Preventive Healthcare and
Strengthening Australia’s Social and Economic Framework

Rural Doctors Association of Australia
January 2005
Preventive Healthcare and Strengthening Australia’s Social and Economic Framework

RECOMMENDATIONS

In response to the call for stakeholder input into the proposed key research themes to be addressed by the National Health and Medical Research Council (NHMRC) in a future targeted research program, the Rural Doctors Association of Australia (RDAA) makes the following recommendations:

1. That given the widespread recognition of the nexus between social and economic factors and health and illness, research must investigate the barriers to the integration of the significant body of evidence already available into national policy and programs and ways to facilitate this in the contemporary cultural, political and fiscal environment.

2. That the proposed NHMRC research program should be formally linked to wider research and reform and review agenda, particularly those related to the National Competition Policy, international trade agreements and income regulation and maintenance policies, to ensure that their impact on the health and well-being of all Australians is understood and taken into account.

3. That the proposed research agenda be closely aligned with the consultative development of a national primary health care policy and coordinated with that of the Australian Primary Health Care Research Institute and other relevant institutions.

4. That all research grants allocated under the future program be required to include specific attention to the health and well-being of the populations of rural and remote Australia.

5. That, given the proportion of the population that lives in rural and remote Australia, their socio-economic and health disadvantage and the previous lack of research into their specific needs, forty percent of all grants under the future program should:
   - have a primary focus on the health of those living in rural and/or remote Australia
   - involve these populations in the design and implementation of research, and
   - be led by appropriately resourced rural based researchers
6. That priority issues for investigation must include:

a. the development of a flexible framework to delineate minimum core health service requirements of small rural communities, including those without resident medical care, and associated tools to enable these communities to assess their needs and resources and practical ways of matching them.

b. viable models of small rural hospitals including preventive and acute health care services tailored to specific community needs

c. the role of small rural hospitals and maternity units in maintaining the health and socio-economic vitality of rural communities

d. the health and socio-economic impact of hospital closure or downgrade on small rural communities and a flexible template for assessing this, and

e. a specific focus on the socio-economic factors associated with chronic disease and its prevention, diagnosis and management in rural and remote Australia.

7. That research into strategic approaches to the impact of social, economic and cultural factors on the health and sickness of Aboriginal and Torres Strait Islander peoples have an increased focus on community control, local social enterprise and concepts of mutual obligation.

The Rural Doctors Association of Australia, which represents general practitioners and specialists from all parts of rural and remote Australia, is well placed to participate in the research outlined above and would be happy to do so.
A. The Rural Doctors Association of Australia

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice.

The RDAA is a federal body with seven constituent members - the Rural Doctors Associations (RDAs) of all States and the Northern Territory. Every RDA is represented on the RDAA Committee of Management which meets monthly by teleconference. Each autonomous State/Territory association works and negotiates with relevant bodies in its own jurisdiction, while the RDAA Committee of Management, supported by a small national secretariat in Canberra, has overall responsibility for negotiations with the Commonwealth and working with national bodies and decision makers.

In keeping with the overall demographic profile of the rural medical workforce, most RDA members are general practitioners (GPs) and most are men. However, the Association takes steps to ensure that the interests and perspectives of smaller groups within the rural medical workforce are incorporated into its advocacy and negotiations. This has led to the establishment of special interest groups for female doctors and rural specialists, both of which meet regularly to discuss specific and generic rural workforce matters. RDAA also works closely with relevant agencies to support the interests of the Overseas Trained Doctors (OTDs) who now make up over 30% of the rural medical workforce.

The RDAA has a primary focus on industrial issues and seeks to promote the maintenance and expansion of a highly skilled and motivated medical workforce that can provide quality care to the people of rural and remote Australia. Much of its work therefore concentrates on recruitment and retention issues and the viability of rural medical practice. However, it also works on particular health and health service issues including Indigenous health, rural obstetric care, small rural hospitals and rural and remote nursing practice.

As the only advocacy body with a specific mission to support the provision of medical services to rural and remote communities, RDAA has a particular responsibility to ensure that the needs and perspectives of people who live in the bush are heard by decision makers and incorporated into the design and implementation of national policies and programs.

B. Public policy

It is now some decades since formal research confirmed what general practitioners and other healthcare professionals have long recognized: that social, economic and environmental factors – income, education, employment, social support, culture, autonomy and infrastructure – have a direct and indirect impact on the health and sickness of individuals and communities. Although the aetiology is not always clear, the evidence is sufficiently robust to demand attention in health policy, programs and service delivery. Yet acute care and clinical investigation continue to dominate health research agenda and funding systems.
Although the determinants of health are increasingly well characterized and well reported, comparatively few resources are directed towards addressing them. Expenditure on preventive and health promotional services, as a proportion of total health expenditure, has remained static over the last 30 years.¹

The benefits of early detection are obvious and compelling evidence supports screening for an increasing group of illnesses. Programs and initiatives like those to address breast and cervical cancer are effective and well received. However, although population screening is inappropriate for a number of conditions, there is very little Medicare support for screening in general practice – the health care service most used by Australians.

Conversely, broad socio-economic research and agendas appear to ignore health implications even more resolutely, or to concentrate on those matters which can be seen to have an obvious and direct impact. For example, public debate on the Free Trade Agreement with the United States included a strong focus on the potential health implications of the impact on the Pharmaceutical Benefits Scheme but little on the potential socio-health implications of broad income and employment issues or importing cheaper American food products that have contributed to the epidemic of obesity in the United States. The Productivity Commission’s Review of National Competition Policy Reforms suggests the possibility of pricing drinking water at its “true” economic value, but does not refer to the impact this could have on some parts of the population.² Suggestions of reduced wage or income maintenance rates have not been accompanied by any analysis of the impact they might have on the health of recipient families.³

There are some deeply embedded reasons for this. The positivist, sharply focused scientific paradigms of the nineteenth century led into previously unthinkable progress in the diagnosis and treatment of many illnesses. The extraordinary pharmaceutical and technological developments of the twentieth century reinforced the position of curative medicine and institutions.

Ironically, the earlier triumphs in public health sought the cause of illness in the wider environment and achieved its prevention through better living conditions, public engineering and often simple behavioural change. Many of the advances of the last century have delayed death by enabling more years of managed disease and prolonged disability. The implications of substituting morbidity for mortality are well recognized in the context of demographic ageing. Quality of life is an accepted criterion at many levels. Yet the imperatives inherent in the juxtaposition of these concepts do not always find their way into integrated public policy.

This paradox is not confined to the health system. The effects of economic conditions on health are more commonly acknowledged than the effects of ill-

³ for example, in the Centre for Independent Studies differential wages plan, November 2003
health on national wealth accumulation and economic productivity. The latter are more insidious and incremental than the former. They are therefore less likely to engage action in an environment of short term political cycles, particularly when change could disadvantage commercial interests or diminish government revenue or popular appeal. The idea of cross-jurisdiction or cross-portfolio responsibility is acceptable, but the significant shift of power and resources which would follow logically from recognition of the mutual benefits of healthy populations and healthy economies is not.

Thus public policy efforts to combat licit substance abuse, obesity or poverty, for example, are diluted or delayed. Implementation often relies on exhortation which, however evidence based, is seldom a powerful tool for promoting change in individuals or jurisdictions.

Yet evidence demands change, and this change must include:

- integrated macro-level social and economic policies, with a particular emphasis on financial and educational disadvantage, living and working conditions and infrastructure
- realistic and sensitive drivers of behavioural modification
- health policies which reflect the importance of preventive care through appropriate funding systems and focus on equity of access, intersectoral collaboration and flexibility in applying good models of care in diverse environments
- differential analyses to monitor and guide its impact on different parts of the population

This change is needed now as the population ages in a rapidly changing socio-economic environment.

Although we must do more research to reinforce and expand our knowledge, we have enough information to start now. This will require resources and bipartisan, whole of government support. While the large burden of disease requires continuing investment in healthcare, we must move beyond alleviating damage once it has occurred and invest significantly in preventative health efforts.4

RDAA therefore recommends:

1. That given the widespread recognition of the nexus between social and economic factors and health and illness, research must investigate the barriers to the integration of the significant body of evidence already available into national policy and programs and ways to facilitate this in the contemporary cultural, political and fiscal environment.

2. That the proposed NHMRC research program should be formally linked to wider research and reform and review agenda, particularly those related to the National Competition Policy, international trade agreements and income regulation and maintenance policies, to ensure that their impact on the health and well-being of all Australians is understood and taken into account.

C. A national primary health care policy

A national primary health care (PHC) policy would provide a sound basis for change within and beyond the health sector. Definitions of primary health care have multiplied and diversified since Alma Ata. However, as a recent literature review summarized those used in Australian jurisdictions:

*Common priority areas include a focus on population health, balancing prevention/promotion/early intervention, and the management of chronic and complex conditions, addressing the social determinants of health and reducing health inequalities, strengthening community capacity and engagement and building organization and system capacity.*

Primary health care is universally seen as the first point of contact between an individual and the formal healthcare system and the gateway to other parts of the system. Consulting a doctor is the most common action related to health care taken by Australians. Nationally, GPs provide on average 4.9 consultations per person per year to 87% of the population. As well as the curative care provided by their urban colleagues, rural medical practitioners are very often also responsible for the acute care of their communities at their local hospital. Preventive health care and surveillance, the management of chronic disease, disability and the conditions of old age are also within their remit. At this level, primary health care, supported by initiatives like the Enhanced Primary Care (EPC) Medicare items, works well.

At a national or population level, however, primary health care is hampered by under-funding and a lack of coherent direction and a clear framework within which knowledge of the social and economic determinants of health can be effectively integrated with clinical expertise and experience into the prevention everyone agrees is better and less expensive than curative and acute care. High profile activities in some areas – to reduce levels of smoking or obesity, for example – are often isolated or fragmented in the sense that they are not well supported in other policy areas. Practical incentives to offer or act on health

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5 McDonald J & Hare L (2004) – *The contribution of primary and community health services: literature review.* Sydney, Centre for Health Equity, Training, Research & Evaluation (CHETRE), University of NSW p11
7 *ibid* p297. These figures are based on Medicare funded services and do not include those funded in other ways, for example through Aboriginal Medical Services or the Department of Veterans Affairs.
promotion are limited. Workforce shortfalls limit the capacity of doctors, nurses and allied health workers to provide opportunistic preventive care.

RDA members are among the many Australians who see the collaborative development of a national primary health care policy as an essential component of much needed reform of Australia’s healthcare systems and structures. Without this, the increasing disparities in health outcomes which mirror the gap between the least and most advantaged groups in the Australian population will continue to widen.

Recognition of the social and economic determinants of health demands that these elements be incorporated into health and wider public policy. However, this does not mean that the role of quality clinical services should be de-emphasized. Universal access to them is in itself a social determinant of health. Eliminating locational, financial and cultural barriers to accessing them must be a fundamental objective of any PHC policy. Applying what is already known about the broader causes of illness is another.

*In the integrated primary healthcare model, the aim is to improve the health of geographically defined populations by providing a comprehensive range of medical, health, social and community services through both horizontal and vertical integration with other parts of the health system.*

RDAA therefore recommends

3. That the proposed research agenda be closely aligned with the consultative development of a national primary health care policy and coordinated with that of the Australian Primary Health Care Research Institute and other relevant institutions.

D.1 Health and illness in rural Australia

The latest health report of the Australian Institute of Health and Welfare (AIHW) summarizes the widely acknowledged disparities in health status and health risk between the urban and rural populations of Australia:

...those who live outside Major Cities [population > 250,000] tend to have higher levels of health risk factors and somewhat higher mortality rates than those in the cities...compared with people in Major Cities, those living elsewhere are more likely to be smokers; to drink alcohol in hazardous quantities; to be overweight or obese; to be physically inactive; to have lower levels of

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8 RDAA will be working with the other members of the General Practice Representative Group (The Australian Medical Association, the Royal Australian College of General Practitioners and the Australian Divisions of General Practice) to develop a national primary health care policy by the end of 2005.

9 McDonald & Hare *op cit*
education; and to have poorer access to work, particularly skilled work. They also have less access to specialist medical services and a range of other health services. In addition, numerous rural occupations (for example farming, forestry, fishing and mining) are physically risky, and traveling on country roads can be more dangerous because of factors such as higher speeds, fatigue and animals on the road.10

The health workforce is the most important of all health system inputs.11 Data from the Australian Bureau of Statistics show that while 67% of the population lives in major cities, 80% of all medical practitioners are resident there.12 The 2001 census recorded approximately 32,000 general practitioners working in Australia. Data from the Australian Rural and Remote Workforce Agencies Group (ARRWAG) recorded 3,855 doctors practising in small rural centres (populations < 25,000) in 2002.13 A report by Access Economics concluded that nearly half (44%) of the rural population live in areas of severe GP shortfall.14

The ABS Index of Relative Socio-Economic Disadvantage shows that non-Metropolitan Australia scores lower on the Socio-Economic Index for Areas (SEIFA) than urban areas. Non-Metropolitan households are more likely to be in receipt of government income support and, in spite of the confounding effect of mining areas, mean annual taxable incomes are lower. The proportion of 16-year olds in full-time education is substantially lower.15

Suppositions that these figures are distorted by the very poor health and socio-economic status of Indigenous people are ill-founded. Approximately half the Indigenous population of Australia lives outside the major cities. Aboriginal and Torres Strait Islander peoples make up about 24% of the population in remote areas and 45% in very remote areas. However, given the very small proportion of Indigenous Australians in other areas, the contribution of Indigenous data to the demonstrated overall disparities in health and income between urban and rural areas as a whole is not great.16 Some Indigenous health research issues will be considered later in this submission.

10 AIHW (2004a) op cit p208
Thus both clinical and socio-economic data indicate the higher health needs of the non-Metropolitan population. The lower access of this population to health care services, including general and specialist medical care, is now well recognized enough to attract a growing body of policy and research. Reviews and evaluations of Commonwealth programs and measures like those developed under the Regional Health Strategy and the MedicarePlus initiatives will contribute to the further development of both.

However, less attention has been paid to research into specific aspects of sickness and health in rural areas and far less into the impact of social and economic factors on them.

Whether or not these determinants affect different populations in different ways is unclear. European health economists have found that while income related health inequalities can be discerned in all countries studied, regional disparities contributed to the burden of disease in some countries but not in others. It is interesting to note that they also found that health policy was more important than income policy in reducing income related health inequalities.\(^\text{17}\)

The diversity of the small communities across Australia suggests that more care should be taken when analysing rural health issues. The health of a community/population cannot be measured properly by using average figures, though this is to some extent inevitable. However, it is at least as informative to look at inequalities between groups within the population. Methods of doing this are increasingly sophisticated, but seldom applied in researching rural health.

Objective investigation of how rural people would prioritize their health needs is another dimension of rural health and social policy which is under-researched. Even where there is overwhelming evidence of high rural risk mirroring higher rural incidence, for example in relation to smoking and obesity and chronic diseases, there is little research to guide ways of addressing this in rural environments. Yet we know that these environments are different in many important ways to the urban environments from which policies and programs emanate.

The urban base of Australia’s research infrastructure is an important factor in this lacuna.

and remote areas is more frequently qualitative than quantitative in nature, further limiting opportunities to gain funding.\textsuperscript{18}

This is also true of Canada, the country where the distribution of the population and the research establishment most resembles our own.

\textit{Although almost a third of Canadians live in rural, remote and northern parts of the country, the conditions that affect their health in unique ways have not received a level of research attention commensurate with their numbers.}\textsuperscript{19}

Fortunately there are signs of growing interest in this field, for example in the development of the national information framework and indicators for rural, regional and remote health by the AIHW\textsuperscript{20}, the expanding role of journals like The \textit{Australian Journal of Rural Health} and the electronic \textit{Rural and Remote Health} and the work of university departments of rural health.

There are still significant areas where data definition and collection remain problematic. However, as with integrated public policy to address the wider determinants of health, gaps in what is known should not excuse procrastination when so much is already known.

The National Health and Medical Research Council (NHMRC) is well placed to redress this delay and urban distortion through its research agenda, and RDAA recommends

4. \textit{That all research grants allocated under the future program be required to include specific attention to the health and well-being of the populations of rural and remote Australia, and}

5. \textit{Given the proportion of the population that lives in rural and remote Australia, their socio-economic and health disadvantage and the previous lack of research into their specific needs, forty percent of all grants under the future program should:}

\begin{itemize}
  \item have a primary focus on the health of those living in rural and/or remote Australia
  \item involve these populations in the design and implementation of research
  \item be led by appropriately resourced rural based researchers
\end{itemize}


\textsuperscript{20} AIHW (2003) – \textit{Rural, regional and remote health: information framework and indicators Version 1}. Canberra, AIHW [PHE 44]
While much of this research requires a broad focus on sickness and health status, the determinants of health, health services and the impact of national and state policy and funding systems, there is also a pressing need to investigate a number of specific issues. These include: the core health service needs of small rural communities, viable models of hospitals for small rural communities, rural obstetric services, and the prevention, diagnosis and management of chronic disease (particularly cancer and mental illness) in rural Australia.

D.2 Health services for small rural communities

Resource restraints inevitably mean that small rural communities cannot have all their healthcare needs met locally. Sometimes the services that they do have are more determined by history and serendipity than current need. Health authorities trying to balance their budgets and community demands face considerable problems, not least of which is the lack of a clear and consistent framework within which to do this.

The process of developing such a framework through a program of community research projects would be consonant with the principles and objectives of primary health care as it would incorporate the wider determinants of health, develop community capacity and focus on both maintaining health and curing and managing sickness in a specific environment.

Such a framework would provide communities and all levels of government with a valuable template for health service and workforce policy and planning.

Its development would be a two stage process. The first would delineate a set of the core minimum requirements necessary to maintain and improve the health of small rural communities in Australia. This would include evidence based and community supported benchmarks for local and regional workforce (medical, nursing, dental and allied health) numbers, primary, acute and residential care and relevant communication and transport services. It would include benchmarks for the number of rural general practitioners, procedural GPs and specialists, the skills mix of the local healthcare workforce as a whole and the optimum utilization of professional, service and information networks in the environs and wider region. It would also include a set of minimum requirements to meet the preventive, acute and emergency care needs of communities too small to have a hospital or resident medical practitioner.

The second stage would enhance the application of the template through a complementary series of local needs assessments. A standardized methodology with sufficient flexibility to allow for the great diversity of small rural communities would be developed. This would assist small communities, most of them without formal research experience, to prepare an audit of their health needs and actual and potential healthcare resources to meet them. Basic fields of enquiry would include access to relevant health services and possible alternatives (for example, an appropriately trained nurse or ambulance officer providing...
extended care in places without a doctor\textsuperscript{21}), utilization of existing resources (recreational areas, public computer access) for health maintenance and infrastructure (including transport, communications and professional networks).

With program assistance, communities could then match this against existing models of healthcare which could be applied in their situation. Innovation as well as adaptation would be encouraged.

Some may not see funding or co-ordination of community needs assessment as a function of the NHMRC. However, though communities might use some of the rapid appraisal tools now available, co-coordinating and synthesizing a series of assessments into a flexible national framework would further the NHMRC’s primary aim to raise the standard of individual and public health throughout Australia. It would also help meet some of the outcome indicators in its Performance Measurement Framework 2003-2006.

RDAA therefore recommends

\textbf{6.a. The development of a flexible framework to delineate minimum core health service requirements of small rural communities, including those without resident medical care, and associated tools to enable these communities to assess their needs and resources and practical ways of matching them.}

\textbf{D.3 Small rural hospitals and maternity units}

About 529 of Australia’s 729 public acute hospitals are small (<50 beds) rural hospitals.\textsuperscript{22} Their distribution is erratic and often based on long defunct transport and health systems. Their asymmetrical bargaining position in relation to large prestigious urban institutions means their share of the funding available through the Australian Health Care Agreements is problematic.

These small institutions are currently being closed or downgraded at a very disturbing rate. At least 120 rural maternity units have been closed over the last decade, often without adequate informed consultation, and apparently largely on the basis of budgetary considerations. Decisions on hospital closure appear to focus on the price of providing a hospital, rather than the social and financial cost to the community of having to go elsewhere for treatment and childbirth. Innuendo about quality and safety frequently accompanies their downgrade or closure.

There is no evidence that closing small rural hospitals improves health outcomes and some evidence to the contrary. However, political decision makers are often

\textsuperscript{21} see, for example, O’Meara PF, Kendall D & Kendall L (2004) – Working together for a sustainable urgent care system: a case study from south eastern Australia. \textit{Rural and Remote Health} 4:312

\textsuperscript{22} AIHW (2004) – \textit{Australian hospital statistics 2002-03}. Canberra, AIHW [HSE 32] p32. The number of small hospitals is likely to be less at the time of writing.
uninformed about safety issues and therefore reluctant to contest the urban myth
that healthcare is better in bigger facilities.

Research in Australia and Canada indicates that small rural maternity units have
obstetric outcomes which are at least as good as those in large metropolitan
hospitals, even allowing for the transfer of high risk patients to tertiary centres. A
soon to be published analysis of 2001 data from the National Perinatal Statistics
Unit shows that small maternity units are very safe places in which to give birth.23
The Society of Obstetricians and Gynaecologists of Canada and the Society of
Rural Physicians of Canada have declared that studies demonstrate good
outcomes in low volume settings when access to specialist consultation and timely
transfer is available and used appropriately. 24

A 2003 study in Western Australia found that experienced surgeons operating on
selected patients with careful nursing care in small country hospitals have
outcomes similar to urban hospitals.25

Small rural hospitals are crucial components of the healthcare, social capital and
economic activity of the communities lucky enough to still have them. Hospitals
are often the major employer in small towns and a significant contributor to their
economic activity through the creation of jobs in businesses that supply services
or which are stimulated by the commercial and household spending generated by
the hospital and its employees. They are also an essential ingredient in capacity
building in rural communities, as an employer, training institution, focal point of
civic pride and source of leadership.

Closing or downgrading them undermines other strategies to sustain and stimulate
regional and rural development.

Reflecting demographic change, small rural hospitals today often include a
residential aged care facility. The social importance of having facilities that enable
frail aged family members to stay within their community is obvious. Local aged
care facilities also generate significant economic activity.

However, there is a threat that such aged care facilities may
be concentrated – ie contracted – to urban and regional areas
for so-called efficiencies. Old people are being forced to move
out of their home town! The effect is similar, though not as high
profile, as hospital closure or downgrade.26

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23 Sullivan E & Tracy S - Does size matter? The safety of having a baby in small maternity
hospitals. In press
24 Society of Obstetricians and Gynaecologists of Canada (SOGC), College of Family Physicians
of Canada (CFPC) & Society of Rural Physicians of Canada (SRPC) (2002) – Number of births to
maintain competence. Policy Statement 113; see also their joint position paper: Rural Maternity
Care, 1998
outcomes of a visiting surgical service to small rural communities. ANZ Journal of Surgery
73,833-835
26 Dr Ken Mackey, immediate past president, RDAA. Pers com 23/01/05
Many of Australia’s small rural hospitals, ambulance services and health centres were set up with community effort which has continued to maintain them by fundraising and volunteered services over the years. To lose them is more than a blow to the economy. A recent Canadian study found that hospital closure is

*a “critical incident” in the life of rural communities which leads to long-lasting medical, economic, and psychological consequences ...Without exception, respondents, often with perceptible emotion, discussed the hospital conversion as a significant event that would change the community’s social, economic, and political future.*

Closing small rural hospitals is inconsistent with other health policies and programs like the Medical Specialists Outreach Assistance Program (MSOAP), rural training for healthcare professionals and the MedicarePlus initiatives to support proceduralists. It increases the workload of busy regional hospitals, usually without a parallel increase in resources, and de-skills or discards local healthcare professionals. This policy conflict is particularly invidious at a time of severe shortfall in the rural health workforce.

The RDAA study of *Viable Models of Rural & Remote Practice* noted that hospital work increased practice viability. Other RDAA research suggests rural practices depend on hospital work for between 10% and 70% of their income. Access to hospital facilities has been identified as an important positive aspect of rural practice. Procedural medicine (surgery, anaesthetics and obstetrics) is an attraction of rural practice and proceduralists stay longer in rural practice - but there can be no procedural practice without a hospital. Closing procedural units has been found to have an adverse impact on both the recruitment and retention of the GP workforce. Current trends towards centralization of services are a major barrier to maintaining procedural practice.

The survival of procedural general practice depends on adequate rural hospital facilities and staffing. The sustainability of procedural general practice is vital to rural communities.

RDAA therefore recommends research to investigate:

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30 Dunbabin J & Sutherland D (2002) - Procedural medicine in rural and remote NSW: workforce issues

31 Australian College of Rural and Remote Medicine (ACRRM) (2002) – Barriers to the maintenance of procedural skills in rural and remote medicine & factors influencing the relocation of rural proceduralists. Brisbane, ACRRM
6.b. viable models of small rural hospitals that can contribute to the provision of primary and acute health care services tailored to specific community needs

6.c. the role of small rural hospitals and maternity units in maintaining the health and the social and economic vitality of rural communities

6.d. the health and socio-economic impact of hospital closure or downgrade on small rural communities and a flexible template for assessing this

D.4 Chronic disease management

Chronic disease (conditions likely to persist for at least six months) constitutes about 80% of the burden of disease in Australia today, a figure which will rise with demographic ageing. Apart from mental disorders and asthma, most chronic conditions are more prevalent in those aged over 65. AIHW figures already show a sharp increase in the reporting of long term health conditions: the figure rose from 66% in 1989/90 to 78% in 2001.\textsuperscript{32}

Understandably enough, the current management of these conditions occupies much more attention in government policy and funding programs than the prevention which would be a long term investment to reduce their incidence and prevalence. Yet it is imperative to find ways of doing so, particularly in rural and remote areas where they are the major cause of death rates 1.1 times higher than the rate in urban areas.

Cardiovascular diseases are the major cause of this excess mortality, though obstructive pulmonary disease, diabetes and cancer also contributed. Cardiovascular disease is also the largest contributor (21.9%) to Disability Adjusted Life Years (DALYs), followed by cancer, mental disorders and injuries.\textsuperscript{33} Co-morbidities are common. All these conditions are debilitating and distressing. They come at high direct and indirect costs to the patient, the community and the health care system.

Yet modifiable risk factors are implicated in all of them.

These conditions are sufficiently prevalent across Australia to warrant their selection as National Health Priority Areas (NHPAs). However, the excess mortality they cause in rural areas demands particular attention to the greater exposure to related risk factors there and equitable access to screening, diagnosis, treatment and management. The NHPAs are already the focus of much research. However, the need for particular scrutiny of how they are experienced by rural populations can be illustrated by looking at cancer.

\textsuperscript{32} AIHW (2004a)
\textsuperscript{33} ibid.
Rural Australians have poorer rates of survival after cancer diagnosis, at least partially due to more advanced conditions at diagnosis and poorer treatment subsequently.\textsuperscript{34} Colorectal and lung cancers contribute about 6% to rural excess mortality. Lung cancer alone accounts for 6% of excess death in rural people under 65.\textsuperscript{35} Modifiable risk factors have been identified for both. They include smoking, poor diet and nutrition, physical inactivity and excess weight, all of which are associated with lower socio-economic status – and with living in a rural areas. Yet few public campaigns to promote behavioural change in these matters appear to be adjusted for relevance to the rural environment or to engage people of lower economic or educational status.

There is strong evidence that population screening for bowel cancer can save lives and the Commonwealth is embarking on a national program to do this. This was properly preceded by a pilot that was reviewed positively in 2004. However, “for logistic reasons”, no sites in inland rural areas, and no small towns, were included in this trial on which the future program will be based. Hence it contains no provision to assist rural people who screen positive to access the colonoscopy which is the next stage in the process. This is in spite of the fact that a concurrent study suggests that there is already a lower probability of rural patients completing treatment when referred for rectal cancer.\textsuperscript{36}

Another study of lung cancer patients in rural and metropolitan NSW suggests that the former were less likely to have pathological confirmation of their lung cancer and less likely to undergo any treatment, especially radiotherapy and chemotherapy. Commenting on survival rates, which were higher in the metropolitan health service district with the highest average incomes and education, it notes other studies that have found excess mortality and poorer survival rates in areas of relative deprivation.\textsuperscript{37}

A recent editorial in \textit{The Medical Journal of Australia} commented

\begin{quote}
\textit{In principle, tackling rural inequality in cancer care and outcomes requires a combination of improved primary healthcare, access to expert multidisciplinary services, and coordination of the two. Evidence that could guide investment decision-making is limited. Present rural health policy is underpinned by the principle that patients should have access to high quality services as close to their homes as is clinically and geographically possible. This policy should improve access to primary healthcare and aid in obtaining earlier diagnosis of cancer and quicker referral to expert care. That these factors will}
\end{quote}


\textsuperscript{35} AIHW (2004a) op cit.


\textsuperscript{39} Jong, Vale & Armstrong op cit
The authors suggest that outreach specialist services in a shared care model with local healthcare professionals would appear to be a solution – but this approach, like the suggested system of well-defined pathways tailored to the needs of rural patients also requires further evidence to back its general implementation. The program to delineate core health service needs outlined above would assist in its collection and application.

RDAA therefore recommends

6.e. That the proposed research program include a specific focus on the socio-economic factors associated with chronic disease and its prevention, diagnosis and management in rural and remote Australia.

E. Indigenous health

It is unnecessary to delineate here the disparities between the health and socio-economic status of Aboriginal and Torres Strait Islanders and other Australians. Moreover, as the documentation inviting this submission pointed out, the NHMRC and Indigenous people and health care professionals have already developed a framework to guide research in this field.\textsuperscript{40} However, this must be assumed to be a dynamic tool flexible enough to incorporate new approaches and evolving concepts.

Developments since then have included the continuing evolution of autonomy based approaches to health via social enterprise and mutual obligation, the publication of papers commissioned as part of the Review of the Australian Government’s Aboriginal and Torres Strait Islander Primary Health Care Program and workforce developments like the establishment of professional associations dedicated to the interests of Aboriginal Health Workers.

RDAA does not presume to speak for Aboriginal and Torres Strait Islander peoples. To do so would be inconsistent with our own policy on Indigenous health.\textsuperscript{41} However, RDA members provide healthcare to Aboriginal people across rural and remote Australia and can comment from this position.

While acknowledging that the significant role of psycho-social, economic, cultural and environmental factors on the health of Indigenous Australians and the need for intersectoral action, RDAA knows that an effective, adequately resourced healthcare system tailored to community need is essential if Indigenous health status is to improve. This system must be based on the primary health care which, in conceptual and practical terms, is most appropriate to their needs.

\textsuperscript{40} National Health & Medical Research Council (NHMRC) (2003) – The NHMRC road map: a strategic framework for improving Aboriginal and Torres Strait Islander health through research. Canberra, NHMRC

\textsuperscript{41} see www.rdaa.com.au - Policies
RDAA believes that all measures to improve Indigenous health must be underpinned by:

- decent infrastructure – sanitation, housing, transport and communication
- opportunities for education, training and employment
- policies and programs designed and implemented by the community in partnership with government
- relationships between individuals, communities and the health care system characterized by a culturally appropriate and consultative approach
- strategies to increase and support the small Indigenous component of the health care workforce.

Two independent reports have recently shown that the funding provided for Indigenous primary health care is abysmally inadequate.

*We conclude that total health spending on Indigenous populations would need to be increased to a level between 3 and 6 times the national average per capita expenditure to achieve equitable access to effective care.*\(^{42}\)

*Giving Indigenous Australians the same level of access to primary health care as non-Indigenous Australians with comparable health status would require substantial increases in the medical workforce, of at least 250 FTE medical practitioners spanning GP, pathologists and medical imaging with commensurate increases in access to allied health professionals (nurses and others). It would also require giving Indigenous Australians much more access to the PBS. Overall, we assess the required increase in funding for primary care to be approaching $400m per annum.*\(^{43}\)

Underspending on primary health care is truly false economy. Failure to prevent, diagnose and intervene in the course of chronic diseases - including diabetes, end-stage renal disease and cardiovascular diseases - leads to significantly higher costs when people come to need acute care. Research suggests that treating a small number of conditions - including heart disease, pulmonary disorders, cancer and trauma, conditions highly prevalent in Indigenous populations - accounts for about a third of increased health spending. Clearly, higher expenditure on their prevention would make good economic and social sense.

The question then is: what interventions are most likely to be the best investment in particular circumstances? Economic modelling suggests that different approaches will lead to higher or lower levels of returns in relation to different conditions. Clinical primary health care, followed by health promotion and prevention, are shown as the best investment and most cost effective use of

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resources in Aboriginal health in the Northern Territory. This is because reducing the burden of disease now requires identifying and treating people with existing conditions. Though health promotion and prevention promise savings in the long term, the economists found they are still less cost effective than clinical primary health care.44

Indigenous people are twice as likely to be hospitalized as other Australians. They are seven times more likely to require dialysis for end-stage renal disease and Indigenous mothers are twice as likely to have low birth weight babies who are more prone to chronic health problems in later life. Research suggests that where primary health care is well designed and adequately funded, it can result in overall savings of between 5 and 11 times the expenditure on it over 5 to 20 years and add from 3 to 13 years of healthy life to Indigenous people.45

Funding is important, but economic issues are only part - and not the most important part - of the picture. If health services are to succeed, they must be culturally appropriate and acceptable to the people they are designed to serve. This is an axiom of all health care and a basic tenet of primary health care. However, it is particularly crucial in Indigenous health.

Indigenous communities and individuals must be allowed to identify the best of all perspectives in the development, implementation and evaluation of strategies based on their own explanatory models, causal theories, aetiologies, and public health formulations.46

Healthcare professionals must become aware of these perspectives and understand how to meld them with Western biomedical techniques and approaches. Failure to do so will inhibit the access implicit in primary health care and render much health investment futile. This is well known, but the principle has yet to be applied, even in most obvious ways. For example, in spite of national agreement on the importance of cross-cultural training for hospital staff, recent reporting indicates that this is often tokenistic and frequently overlooked.47

Aboriginal Health Workers are crucial to the effective delivery of primary health care: they make up 27% of the primary health care workforce (compared to nursing staff and GPs who comprise 9.4% and 7% respectively of it).48 The quiet achievements of Aboriginal Health Workers across the country are acknowledged by all who know them, but this appreciation has not been translated into sufficient

45 Econtech Pty Ltd (2004) – Costings models for Aboriginal and Torres Strait Islander health services. Aboriginal & Torres Strait Islander Primary Health Care Review: Consultant Report 3. Canberra, OATSIH
48 ibid. p83. Figures based on full-time equivalent positions in Commonwealth funded primary healthcare services.
practical support measures, adequate remuneration or the recruitment and training strategies needed if their numbers and effectiveness are to expand.

Aboriginal Health Workers are a valuable part of the general practice team in many areas and RDAA believes steps must be taken to ensure they can be included in all Commonwealth practice nurse initiatives. Their role in community health should be recognized and rewarded in any extension of these measures. This will only be possible when supportive rhetoric turns into national recognition, standardized qualifications, and appropriate legal protection.

Aboriginal Community Controlled Health Services (ACCHSs) are well established and well accepted. They provide comprehensive primary health care to the vast bulk of Aboriginal peoples. However, according to their peak body, the National Aboriginal Community Controlled Health Organisation (NACCHO), their role in research is undervalued and there is enormous scope for enhancing their capacity in clinical research, particularly through multi-centre studies like the NACCHO Ear Trial.49

Studies of the social determinants of health all refer to the negative impact of lack of control over important aspects of life. This concept can be extended to communities where the effect may be exacerbated by ongoing personal and group trauma. Earlier approaches to Indigenous health which, however well-meaning, ignored this, failed to achieve their objectives. Yet again, this salutary lesson has yet to be applied in many areas of service design and delivery.

Fortunately the paternalism and welfareism of the past are being overtaken by concepts more appropriate to healing and health. Indigenous leaders are putting rights like adequate government services into a framework of shared responsibility. The implied mutual obligation presents an opportunity to move forward through respectful contractual relationships which can guide models of good practice and emerging evidence.

While these concepts are compatible with values explicit in mainstream and Indigenous Australian cultures, their application to health care delivery and intersectoral negotiation is supported by a meagre research base. RDAA believes that Indigenous health research agenda must include examination of these ideas and ideals as drivers of primary health care and other initiatives and recommends

7. That research into strategic approaches to the impact of social, economic and cultural factors on the health and sickness of Aboriginal and Torres Strait Islander peoples have an increased focus on community control, local social enterprise and concepts of mutual obligation.

F. Conclusion

The impact of social and economic determinants on the health of individuals and populations is clear. Though the mechanisms by which this occurs are not yet well understood, their effects are strong enough to demand immediate attention. What is lacking is evidence to inform the translation of what we do know already into effective public policy. The fact that the NHMRC is tackling this complex challenge encourages RDAA to believe there will soon be an exciting opportunity for objective scrutiny of a number of major issues for the health of rural and remote Australia in which it will be happy to participate.

General References


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