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Introduction

On average, Australians have a life expectancy that is very high by international standards and that continues to improve. Although Australians living in rural areas (including all rural, regional and remote areas) have shared in absolute improvements in morbidity and mortality, in relative terms they remain disadvantaged compared with their metropolitan cousins.

The Australian Institute of Health and Welfare (2012) reports that people living in rural areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities ... (and that) people living in rural Australia do not always have the same opportunities for good health as those living in major cities. For example, residents of more inaccessible areas of Australia are generally disadvantaged in their access to goods and services, educational and employment opportunities, and income.²

There is also a substantial body of evidence which identifies the critical contributions made by the social and economic determinants of health (Marmot and Wilkinson 2005; Dixon 2000). Distance itself is a substantial barrier to the effective prevention of disease and the management of health. There is a significant and unacceptable gradient in the status of health and well-being for individuals as one moves from major cities to rural and then to remote areas. Health outcomes generally worsen with distance from the major cities. This gradient is caused by a combination of the health risk factors experienced by people in different areas, by their differential access to health services, social factors and cultural attitudes such as a commitment to stoicism. As a consequence of metropolitan-rural differences in these factors, people living in rural and remote communities have quite distinct needs not readily met by models of care and intervention designed for metropolitan application.

This is the essence of the perception of people in the rural and remote health sector: that they stand within but separate from the mainstream of the Australian
health system. The development of that separateness – the main narrative of this chapter – has been an essential underpinning of activity to remove the rural health inequity.

Chapter overview

Health is a major policy issue to be considered in a book such as this. However within the space available it is only possible to provide a brief overview of the trials, tribulations and successes of the rural and remote health sector in Australia over the past three decades. This chapter is broad in scope, its concern being to assess the extent to which national health programmes implemented in the last 20 years, as well as those specifically targeted to rural and remote areas, have succeeded in reducing the gap between metropolitan and rural health and well-being.

Health status is determined by many factors and a comprehensive analysis of the health gap would therefore require considerations well beyond the health system. Programmes affecting rural health span local, state and federal governments; health and health-related portfolios; and whole-jurisdiction programmes as well as those specifically targeting, and only available in rural areas.

The chapter will:

- Provide an overview of the health status of rural Australians.
- Discuss the factors influencing health status.
- Describe and comment on the emergence of ‘rural and remote health’ as a separate and distinct part of Australia’s health system.
- Comment on the impact of some of the major national health developments on the health status of the residents of rural and remote areas; and
- Discuss some of the outstanding barriers to resolving rural health challenges.

Rural health outcomes

People in rural areas are persistently documented to have poorer health outcomes and higher mortality rates than those in metropolitan areas. When compared with metropolitan areas, mortality rates in rural areas are 1.05–1.7 times higher, with mortality rates for Indigenous Australians over three times higher than the general population in rural areas (Phillips 2009). The higher mortality rates have been shown to be due to coronary heart disease (CHD), diabetes, chronic obstructive pulmonary disease and cancers (particularly lung and prostate cancers) (Phillips 2009). When specifically looking at the farming community there is a higher prevalence of cardiovascular disease (CVD) risk factors and psychological distress than national averages suggest (Brumby et al. 2012).

The prevalence of disability across rural and metropolitan areas is similar for women but is 20 per cent higher for men in rural areas, with higher incidences of psychiatric disability, sensory/speech disability, acquired brain injury and physical
disability (Phillips 2009). Coupled with the high rate of psychiatric disability is the increase in male suicides over the past 20 years (Alston 2012; Phillips 2009). Suicides are continuing to increase as climatic conditions force farmers to make major decisions about whether to leave agriculture (Alston 2012).

The health of Aboriginal and Torres Strait Islander people is also a separate and significant national issue. The Australian Institute of Health and Welfare reports that,

Indigenous Australians experience lower levels of access to health services than the general population, are more likely than non-Indigenous people to be hospitalised for most diseases and conditions, to experience disability and reduced quality of life due to ill health, and to die at younger ages, than other Australians. Indigenous Australians also suffer a higher burden of emotional distress and possible mental illness than that experienced by the wider community.

Factors influencing the health outcomes of people living in rural areas are discussed in the following sections. These factors include access to services, social determinants and rural culture.

**Access to services**

The documented poorer health outcomes are in part the result of limited access to services. Living in a rural area impacts on the ability to access health services, with fewer services available per capita and greater distance to travel, potentially on poor quality roads, to reach the available services (Alston et al. 2006; Dixon and Welch 2000; Smith, Humphreys and Wilson 2008). Australian Bureau of Statistics figures reveal that the number of doctors per head of population varies from 308 per 100,000 in major cities to 77 per 100,000 in very remote areas. A survey of rural women has identified that as well as a lack of medical services, there is a paucity of general health and well-being support such as maternity services, mental health services, care and respite services and domestic violence services (Alston et al. 2006).

Attracting and retaining health professionals is a key issue in the delivery of rural health services (Alston 2007; Moore, Sutton and Maybery 2010). Although there are positives of working in a rural area such as feelings of personal and professional belonging, the rural lifestyle, supportive networks and ease of childcare, there are also barriers to attracting staff (Fisher and Fraser 2010). These include: professional isolation, limited access to educational opportunities and supervision, shortage of employment opportunities for spouses, lack of career structure, lack of anonymity, large caseloads and excessive travel (Fisher and Fraser 2010; Struber 2004). There is also a lack of recognition of the skill base required for effective rural practice.

In an attempt to address health professional shortages the Federal Government has introduced a scheme to encourage overseas-trained doctors to work in
rural areas. However, there are limitations associated with this initiative such as language and cultural differences as well as ensuring standards of care are met (Alston 2007). There is also a large body of literature investigating rural intention (what it is that drives health professionals to work in rural areas). Those who have spent time living or studying in rural areas, have a partner who has lived in a rural area, intended to work in generalist rather than specialist practice and who held a scholarship during university are more likely to work in rural areas (Laven et al. 2003; Jones, Humphreys and Prideaux 2009).

Social determinants

Poorer health outcomes are not solely the result of limited access to services; social determinants, including economic, social and cultural factors, are also influential (Marmot and Wilkinson 2005; Smith, Humphreys and Wilson 2008). These include a higher prevalence of short-term high-risk alcohol consumption, psychological distress and obesity (Brumby, Kennedy and Chandrasekara 2013). The nature of a farmer’s work (long working hours, limited social interaction, increasing automation of tasks and increased sedentary activities) may make it difficult for farmers to participate in physical activity for the associated physical and psychological benefits (Brumby et al. 2012).

Rural culture

Men in rural areas have shown a commitment to stoicism in which they will keep going through hardship or illness, not acknowledge difficulties and blame themselves for failures (Alston 2012; Hogan et al. 2012). This attitude can be linked to reluctance to access health services and to increasing psychological distress and suicide rates during the ongoing drought (Alston and Kent 2004; Alston 2012; Brumby et al. 2011; Brumby et al. 2012). While both men and women in rural areas may theoretically understand when they should seek medical assistance (e.g. for chest pain), the greater the distance they live from a health service, the longer they will wait to seek assistance, not wanting to travel the distance unnecessarily (Baker et al. 2011).

A brief history of rural health

In Australia, governments were slow in starting to acknowledge and respond to the distinctive health needs of rural and remote communities. Once started, progress was relatively rapid on some fronts, such as support for general practice, and relatively slow on others, such as in recognising the importance of allied health. However, given the economic, social and cultural importance of Australia’s rural areas to the nation, the particular circumstances relating to health in rural areas were always given at least a nod. For instance, in a 1976 report the Hospitals and Health Services Commission (p. 2) stated that:
Many country people find it difficult to obtain adequate health care. There is a shortage of doctors, dentists and other health personnel, and difficulties in maintaining health facilities in many districts ... even where an adequate range of services is available, access may be impeded by lack of public transport or poor roads...

Since the focus of a good deal of rural health policy today is still on these same issues, it might be argued that not much has changed in the intervening 35 years and more. In what follows, however, it will be shown that there have in fact been notable advances and achievements in rural health policies and in health outcomes. The precise relationship between better health policies and better health is uncertain because of the critical impact of the social determinants of health such as income, education, housing and food.

The 1976 report by the Hospitals and Health Services Commission was followed in 1978 by a seminal event: the Country Towns-Country Doctors Conference. Organised by the Royal Australian College of General Practitioners (RACGP), this conference highlighted many of the issues confronting rural health, albeit through a largely medical lens. Its key concern was the shortage of doctors in rural areas, an issue that was to become overtly political a decade later. Despite this focus on GPs, and with the benefit of hindsight, that conference certainly played an important early part in claiming the distinctiveness and significance of rural health issues. However, over 30 years later, following the implementation of the strategies and programmes below, the shortage of health professionals in rural areas is still of utmost concern.

Institutional and political developments continued. In 1982 the Council of Remote Area Nurses of Australia (CRANA) was established. It was, at least in part, a response to the recognition of the benefit of collective action in getting governments to respond to the health care issues experienced by the residents of remote (as distinct from rural) communities. The uniqueness of remote issues remains an important principle for many in the ‘rural health’ sector.

In 1990 a report from the Australian Health Ministers’ Advisory Council (AHMAC) Rural Health Care Task Force identified the following priority rural health issues (AHMAC 1990):

- The health needs of rural and remote communities, and specifically those of particular population groups.
- Improving education, training and career structures in rural practice.
- Overcoming disincentives for rural practice.
- Improving resource allocation mechanisms and rural infrastructure.

The New South Wales (NSW) doctors’ dispute of 1988 led directly to the establishment of the Rural Doctors’ Association of NSW and then, in turn, to the Rural Doctors’ Association of Australia (RDAA). It was RDAA that took the lead in running the 1st National Rural Health Conference in Toowoomba in 1991, which was a watershed moment in rural health (a chronology of major
rural health policies in the decade that followed is listed in Table 12.1). It was joined in this venture by CRANA, some much older bodies like the Country Women’s Association and the Australian Nursing Federation (ANF), and a number of passionate and resilient individual rural nurses, allied health professionals, consumers and public servants engaged in health. Because of that 1991 Conference, Toowoomba is widely regarded as the birthplace of Australia’s rural health movement. And thanks to the Cunningham Centre and the Toowoomba Hospital Foundation, the city retains a special place in the sector through its continued support for some awards at the Conference, which has been held biennially since 1991.

The report from the Toowoomba Conference was entitled *A Fair Go for All*. Its recommendations resulted in the first significant national programmes for rural health. They included the Rural Health Support Education and Training (RHSET) grants programme, commitment to the development of a National Rural Health Strategy, and a range of special programmes for rural general practice.

The *Australian Journal of Rural Health* was launched in 1992, while the 1990s also saw three national rural health policy documents endorsed by the Australian Health Ministers’ Conference. They were the 1994 *National Rural Health Strategy*, the 1996 *National Rural Health Strategy Update* and, in 1999, the first iteration of *Healthy Horizons*. These were instrumental in guiding early changes and initiatives designed to address rural health issues and problems.

Such developments would not have occurred without the consistent support of a small number of public servants and ministers of the day who became committed – in various measures and for various reasons – to rural and remote health. From the beginning the Federal Government had an unequivocal and widely accepted responsibility for the general practice workforce, but not for nurses and allied health professionals. One of the main reasons was of course the existence of Medicare, with the Commonwealth responsible for open-ended, demand-driven payments under the Medical Benefits Schedule (MBS). This clear responsibility is what underpinned the development of a plethora of programmes relating to general practice – and rural and remote general practice in particular.

Like the Commonwealth, the state and territory Health Departments grew their specific capacity to deal with policy issues relating to rural and remote areas, including through the establishment of Rural Health Policy Units. However, this was always an uneven and vacillating process, with the wheel turning from time to time on what was deemed necessary and desirable, just as it did on the ‘best structure’ for a jurisdiction’s administration of health services (small Areas; large Regions).

In 1996 the first University Departments of Rural Health were established. This was a major initiative for the support of health workforce programmes in selected regional areas, and the importance of these entities has grown steadily over time. That year also saw the publication of *Healthy Horizons*, a joint development of the National Rural Health Policy Forum and the National Rural
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<tr>
<th>Year</th>
<th>Policy/event</th>
<th>Policy impact and programme activity</th>
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  - Rural Health Support Education and Training programme.  
  - Beginnings of the National Rural Health Alliance. | Landmark document setting the agenda for many of the Commonwealth initiatives of the 1990s.  
  Funded specifically rural health initiatives across Australia.  
  Australia’s peak NGO for rural health, providing significant impetus for profiling rural health and associated policy development. |
| 1992 |  
  - Australian Association for Rural Nurses established.  
  - Australian Journal of Rural Health established. | Organisation to provide leadership and focus for rural nursing issues.  
  National and international focus for disseminating rural health research. |
| 1993 |  
  - 2nd National Rural Health Conference, Armidale, NSW.  
  - General Practice Rural Incentives Programme.  
  - Review of nursing workforce issues. | Minister proposes national Office of Rural Health and funding for National Rural Health Unit.  
  Funding to encourage doctors to practise in rural and remote areas, and measures to provide professional support in the form of appropriate education, training and locum relief for practising rural and remote area GPs.  
  Broadening the national rural health agenda to include nursing. |
| 1994 |  
  - Divisions of General Practice established.  
  - National Rural Health Strategy endorsed by Australian Health Ministers’ conference.  
  - Establishment of Rural Health Policy Units within some State Health Departments.  
  - Establishment of Rural Health Training Units in all States. | Regional support for GPs who opt in to membership.  
  National framework to guide Commonwealth, State and Territory rural health funding and programmes.  
  Became the focus for National Forum of Commonwealth-State representatives on rural health matters. |
| 1995 |  
  - 3rd National Rural Health Conference, Mt Beauty, Victoria. | The first to be managed by NRHA; the last small community-based one. |
| 1996 |  
  - National Rural Health Strategy Update endorsed by Australian Health Ministers’ conference.  
  - Announcement of University Departments of Rural Health to be established.  
  - Formation of SARRAH. | Progress in achieving rural health proposals set in the National Rural Health Strategy reviewed and new strategic directions outlined.  
  Significant ongoing funding initiative in establishing major rural health nodes in seven regional centres.  
  The first peak organisation for individual rural and remote allied health practitioners. |
1997 • 4th National Rural Health Conference, Perth.
- Australian College of Rural and Remote Medicine
- John Flynn Scholarships.

1998 • National Review of General Practice Training and General Practice Strategy Review.

1999 • 5th National Rural Health Conference, Adelaide.
- Healthy Horizons endorsed by the Australian Health Ministers’ Conference.
- Budget provides funding for GP retention grants, James Cook University medical school, Wagga Wagga clinical school and new Regional Health Service Centres.
- Regional Australia Summit convened by Deputy Prime Minister in Canberra.

2000 • More Doctors, Better Services Regional Health Strategy.
- Rural Health Stocktake and NHMRC Rural Health review.

2001 • 6th National Rural Health Conference, Canberra.
- Minister Wooldridge announces new University Departments of Rural Health (UDRH) and Regional Clinical Schools (RCSs).
- General Practice Education and Training Limited established.

Numbers rise to c. 700.
Peak professional association for rural medical education and training in Australia.
To provide on the ground rural experience to medical students.

Significant leap forward in setting the parameters of ongoing General Practice activities.
Major initiative focusing attention on public and population health and towards a primary health care approach.

Management of AJRH passes from AARN to NRHA.
National framework for improving the health of rural, regional and remote Australians.
Largest yet integrated package of new measures for rural and remote health.

National gathering provides major impetus for 2000–2001 Budget initiatives.

$562 million Budget to fund more rural health professionals, regional clinical schools and regional health services programme.
Independent reviews of investments to date.

Settles significance and role of UDRHs and, for rural medical education, of RCSs.
Political decision to locate GP training money with a new, independent body.
Health Alliance (NRHA) for the Australian Health Ministers’ Conference. For the first time Commonwealth, state and territory governments recognised the wisdom of involving and locking in national associations and interest groups with the capacity to deliver on some of the content of the statement. Having awakened the sleeping giant, the interest groups were invited by it to commit themselves to the agreed action. For this reason the National Rural Health Alliance was a co-signatory to Healthy Horizons. No longer a strategy, this national policy document was endorsed as a ‘framework for improving the health of rural, regional and remote Australians’. It gave highest priority to addressing ‘the worst first’, including the poor health of Aboriginal and Torres Strait Islander people.

The Federal Budget of 1999 saw the largest package yet of new measures specifically for rural and remote health. They included funding for GP retention grants, the establishment of the James Cook University Medical School and the Rural Clinical School in Wagga Wagga. The 1999 Regional Australia Summit convened by Deputy Prime Minister John Anderson had a rural and remote health stream. Most of the health issues highlighted in it were by then familiar.

This was followed in Budget 2000 by More Doctors, Better Services, regarded by many people as Minister Michael Wooldridge’s greatest success and gift for rural and remote areas. In 2001–2002 health was not much on the front pages, except for the challenges of medical indemnity. The sector saw few significant structural alterations but continued to be characterised by ongoing tensions and generally uncooperative relationships between the Commonwealth and the states. These were typified by the acrimonious ‘negotiations’ over new Australian Health Care Agreements (AHCA) in 2003. A chronology of major rural health policy initiatives and events between 2002 and 2011 has been outlined in Table 12.2. As far as the rural health sector was concerned, 2003 saw Michael Wooldridge’s 2000 Regional Health Strategy rebadged as the Rural Health Strategy under Health Minister Kay Patterson. That year also saw the release of a little-noticed report from the Australian Institute of Family Studies (AIFS) on child abuse in the Northern Territory (Stanley 2003). Four years later that report was to be detonated with considerable collateral damage – and ongoing ramifications.

In the meantime there was fallout from the Australian Health Care Agreements (known as the ‘AHCA’s’). A number of specialised working groups had been established to provide input to the negotiations for the AHCA. When nothing came of this work and governments retreated once more to bickering and point scoring, many of the experts who had gathered for another purpose threw their support behind a new health reform body: the Australian Health Care Reform Alliance (AHCRA). Led initially by John Dwyer, AHCRA provided a new voice for many in the health sector who believed that major reform of the sector was essential and long overdue.

In the next few years this push for reform by ‘health experts’ was joined by a far more powerful force: the weight of public opinion. It was highlighted – perhaps led – by the situation facing Australia’s mental health system. Much
public attention was given in 2004–2005 to the unlawful detention for ten months of Cornelia Rau, whose unstable behaviours were caused by schizophrenia and other disorders. Then there was considerable publicity in 2005 given to the unlawful removal to the Philippines of Vivian Solon, whose mental and physical health problems were not given due attention. These and other cases provided the background for consideration of two publications skilfully prepared and promoted by the Mental Health Council of Australia (MHCA): Out of Hospital, Out of Mind (published in 2003) and Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia (2005).

Importantly, on 2 April 2007 the Close the Gap campaign was launched in Sydney. There was then an unexpected explosion relating to child abuse in the Northern Territory. The Little Children Are Sacred report was handed down in June 2007. This led swiftly to the Northern Territory National Emergency Response, also known as ‘the Intervention’. With widespread awareness of such tragic situations as these in Indigenous health and mental health, the reformist views of health experts gained greater traction. It became impossible for politicians and the public to remain complacent about the health system. Very fertile ground was created for a Prime Minister with aspirations for extensive health reform which broadened the focus from predominantly medical care to include broader health and well-being.

The Rudd Government was elected in November 2007. This ushered in an ambitious agenda of health reform relating to the structure and funding of the health system as a whole, a national approach to primary care, and greater emphasis on preventive health. The stronger focus on prevention gave brief hope that the planned health reform might result in some increased appetite within both the government and the sector for a true primary health care approach – one part of which is primary care. This would involve greater attention to the social determinants (education, housing, employment) and to holistic, interdisciplinary action on health. However, despite more widespread and undisciplined use of the term ‘primary health care’, it was a false dawn.

Five different models have been identified for providing primary care in rural areas and have been shown to be successful in meeting their stated goals (Wakerman et al. 2008). These models are ‘discrete services’ where GP services are delivered from an identifiable site in the community, ‘integrated services’ emerging from a community health service approach in which multiple services work in a team, ‘comprehensive primary health care services’ of which primary care is a part, such as the Aboriginal Community Controlled Health Services, ‘outreach models’ and ‘telehealth’ (Wakerman et al. 2008).

Medicare Locals have been introduced to improve the coordination of primary care service delivery and ensure the needs of each local community are met (Russell et al. 2013). It is hoped and expected that, like Aboriginal Health or Medical Services, they will also have some capacity to provide broad primary health care, through such things as special services for the unemployed, those with a disability, the homeless and the incarcerated. First and foremost, however, Medicare Locals will better link local GPs, nursing and other health
Table 12.2  A chronology of major rural health policy initiatives and events in Australia, 2002–2011

<table>
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<th>Year</th>
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| 2002 | • $740 million in drought relief for financial assistance, counselling and employment services; tax relief.  
      • Funding for HealthConnect, a proposed electronic health records information network. |
      • MedicarePlus: $2.4 billion to increase bulk billing and convenience for patients to claim rebate.  
      • $47.3 million for rural and remote GP retention payments.  
      • New Australian Health Care Agreements: Federal funding for public hospitals.  
      • 7th National Rural Health Conference, Hobart, Tasmania. |
| 2004 | • The Rural Health Strategy: $830 million over four years, mainly to improve distribution of GPs.  
      • Rural Procedural Grants to help procedural GPs maintain skills.  
      • Bonded Medical Places Scheme introduced.  
      • MedicarePlus extends MBS to selected dental and allied health procedures. |
| 2005 | • Rural Nursing Scholarships: $20.6 million to help remove barriers to recruitment and retention.  
      • Rural undergraduate scholarships for allied health.  
      • 8th National Rural Health Conference, Alice Springs, Northern Territory. |
| 2006 | • MBS Better Access Programme: $507 million for Psychiatrists, Psychologists, GPs and Allied Health Professionals.  
      • E-health: $70.2 million to establish a national electronic health records system.  
      • Public disclosure of sexual abuse and violence in Central Australia. |
| 2007 | • Close the Gap Campaign launched.  
      • Highway to health: Senate Report on Patient Assisted Travel Schemes.  
      • Public release of the Little Children Are Sacred Report.  
      • NT National Emergency Response (the Intervention).  
      • New $223.4 million Royal Flying Doctor Service Funding Agreement 2011–2015.  
      • National Health and Hospitals Reform Commission (NHHRC) established.  
      • 9th National Rural Health Conference, Albury, NSW. |
2008
- Audit of Health Workforce in Rural and Regional Australia.
- Office of Rural Health established in response to Audit of Rural Health Workforce.
- Beyond the blame game: NHHRC’s proposals on the next Australian Health Care Agreements.
- Evaluation of University Departments of Rural Health Programme and Rural Clinical Schools Programme.
- COAG establishes Australian Health Practitioner Registration Agency for ten health professions.
- Rural Health Workforce Strategy: $134.4 million to encourage doctors to rural areas.
- Royalties for Regions – political principle features in WA State Election.
- Apology to the Stolen Generations.
- Review of Healthy Horizons.

2009
- NHHRC’s Interim and Final Reports: A Healthier Future for all Australians.
- ASGC-RA classification system to replace RRMA as basis for funding rural health programmes.
- Primary health care reform in Australia: Strategy to guide future policy and practice in Australia.
- Rural and Remote Health Workforce capacity: Australian National Audit Office report on programmes administered by the Department of Health and Ageing.
- National Rural and Remote Health Infrastructure Programme: Health and Hospitals Funding for rural and remote communities.
- Health Workforce Australia established: Responsible for implementing COAG $1.6 billion health workforce package.
- First Minister for Indigenous, Rural and Regional Health (Warren Snowdon).
- 10th National Rural Health Conference, Cairns, Queensland.

2010
- National Health and Hospitals Network: foreshadows Medicare Locals and Local Hospital Networks.
- $1.8 million Health and Hospital Funding – Regional Priority Round for health infrastructure.
- $632 million to increase GP training places from 700 to 1,200 a year; specialists from 360 to 900.
- MBS and PBS benefits for specific services of nurse practitioners.

2011
- New expenditures for mental health.
- Medicare rebates payable for specialist video consultations with patients in rural areas and eligible aged care facilities and Aboriginal Medical Services.
- Rural and Regional Health Australia established in Department of Health and Ageing.
- House of Representative Inquiry into Registration Processes and Support for Overseas Trained Doctors.
- National Advisory Council on Dental Health established.
- 11th National Rural Health Conference, Perth, Western Australia.
professionals, hospitals and aged care, identify where local communities are missing out on services they might need and coordinate services to address those gaps (Department of Health and Ageing 2011).

Much of the impact of the 2007 reform agenda on health outcomes and the distribution of health services for rural and remote people remains to be seen, including the extent to which the expectations of Medicare Locals can be met. Already, however, several mooted reforms (such as having a single funder for health, or making the Commonwealth responsible for policy and funding in primary care) have been significantly compromised ‘until the next time’.

In 2008 there was an Audit of Health Workforce in Rural and Regional Australia – a modest piece of work compared with the three national health reviews then in train. It resulted in the establishment of an Office of Rural Health in the Department of Health and Ageing. The wheel was still a-turning. Kevin Rudd’s health reform aspirations led to three particular pieces of work and resulted in three reports, all published in 2009 – each of which was and remains highly regarded. They are A Healthier Future for all Australians from the National Health and Hospitals Reform Commission; Primary Health Care Reform in Australia from the Department of Health and Ageing and its External Reference Group; and Australia: the healthiest country by 2020 from the National Preventative Health Taskforce.

These were all valuable pieces of work, conscientiously undertaken and with a raft of potentially valuable recommendations. Unfortunately, however, the health sector poses more challenges to fundamental structural reform than almost any other, and the people of rural and remote areas remain among those most seriously disadvantaged by what remains undone.

Australia’s first National Primary Health Care Strategy (Department of Health and Ageing 2010) and the National Preventative Health Strategy (National Preventative Health Taskforce 2009) both highlighted the critical part played in determining health status by taxation, employment, education, housing, transport, regional development, reconciliation, the arts and social security. Unfortunately, it remains very difficult to implement a whole-of-government approach to health, with the competition for resources between portfolios and the very purpose of the central agencies (Treasury and Finance) both acting against such a thing.

There was optimism about the establishment in 2011 of Rural and Regional Health Australia, an agency mandated to take on a strong advocacy role within government to promote a joined-up government approach to rural health, and to provide high-level input to budget and policy development on key rural, regional and remote health and ageing issues. The promise of that organisation is yet to be seen.

The dependence of the Gillard Government on the support of two independent rural MPs has been instrumental in the recent orientation of national policies and programmes to deliver more focus on and resources to non-metropolitan regions. The importance of a rural voice holding the balance of power in the parliamentary arena is also illustrated in Western Australia, where the National Party negotiated a ‘royalties for regions’ agreement, such that 25 per cent of the state’s
mining and onshore petroleum royalties are returned to regional areas each year as an additional investment in projects, infrastructure and community services. Despite its critics, the hung Parliament has been beneficial for rural regions. It has provided an opportunity for some much-needed ‘catch-up’ for infrastructure, workforces and services associated with rural health and well-being.

**Barriers to improvements**

Throughout the period since 1991, in its health activity the Commonwealth government remained overwhelmingly involved with general practice and Medicare. Despite some initiatives designed to support nurses and allied health professionals, there is still a very long way to go to achieve any sort of equivalence between medicine and the other health professions, especially in rural areas. The major education, training, service provision and population health initiatives set in place in the 1990s are now beginning to improve the lives of rural and remote Australians. University Departments of Rural Health (UDRHS) and Regional Clinical Schools (RCSs) have become established as vital infrastructure supporting the devolved education and training of Australia’s future rural and remote health workforce. Substantial funding made available through the Health and Hospitals Fund, the National Rural and Remote Health Infrastructure Programme and others boosted health-related infrastructure in rural areas. Other initiatives, such as the Medical Specialist Outreach Assistance Programme (MSOAP) and Medicare rebates for video consultations to link specialists and consultant physicians with patients are also helping to improve the access of rural and remote patients to health care.

Despite such progress, the persistence of poorer health in rural Australia suggests that much more is required. A focus on medical solutions, whilst positive, has missed other opportunities to reduce the divide. In rural communities there are so many occasions to contribute to health, well-being and safety and these occasions exist not just in the health and medical domain.

Crossover and interaction occurs routinely and commonly in the lives of rural people between health, education, agriculture, welfare, transport and communication and in all tiers of government. Whilst this interaction should in theory provide an opportunity to address poor rural health from numerous angles through cross-sector collaboration it has mostly remained a siloed approach across departments, and sadly within them (Brumby 2013). Collaboration is required to grow within the health department and its numerous health disciplines and between the common departments that service rural areas. Delineation and shifting the buck (‘it’s not a health problem, it’s an industry problem’, ‘it’s not industries, it’s education and training’) must cease, and instead the focus should be on a population that is missing out. For a country that prides itself on innovation and ‘can do’ there is still much to do.

A fundamental reason why rural health status is not being improved as quickly as it should is the nation’s and the health sector’s failure to address the barriers in the system in which decisions are made, resources allocated and programmes implemented.
Resource availability

There is a consistent health underspend in rural areas compared with what is both fair and needed (AIHW 2011; NRHA 2011). Lack of funding for rural health is further complicated by Australia's complex health financing arrangements, and a failure to resolve Commonwealth-state relationships (especially 'cost shifting').

Problems associated with programme duplication, lack of coordination and integration of programmes, cost-shifting, cross-border issues, and lack of mutual professional recognition continue to inhibit the quest to overcome workforce problems and to deliver efficient and appropriate health services effectively. These problems were highlighted in the National Hospitals and Health Reform Commission's report (2008), but the opportunity for change under that reform agenda appears to have passed.

Much more remains to be done on the resourcing front. Allocation of health dollars according to health need would see people in rural and remote areas among the main beneficiaries. But such a system would require substantial revision of the architecture of the nation's health system, including two of its best features: Medicare and fee-for-service medicine.

Workforce shortages

Rural health workforce shortages remain a critical first-order problem, often being the main reason why an effective health service cannot be provided in a rural area. Even large regional centres suffer significant health workforce shortages, requiring residents to seek health care from capital cities.

The difficulties of workforce recruitment and retention are exacerbated by the persistence of some negative images of rural communities, including among some of those who are teaching and mentoring the health professionals of the future. The 'good news' rural health stories seldom warrant a priority, despite ample evidence that rural Australia has long been the incubator of successful innovation. One promising development is the increasing capacity of social media and internet sources like Croakey and Crikey to provide more broadly based views on health than are found in 'mainstream' media.7

Contextual considerations

Rural context and the portrayal of regional and rural communities are important in shaping the health behaviours and health actions of its communities. Messages that reinforce rural stoicism and a 'she'll-be-right' attitude are unhelpful in addressing rural health inequity. Rural populations are often shocked to learn they experience higher rates of morbidity and premature death through accident and preventable diseases. To be knowingly stoic one must be informed and aware of the consequences of choosing not to act, rather than not knowing how or where to act (Brumby 2014). Much remains to be done to communicate health
messages that recognise and address rural context rather than using a backwash of metropolitan campaigns or reinforcing stoic behaviours that promote inequity.

**Cross-sector collaboration**

The opportunity for improved health, well-being and safety outcomes through cross-sector collaboration is promising for rural populations. However, it is easy to talk about but difficult to do beyond physically or virtually meeting about it. Whole of government approaches that address critical social and economic determinants of health will provide more collateral strength in resourcing to address rural equity. This multi-pronged collaboration should be on every local, state and federal government departmental strategy.

**Commonwealth-state relations**

Despite the existence of a range of National Healthcare Agreements and many jointly funded health programmes, the rural health scene is littered with problems associated with poor delineation of responsibilities, lack of coordination and integration of programmes, cost-shifting, cross-border issues, and lack of mutual recognition.

One thing that would help greatly is a better data set for ‘current effort’. It is not surprising that the Commonwealth has found it challenging to be involved again in the funding of oral health programmes. Its fear is that for every extra dollar it puts into child oral health, for example, the states could divert an existing child oral health dollar to some other use.

**Conclusion**

In the last three decades considerable progress has been made in addressing the barriers to improved rural health outcomes. However the deficits and the gradient from major cities to very remote areas remain. There are still urgent challenges in a number of areas, including in Indigenous health as a whole, oral health and mental health. Some health risk factors are still much worse in rural areas than the major cities, including rates of smoking, dangerous levels of alcohol consumption and obesity.

Rates of smoking have been coming down in the cities at much faster rates than in rural and remote areas, which suggests the need for a fresh look at how health promotion is undertaken in rural areas. Without greater success on smoking rates in rural areas, Australia is very unlikely to meet its target of 10 per cent nationally by 2018.

A key question is the extent to which major improvements in rural health can be achieved without extra resources: how much more and better can be done with existing allocations. The prospect of increases in real expenditure on rural health is limited by fiscal fears and realities. Australians are now familiar with the scenario in which China sneezes and Australia catches a cold, and Europe
and the US have not been in the best of economic health for some time. A strong aspiration to balance the national budget or achieve a surplus will increase the drive for a financially sustainable national health system and, as this chapter has clearly demonstrated, the rural health sector is a part of that. This provides an opportunity for seeing health promotion and illness prevention as good investments for the economy as well as for the people.

If this argument is not won, however, there will need to be zero-net-cost changes, including in relation to the health workforce. Most of the desirable changes of this kind have been canvassed in the ‘health reform’ processes of the last five years. For example the National Health and Hospitals Reform Commission’s (NHHRC) Final Report (2009) included specific recommendations about the redistribution of resources to rural areas, but redistribution means that some will get less. This perhaps explains why those ideas fell on barren ground. The fact that there has been no national rural health strategy since the expiry of Healthy Horizons in 2007, and no rural health plan either, does not help the rural case.

The Council of Australian Governments (COAG) Reform Council is reporting annually on targets set in National Healthcare Agreements and its special rural supplement is a bright spot in terms of the use of evidence and public accountability. AHMAC’s current work on progress with key performance indicators in the National Strategic Framework for Rural and Remote Health may also deliver some much-needed means by which governments and other stakeholders can be held more publicly accountable.

People matter. Maximising their health status and life chances can only be assured through the provision of appropriate health care services - preventive, acute and rehabilitative. In the interests of people and national and state budgets, but particularly for residents of rural and remote communities, greater attention must be paid to a primary health care approach. This will see greater focus on the determinants of health, upstream of the health sector itself. True primary health care includes relevant activity in preschools and schools, health promotion initiatives such as fluoridation of water or quit smoking campaigns, workplace initiatives, targeted work relating to food, exercise and parenting and cross-sector collaboration. A good primary health care system includes access to good primary care: from a doctor, a community nurse, an allied health professional or dentist. In the health sector per se, there needs to be more emphasis on health promotion and illness prevention, the implementation of cross-sector collaborations and not so much on acute care and hospitals.

Such shifts in Australia’s health system will require changed attitudes and behaviours, and this will take time and patience. However, once achieved it will put the health system on a financially sustainable basis and the people of rural areas will be among the main beneficiaries. For, despite the improvements of the last three decades, there is still a significant metropolitan-rural health inequity. And it is large enough for us to be sure that, given any erosion in the general capacity of the national health system, it will be felt worst by the people of rural areas.
Notes

1 This chapter began life loosely based on two review articles published in the Australian Journal of Rural Health (AJRH): Humphreys et al. 2002; and Humphreys and Gregory 2012.


3 More reports on various aspects of rural and remote health can be found at www.ruralhealth.org.au.


6 Some of the history of AHCRA can be found at www.healthreform.org.au/history-of-ahcra/.


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