'Rural proofing' is the notion that it is practicable to require policy makers across all government departments to ensure that the interests of rural people, communities and businesses are considered in the development and implementation of all policies and programs - and that those policies and programs are amended if damage is likely to be done.

It is difficult to assess the actual level of impact of such a requirement on policies and programs and their impact on the health and wellbeing of country people. It is in effect 'Rural in all policies' - first cousin to 'Health in all policies'.

**The rural proofing process**

To be effective the rural proofing process requires policy-makers across all government departments to ensure rural people are consulted and that the needs and interests of rural people, communities, primary industries and businesses are considered *and acted upon* in the development and implementation of all policies and programs. Policy makers must consider whether the policies they are developing will have any impacts on rural areas, assess the significance of those impacts and, where appropriate, adjust the policy to ensure that the needs of those who live in rural areas are addressed and the risks mitigated.

Rural proofing may recognise that rural communities do not necessarily require the same outcome or exactly the same level of service as their urban counterparts but rather that policies should be sufficiently flexible to apply fairly in all areas and deliver quality services that meet the needs of those living in all areas.¹

One means in which rural proofing may be done is through the preparation of Regional Impact Statements (RISs). These require consultation between an agency and rural stakeholders in order to assess and understand the nature, quantum and timing of a planned change to the standard or level of an existing service provided to rural and regional communities. It should identify the consultation, assessment and research that has occurred and the anticipated social, economic and environmental implications of the change for the principal users or beneficiaries of that service.

**International experience**

Over the past decade, a number of countries have introduced rural proofing as part of the attempt to address the inequities that exist in health service provision across urban and rural areas, and there are lessons to be learned. Progress with rural proofing has been patchy and inconsistent, and the reasons commonly cited for this include:

- a lack of awareness among policy makers of their rural proofing responsibilities;
- the failure of action agencies to take up information, advice and guidance about rural proofing;
- inadequate use of the evidence on what the rural effects would be;
- failures in consultation and engagement;
- the lack of a systematic approach to addressing rural proofing within Impact Assessments;
- the treatment of RISs as merely a 'tick box' exercise;
- a lack of time for thorough consultation and analysis;

proofing overload (with policy makers possibly having to undertake rural, climate change, ageing and sustainable development proofing amongst others); and

- a lack of direct evidence of rural proofing outcomes.²

The requirement of making RISs public appears to prompt a more considered approach, to the extent that more effort is put into community engagement and mitigation of any potentially negative impacts to the region and businesses concerned. Making them public also increases both political risk and its corollary: political risk to the government of the day.

Where rural proofing has been implemented more successfully, the policy areas have embedded the rural proofing process within key policy making processes, applied rural proofing to the design and delivery stages of policy development, and received strong support for rural proofing from senior officials. Its implementation is also largely dictated by three main factors: adequate guidance on the process by which issues are identified, defined and presented for consideration and action; the skills and expertise of the people undertaking the consultation or impact assessment; and the ease with which relevant resources and information can be gathered.

Feedback from policy makers suggests it clarifies and confirms the objectives of the project; promotes risk mitigation; establishes ongoing networks; can be used to shore up funding; provides for the collection of data and its centralisation; allows better decision-making; helps to streamline the approval process; creates greater empathy of Government with constituents; helps to develop in-house research and analysis skills; can be used to inform/educate the community; and provides feedback/public accountability.

**Rural proofing in Australia**

All states in Australia, with the exception of New South Wales, have embedded RISs into their Cabinet submission process and, by doing so, made it a mandatory consideration. However, the consideration of the impacts is subject to Cabinet confidentiality and not open to public scrutiny, making it difficult to assess the extent to which the rural impact is considered in the policy-making process. South Australia, however, extends its Cabinet submission process by requiring submitting agencies to release the RIS report (which accompanies the Cabinet submission as an attachment) to the public, thereby increasing transparency of decision-making.

Each state has its own requirements for the preparation of RISs and the agencies to whom policy makers are accountable. South Australia provides the most developed publicly available example of the policy’s implementation. It was the first state to integrate rural proofing into the policy making process. It has a clear, easily locatable [Regional Impact Assessment Statements Policy](http://www.ghkint.com/Services/PublicPolicy/RuralDevelopment/EvaluationofRuralProofingActivitiesinGovernm.aspx) and [A Guide to Regional Consultation](http://www.ghkint.com/Services/PublicPolicy/RuralDevelopment/EvaluationofRuralProofingActivitiesinGovernm.aspx) to support policy makers.

**Health in all policies**

The Health in All Policies (HiAP) approach is built on the rationale that health status is determined by multiple factors outside the direct control of the health sector, such as education, income, housing and transport. Policy makers in other sectors routinely consider health outcomes, including health benefits, harms and health related costs in making their decisions. The health sector supports these other sectors to achieve their goals in ways that can also improve health and wellbeing.

South Australia is considered to be one of the international leaders in implementation of Health in All Policies. It commenced there more than 5 years ago. The South Australian HiAP model includes two

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² Evaluation of Rural Proofing Activities in Government, ICF GHK,
key elements: central governance and accountability; and a Health Lens analysis process. These are explained here.

Possible asks

The Alliance calls on the Government to undertake formal rural proofing of all proposed health-related policies and programs to ensure they are sensitive to the probable significant differential impact in rural and remote Australia. This process should be thorough (i.e. not simply a tick box exercise) if it is to have any real value. All Governments should follow South Australia's lead by requiring agencies to release their RIS report (which accompanies the Cabinet submission as an attachment) to the public, thereby increasing the transparency of decision-making.

The Alliance would also like to ask the parliamentarians:

• "Are you aware of the importance and benefits of rural proofing?"
• "How (if at all) do you and your colleagues carry out the process?"

The Alliance encourages policy-makers to recognise the importance and benefits of rural proofing and, whether required to or not, consider the following in the development and implementation of all policies and programs:

Aspect 1: Service delivery
• Are the services available in rural areas?
• Where and how will services be accessed in rural settings?
• Will rural patients experience continuity of care?
• Are there any challenges in ensuring services are delivered safely and effectively in rural areas?
• Are there areas of inefficiency and wastage in the delivery of these health services in rural areas?

Aspect 2: Workforce
• What kind of health care workers are needed to implement this policy in rural areas?
• What skills are needed to implement this policy in rural areas?
• Are the health care workers with the necessary skills available in rural areas?
• Are there problems with workforce numbers or distribution that will affect the implementation of this policy?
• Are there are ready solutions available that might help address workforce shortages?
• What sort of training is required to ensure this policy is successfully implemented in rural areas?

Aspect 3: Health information systems
• What key indicators are needed to assess the impact of this policy in rural areas?
• Are these indicators routinely collected?
• Are these indicators publicly reported?

Aspect 4: Access to essential supplies (e.g. medicines)

3 Feedback from policy-makers suggests rural proofing clarifies and confirms the objectives of the project; promotes risk mitigation; establishes ongoing networks; can be used to shore up funding; provides for the collection of data and its centralisation; allows better decision-making; helps to streamline the approval process; creates greater empathy of Government with constituents; helps to develop in-house research and analysis skills; can be used to inform/educate the community; and provides feedback/public accountability.
• Are patients in rural areas likely to be able to access necessary supplies (e.g. medicines, equipment)?
• What could be done to facilitate access to necessary supplies?
• Are there any risks to supply chains in rural areas that need to be considered?

Aspect 5: Financing and budgeting
• Have the costs of implementation in rural areas been considered?
• Have the costs associated with accessing care been considered for rural patients?
• Have health worker costs associated with this policy been considered?
• Have additional supply chain costs and diseconomies of scale in rural areas been considered?
• Are there alternative ways of delivering services in rural areas that would reduce costs without compromising quality or effectiveness?

Aspect 6: Governance and leadership
• For this policy to work in rural areas, is it necessary to have different delegations of authority?
• Will the oversight processes and systems in place be adequate in rural areas?
• Are performance monitoring systems in place functional in rural settings?
• Are rural stakeholders actively involved?