Chapter 1
Rural and remote health — definitions, policy and priorities

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Learning objectives

- Explain what is meant by rural and remote health practice.
- Outline the main geographical classification systems in use in Australia, and understand their significance in health decision making.
- Identify important aspects of Australian rural health policies from the 1970s to the present.
- Identify the main challenges to improving rural health in Australia.

Introduction

There are important differences between metropolitan, rural and remote Australia. As one moves away from the major cities on the edge of our vast continent, population dispersion increases, health outcomes decline, access to services becomes more difficult, prices rise and the wherewithal to meet these costs declines. At the same time, rural and remote Australia is also an incubator of new ideas, like the Royal Flying Doctor Service. In this highly urbanised country, the outback still helps to define our national identity.

In response to some of these inequalities, there have been substantial developments in rural health policy and rural and remote academic infrastructure and health services in Australia in recent decades. This new wave of rural and remote health developments commenced with the first National Rural Health Conference in Toowoomba in 1991 and was manifest in the first National Rural Health Strategy, launched in 1994. It is important for any student of rural health to understand this policy context, and what we mean by terms such as ‘rural’, ‘remote’, ‘rural health’ and ‘remote health’.

This chapter discusses the methods used to characterise areas or populations as rural and remote, summarises the main policy developments since the 1970s, and identifies the main challenges in improving rural health in Australia.

Geographical classification systems

Many rural–urban classification systems have been developed in Australia and overseas. These systems define rurality predominantly in terms of environmental parameters that influence access to services or in terms of physical remoteness from population centres. Some classification systems include sociodemographic indicators of varying complexity. These taxonomies are used in determining differences between rural and urban health or as the basis for resource allocation and health care planning; however, none incorporate any measure of need for health care.

Classification systems used in Australia have included the:

- Faulkner and French Index of Remoteness (Faulkner and French 1983)
- Griffith Service Access Frame (Griffith 1996)
- Rural and Remote Area classification (RARA) (DHSH 1994)
- Rural Remote and Metropolitan Areas classification (RRMA) (DPIE and DHSH 1994)
- Accessibility/Remoteness Index of Australia (ARIA) (DHAC 1999)
- Australian Standard Geographical Classification (ASGC) (ABS 2002).

The last three of these taxonomies — RRMA, ARIA and ASGC — are currently commonly used in Australia.

The RRMA, developed in 1994, is still used for research, policy and funding purposes. This taxonomy uses population size and calculated direct distance from the nearest service centre to determine seven discrete categories: capital cities, other metropolitan centres, large rural centres, small rural centres, other rural areas, remote centres and other remote areas.

ARIA uses a geographical information system (GIS) database to define road distance (in km) to 201 service centres with a population of more than 5000, to produce a sliding scale of remoteness. This continuous scale has also been divided into five classes: highly accessible (0–1.84), accessible (>1.84–3.51), moderately accessible (>3.51–5.80), remote (>5.80–9.08) and very remote (>9.08–12). ARIA overcomes some of the shortcomings of the RRMA by using a continuous rather than a discrete variable, based on road distance (not straight-line distance) and providing a weighting for island communities. However, this purely geographical method can result in the grouping of quite dissimilar localities.

The ASGC is based on ARIA+, a refinement of ARIA, which consists of five discrete categories: major cities, inner regional, outer regional, remote and very remote.

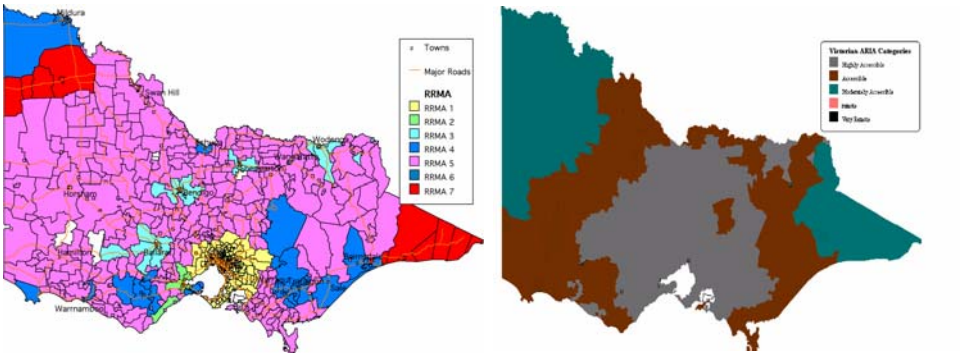
The choice of rural–urban classification used to underpin health decision making is significant. Table 1.1 compares RRMA classification with the ARIA categories. The geographical delimitation resulting from the two methods has major implications in terms of assessing health and workforce needs, and the resources allocated to meet them.

Table 1.1 Comparison of the Rural Remote and Metropolitan Areas classification and the Accessibility/Remoteness Index of Australia

RRMA classification	ARIA categories
Metropolitan zone	
RRMA 1 — Capital cities RRMA 2 — Other metropolitan centres (urban population >100 000)	Highly accessible (ARIA score, 0–1.84) — relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction
Rural zone	
RRMA 3 — Large rural centre (urban centre population 25 000–99 000) RRMA 4 — Small rural centre (urban centre population 10 000–24 999) RRMA 5 — Other rural area (urban centre population <10 000)	Accessible (ARIA score, 1.84–3.51) — some restrictions to accessibility of some goods, services and opportunities for social interaction Moderately accessible (ARIA score, >3.51–5.80) — significantly restricted accessibility to goods, services and opportunities for social interaction
Remote zone	
RRMA 6 — Remote centre (urban centre population 5000 or more) RRMA 7 — Other remote area (urban centre population <5000)	Remote (ARIA score, >5.80–9.08) — very restricted accessibility of goods, services and opportunities for social interaction Very remote (ARIA score, >9.08–12) very little accessibility of goods, services and opportunities for social interaction

The RRMA, ARIA and ASCG systems have different strengths and weaknesses. The RRMA's three zones — metropolitan, rural and remote — are logical groupings. All localities within a statistical local area (SLA) are given the same classification, therefore making it a simple tool for research or funding allocation. However, some SLAs are heterogenous in relation to access to services. The RRMA uses straight-line distances to urban centres, which may be quite different to road distances. The RRMA also fails to distinguish between access for those living in inner suburbs of capital cities and those on the fringes who often experience difficulty with access to services.

ARIA is a better measure of accessibility than the RRMA. It uses road distance to service centres. Unlike RRMA values, ARIA values are also less likely to change over time as they are independent of SLA boundary changes, but may change with significant population change. Dissimilar areas may, however, be given the same remoteness scores. Figure 1.1 shows the impact and differences of RRMA and ARIA for Victoria.



Source: RWAV (2002)

Figure 1.1 Rural, Remote and Metropolitan Area classification (left) and Accessibility/Remoteness Index of Australia classification (right) applied to Victoria

The ASGC tends to better group areas with similar characteristics. It defines the least remote areas more 'tightly' than ARIA, identifying those on the outskirts of major cities as 'inner regional'. It also distinguishes between capital cities. For example, areas in Darwin are classified as 'outer regional' because Darwin is not a category A service centre (population of 250 000 or more). All geographical classificatory systems are subject to limitations such as population and boundary changes over time (AIHW 2004). Using geographical classificatory systems alone for funding purposes can lead to problems, as they also do not take into account factors such as morbidity levels or the nature of the physical and social environment (AIHW 2004).

As well as geographical measures, various other quantitative and qualitative sociodemographic indicators are used to characterise metropolitan, rural and remote populations; for example, population, population density, Indigenous proportion of population, environmental considerations, health 'need', community resources, transport and communication (Humphreys 1998a). Other potential indicators, particularly in the remote context, include mobility (Warchivker et al 2000) and access to information (d'Plesse 1993).

Definitions and characterisation of rural health and remote health

Rural health and remote health are often subsumed in the term 'rural and remote health', but doing so fails to distinguish the differences in practice in these two settings.

The Royal Australian College of General Practitioners (RACGP) has defined rural health as (RACGP 1993):

> … medical practice outside of urban areas where the location of practice obliges general/family practitioners to have or acquire procedural or other skills not usually required in urban practice.
>
> Remote rural practice is practice in communities more than 80 km or one hour by road from a centre with no less than a continuous specialist service in anaesthesia, obstetrics and surgery and a fully functional operating theatre.

Hays and colleagues (Hays et al 1994) surveyed rural doctors in Australia and defined rural medical practice as:

> … that which occurs in an environment where a full complement of medical, other health professional and community services is at least 80 km or 1 hour away by road, resulting in the need for a wide range of clinical skills.

In the same paper, remote medical practitioners are characterised as more than 300 kilometres or 3 hours from support services (Hays et al 1994).

Bourke et al describe five salient aspects that characterise rural health practice (Bourke et al 2004). These characteristics, which are discussed in Chapter 2, are:

- rural–urban health differentials
- access
- confidentiality
- cultural safety (cultural security)
- team practice.

The economic and demographic nature of rural communities, their greater disease burden, fewer services, dispersed populations and higher cost of living result in patient needs and a type of practice that is quite different to urban or metropolitan practice in Australia. These are explored in some detail in Chapter 2.

Wakerman (2004) distinguishes between ‘rural’ and ‘remote’ practice. In particular, he highlights some of the distinct features of the remote context. The population is sicker and more dispersed, the workforce is sparser, costs are higher and a greater proportion of the population is Indigenous. Remote health practice also differs from that in rural areas.

Wakerman (2004) defines remote health as:

> … an emerging discipline with distinct sociological, historical and practice characteristics. Its practice in Australia is characterised by geographical, professional and, often, social isolation of practitioners; a strong multidisciplinary approach; overlapping and changing roles of team members; a relatively high degree of GP substitution; and practitioners requiring public health, emergency and extended clinical skills. These skills and remote health systems need to be suited to working in a cross-cultural context; serving small, dispersed and often highly mobile populations; serving populations with relatively high health needs; a physical environment of climatic extremes; and a communications environment of rapid technological change.

Parkes et al (1985) distinguish between isolation and remoteness. Isolation is essentially a construction of the senses: a pathological or undesirable component of human ecosystems. Remoteness, on the other hand, is a fundamentally geographic state that is derived from a measure of distance.

Classification systems used overseas

In the United Kingdom, Cloke and colleagues developed an index of rurality based on multivariate analysis of a range of demographic indicators (Cloke 1977, Cloke and Edwards 1986). The United States has a plethora of classification systems. Rurality is generally defined by either the Bureau of the Census, Urban–Rural Classification of Areas and Population or the Office of Management and Budget Metropolitan and Non-Metropolitan Classification of Counties (Ricketts et al 1998). Rural is fundamentally defined as 'not urban'.

In the United States, the equivalent to a remote area is the concept of frontier; a frontier area being based on one or more of the following characteristics (Ricketts et al 1998):

- population density (six or fewer persons per square mile)
- distance (45 miles) and/or time (60 minutes) from primary care to the next level of care
- service area (500–3000 residents within a 25-mile radius of a health service site or within a logical trade area).

Definitions of 'rural' and 'remote' can also be descriptive and health practice-based, in which case they are largely medico-centric. For example, the Rural Committee of the Canadian Association of Emergency Physicians offers the following definitions (CAEP 1997):

- Rural remote — rural communities about 80–400 km or about 1 to 4 hours transport in good weather from a major regional hospital.
- Rural isolated — rural communities greater than 400 km or about 4 hours transport in good weather from a major regional hospital.

There are various other indices used in Canada and New Zealand. For example, in Ontario, isolated or specified communities qualify for additional incentives for doctors. 'Isolated' communities are those with fewer than 10 000 people, more than 80 km from a regional centre of more than 50 000 people (Rourke 1994).

The General Practice Rurality Index of Canada (GPRI) scores six factors — remoteness from a basic referral centre, remoteness from an advanced referral centre, population size, number of general practitioners, number of specialists and presence of an acute care hospital (Ludec 1997). The New Zealand GP Network Rural Ranking Scale uses concrete practice factors such as travel time for GP from office to hospital, while on call, geographically to discuss with nearest colleague or visit the most distant patient and consult at a number of regular peripheral clinics (Rourke 1997).

Australian rural and remote health policies

Rural and remote areas in Australia are characterised by poorer health status than metropolitan areas (AIHW 2005a). In seeking to ensure optimal health for all, programs and initiatives are unlikely to significantly affect many health outcomes unless they are part of a strategic approach to address the environmental (both physical and social) and behavioural determinants underpinning these health differentials. Policy is thus important in setting the principles, the overarching strategic framework and the guidelines for programs designed to address those health differentials characterising rural and remote Australia that are considered to be unnecessary, avoidable, unfair and unjust (Humphreys et al 2002a).

Winston Churchill once said 'the further backward you look, the further forward you can see' (Kamien 1997). What follows in this section is a brief excursion through the 'macro-scale' policies that have set the national rural health agenda over recent decades, and have underpinned the decisions relating to resource allocation, service provision, workforce supply and collaborative arrangements relating to rural and remote health. Table 1.2 outlines a broad chronology of periods during which rural health issues were the subject of different priorities and responses by the Australian Government.

The 1970s

Australia experienced significant changes following the election of the Whitlam Labor government in 1972. Driven by a fundamental belief that 'Increasingly, a citizen's real standard of living, the health of himself and his family … are determined not by his income, not by the hours he works, but by where he lives' (Whitlam 1972), Whitlam's urban and regional development policies focused on geographical inequalities characterising rural and remote regions. The policies were also developed in response to disadvantaged areas in inner city suburbs and the outer western suburbs of capital cities. In conjunction with the introduction of Medibank, a universal health insurance scheme designed to provide equality of access to health care regardless of where one lived, the Whitlam government funded a program of community health centres to increase the geographical access of socioeconomically and ethnically disadvantaged groups to primary care services. This strong public sector response was designed to redress the inherent failure of the marketplace, and ensure equality of access to health services based on need.

The dismissal of the Whitlam government in 1975 saw the end of Medibank and stringent economic cutbacks as the Fraser government expenditure review committee (commonly referred to as the 'razor gang') attempted to dismantle many of the Whitlam initiatives. In these circumstances, the outcomes of a landmark national review of the state of rural health in Australia went largely unnoticed, despite the findings 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. (HHSC 1976)

These conclusions were reinforced at the first ever major rural doctors' conference held in Australia (Walpole 1979), but it would be another decade before there was any significant policy response.

The 1980s

The election of the Hawke Labor government in 1982 brought a renewed emphasis on access and equity to national policy. During this decade, the Commonwealth Grants Commission was used as a mechanism for ensuring that funding was distributed to the states in a way that took account of differences in their ability to service the needs of their inhabitants for similar level and quality of services, including health. Nonetheless, it was during the 1980s that rural health issues in particular came to the fore in a more explosive way than ever before. Following several key government reports on the medical workforce in Australia (Doherty 1988) and the country doctors' dispute in NSW, the Australian Government Department of Health set up a rural health care task force to 'consider the problems of provision of health care services to rural and remote areas', and report to the Australian Health Ministers' Advisory Committee (ARHCTF 1990). It was the outcomes of this report that laid the foundations for a major national conference in Toowoomba to consider a national strategy and program of initiatives designed to meet specific health needs.

Table 1.2 Chronology of policy approaches to rural health issues in Australia

Time period	Nature of the problem				Policy and program activity		
	Key rural health issue	Locus of the problem	Explanation	Key concept	Drivers of change	Type of change sought	Method of change
1970s	Social and geographical disadvantage	Disadvantaged subgroups and regions	Market-generated inequalities	Inequitable life-chances	Australian Government	Community and regional development	Regional development
			Poor access to mainstream services and high level of health needs	Human rights and equity of access	Aboriginal communities and organisations	Equity of access; Aboriginal Community Controlled Health Services	Universal health coverage (Medibank); community health centres; Aboriginal Community Controlled Health Services
1980s	Funding of rural services	Grants Commission	Inequitable fiscal distribution; service closures	Equity of access	States	Redistribution of funding	Commonwealth –state forums; fiscal equalisation
	Rural workforce issues	Failure to recognise workforce needs	Rural practice not properly recognised	Recognition and remuneration	Professional Associations (RDAA, AMA)	Remuneration and support for rural doctors	Alternative funding arrangements
1990s	Unmet rural health needs	Inadequate focus on specific rural issues	Failure of mainstream policy to address specific rural issues	Social justice; Indigenous health	Ministers; doctors; Royal Commissions (eg Burdekin, Aboriginal Deaths in Custody); peak bodies such as NRHA	Community empowerment	Specific rural health policies and programs to target rural, remote and populations subgroups
	Workforce shortages and maldistribution	Universities; professional colleges	Education and training failures	Workforce	Australian Government	Enhanced rural training programs	Positive discrimination policies and incentives

Time period	Nature of the problem				Policy and program activity		
	Key rural health issue	Locus of the problem	Explanation	Key concept	Drivers of change	Type of change sought	Method of change
2000–present	Unmet rural health needs	Service centralisation and rationalisation	Demise of rural communities; inadequate service models	Service access	Australian Government	Improved local service models	New models of delivery; telehealth
		Ageing of population	Demographic changes	Ageing, chronic diseases	National health priorities; Inter-generational Report	Primary health approach	Care coordination and service integration
	Rural workforce issues	Supply, recruitment and retention	Problem with existing training programs	Workforce	Australian Government; universities	Multidisciplinary, rural-based training	Rural clinical schools; IPE; IMGs
	Health system/ service failures	Federalism arrangements	Commonwealth –State relationships	Health financing arrangements	Escalating health costs; health reform groups; Productivity Commission and COAG	Health system reform; changing practice arrangements and models of care	Primary health approach; health system reform

AMA = Australian Medical Association; COAG = Council of Australian Governments; IMG = international medical graduates; IPE = interprofessional education; NRHA = National Rural Health Alliance; RDAA = Rural Doctors Association of Australia

The 1990s

The 1990s were characterised by the most significant program of rural health reforms ever seen in Australia. In 1994, the Australian Health Ministers Council endorsed a National Rural Health Strategy. The declared purpose of this strategy was to provide a coordinated framework for ensuring equitable access to effective health care for rural and remote communities. The strategy would achieve its aims through the provision of appropriate health services, the promotion of measures designed to maximise the health status of rural and remote residents, and the adoption of strategies that minimise barriers and problems that impede the delivery of effective health care (AHMC 1994). This strategy represented the first systematic attempt to effectively target the specific health needs of residents of rural and remote Australia. It was, in effect, a public acknowledgment that, up until this time, mainstream health policies and programs had failed to adequately address rural health requirements. Central among the principles underpinning the National Rural Health Strategy were that rural health services should be

accessible, needs-based, accepted by the community, comprehensive, multidisciplinary, integrated and coordinated, able to provide continuity of care and sufficiently flexible to respond to changing needs.

Driven by the National Rural Health Strategy, numerous Commonwealth, state and territory rural and remote initiatives followed. In recognition that states and territories were largely responsible for the funding and provision of non-medical health providers, Australian Government programs such as the RHSET Program and the Rural Incentives Program focused largely on doctors in the first instance. Other initiatives included the setting up of a network of divisions of general practice and the introduction of retention grants for rural doctors. These Australian Government initiatives were led and embraced by health ministers and 'champions' working within the health department. At this time too, a number of peak rural and remote health professional bodies became more active professional groups lobbying on behalf of their constituents. These were the Rural Doctors Association of Australia (RDAA), the Association for Australian Rural Nurses (AARN), Services for Australian Rural and Remote Allied Health (SARRAH), the Council of Remote Area Nurses of Australia (CRANA) and the National Aboriginal Community Controlled Health Organisation (NACCHO). The peak non-government rural health body, the National Rural Health Alliance, was also active (Chater 1993).

Many of these rural and remote health program initiatives were maintained by the Howard Coalition government under the 'rebadged' General Practice Rural and Remote Program. In addition, a rural health stocktake was undertaken in the late 1990s (Best 2000), and the University Departments of Rural Health (UDRH) were established in regional centres of all states and the Northern Territory. At the same time, in response to evidence showing that rural and remote doctors warranted increased remuneration to obtain parity in terms of the relative value of their work, the government funded several major consultancies to further investigate workforce supply, alternative sustainable models of health services for small rural and remote communities, and the role of Divisions of General Practice.

The Australian National Audit Office 1998 review highlighted the failure of mainstream health programs to meet the health needs of rural Australians adequately, noting in particular the failure of many Australian Government health programs to have a specific rural focus, the absence of rural health as a key priority within its programs, the meagre financial resources allocated to rural health and the lack of performance indicators for the measurement of outcomes as all contributing to shortcomings in addressing the health needs of rural Australians (Auditor General 1998). The response from the Australian Government has been a plethora of program initiatives targeting some aspect of rural, remote or indigenous health — more than 60 at the time of writing this chapter.

Many commentators have argued that the real impetus behind any significant government response to the health needs of rural and remote communities, however, resulted from the emergence of Pauline Hanson and the One Nation party as a real political threat (Tonts and Haslam McKenzie 2005). The then deputy prime minister convened a Regional Australia Summit in Canberra, following which the health minister announced the largest ever Regional Health Services program with a budget in excess of $500 million to

address some of the outstanding issues relating to the rural health workforce supply, needs for education and training, and alternative models of service provision. Funding was provided to establish rural clinical schools throughout all states and territories. Although this response did not achieve the major health system reforms being advocated by the Australian Health Care Reform Alliance, it did result in significant changes to university medical education and training, with a view to ensuring a sufficient workforce supply to meet the shortfall in rural and remote areas.

The present decade

In 1999, the Australian, state and territory governments developed Healthy Horizons (NRHPF and NRHA 1999) with the National Rural Health Alliance (NRHA) as the national framework to guide rural and remote health activity for the following five years, a policy framework that has been reaffirmed through to 2008. As a result, there is now general agreement across governments on the need for a specific policy response to rural health issues and the guiding principles that should underpin planning for the provision of health care services:

- The Primary Health Care approach is supported as it provides the opportunity to keep people healthy within the community setting and to intervene at the earliest possible stage to support and maintain good health.
- Public health forms the basis of improvements in health outcomes and is essentially about activities and programs directed towards prevention. In recent years, the term 'population health' has been used to more clearly describe prevention at the population level and encompass broader determinants of health. The population health approach is important as a basis for a range of actions, such as deciding the location and number of services, informing and educating people about changes needed in their services to meet changing health priorities, and fostering innovation in service delivery and facilities to achieve optimum health outcomes.
- Social capability and the physical capacity to plan and implement local programs are required for communities to improve and maintain their health.
- Community participation by individuals, communities and special groups in determining their health priorities should be pursued as a basis for successful programs and services to maintain and improve their health.
- Ensuring appropriate access to comprehensive health services that are culturally sensitive is fundamental for all people in rural, regional and remote Australia.
- The ability to sustain good health and a system of care is a necessary part of sustaining rural, regional and remote communities.
- The establishment of effective partnerships in the delivery of services, and collaboration for the benefit of communities are essential ingredients in successful implementation of health improvement programs.
- There will be no compromise on the safety and quality of health services provided to people living in rural, regional and remote Australia. Safety and quality are paramount in the development and implementation of health services and programs

(AHMAC, NRHPS and NRHA 2003).

Healthy Horizons identified seven interdependent goals as the focus of the national framework for rural and remote health care activity. These goals are to:

- improve the highest health priorities first
- improve the health of Aboriginal and Torres Strait Islander peoples living in rural, regional and remote Australia
- undertake research and provide better information to rural, regional and remote Australians
- develop flexible and coordinated services
- maintain a skilled and responsive health workforce
- develop needs-based flexible funding arrangements for rural, regional and remote Australia
- achieve recognition of rural, regional and remote health as an important component of the Australian health care system.

Since 2000 there has been a significant emphasis at all levels of governments on recruitment and retention measures to ensure an adequate supply of all health professionals — doctors (including national endorsement of international medical graduates to take up practice in Australia), nurses and allied health practitioners. The significance of workforce problems was highlighted by submissions to, and the response of, the Productivity Commission's *Australia's Health Workforce* study (Productivity Commission 2005). However, this report, which is responsible for driving the Council of Australian Governments (COAG) response, did not situate the problems of rural and remote health within the broader political and economic arena that largely determines the attractiveness and economic fortunes of rural and remote communities. Nor is it likely to tackle the key inhibitors to health system reforms so forcefully advocated by the Australian Health Care Reform Alliance. No longer 'flavour of the month', rural and remote health issues are in danger of becoming subsumed within mainstream primary health care programs that seek to tackle the problem of how to prevent and manage the escalating chronic disease burden. Indeed, it appears that rural and remote health is becoming marginalised in an agenda dominated by economic management of the broader health care system.

The health and wellbeing of all Australians living in rural and remote communities is influenced by a wide range of policies that cut across many Commonwealth, state and local government functional areas and departments. However, the need to maintain and review a specific national strategy to target the health needs of rural and remote Australians is unequivocal. Academic research has long advocated the need for specific rural measures (Humphreys 1998b, Humphreys et al 2002a) and the distinctiveness of rural and remote practice (Strasser 1995, Wakerman 2004).

The key question is whether the policy-led initiatives and programs will ensure an adequate workforce supply and access to appropriate, sustainable health care services, to

increase the health status of non-metropolitan Australians. 'Those who cannot remember the past are condemned to repeat it' (Santayana 1905). At the peak of the rural health policies and programs in the mid-1990s, Clark and Martini (1998) noted seven 'foundation issues of fundamental concern' relating to rural and remote health: workforce, local management, service delivery, research, public health, Indigenous health, and organisation. Ten years later, these are still central issues accounting for the poorer health status of rural and remote communities throughout Australia.

Challenges to improving rural and remote health

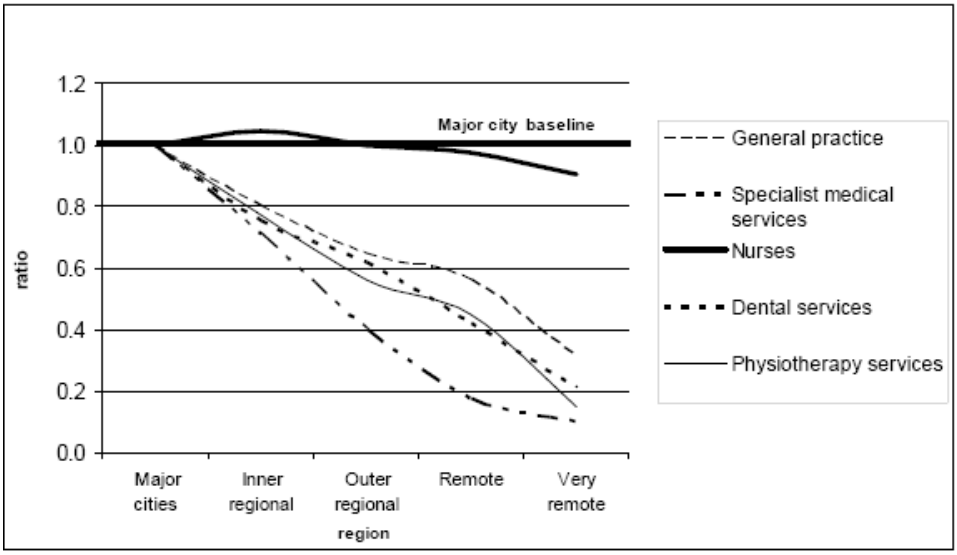
Despite the many workforce initiatives over the past decade, particularly medical workforce initiatives, there are still outstanding social, economic and demographic issues, including broader health service issues, that have characterised the health and health care problems facing rural communities.

Rural and remote communities, particularly those smaller and more remote, have been subject over the past decade to social and economic drivers that to a large extent work against improving health and wellbeing, and therefore fail to close the gap in health outcomes between the city and the bush. Global economic forces and re-adjustment by the rural sector have put economic pressure on rural areas for some decades. The neoliberal policy orientation of many western governments over recent years has resulted in a diminished role for government and greater emphasis on the marketplace for allocating resources. It has been suggested that this has resulted in central agencies in Australia, such as Treasury, viewing health and education as an expenditure rather than investment in the human and social capital of rural Australia (Tonts and Haslam McKenzie 2005). There has also been a policy momentum away from supporting very remote communities. Drought and the ongoing impact of climate change have added to the pressure on many rural communities. These have all resulted in continued population movement away from smaller rural and remote communities to regional and coastal centres, and made the job of closing the health differential and economic gap more difficult. 'Sustainable health services depend on sustainable communities' (Humphreys 2005a).

In relation to specific health sector issues, institutional capacity has grown significantly since 1991, with a range of organisations, including RCS and UDRH, the NRHA and various rural and remote professional groups. The Australian Government in particular has focused on workforce policies and programs, particularly the medical workforce.

In the face of a global health workforce shortage, an ageing population and an ageing health workforce, significant workforce problems remain. The overall health workforce shortage in Australia is worse in rural and remote areas (see Figure 1.2, Productivity Commission 2005). The maldistribution of the medical workforce appears to be worsening. Between 2000 and 2004, the supply of medical practitioners increased in metropolitan areas but fell in non-metropolitan areas (AIHW 2006a). Remote areas have been particularly affected. In ASGC 'very remote' areas, the number of GPs fell alarmingly — by 33% — from 100 per 100 000 people in 2000, to 67 per 100 000 in 2004 (AIHW 2006a). At the same time, nurses, who make up the largest element of the

workforce, showed a much more even distribution across metropolitan, rural and remote areas (AIHW 2006b). International graduates form 25% of the medical workforce, and Australia's rural and remote communities now rely particularly on these and other overseas-trained health professionals (Productivity Commission 2005).



Source: Productivity Commission (2005)

Figure 1.2 Practitioner to population ratios by ASGC area

In light of global pressures, an ageing workforce and an ageing population, addressing workforce disparities alone will not be sufficient to improve access. Effective, sustainable services will increasingly depend on developing appropriate service models that take into account a range of issues that include, but are not limited to, workforce. A number of environmental enabling factors and essential requirements, summarised below, will need to be addressed in a comprehensive and systematic fashion (Wakerman et al 2006).

Environmental enablers

Environmental enablers include the following:

Supportive policy: Effective, sustainable health services in rural and remote communities require an explicit rural and remote health services policy that specifically takes account of the unique rural and remote considerations that distinguish this context.

Improved Commonwealth–state relations: Given the scarcity of health resources and the need to allocate them across widely divergent geographical settings, it is important to

avoid inefficiencies and duplication of activities, as well as the complex funding, reporting and accountability requirements that characterise existing Commonwealth and state arrangements (Productivity Commission 2005).

Community readiness: Central to primary health care services is an appropriate level of community involvement in the identification of health needs, planning and governance of the health service.

Essential requirements

Essential requirements include the following:

Workforce organisation and supply: Adequate workforce supply, appropriate staffing mix and effective working relationships are all important. Multidisciplinary practice using the combined skills of doctors, nurses, allied health, Indigenous health workers and newer categories of workers will be an increasingly urgent necessity. Strategies need to include recruitment, retention and succession planning.

Funding: Funding should be adequate to meet the identified health needs of the community; it should also be appropriate, sustainable and clearly identified within program budgets. Appropriate financing relates closely to streamlining of Commonwealth–state relations, such as with a 'pooled funding' or 'block funding' model (Productivity Commission 2005).

Governance, management and leadership: Appropriate governance structures, adequate management skills and systems, and champions, are all hallmarks of successful services.

Linkages: Linkages are critical within the health service and with external agencies and services relevant to patient care.

Infrastructure: Infrastructure should be adequate and include physical infrastructure such as clinics, accommodation, equipment and vehicles, and ICT systems appropriate to the service.

In addition to these specific health service issues, the evidence base and literature that evaluates the effectiveness of different health service models is sparse (Productivity Commission 2005, Wakerman et al 2006). A recent systematic review highlighted the paucity of rigorous evaluations of the impact and sustainability of innovative rural health services, many of which were set up as pilots or demonstration models (Wakerman et al 2006). In the absence of a comprehensive understanding of what programs work well where and why, government ability to respond effectively to the rural–urban health differential will continue to remain limited.

Finally, we need an effective, coordinated, evidence-informed rural and remote health policy that addresses all of these areas. The policy needs to be comprehensive, coordinated and supported by different levels of government and key rural organisations.

Through the development and implementation of such a policy, improved access to health services in rural and remote Australia should contribute to decreasing health inequalities.

Conclusion

There is no doubt that residents of rural and remote communities have poorer health than their metropolitan counterparts. Overcoming this rural–urban differential will require several things. First, better agreement is required on the classification schemes employed to identify the rural–urban health differential, and should be used as the basis for appropriate resource allocation and planning responses. Second, it is vital that governments understand the nature of the rural–urban differential and its underlying aetiology (including the role of social and economic determinants). Further research is required to determine to what extent rural and remote health problems are due specifically to the nature of rural and remote environments (both physical and human), or to what extent they are manifestations of broader-based societal issues. That is, to what extent is the 'rural' and 'remote' in the health problem causal or symptomatic (Humphreys 2005b)? In the absence of a specific rural or remote aetiology, the question emerges, why not address these health issues through a mainstream assault on the relevant determinants of health status — particularly the socioeconomic system responsible for poverty and inequality, the inefficiencies and inequities in resource allocation, and the paradox of contradictions and gerrymanders inherent in the current market-driven system? Third, comprehensive program evaluation is necessary to determine which policies, service models and programs are most effective at addressing the rural–urban health divide (Tonts and Haslam McKenzie 2005). Only with such knowledge will governments be able to respond efficiently and effectively within their constrained budgets.

Recommended readings and resources

- AIHW (Australian Institute of Health and Welfare) (2004). *Rural, Regional and Remote Health: A Guide to Remoteness Classifications*, AIHW, Canberra. http://www.aihw.gov.au/publications/index.cfm/title/9993

This is a useful monograph which describes how commonly used geographical classification systems in Australia have been developed, and their relative strengths and weaknesses.

- AIHW (Australian Institute of Health and Welfare) (2005a). *Rural, Regional and Remote Health Indicators of Health*, Rural Health Series 5, AIHW, Canberra. http://www.aihw.gov.au/publications/index.cfm/title/10123

This monograph provides a comparative overview of health, social, economic and service indicators across geographical regions in Australia.

- Bourke L, Sheridan C, Russell U, Jones G, DeWitt D and Liaw S-T (2004). Developing a conceptual understanding of rural health practice. *Australian Journal of Rural Health* 1:181–186.

The authors provide a conceptual framework for considering rural health issues in Australia and describe five salient aspects that characterise rural health practice: rural–urban health differentials, access, confidentiality, cultural security and team practice.

- Humphreys JS, Hegney D, Lipscombe J, Gregory G and Chater B (2002). Whither rural health? — Reviewing a decade of progress in rural health. *Australian Journal of Rural Health* 10:2–14.

This paper reviews rural health policy and developments in the latest wave of rural health activity in Australia, and discusses measures required for overcoming outstanding impediments to improving rural health. It is written by rural health leaders from different disciplines.

- Wakerman J, Humphreys J, Wells R, Kuipers P, Entwistle P and Jones J (2006). *A Systematic Review of Primary Health Care Delivery Models in Rural and Remote Australia 1993–2006*, Australian Primary Health Care Research Institute, Canberra. http://www.anu.edu.au/aphcri/Domain/RuralRemote/Final_25_Wakerman.pdf

This systematic review documents a conceptual model of rural and remote primary health care (PHC) delivery in Australia. It defines a number of environmental enablers and essential requirements of rural and remote PHC services that are useful to policymakers, service deliverers and students. It also documents a number of exemplary remote and rural PHC services.

Learning activities

1. Examine a state government health initiative (eg a Victorian stroke management plan) for any evidence of how the rural health issues are addressed. In particular, describe how the main Australian geographical classification systems have been applied.
2. Examine the rural health policy relevant to your profession and how it may affect you. Compare and contrast any differences between federal and state or territory governments, and between the major political parties.
3. List the main challenges to reducing the rural–urban health differentials in Australia.