NATIONAL RURAL HEALTH ALLIANCE INC.

2001 Election Charter

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NATIONAL RURAL HEALTH ALLIANCE INC.

The National Rural Health Alliance (NRHA) is pleased to present its Election Charter for 2001.

The Alliance is the peak non-government rural and remote health organisation working for good health and well-being in rural and remote Australia. It is comprised of twenty-two Member Bodies representing consumer and health provider organisations. Each Member is a national organisation in its own right and its affiliation to the Alliance is regularly accredited. A list of the current Member Bodies is at the end of this document.

The Issue Statements within the Charter represent the agreed position of the twenty-two Member Bodies of the National Rural Health Alliance but not necessarily the entire view of all individual Member Bodies.

They should be seen in the context of the Alliance's general priorities, which are family issues, political empowerment, workforce and infrastructure. There are many other specific issues within the general framework to which the Alliance is committed and on which it is working. These issues include some of those endorsed by participants at the 6th National Rural Health Conference.

The agreed Issue Statements will be used as a benchmark upon which the major political Parties' Election Platforms in health and rural affairs may be measured. It is hoped that they will inform the decisions of rural health policy makers, managers, researchers, consumers and professional bodies for the decade of commitment that is needed in rural development and rural health. If that can be achieved it will build significantly on the positive developments in rural and remote health over the past decade.

If you would like to make comments, we would be pleased to receive them.

The NRHA 2001 Election Charter will also available on the NRHA website at www.ruralhealth.org.au

We hope that you find the statements useful and informative.

Gordon Gregory
Executive Director
September 2001

Nigel Stewart
Chairperson
September 2001

These Issue Statements were adopted by the Council of the National Rural Health Alliance (NRHA) face-to-face Council Meeting on 15 September, 2001. They are published as part of the Alliance's core work to promote good health and well-being in rural and remote Australia.

The Vision of the National Rural Health Alliance, as the peak non-government rural and remote health organisation, is good health and well-being in rural and remote Australia.

The National Rural Health Alliance (NRHA) is a collective of national organisations which represents the consumers and/or providers of health services in rural and remote Australia. The NRHA is comprised of such organisations as are admitted as Member Bodies from time to time.

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NATIONAL RURAL HEALTH ALLIANCE INC.

Successes of the Past Ten Years

Governments and community leaders have led some significant developments in rural and remote health over the past ten years. They have responded to some of the justified calls for action and there have been significant successes. They include the following:

- the sequence of programs beginning with Multi-Purpose Services and resulting in the Regional Health Services Program;
- the first and second National Rural Health Strategies, leading to *Healthy Horizons* which is still current;
- budget 2000 – in which $670m was allocated over four years to new initiatives in rural and remote health. (This builds up from a low base in 2000/1 to substantial new resources in 2003/4);
- enhancing the voice of rural general practice, including through Divisions of General Practice;
- building the capacity of University Departments of Rural Health and Rural Clinical Schools;
- a significant emphasis on rural mental health; and
- beginning to provide some national leadership on rural nursing, pharmacy and allied health.

The Alliance is pleased to have been involved in these initiatives but it makes the point that there are still major deficits in the status of health of people in rural and remote areas and in the level of their services. This Election Charter provides constructive proposals for adding to these past developments.

NATIONAL RURAL HEALTH ALLIANCE INC.

30% FAIR SHARE FOR RURAL HEALTH

Recommendation

The Federal, State and Territory Governments should commit to spending 30% of the overall health dollar in rural and remote areas. 30% of Australians live outside the metropolitan centres. Over time this 30% should be increased to include a loading to reflect the poorer health status and the higher cost of delivering a unit of health care and the higher cost of infrastructure development such as education, transport and communication.

Background

The health status of people living in rural and remote Australia is poorer than that of people in metropolitan areas. There is a higher rate of mortality and higher incidence of cardiovascular disease, preventable accidents, cancer and diabetes. Health status declines along a continuum as one moves away from the capital cities. The health status of Australia's Indigenous Peoples, a high proportion of whom live in rural and remote areas, is comparable with some third world countries.

Key factors contributing to this poorer health status include lower socio-economic and employment levels, risky behaviours, occupational and environmental hazards and a lack of health services. Critical shortages of health professionals combined with the lack of public transport and less access to communication networks in rural and regional areas makes access to health services very difficult for the financially disadvantaged, the aged, sick, disabled and people who do not drive. The lack of access to GPs, nurses, midwives, pharmacists, dentists, and members of the allied health professions undermines the delivery and utilisation of health services in rural and remote areas.

The backbone of the Australian health system is the publicly funded Medicare program. While eligibility for Medicare is unaffected by location of residency, difficulty recruiting a full range of health professions, in combination with long distances, means that access to the services provided through Medicare is more difficult in rural and remote areas.

On average, people in rural communities receive $92 per year in Medicare services compared with $145 in urban areas. The difference is even starker in remote areas. Rural people receive $460m (19.6%) of the total $2.3b of Medicare rebates for non-referred consultations. $250m in additional Medicare funds would achieve the "30% fair share" for rural people on this measure alone.

Some of this gap may be offset by the increased use of other services in rural and remote areas, such as hospital services, salaried community medical services (including the Aboriginal Medical Services) and other primary care providers such as Aboriginal Health Workers and remote area nurses. However, the use and availability of non-Medicare services does not fully compensate for the discrepancy between rural/remote and urban benefits from Medicare.

NATIONAL RURAL HEALTH ALLIANCE INC.

AGED CARE

Recommendation

The Federal, State and Territory Government should allocate additional growth funding to home and community care program specifically for rural areas, to address the current and growing gap in available services, including for appropriate residential accommodation in rural areas for elderly people. The goal of this should be to ensure that people can be effectively and appropriately supported to live at home and remain in their rural community. This will help in the recognition that if 'Ageing in Place' is to be a reality in rural and remote communities, adequate funding must be provided.

Background

The demographic profile of rural and remote communities continues to age with 14% and 16% of their respective populations aged 65 years or over compared with the national average of 12%.

The provision of aged care services in rural and remote areas presents many challenges in relation to the higher cost of goods and services, access to specialist health care professionals such as doctors, nurses and allied health professionals and lack of professional networks. The smaller catchment areas for rural and remote services often means that they cannot achieve the economies of scale of larger facilities and services in urban areas.

The current allocation of funds to improve and upgrade facilities and services in rural and remote areas continues to be inadequate to address the problems. The concept of Ageing in Place is a dream for many rural communities and unless additional funding is forthcoming will continue to be a dream.

The realities of the ageing rural population, the isolation of communities and the aged members of those communities, the lack of appropriate aged care services to support people to 'age in place' are not recognised in current funding provisions.

The current Review of Aged Care Planning for Rural and Remote Areas is structured around three objectives

- better planning;
- better funding; and
- better information.

In planning for rural aged services there needs to be more emphasis placed on the funding of services based on the assessment of community needs and improving the connection between rural communities and the aged care program.

Resources should be allocated on the basis of known programs that work well in rural and remote areas.

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NATIONAL RURAL HEALTH ALLIANCE INC.

ARTS-IN-HEALTH

Recommendation

Without diverting existing health expenditures or reducing the investment in mainstream health services, funding for arts-in-health projects and art-based health services should be increased. This increased funding should be provided by both health agencies as well as arts bodies.

Governments and arts organisations should collaborate on rural and remote programs for arts-in-health and arts in community development.

Background

Participation in arts activities, both as a practitioner and as a viewer, contributes significantly to individual and community health. Regular creative practice promotes well-being.

The 6th National Rural Health Conference, March 2001, recognised and celebrated the powerful role of the arts in improving health outcomes. The 6th Conference showcased projects from across the Australia which demonstrated the effectiveness of individual and group art practice as a means of promoting health. Successful health projects demonstrated the potency of art practice for promoting health and well-being. Many projects also highlighted the effectiveness of art as a medium for communication and discussion of health issues.

Whereas the role of sport and recreation in preventative health is well accepted and fits culturally with Australian values and norms, there is still need to recognise and encourage arts-in-health. The value of arts practice and participation is well accepted by many health professionals and yet arts projects would appear to be relatively underutilized given their potential for promoting individual and community health.

It is possible that arts projects and arts-based health services are currently underutilized and underfunded because these projects and services are not recognised as mainstream health programs. At present, arts-based projects and services are more commonly viewed as special projects and are funded only by arts programs and almost never from mainstream health programs.

Given the potential benefits for rural and regional health it is considered important that arts-based projects and services become more acceptable for funding by health agencies, without reducing current allocations to mainstream health programs and professions.

'Arts-in-health' *is the term used to describe a range of artistic activity used directly to improve health outcomes. It includes theatre, music, fine art, photography, dance, story telling and writing.*
The NRHA's main interests in arts-in-health are two-fold: one, for its use as a means of communication, education or promotion tool (eg theatre to explain and promote understanding of cancer, men's health or substance abuse); two, for its direct therapeutic effect on individuals and communities (eg painting and singing as therapy for individuals or singing or dance workshops as a means of community development).

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NATIONAL RURAL HEALTH ALLIANCE INC.

CHILD HEALTH

Recommendation

Commonwealth, States and Territory Governments should commit to a partnership to explore the new knowledge on childhood development, both Australian and international, and then apply this knowledge to model programs in every State and Territory. Each of these programs should be in a rural or remote region, and priority should also be given to regions with a significant Indigenous population. These models should be evaluated and then applied systematically to improve children's education, health and welfare. An emphasis should be on the early years - in particular pregnancy, the birthing process, infancy and pre-school years.

Background

Australia has a National Child Health Policy, dated from 1993. This document is rarely referred to. There is a need to revitalise children's health. Australia has excellent child health services in terms of children's hospitals and specialist and sub-specialist care.

Major developments worldwide in child health have acknowledged the social determinants of health, which affect children as much if not more than adults, and the fact that many factors of our future health, both physical and psycho-social, are determined in the first four years of life. Other nations, such as Canada with its 'Early Years Study', have acknowledged the importance of this issue.

In Australia there has been much interest in child health circles in these programs. The international knowledge and literature has been applied in a number of urban settings in almost every State and Territory. However there have been no trials or systematic applications of this knowledge and early intervention studies in rural and remote Australia.

The studies have also not been comprehensive, often targeting particular groups. It is proposed that international and Australian knowledge be collated and then applied in individual States and Territories with different models and different types of service. These would need to be evaluated independently and then the Commonwealth, State and Territories, as part of a renewed commitment to children and to child health, would be in a position to apply effective interventions to improve physical and psycho-social health of rural and remote Australian children.

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NATIONAL RURAL HEALTH ALLIANCE INC.

FLEXIBLE EDUCATION FOR HEALTH CARE PROFESSIONALS

Recommendation

The Federal Government and relevant educational bodies should ensure that undergraduate curricula for all health disciplines include health promotion, primary health care, population health and *cultural safety* components. This will help to ensure the provision of high quality health services that meet the needs of people in rural and remote areas.

Background

Education and training emerged as major issues in the 6th National Rural Health Conference. Delegates stressed that the maintenance of a high quality health service in rural and remote Australia is contingent upon the continuing development of flexible education and training programs that are locally, culturally and socially appropriate.

> ***'Cultural safety'*** *is about all practitioners having a minimum level of competence and knowledge of Indigenous and multicultural communities to enable them to practise with those patients effectively, safely and with due diligence.*

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INDIGENOUS HEALTH

Recommendation

The Federal Government, through the Prime Minister and Cabinet colleagues, should lead a national campaign to improve the status of health of Indigenous people. This will involve action by a range of departments, including the Department of Health, and by other levels of Government and Indigenous community organisations. The campaign should be informed by two other principles. The first is self-determination for Indigenous people. The second is an emphasis on primary health care services and community capacity building. The campaign will be cognisant of the recommendations of three major reports into Indigenous affairs over the last decade: the National Aboriginal Health Strategy (1989), the "Bringing Them Home" - National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children (1997) and the Royal Commission into Aboriginal Deaths in Custody (1989). It will also build on the findings of the Aboriginal and Torres Strait Islander Coordinated Care Trials National Evaluation (2001).

Background

The morbidity and mortality rates for our Indigenous peoples are higher than for any other group in Australia. In the more remote areas of our country these rates are similar to those applying in third world countries.

The issues involved in Indigenous health are complex and challenging. The importance of working in partnership with Indigenous people and organisations is critical. The involvement of the community-controlled sector that includes in excess of 90 rural and remote Aboriginal Medical Services is vital.

There have been three major reports on Aboriginal issues in recent years that have addressed issues to improve Indigenous health. The major recommendations of these reports relate to health service infrastructure, intersectoral collaboration, social justice and self determination, land and cultural integrity, training and education, juvenile justice, women's business, alcohol and substance abuse, family reunion, violence and racism, and physical infrastructure such as housing, sewerage, water supply and communications. Many of the recommendations in these reports are still to be implemented. The reports emphasise the need for primary health care services that recognise the value of community leadership.

There is a dire need to expand resources of both Indigenous and non-Indigenous staff in the provision of health care services. Chronic disease in Indigenous Australians is not adequately addressed. There need to be positions identified and funded specifically for the treatment and prevention of chronic disease.

Strong bipartisan political commitment to improved health status of Indigenous Australians is required, as well as strong national leadership and inter-governmental collaboration.

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IT CAPACITY, HARDWARE AND TRAINING

Recommendation

If the contestability processes announced by the Government do not have the effect of materially improving service levels in regional, rural and remote areas, the Government should reassess policy measures, including the Universal Service Obligation (USO), with a view to ensuring the contemporary telecommunications needs of all Australians are met. (From the Besley Report[1])

The Government should establish a national communications fund to assist significant communications projects by key users such as education or health. A core criterion for funding such projects should be the extent to which they will also improve communications services generally available to surrounding regional, rural and remote communities. (After Besley.)

Background

The Besley Report says in part:

> *Australians living in (rural and) remote areas need telecommunications services to offset the social effects of isolation, as a stimulant to the local economy, and as a means of accessing other services such as education, business information and banking.*

Health services, especially in remote areas, can clearly benefit from improved telecommunications. IT is fast becoming an indispensable tool for rural practitioners, researchers and educators. However, effective use of the new technologies is hampered by lack of skills and of ready access to IT supports. Ongoing training and support are essential to ensure that practitioners gain confidence in use of the system. Training is also required so that the systems, once in place, can be effectively used.

On the **supply** side, service availability can be a problem in rural and remote Australia where terrestrial telecommunications infrastructure is often sparse and technically limited. On the **demand** side, socio economic factors – such as income, education levels, employment status and type, language and cultural background, age, gender and disability – can be a barrier. Where both factors are not optimal, such as in rural and remote Australia, the impediments to meeting demand can be particularly pronounced.

While there have been great improvements in service delivery, it is of concern that the ongoing advances in telecommunications continue to bypass many rural and remote communities. Particularly affected are those customers who are still struggling with costly Internet access and frustratingly slow line speeds.

As the State of the Regions 2000 report emphasised the Internet is now used for text, images, sounds, software, video and telephony. Efficient use of these services requires reasonable access and transfer speeds. This in turn requires a broad bandwidth connection. That report recommended access to a minimum standard of 128 kbps by 2005.

The ‘digital divide’ is likely to widen, unless new initiatives are put in place to equip rural and remote business and communities with digital skills, relationships and local applications to

enable them to continually upgrade skills and assist them to be incorporated into electronic networks that adds value to their activities.

The continuing advances in telecommunication, information technology and telehealth offer a significant opportunity to improve the effectiveness and efficiency of health services in regional, rural and remote regions. The aim is to choose those technologies which are both cost effective and address high priority health needs.

Telecommunications can be carried out either by telephone or by using video conferencing which can be augmented by pictures of Xrays. Telehealth in this fashion has been used successfully in specialties as diverse as psychiatry, orthopedics, dermatology, renal medicine, medical oncology and emergency medicine. It can be used also for interpreter services and continuing education for health care professionals.

None of the above is a substitute for face-to-face contact with rural and remote health professionals.

[1] Telecommunications Service Inquiry ('The Besley Report'), September 2000.

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MEN'S HEALTH

Recommendation

The Department of Health and Aged Care (DHAC) should fund research on men's health which draws on the methods and strategies developed by the Australian Longitudinal Study on Women's Health (ALSWH). At the same time DHAC should continue to provide funding for the ALSWH and its results should be further promoted. There should also be the development, within two years, of a National Male Health Policy that encompasses all Australian males.

Background

The discrepancy in the levels of health of males and of females is especially significant in rural and remote Australia. Men typically go to the general practitioner (GP) or hospital only when they have symptoms, rather than practising preventative health care. Men need to reduce risky behavior patterns, seek regular check-ups and adopt healthy lifestyle practices. A research program in this area will go a long way to reducing the male mortality rate and provide a pathway for men to enjoy a happy, healthy and longer life.

Men are the lowest users of preventative health services, have been described as the sickest group in society after Indigenous Australians and are more likely to die from all selected causes than women. Only a small proportion of these differences can be attributed to genetic factors and these are less important than adverse lifestyle factors adopted by males. There is a growing recognition of the importance of social factors, such as norms associated with masculinity, lifestyle, health habits and propensity to seek treatment.

What is needed from a sociological perspective is a better understanding of the male psyche, maleness and masculinity to try to identify strategies to overcome men's traditional attitude to their health. Men do not talk candidly about their own health even to other men.

A strong research model is provided by the Australian Longitudinal Study on Women's Health. There are also some good grassroots programs in place, including the model advanced by the Centre for Advancement of Men's Health (CAMH), a collaboration of the Men's Awareness Network (MAN) and Hepburn Health Service in rural Victoria. The purpose of CAMH has been to pilot and evaluate different strategies that enable men and adolescents to effectively address health issues of relevance to them in a community context.

The mobile men's health package called 'Pit Stop' developed by the Gascoyne Public Health Unit and Compari Community Drug Service Team of Carnarvon, WA, is another valuable model in this area.

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NATIONAL RURAL HEALTH ALLIANCE INC.

MENTAL HEALTH

Recommendation

The Commonwealth, State and Territory governments should focus their mental health funding in rural and remote areas on building partnerships between health and welfare providers and local communities, as well as on other strategies. These partnerships would address locally identified mental health needs, in particular mental health promotion, illness prevention and suicide intervention.

Background

According to the National Survey Mental Health and Well-Being (1997), one in five Australians aged 18 years and over suffered from a mental disorder during the 12 months prior to the survey. This equates to over one and a quarter million people living in rural and remote Australia who will at some point in their life experience a mental illness.

The most common disorders are major depression and related disorders including anxiety.

There are huge economic implications for all Australians, as well as the direct burden on individuals and their families. Sufferers of a mental illness are at a greater risk of committing suicide, with 80% of suicides having a pre-existing mental illness. Rates of suicide are consistently higher in rural and remote areas compared to the metropolitan and regional areas. Rates are particularly high for males aged between 25-44 years with a steady increase in the rates for young males, particularly Indigenous males.

There are a number of factors which exacerbate the problems in rural and remote Australia. People in rural areas are poorer, face higher rates of unemployment, and face additional challenges such as isolation, stigma as a result of less anonymity, exposure to environmental hazards, lack of appropriate services and service providers, and the effects of economic restructuring.

Lack of services is a major issue in rural Australia. There is a shortage of mental health nurses, psychiatrists and psychologists in rural and remote communities. As a consequence, non-mental health professionals in rural areas are more likely to be treating people with a mental illness. This undermines the treatment and development of intervention and prevention strategies for people at risk.

Lack of access to training, professional isolation, heavy workloads and limited resources affect the recruitment and retention of mental health personnel in rural and remote areas.

The development of partnerships between consumers, schools, general practitioners, Aboriginal health services and communities, emergency services, police, private mental health sector, Rural Counsellors, non-government and government services and the broader community will provide a more supportive network for service providers within the sector and a targeted and preventative program for rural and remote clients.

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NATIONAL COMPETITION POLICY

Recommendation

Competition policy should be recast into a positive framework for the promotion of rural development. It should be re-balanced to provide greater emphasis on those features that promote rural development, and less emphasis on those that have the opposite effects. This should be part of a comprehensive approach to rural development - one that recognises the social and economic benefits of a more equitable spatial distribution of economic opportunities.

Background

National Competition Policy is not having the positive impact on rural development, and hence on rural health outcomes, that it could have. This is because National Competition Policy has been designed and implemented in a way that directs most of its benefits to metropolitan areas.

The over-riding need in rural areas is for the development and implementation of a positive rural development framework. National Competition Policy should be joined with other arms of policy within such a framework. Such a framework is required to reduce the disparities in socio-economic outcomes, including real incomes and unemployment rates, between metropolitan and non-metropolitan areas. Reducing socio-economic disparities would also substantially reduce the disparity in health outcomes between rural and metropolitan areas.

National Competition Policy favours metropolitan areas because markets are more likely to be competitive in metropolitan areas and hence competition is more likely to be able to deliver economic and social benefits in those areas. Moreover, some arrangements implemented under the auspices of National Competition Policy, such as competitive tendering, have the effect of favouring larger metropolitan-based enterprises at the expense of smaller local organisations in rural areas. Particular concerns have arisen in respect of rural health services, where National Competition Policy is threatening to impede collaborative arrangements for service delivery, with the potential consequence of significantly reducing service availability and hence health outcomes.

National Competition Policy therefore needs to be recast into a positive framework for promoting rural development. This would include:

- retaining those features that have a positive impact on rural areas, eg, removal of regulatory arrangements that impede the development of country-based industries;
- dropping those features that clearly have a negative impact on rural areas, such as the potential barrier to collaborative health service delivery; and
- reviewing opportunities that may exist in competition policy to promote rural development through, for example, bringing beneficial competition in areas where this might not otherwise occur.

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NEEDS-BASED FUNDING

Recommendations

The Commonwealth Government should lead a national effort to collect, collate and analyse data related to health status and expenditure so that it is possible to improve morbidity and mortality evidence for all individuals in society and to know the 'total effort' being spent on individuals in various parts of the country. The data collated will include those from hospital admissions, the Health Insurance Commission and pharmaceutical benefits. If better data are available on morbidity and mortality, on one side, and on total effort on the other, it would be easier to spend health resources on areas of greatest need.

Background

In a perfect world scarce health dollars would be distributed according to comparative health status and comparative cost of delivering each unit of health care. This would mean that people with poor health would receive more of the health dollar than people with good health, and a person of a given level of poor health in a remote area would cost the system more than a person of the same level of poor health in a capital city. To be certain about the current situation would require detailed information about distribution of health status and about 'total current health effort'. This last is the total amount being spent on individuals by all levels of government and by the consumers themselves.

There is very little clear and comprehensive data on the status of health of all individuals in Australia. Aggregated data show that rural and remote people have poorer health than those in the cities, particularly in relation to cardiovascular disease, certain cancers, diabetes and avoidable injury and accident. It is also impossible to say precisely what the 'total current health effort' is for a particular individual. There are difficulties of measurement and the total effort consists of services and programs provided by Commonwealth, State and local governments, the private sector and the individuals themselves. Therefore it is impossible to show quantitatively and certainly that some people are 'missing out' on their fair share of health resources. The case for special treatment of rural and remote people is based on aggregate evidence: that overall their health status is poorer, that overall the cost of providing a given level of service is higher, and that overall they have poorer access to almost all services.

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ORAL AND DENTAL HEALTH

Recommendation

The Commonwealth, State and Territory Governments should increase their spending on public dental services in rural and remote areas and for people on low incomes in all areas. They should also work with relevant professional organisations on workforce initiatives for oral and dental health.

Background

Oral and dental health is generally poor in rural and remote areas and among people on low incomes in all areas. This has adverse implications for a person's overall health status and esteem. Oral disease is mostly preventable. There is clear evidence that a program such as the Commonwealth Dental Health Program (1994-96) can bring significant improvements to the situation.

The more remote an individual's location, the poorer is their access to fresh food, fluoridated water and dental services. In general, rural and remote people also have lower incomes than their peers in the major cities. People on low income tend not to visit private dental practitioners for check-ups because of the cash and logistical costs involved. A lower proportion of people in rural and remote areas have private health insurance.

This combination of factors results in a poorer state of oral and dental health, and a greater incidence of emergency interventions (including extractions) than in the cities.

Between 1994 and 1996 these problems were reduced through the Commonwealth Government funding a public dental health program which reduced waiting lists and provided low cost services to people who normally had poor access.

Since that time the Commonwealth has argued consistently that oral and dental health services are the responsibility of the State and Territory health jurisdictions. There is limited activity in the area by the States and the issue is one that falls into the crack between Commonwealth and State Governments.

There is also a shortage of oral and dental health specialists living or working in rural and remote areas. As with other health professions, a solution to the poor state of dental health through workforce initiatives is certain to take a very long time. The seriousness of the situation calls for more immediate action in addition to whatever might be done through workforce initiatives.

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NATIONAL RURAL HEALTH ALLIANCE INC.

RESOURCES FOR NURSING, ALLIED HEALTH, DENTISTRY AND PHARMACY

Recommendation

As a matter of urgency, the Australian Health Ministers' Conference (AHMC) should agree on a plan for increasing substantially the level of resources to rural and remote non-medical health professionals for recruitment, retention, education, training and support. A major part of this plan would relate to undergraduate students. This plan should use the models and lessons of programs for rural general practice but not be restricted to them. Consideration should be given to scholarships for health science graduates from rural and remote areas, and resources for rural and remote placements and related accommodation, travel and information technology support. Consideration should be given to HECS exemption for students who choose to work in selected areas.

Background

There is a general shortage of nurses, allied health professionals, dentists and pharmacists in rural and remote communities. The availability of these services is taken for granted in metropolitan areas of Australia. Major difficulties arise as a result of the lack of professional support and training structures, poor career progression, social isolation and family issues, the rationalisation of health and community services, and the lack of preparation for rural practice.

The need for these services is not decreased by a rural or remote lifestyle. Rural and remote communities have an increasing rate of cardiovascular disease and cancer, high rates of injury, a high incidence of chronic conditions such as diabetes, respiratory diseases and circulatory problems and higher rates of youth suicide.

The training of undergraduates with rural backgrounds has been shown through the programs established for rural general practice to be an effective mechanism for attracting and retaining health professionals in rural practices. Initiatives other than direct scholarships and placement funding could include the waiving of HECs for those students who on graduation agree to work in their profession in a rural or remote area for a number of years.

The health departments of the States and the Northern Territory provide a number of programs to support non-medical health professionals but it is done on an ad-hoc and limited basis. The Commonwealth Department of Health and Aged Care has recently established the Commonwealth Undergraduate Rural and Remote Nursing Scholarship Scheme. These initiatives provide the basis of the comprehensive and well-organised system that needs to be put in place urgently.

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RURAL DEVELOPMENT

Recommendation

The Commonwealth should establish a Rural Development Commission to receive references from, and report to, all levels of government, and to perform consultation, representation and informational roles with rural, remote, and regional communities. The National Rural Health Alliance would work collaboratively with such a Commission and with other organisations to support the economic and social development of rural and remote communities.

Background

Rural residents are deeply concerned by the continuing decline in various aspects of their economic, social and natural environments. Left to themselves, the processes of structural change that have led to these deteriorating conditions will impose lasting and at times irreversible damage to both individuals and communities. There are close relationships between the health of rural people and the economic, social and environmental conditions of rural communities. These conditions have numerous direct and indirect effects on the health status of rural residents. Conversely, there are numerous aspects of the health sector in rural areas that directly or indirectly influence the economic and social condition of those regions.

The rural and regional development policies that currently exist are not maximising the potential of non-metropolitan communities and industries. This means that the nation as a whole and rural people in particular are missing out on income and quality of life that could be theirs. While in the past rural development was assumed to be closely identified with the growth of agriculture, the relatively declining role of agriculture in the national economy has left rural areas without a clear rationale and focus for pro-active regional policy. As well, Governments' experiences with previous efforts to achieve deliberate development visions in rural areas have made them wary of major interventionist programs. At times the costs of these efforts - economic, social and environmental - have been high, and their benefits apparently meagre or fleeting.

The predominant focus on policies for 'getting the economic fundamentals right' over the past fifteen years may well have worthwhile returns to a national economy which has been unavoidably exposed to global economic forces. But markets on their own do not necessarily produce either efficient or equitable outcomes in areas with small or sparse populations. Policies and programs that may be in the national interest, in the sense that they may have delivered net benefits to the nation overall, have inevitably imposed stresses and disadvantage on particular places and sectors of rural Australia. While the overall national impacts of policy are often well examined by bodies such as the Productivity Commission, the specifically rural sectoral implications of policy and other changes need to be addressed with similar analytical care, and coherent and consistent policy responses elaborated. The sources and processes of rural change are complex, and their effects on diverse populations and sectors require much more concerted attention.

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NATIONAL RURAL HEALTH ALLIANCE INC.

SUMMITS ON RURAL AND REMOTE NURSING, AND ALLIED HEALTH

Recommendation

The Federal Government should support National Summits on Rural and Remote Nursing, and on Rural Allied Health, as a means of continuing the development of workforce and other initiatives for those professions. There are models for rural health workforce initiatives from the general practice sector which we need to continue to pursue. These models can be used as the basis for expanded and comprehensive programs for nursing and allied health. People in rural and remote areas need primary health care teams in which there is close collaboration between all health professions.

Background

There are serious workforce shortages and other recruitment, retention and support issues affecting rural and remote nurses and allied health professionals. There have been significant moves recently to recognise these issues but the development of policies in the area still remains ad hoc and incomplete.

The Federal Government has the strongest interest in the education and training of the graduate workforce, including nurses and allied health professionals. It also has the strongest interest in the aged care sector in which many members of both groups of professionals work. There is, nevertheless, still significant reluctance on behalf of the Federal Government to play the dominant role in relation to nursing and allied health issues. The NRHA welcomes the Federal Government's increased involvement as evidenced for example by the Undergraduate Nursing Scholarships, and also the ongoing commitment of the States and Northern Territory to nursing and allied health workforce issues.

The 6th National Rural Health Conference recommended that the NRHA convene national summits on rural and remote nursing and on rural allied health – a responsibility which the Alliance is keen to take up, given support from all governments and relevant national associations. The Federal Government's potential support would be a key to the successful running of such summits.

The summits would not be 'talkfests' but opportunities to collate evidence about current problems and about the existing initiatives in rural and remote nursing and in rural allied health. It could then be expected that improved national and State programs for the non-metropolitan workforce in both nursing and allied health would be articulated. This required extension to the non-medical rural health workforce of programs equivalent to those for general practice was the most strongly-felt issue for delegates at the 6th National Rural Health Conference in March 2001.

Election Charter, September 2001

NATIONAL RURAL HEALTH ALLIANCE INC.

VULNERABILITY OF RURAL SERVICES AND INFRASTRUCTURE

Recommendation

There should be an urgent national effort, led by the Federal Government, to increase the security of supply of essential services and infrastructure to people in rural and remote areas. It should include work to establish the world's best practice for providing transport, communications and education services in those areas, and to apply them to Australian conditions. There should be further investigation of a Community Service Obligation approach to the provision of such services.

Background

The recent loss of Ansett services is potentially a crippling blow to regional, rural and, in particular, remote quality of life and business. The availability and affordability of such fundamental services as air transport are key access and equity issues for people in regional and more remote areas. Governments should recognise the fundamental need for transport, and the national response to this current emergency should be as comprehensive and supportive as it was, for instance, in the case of the interruption to Victoria's gas supply.

Meeting this last weekend, those Members of the Alliance's Council who were still able to reach Canberra agreed very strongly on the human rights as well as health implications of Ansett's closure. In many rural regions the Royal Flying Doctor Service is currently the only air service operating. People with specialist appointments in regional centres and capital cities have no means of obtaining diagnosis and treatment services. "No planes equals no PATS (Patients' Assistance Travel Scheme)." "At a single stroke we've lost our bridge to health care." "It's about feeling secure in the place you live in."

The erosion of reliable air services will severely limit rural people's capacity to participate in many aspects of our democracy. Without a robust transport infrastructure, many will find it increasingly difficult to commit themselves to any organisational work that requires them to travel. People unable to take part in normal social activities will be unwilling to commit themselves to rural life. "It's about feeling secure in the place you live in." Council of the Alliance heard of people who had saved for ten years for a holiday who have now lost their money. "People's rights have been abrogated." The economic base of more remote areas will be compromised unless regional air services are re-established and enhanced.

There is already a workable system of Community Service Obligations in telecommunications. The Alliance believes that this approach could be extended to transport and health services, with government regulation to support less profitable activities. Just as there has been consideration of a minimum level of services in health, so should there be a workable commitment to a minimum level of transport services.

Infrastructure in rural and remote areas is also seriously degraded. The recent Infrastructure Report Card confirmed the need for major new investment in areas like road, rail, electricity, gas and water infrastructure, including in rural areas.

Election Charter, September 2001

Member Bodies of the National Rural Health Alliance

The National Rural Health Alliance currently has twenty two Member Bodies:

- Association for Australian Rural Nurses (AARN)
- Rural Interest Group of the Australian Community Health Association (ACHA)
- Australian College of Health Service Executives (rural members) (ACHSE)
- Rural Policy Group of the Australian Hospital Association AHA (RPG)
- Australian Nursing Federation (rural members) (ANF)
- Australian Rural and Remote Allied Health Taskforce of the Health Professions Council of Australia (ARRAHT)
- Aboriginal and Torres Strait Islander Commission (ATSIC)
- Council of Remote Area Nurses of Australian Inc. (CRANA)
- Country Women's Association of Australia (CWAA)
- Health Consumers of Rural and Remote Australia (HCRRA)
- Isolated Children's Parents' Association of Australia Inc (ICPA)
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Association of Rural Health Training Units (NARHTU)
- National Rural Health Network (NRHN)
- Rural Doctors' Association of Australia (RDAA)
- Rural Faculty of Royal Australian College of GPs (RF of RACGP)
- The Australian Council of the Royal Flying Doctor Service of Australia (RFDS)
- Rural Pharmacists Australia - Rural Interest Group of the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia (RPA)
- Services for Australian Rural and Remote Allied Health (SARRAH)