policy and delivery on the consumer, and identifying the catalysts that underpin the implementation of effective rural health strategies.

CONFERENCE RECOMMENDATIONS AND ACHIEVEMENTS

So what progress has resulted from the outcomes of previous National Rural Health Conferences? No fewer than 326 recommendations aimed at solving health problems of real concern to the rural and remote community have emerged from the previous four National Rural Health Conferences. These recommendations have focused on several themes of fundamental importance to the future of rural and remote health.

They include:

- workforce issues (such as education, training, use of technology, recruitment and retention),
- local management (including primary health care, hospitals, providers, consumers, community control and participation),
- service delivery (including multipurpose services, policy, funding, transport, and service models),
- research,
- public health,
- Aboriginal health, and
- the need for appropriate organisations (Clark & Martini, 1998).

In reviewing the implementation of conference recommendations since the 1st National Rural Health Conference it is clear that there have been some notable achievements. Conference recommendations have been a major impetus to rural health planning and service provision, and to activities designed to address workforce issues (in particular to improve the education and training of rural and remote health providers). Commonwealth and State Health Authorities have drawn on them as the basis for many initiatives funded through State Rural Policy Units, the Rural Health Support Education and Training program, and the previous General Practice Rural Incentives Program. These activities are exemplified in:

- the various incentive and affirmative action schemes for recruitment and retention,
- revision of curricula to reflect the needs of rural health practice,
education and training support for health workers,
student scholarships,
the establishment of rural health training units in regional centres,
funding support for conferences and organisations such as the National Rural Health Alliance, the Association for Australian Nurses and the Council of Remote Areas Nurses of Australia,
support for flexible learning and distance education packages, and
support to trial new information technology.

The focus on workforce issues is hardly surprising given the emphasis placed on workforce problems at each National Rural Health Conference and the continuing need for urgent action in this area.

While the significance of the practical workforce outcomes should not be underestimated, actions to date have been insufficient to overcome many of the problems relating to workforce recruitment and retention and ensuring adequate access to appropriate health care services. In the words of Max Kamien (1997: 179), "little of this pilot activity has been translated into major differences for how rural people access health care and use it to provide them with a better standard of health".

What is apparent is that those actions which are having the most lasting effect are ones founded on a solid basis of evidence. For example, there is now ample research to show that growing up in a rural community and experience in a rural practice as a student significantly influence a student’s choice of medical practice. Knowing this, university medical schools have been able to focus changes to their programs on student selection, the rural educational experience of medical undergraduates, and the provision of support systems for students and staff with a view to increasing the recruitment and retention of rural doctors. While it is too early to evaluate fully the outcomes of this program, there is little doubting that it has been an important catalyst for a change of culture and more appropriate medical training (Commonwealth Department of Health & Family Services, 1998).

Other less tangible outcomes from the conferences have been no less important. These outcomes are pre-requisites to ensuring ongoing improvements in the state of rural health and are critical in enhancing the capacity of rural Australians to maintain healthy communities in a changing health care environment. Let me comment on just three of these.

First, the National Rural Health Conferences have been instrumental in formulating and endorsing key recommendations which had led to, and underpin, specific rural and remote health strategies, policies and frameworks. The 1994 National Rural Health Strategy, the 1996 Update and today Healthy Horizons frame the policy environments which guide rural health activity (Australian Health Ministers’ Conference, 1994, 1996, 1999). Following its launch last evening, Healthy Horizons is particularly significant in reflecting the philosophy and principles which should underpin the approach to bringing about health improvements throughout rural and remote Australia. Recognising that the goal of equitable health care is most easily achieved before the need for
curative treatment and care arises, Healthy Horizons endorses the importance of a primary health care approach (World Health Organisation, 1978).

Another important achievement resulting from previous conferences has been their effect in galvanising a significant group of people who share the common concern of seeking to improve the health status of rural Australians. Through bringing together representatives from all the major rural health stakeholder groups the conferences formed the start of an ongoing consultative process between governments, professional bodies, universities and other agencies in the quest to address rural health issues. Since human resources remain the key to achieving change and betterment for rural communities, this collaboration is an important outcome. It is noteworthy that the National Rural Health Alliance, Australia’s peak multiprofessional non-government rural health organisation, was founded on the galvanising of rural health interests which followed the Toowoomba Conference.

Thirdly, the significance of the considerable social and geographical diversity of rural Australia is now fully recognised. Since “the diversity and individuality of this vast subcontinent does not allow for all-embracing or uniform solutions...” (Walpole, 1979:3) and since health issues vary from region to region, multiple approaches are likely to be most effective in improving the availability of health care in non-metropolitan Australia. Today, residents of different communities located throughout rural and remote regions will gain satisfaction from the fact that their specific health needs and issues are recognised in their own right and that full community involvement is now accepted as necessary and integral to bringing about improvements in rural health.

THE WAY FORWARD – FUTURE STRATEGIES

Despite the considerable progress that has been made in some areas since the 1991 Toowoomba National Rural Health Conference, there is much that remains to be done before the goal of “optimal health for all people in rural and remote Australia” will be achieved. I do not have time to list all the outstanding problems. However, prominent among the priority issues is the need to address the appalling state of indigenous health. This must be a priority of national concern. Particularly apparent too is the under-supply of appropriate health workers in rural and remote communities, and continuing problems of recruitment and retention. Moreover, the problems associated with inadequate and inappropriate services is exacerbated by the significant and worsening gap between the level of well-being in metropolitan and rural regions.

Arguably some of these problems persist because previous conference recommendations which possessed considerable merit have not been implemented. Other rural health problems requiring attention have emerged because of the changing health care and fiscal environment.
The critical concern now is how to accelerate progress towards bringing about improved health outcomes for rural and remote Australians. I believe that strong collaboration of all key rural health stakeholders and a sound base of evidence from which to formulate appropriate action remain the two most important things required to accelerate progress to overcome existing barriers that are responsible for the continuing poor health status characterising many rural and remote communities throughout Australia. Let me illustrate.

**Collaboration as a means for changing attitudes and mindsets**

One of the major impediments to overcoming rural health problems remains the mindsets and attitudes held by key decision-makers responsible for resource allocation and policy implementation. Ours is a plural society characterised by a diversity of interests and values over which stakeholders often disagree. It is important to acknowledge this. We need to appreciate and accept these differences and diversity of viewpoints and use this understanding to enrich the policy and enhance the chance of success. At the same time we need to ensure that attitudes towards, and knowledge of, rural Australia in general, and rural health in particular, are not based on ignorance, unsubstantiated myths and false stereotypical images. Collaboration can be a vital tool for overcoming attitudinal barriers between city and country, and even among rural health stakeholder organisations, which hinder progress towards improvements in the status of rural health.

First, the city-country divide. Recently the media have given considerable coverage to the social and geographical polarisation characterising Australia today. The myth of egalitarianism is dispelled when one explores the chasm that exists between urban and regional Australia in terms of employment outlook, health services and educational opportunities. The traditional mutual self-reliance, sense of place, solidarity and resourcefulness characteristic of most rural communities is no longer sufficient to overcome many of the effects of polarisation brought about by market forces. Calls for intervention to counter the negative impacts of economic rationalist policies and market forces on effective regional development have become louder, led somewhat ironically by people such as Malcolm Fraser.

At the 2nd National Rural Health Conference it was reported that “Rural health has come of age in Australia … and is now a vital and respected element in our nation’s health scape” (Owen, 1993:17). I would argue that much remains to be done in order to ensure that rural health is seen by all Australians as a distinctive, legitimate and important field of endeavour. No-where is the need to understand rural health issues greater than in metropolitan areas where governments, many universities and training institutions, professional organisations and the media have their head-quarters. Within many of these organisations, there persists widespread ignorance of rural issues, aggravated by a perception that life and work outside of metropolitan cities are somehow second status. Such a perception must be changed. The significant contribution of rural and remote Australia to the national economy, well-being and psyche and the important symbiosis between city and country needs to be recognised.
and encapsulated in a national vision which fully acknowledges the importance and value of rural communities and rural development. At the moment Australia lacks such a vision, something which has undoubtedly impeded sustainable economic and social development in rural Australia.

Part of what is needed to develop such a national vision, to overcome the divisiveness that separates city and country, and to bring about change in attitudes and mindsets is the opportunity to discuss key over-arching issues that are so fundamental in determining the health of the nation. These issues include an assessment of:

- the sort of society we want in Australia;
- the costs to society as a whole of maintaining increasing levels of social and geographical inequity;
- the need for and importance of reconciliation;
- the role of the state in serving and maintaining the type of society we want; and
- whether there are any health service access rights to which all people should have access regardless of where they live (Humphreys, 1999).

Australia can no longer afford to drift aimlessly at the whims of the marketplace. Just because a person lives in a remote or small isolated rural community it should not follow that they are therefore condemned to a diminished set of life chances, health status or quality of well-being. The outcomes of such debates provide the basis for determining the allocation and distribution of resources and consequently the structure of the health care system. In turn they determine government commitment and capacity to implement policies.

At the same time that we seek to bond city and country more closely, it is necessary to maximise the common ground within the rural health constituency and overcome the differences that form divides between bureaucrats and health workers, between professional organisations, between medical and health ideologies, between indigenous and non-indigenous Australians, and between the Commonwealth and States. Successful collaboration and teamwork requires that sometimes we step outside of our personal world so that the policy process does not get waylaid by personal prejudices and professional jealousies. Health professions and institutions, while safeguarding the interests of their constituents, must be cognisant of the need to relinquish blinkers and prejudices that hinder the attainment of agreed rural health goals and targets. They may even need to make some sacrifices in order to achieve a collective good that is greater than the sum of the parts. Conferences such as this one can enhance the scope for maximising the area of commonality among rural health stakeholders.

Research and evidence based-activity

‘Big picture’ debates around the issues I am advocating provide the opportunity to develop shared visions and agreed approaches to guide policy. Rural health policies outlining specific activities require a solid foundation based on evidence. Rural health care policy in Australia, with few exceptions, has been characterised by a process of incremental change (Lindblom, 1959), with progress towards policy goals based on the evaluation of previous predictions.
against outcomes. Herein lies the rationale for sound rural health research and evidence-based activity. Given resource limitations, it is vital to concentrate our resources where the need and scope for bringing about health status improvements is greatest. It is through research and evidence-based evaluation that we know what is efficient and what makes a difference to people’s health and what doesn’t.

Evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of patients (Sackett et al. 1996). Applied to populations in different rural and remote communities, an evidence-based approach can determine the most effective interventions. It can help to identify situations where changes in services can achieve improved health, as well as highlighting those areas of practice where additional strategies or services may be required (Alperstein & Nossar, 1998:110). The agenda outlined in the Healthy Horizons framework not only identifies priority areas, but also incorporates the basis for benchmarking standards against which all stakeholders can monitor and evaluate progress.

Concurrent with evidence based evaluation is the need for a strong research program. Importantly research is much more than simply collecting data. Data are simply unrelated facts, the raw material of information. As building blocks for knowledge data are important and ongoing data collection is necessary. For example, understanding health status differentials and recruitment and retention issues requires much more data to be collected on health status and workforce indicators. However, we must be conscious that we do not focus solely on data collection. The world is full of ‘data cemeteries’, while at the same time the need to address and resolve major social problems is becoming increasingly urgent.

The real challenge for research is to process data into some useful form that contributes to knowledge (Martin, 1988, 8). Stated simply research is about rendering the unknown knowable. Research should always be problem driven, not data driven. Solutions to problems will only emerge with an understanding of phenomena. Unless the data are turned into information that can be understood by, and disseminated to, its intended audience, there is little likelihood of it resulting in any sort of change. In the absence of dissemination of research findings “the majority of health workers at the rural and remote coalfaces have either never heard of this activity or do not have their day-to-day work influenced by it in any way” (Kamien, 1997:179).

No doubt there are many rural health issues that require further research. One critical research problem is the link between geographical location and the “fundamental social causes” which underpin rural health problems. While geographical location and the tyranny of distance continue to impact upon rural health problems, “rurality” and “remoteness” need to be considered alongside a wide range of other determinants which impact on the health status of rural and remote Australians.
Unless we understand what factors put people at risk of exposure to illhealth, our efforts to change behaviour may be hopelessly ineffective. Focusing on individually-based risk factors such as diet, cholesterol level, exercise and the like is not sufficient. The fundamental causes of ill-health relate to social factors such as socio-economic status and social support (Link & Phelan, 1995). These involve access to resources such as money, knowledge, power, prestige and social support that can be used to avoid risk to health or minimise the consequences of disease once it occurs.

What this means is that we need to examine and understand how general resources like money, knowledge, power, prestige and social connectedness are translated into health-related resources that generate patterns of morbidity or mortality. If we wish to alter the effects of determinants of ill-health, we must do so by directly intervening in ways that change the social conditions themselves and the inequality they entail. Some might argue that this is impractical. Because inequality is entrenched, nothing can be done. This is not so. There are many policies that have a direct bearing on the extent of inequality in our society and thus on the extent to which different people from different social circumstances have access to health related resources - for example, minimum wage, housing for homeless people, transport, capital gains tax, parenting leave and other such initiatives. While they may lie outside the domain of health policy experts, the potential health impact of these broad policies needs to be thoroughly understood. Nowhere is this more so than in rural and remote regions.

It is heartening to note that Healthy Horizons now incorporates acknowledgment by governments of the need for a whole-of-government approach to solving the problems characterising rural and remote health.

CONCLUSION

Let me bring my address to a conclusion. It is apparent from our current state of knowledge that there is no simple solution to the health challenges confronting rural and remote Australia. With collective commitment and goodwill I believe that these challenges can be met. In this regard it is apposite to reflect on the words of one of Australia’s greatest ambassadors for rural health. In 1993 Col Owen outlined three requirements in order to go forward:

- we need the perspicacity and honesty to recognise the truth, based on good research;
- we need the wisdom to make the right decisions, based upon this good evidence; and
- we need the courage, where necessary, to stand up and say that this is not the right way to go.

These requirements remain as valid today as six years ago.

I have argued strongly that continued collaborative activity based on sound evidence is critical in order to accelerate progress. The collective wisdom of delegates attending this conference is very considerable. It is vital that we harness this knowledge, expertise and experience to produce the best possible outcomes. Backed with strong endorsement of Conference recommendations and the Healthy Horizons framework and with adequate resourcing by
governments, communities throughout rural and remote Australia can face the new millennium not in the nostalgic way portrayed by Kenneth Slessor as ‘sleepy’ country towns but with the prospect of vibrancy, sustainability and optimism. This conference will play a vital role in providing the momentum required to ensure that the goals outlined in Healthy Horizons are achieved. Only then will residents of rural and remote areas be “as healthy as other Australians and have the skills and capacity to maintain healthy communities”.

Thank you all for your attention.

REFERENCES


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