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**Submission to
Department of Health and Ageing
on
Development of a New National Women's Health Policy**

July 2009

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Submission to the Department of Health and Ageing on Development of a New National Women's Health Policy

EXECUTIVE SUMMARY

The women of rural and remote Australia face particular health challenges, but the strength of rural and remote communities in coming up with creative solutions for health care based on the connections between local people, organisations and health service providers is widely recognised.

The Alliance welcomes the consideration being given in the development of the National Women's Health policy to the broad determinants of health including societal and socioeconomic factors, as well as health behaviours and biomedical factors.

In this submission, the Alliance considers the health status for women in rural and remote areas, compared with their counterparts living in Australia's major cities, in relation to the five principles proposed for the National Women's Health Policy:

- Health equity between women
- Gender equity
- A focus on prevention
- A life-course approach
- A strong and emerging evidence base.

The health of women in rural and remote areas is poorer than in major cities of Australia, death rates being 1.05-1.10 times as high in regional areas, and 1.15 to 1.70 times as high in remote areas. Much of the higher rate of death in remote areas appears to be due to the high prevalence of Indigenous people in remote areas of Australia and their higher rates of mortality overall.

Australia's Aboriginal and Torres Strait Islander women experience death rates that are about 3 times higher than other Australian women.

Causes of death raising the death rate of women in regional areas above that in major cities are circulatory diseases (50%), cancers (~18%), injury (~13%), and endocrine diseases (particularly diabetes) (4%–15%).

Causes of death raising the death rate of women in remote areas above that in major cities are circulatory diseases (~25%), endocrine diseases (particularly diabetes) (~20%), injury (~15%), and diseases of the digestive system, cancer and respiratory diseases (contributing less than 10% of excess deaths each).

Women in rural and, especially, remote areas have measurably reduced access to a range of health services including primary care, diagnosis, life saving hospital procedures (eg coronary artery bypass graft) and mental health care.

Of critical importance to the health of women in rural and remote areas is the environment in which they live. Healthy economies, access to education, work and a range of community or social activities, community resilience and identity, decent housing and services are all keys to good health.

Climate change threatens the viability of primary production, at least in southern Australia, through its impacts on rainfall, evaporation, agricultural productivity, river water flows, bushfire and the prevalence of arboviral disease, amongst others. Reduced agricultural, forestry and fishing yields threaten the economic basis and of many of Australia's rural and remote communities. Climate change also provides opportunities for substantially broadening the basis of economic activity in rural and remote areas, for example through the development of renewable energy and carbon sequestration industries in rural and remote areas.

Prevention should be a major (but not the only) thrust of any strategy to address women's health. Issues including lifestyle choices (eg to smoke or not to smoke), attitudes (eg to risk and to seeking help), behaviours, working environments, their critical role and responsibilities for children, and their personal expectations could all be fruitful areas to explore and address.

The key concern of the Alliance is to ensure that the perspectives of rural Australia are highlighted and that sufficient resources are allocated, in a flexible system, to ensure a needs-based approach and equity in access to population health measures for all people, including the women, who live in rural and remote areas. In this work there must be meaningful engagement with the people and communities most at risk. Aboriginal and Torres Strait Islander peoples should command high priority under preventative health programs.

Rural and remote areas have ageing populations with high rates of chronic disease, health workforce shortages, and extensive drought and other problems affecting the social economic and environmental sustainability of their communities. There is an acute shortage of health related infrastructure, personnel and services in many rural and remote areas.

The Alliance is promoting the development of a National Rural Health Plan, building on the success of *Healthy Horizons* and including more specific performance indicators and accountability. The piecemeal approach to rural health challenges is not delivering adequate or fair levels of care to rural women.

The Alliance has long argued for increased funding to improve the availability of statistical information about the health of people in rural and remote areas. Key strategies would include ongoing funding for key data agencies (eg AIHW) to continue their work on rural health, the formation of a rural and remote health research institute (a strategic approach to rural health research), and regular, independent evaluation of the effectiveness of government rural health programs.

The National Rural Health Alliance looks forward to making a strong and practical contribution to the development of the National Women's Health Policy.

Recommendations

The new Australian women's health policy should focus on preventive health, improve access to preventive services, and encourage women to reduce their personal health risks, while retaining a focus on improved access to health services in ways that meet the needs of rural women.

A women's health policy should also help create positive economic environments. In rural and remote areas, diversification of industries, adaptation to climate change, installation of broadband, development of specific infrastructure and healthier town planning would bolster rural economies, and the health of the women, men and families in country communities.

The Alliance urges the government to establish a rural health research institute to shape a strategic approach to rural health research, including that related to women's health.

Patients' travel and accommodation assistance schemes have to be augmented and better promoted, and must accommodate the need for travel relating for all health care including maternity services, as well as recognising the needs of families and carers.

As part of a lifecourse approach, the new women's health policy must provide strategic background and support for the proposed National Maternity Services Plan, which will implement the principle that all women will be able to give birth in or as close as practicable to their own communities, supported by their families and to have continuity of care, as far as is practicable, by their own local health care professionals. (Note: a range of subsidiary recommendations for the Maternity Services Plan, including proposals to help build a better maternity services workforce, are listed towards the end of this Submission.)

The National Women's Health Policy will need to consider strategies for addressing the special needs of rural women as they age and/or care for the elderly. (Note: proposals for achieving more equitable outcomes for aged care in rural areas are included.)

In its rural and remote aspects, the new women's health policy should be compatible with a national rural health plan such as the Alliance is promoting.

INTRODUCTION

The National Rural Health Alliance is the peak non-government body concerned with rural and remote health issues in Australia. It comprises 28 Member Bodies, each a national body in its own right, representing health professionals, service providers, consumers, educators and researchers. The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, with the specific goal of equal health for all Australians by 2020. (A list of Alliance Member Bodies is at Attachment 1.)

It has been 20 years since the development of the first National Women's Health Policy and the commencement of a longitudinal study of women's health in 1996.¹ The Australian Government has made an election commitment to revisit the issues and concerns of Australian women and develop a new National Women's Health Policy. The new policy will focus on prevention, addressing health inequalities in our society, and the social determinants of those health inequalities.² While the average life expectancy of Australian women continues to rise (83.3 years at birth) and is higher than for men (78.5 years),³ there are significant health inequalities between different groups of Australian women, and significant differences in health outcomes and needs between women and men.

The National Rural Health Alliance welcomes the Government's commitment to addressing health inequalities for Aboriginal and Torres Strait Islander women and women in rural and remote areas; as well as women from culturally and linguistically diverse backgrounds including refugees and women from disadvantaged backgrounds.

Women are the majority of health consumers, the majority of health service providers and the majority of carers in the Australian community. They constitute an increasing proportion of the Australian workforce, as well as providing a large proportion of the unpaid (domestic and child rearing) workforce. They therefore contribute very substantially to the Australian economy. Improving the health of Australian women will improve the health and productivity of the whole community.

The women of rural and remote Australia face particular health challenges, but the strength of rural and remote communities in coming up with creative solutions for health care based on the connections between local people, organisations and health service providers is widely recognised. The National Rural Health Alliance looks forward to making a strong and practical contribution to the development of the National Women's Health Policy.

THE PROPOSED NATIONAL WOMEN'S HEALTH POLICY

The purpose of the new National Women's Health Policy, as outlined in the Consultation Discussion Paper,⁴ is to improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health; encourage the health system to be more

¹ The Australian longitudinal study on women's health. The Women's Health Australia project. <http://www.alswh.org.au/> (viewed July 2009)

² Australian Government Department of Health and Ageing, 2009. Developing a women's health policy for Australia - setting the scene. <http://www.health.gov.au/internet/main/Publishing.nsf/Content/phd-women-policy>

³ ABS 2006 Deaths, Australia, 2005. ABS cat. No. 3302.0. Canberra: ABS.

⁴ Australian Government Department of Health and Ageing, 2008. Developing a Women's Health Policy for Australia – Setting the scene. <http://www.health.gov.au/internet/main/Publishing.nsf/Content/phd-women-policy>

responsive to the needs of women; actively promote participation of women in health decision-making and management; and promote health equity among women.

The Policy will adopt the World Health Organization's broad definition of health: "complete physical, mental and social wellbeing and not merely the absence of disease and infirmity".⁵

Five principles are suggested as the basis for the development of the new National Women's Health Policy:

- Health equity between women
- Gender equity
- A focus on prevention
- A life-course approach
- A strong and emerging evidence base.

The Alliance welcomes the consideration being given in the consultation paper and in the development of the policy to the broad determinants of health including societal and socioeconomic factors, as well as health behaviours and biomedical factors. In this submission, the Alliance considers the health status for women in rural and remote areas, compared with their counterparts living in Australia's major cities, in relation to the five principles proposed for the National Women's Health Policy.

ACHIEVING HEALTH EQUITY FOR RURAL WOMEN

On many measures, women living in rural, regional and remote (hereinafter 'rural') areas generally experience higher death rates, poorer health and are more likely to be psychologically troubled in comparison to their city counterparts. They are more likely to engage in daily smoking, drink excessive amounts of alcohol, have less active lifestyles, suffer injury and disability and be overweight or obese. Some of this disparity is a reflection of the disadvantage of many of Australia's Aboriginal and Torres Strait Islander women.

However, even after accounting for the higher proportion of Indigenous women, the health outcome for women in rural and remote areas is measurably worse than for their counterparts in major cities. Also, rural women overall have fewer educational and employment opportunities, lower income, poorer access to healthcare providers, and less choice of recreational and other health promoting activities, while also having lower levels of access to life-saving surgical procedures.⁶

Health status of women in rural and remote areas

Judged from age specific death rates in Figure 1 below, females in rural areas have worse health outcomes than their female counterparts in Australia's major cities, while those in remote areas have much worse outcomes.

⁵ WHO 1946. Constitution of the WHO, 45th ed. Supplement, October 2006.

⁶ AIHW 2006a. Australia's health 2006. Cat. no. AUS 73. Canberra: AIHW.

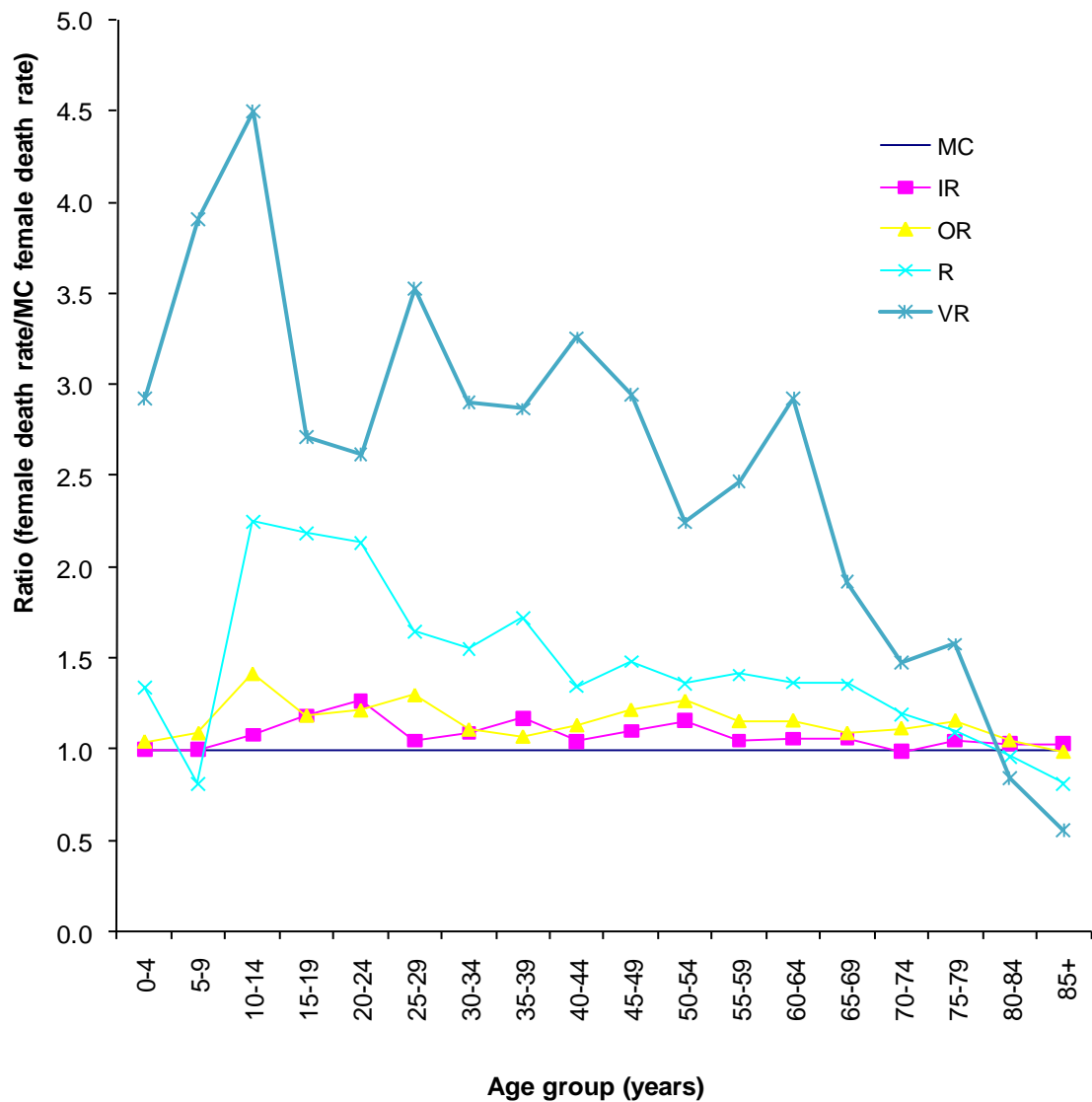


Figure 1: Age-specific death rates of regional and remote area females compared with those for similar aged females in major cities, 1997–1999.

Note: A ratio of 1.0 indicates a death rate identical to major cities women of comparable age. A ratio of 3.0 indicates a death rate that is three times that for major cities females.

(MC Major Cities; IR Inner Regional; OR Outer Regional; R Remote; VR Very Remote)

Source: Derived by NRHA from AIHW data: AIHW 2003. Rural, regional and remote health: a study on mortality. AIHW cat. no. PHE 45. Canberra: AIHW.

Overall, about 4,400 more people die annually outside major cities areas than if death rates were similar across the board⁷. Of these additional deaths, 35 per cent were female.

Indigenous and non-Indigenous women's health

Some of the greater disadvantage, particularly in remote areas, reflects the prevalence of Indigenous people in those areas. Seventy per cent of all Aboriginal females live in rural, regional and remote areas. A sustained focus on improving the health of Australia's Indigenous peoples must therefore remain a very high priority for the Australian, State and Territory governments – including in a new National Women's Health Policy.

Figure 2 below, shows that death rates of non-Indigenous females in regional areas are 1.1 to 1.2 times higher than for similar aged females in major cities. The differences between non-Indigenous females in remote areas and major cities are less obvious. However, it is very clear that average death rates⁸ for Indigenous females in almost all age groups are very high compared with any of the other groups.

⁷ These 4,400 deaths are 'excess' deaths as described by the Australian Institute of Health and Welfare in AIHW, 2003. Rural, regional and remote health: a study on mortality. AIHW cat. no. PHE 45. Canberra: AIHW (Rural Health Series no. 2) at <http://www.aihw.gov.au/publications/index.cfm/title/9411>

⁸ We should stress that statistical averages are just that - averages. While it is undoubtedly true that many Aboriginal and Torres Strait Islander women have poor health outcomes, many other Aboriginal and Torres Strait Islander women have much better outcomes. Simply being Indigenous is not the major influence on health outcomes. Aboriginal and Torres Strait Islander women who had healthy childhoods and who have good access to services, jobs, education, good food, sport, and who don't smoke or drink heavily, and who are not overweight etc, will tend to have good health outcomes.

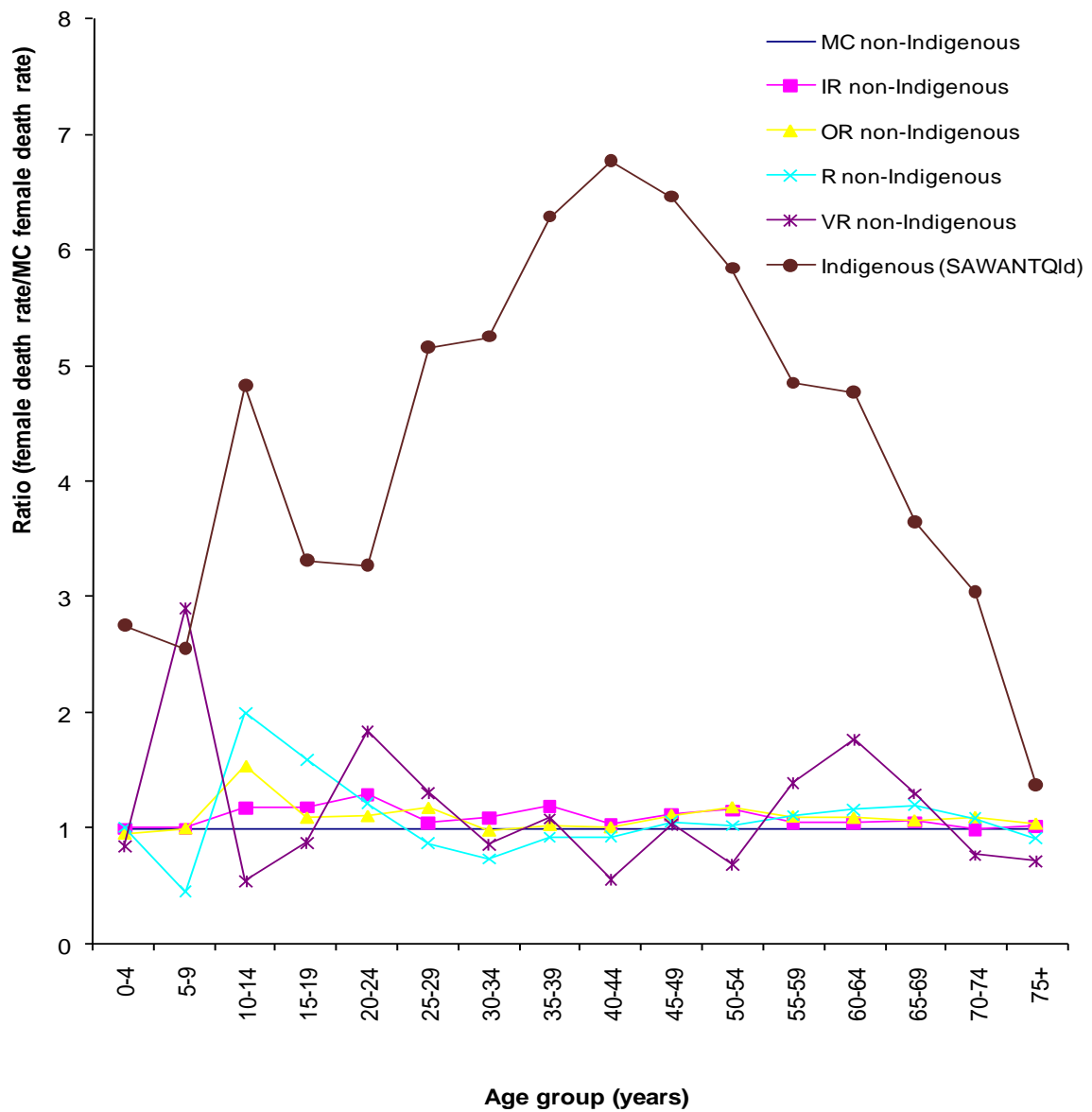


Figure 2: Age-specific death rates of regional and remote area non-Indigenous females and Indigenous females in SA, WA, NT and Qld, compared with those for similar aged non-Indigenous females in major cities, 1997–1999.

Note: A ratio of 1.0 indicates a death rate identical to major cities non-Indigenous women of comparable age. A ratio of 3.0 indicates a death rate for females that is three times that for major cities non-Indigenous females.

(MC Major Cities; IR Inner Regional; OR Outer Regional; R Remote; VR Very Remote)

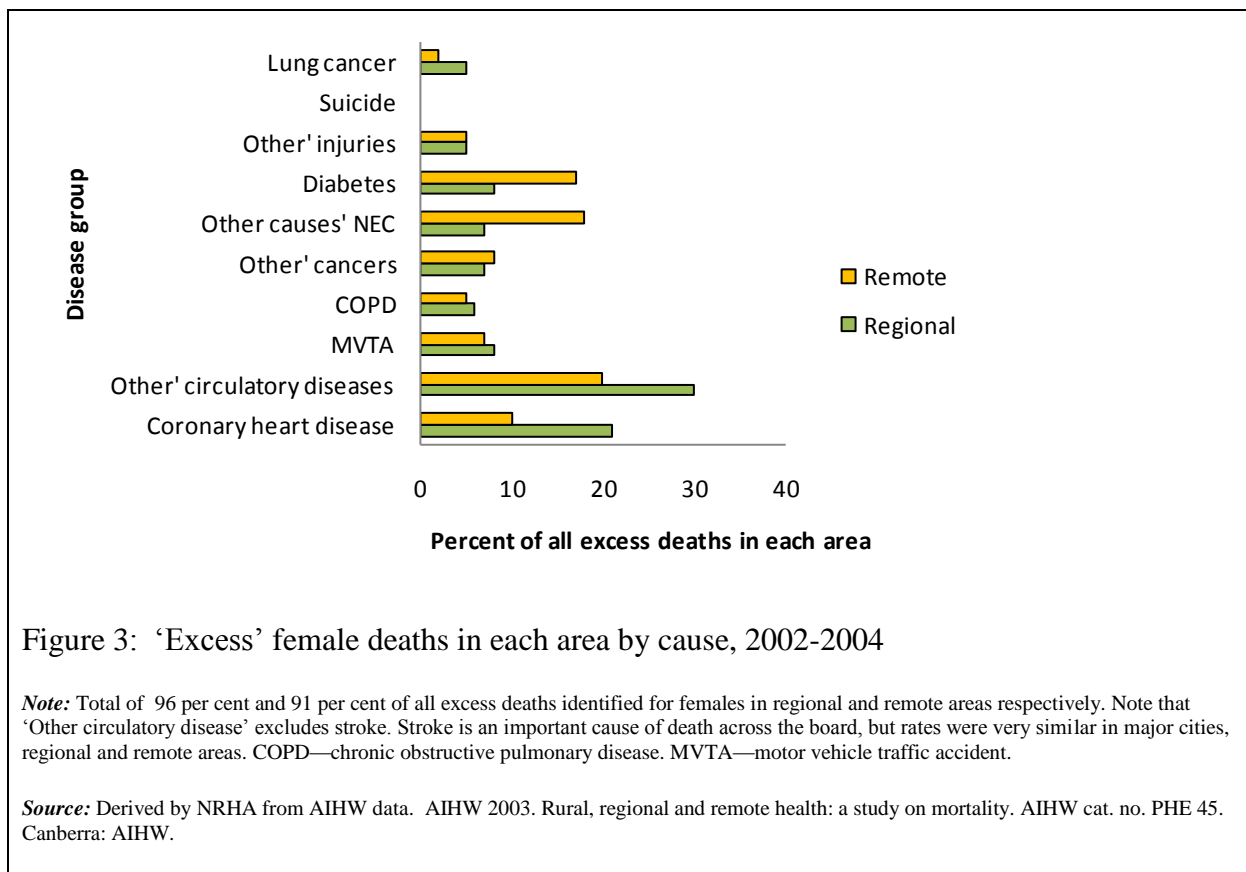
Source: Derived by NRHA from AIHW data. AIHW 2003. Rural, regional and remote health: a study on mortality. AIHW cat. no. PHE 45. Canberra: AIHW.

Specific diseases and trauma

With the data available, it is difficult to compare rates of disease for women in regional and remote areas with those in major cities, but it is possible to compare rates of death due to these causes.

During the period 2002–2004, the main contributors (Figure 3) to the annual 1,544 extra deaths of females outside major cities were a raft of chronic diseases - coronary heart disease (19 per cent), other circulatory diseases excluding stroke (which is an important cause of death in women but similar across the board) (28 per cent), emphysema and bronchitis (COPD) (6 per cent), cancers (strongly featuring lung cancer) (11 per cent), and diabetes (as primary cause of death) (9 per cent). Injuries were responsible for much of the rest of these extra deaths, with motor vehicle accidents (8 per cent) featuring strongly.

National surveys provide limited information about health in regional areas, and very little about health in remote areas. Hospital data reflect the availability of services and admission patterns as well as clinical need. Mortality data remain one of the best means of comparing health across the areas, notwithstanding their disadvantage as a blunt tool.



Death rates due to coronary heart disease and 'other' diseases of the circulatory system in regional and remote areas are typically 1.1 to 1.5 times the rates in major cities. This is not surprising given the poorer risk profile (eg smoking, overweight and lower rates of exercise), the lower rates of preventive medical procedure (eg coronary angioplasty) undertaken, and the lower access to health services generally (including primary health care) for people living in these areas.

Death rates for females in regional and remote areas due to motor vehicle accidents are at least twice as high as in major cities, and six times as high in very remote areas.

The incidence of new cases of many cancers (eg lung and melanoma) in rural and remote areas is not only higher than in major cities, but also the 5-year cancer survival rates are significantly lower than in the major cities. One of the likely explanations of lower cancer survival in regional and remote areas is the greater extent of the disease at diagnosis (broadly analogous to the later stage of the cancer at diagnosis).⁹ The NSW Cancer Council has recently commented that distance can also reduce access of rural patients to cancer treatments involving radiotherapy.¹⁰ Lung cancer death rates for females in regional and remote areas are roughly 1.1 times higher than those in major cities. While colorectal cancer death rates in regional areas are up to 1.1 times those in major cities, rates of death due to breast cancer amongst rural and remote women are similar to those in major cities.¹¹

The incidence of melanoma due to sun exposure is higher in regional areas than in metropolitan areas and has been steadily rising over the last 20 years. While melanoma was responsible for about 1,300 deaths annually, and was only the tenth most common form of cancer death in 2005, for females in regional areas, there were more excess cases of melanoma than of new cases of cancer in total.^{11,12} UV exposure may be greater outside major cities and it may also be that women are not protecting themselves as effectively or being diagnosed early enough, or they may not be receiving adequate treatment because of difficulties accessing services.

Death rates for females in regional and remote areas due to chronic obstructive pulmonary disease are 1.1 and up to twice the rates in major cities.

Death rates for females in regional and remote areas due to diabetes are, respectively, 1.1–1.4 and 2.5–5.5 times rates for females in major cities. This differential is largely influenced by mortality of Indigenous women for whom rates are 15 times those for women in major cities (although rates are still elevated for non-Indigenous women in outer regional and remote areas).

The rate of potentially preventable hospitalisation is 1.15 to 1.35 times and 2.2 times higher for people in regional and remote areas, compared with those in major cities.¹³

⁹ Australian Institute of Health and Welfare, Cancer Australia & Australasian Association of Cancer Registries 2008. Cancer survival and prevalence in Australia: cancers diagnosed from 1982 to 2004. Cancer Series no. 42. Cat. no. CAN 38. <http://www.aihw.gov.au/publications/can/cspia-cdf-82-04/cspia-cdf-82-04.pdf>

¹⁰ Cancer Council, 2009. Radiotherapy call-in.

http://www.nswcc.org.au/html/aboutus/media/mediareleases/mar0309_radiotherapy_callin.htm

¹¹ AIHW 2008. Rural, regional and remote health: indicators of health status and determinants of health. Rural Health Series no. 9. Cat. no. PHE 97. Canberra: AIHW.

<http://www.aihw.gov.au/publications/index.cfm/title/10519>

¹² Note that amongst females in 2005, there were 244 more new cases of cancer diagnosed in regional and remote Australia than would be expected if major cities age specific rates applied to the populations in regional and remote areas; however, in the same year, there were 337 more new cases of melanoma diagnoses in these areas than would have been expected.

¹³ AIHW, 2008. Australian Hospital Statistics 2006-07. Health Services Series. No. 31. Cat. No. HSE 55 <http://www.aihw.gov.au/publications/hse/ahs06-07/ahs06-07.pdf> page 343.

Why rural women have poorer health outcomes

In order to achieve equity of health outcomes the National Women's Health Policy will need to consider the context in which rural women live.

About 32 per cent of the Australian population or about seven million people live outside major cities.¹⁴ While some of them are farmers, miners, forest workers or fishermen and their families, most workers in rural and remote Australia are found in the retail, health, education, government, manufacturing, processing, transport and other sectors. Most of the seven million live in regional cities and country towns of various sizes.

While life outside major cities offers cultural, social, economic and personal opportunities not available in metropolitan areas there is little empirical evidence on the health benefits and the available statistics point to some quite substantial negatives.

The environmental, social and economic reasons why women in rural and remote areas have worse health than their peers in major cities fall into a number of broad categories.

- Environment
 - Locational issues related to remoteness and population density.
 - Riskier occupations.
 - More dangerous driving conditions, frequently at higher speeds.
- Socio-economics
 - Average lower income and education.
 - Indigenous Australians.
 - Challenges for industry.
- Risk factors
 - Poorer personal health risk factors.
 - Possibly riskier cultural characteristics, including attitudes and behaviours.
- Access
 - Less availability and greater barriers to accessing primary health care, dental, sub-acute and acute care services.
 - Longer retrieval times after trauma.

¹⁴ National Rural Health Alliance, 2009. The state of rural health. Fact sheet 9.
<http://nrha.ruralhealth.org.au/cms/uploads/factsheets/fact-sheet-09-state-rural-health.pdf>

Environment

Many people choose to live outside major cities for environmental reasons including a sense of community, peace, reduced traffic, contact with nature and other lifestyle factors.

Ironically, access to fresh fruit and vegetables can be constrained in some rural areas, and they are sometimes unavailable (or unaffordable) in remote areas. Conversely, processed foods that are high in fats, salt and sugar, and cigarettes, are generally readily available.

Greater exposure to the natural environment also raises challenges such as the long term population loss from small towns, exacerbated over the last several years by serious drought and associated with social fragmentation and related health issues. In other regions, the local environment can increase the risks of arboviral diseases (eg Ross River Virus) and zoonoses (eg Q fever). Climate change and the threats to sustainability of water intensive industries and the regions they support and to places experiencing town water shortages are matters of great importance and widespread applicability already.

Underspend by local government has resulted in deterioration of the condition of local infrastructure that binds communities together and fosters social inclusion, such as roads, libraries, community halls, galleries, museums, swimming pools, sports fields, drainage and sea walls.¹⁵ The quality of town planning and infrastructure affects opportunities for exercise, recreation, healthy living and a sense of joy. Without planning for a pleasant or safe environment in which to walk, play sport, swim, cycle or socialise, the options for a healthy personal and family lifestyle are restricted.

The quality of housing for many of Australia's poorest people and for many of our Indigenous people is a national scandal. Overcrowding and poor sanitation provide excellent opportunities for the development and spread of infectious diseases, frequently among children, greatly reducing their opportunity for a healthy and long (or even average) life.

A major compounding issue is that reducing opportunities for good health also reduces opportunity for education and economic productivity, which in turn reduces the opportunity for decent living conditions, and so the cycle continues. Whereas less than three per cent of households across the nation are considered to be crowded, 14 per cent of households in very remote areas are crowded, and up to 40 per cent of Indigenous households are crowded.¹⁶

Regional development and good health are mutually supportive. By providing jobs, services and infrastructure, regional development contributes to the social determinants of good health. In return, a healthy community provides one of the bases for successful local businesses. The development of the National Women's Health Policy must provide for links with regional development.

¹⁵ National Rural Health Alliance, 2009. Regional development and health. Fact Sheet 7.

<http://nrha.ruralhealth.org.au/cms/uploads/factsheets/fact-sheet-07-regional-development.pdf>

¹⁶ <http://www.aihw.gov.au/publications/index.cfm/title/10123> AIHW 2005. Rural, regional and remote health—Indicators of health. AIHW Cat. No. PHE 59. Canberra: AIHW.

Socioeconomics

Income and cost of living

Incomes and educational levels in rural and remote areas tend to be lower on average compared with major cities. For example, about 35 per cent of people in major cities live in Australia's least disadvantaged areas, compared with about 10 per cent of people in regional and remote areas and 2 per cent of people in very remote areas. Conversely, 20 per cent of people in major cities live in Australia's most disadvantaged areas, compared with about 30 per cent of people in regional and remote areas, and about 55 per cent of people in very remote areas.¹⁰ While rents and mortgages in regional and remote areas tend to be 0.6-0.8 times what they are in major cities, prices for commodities tend to be higher (eg food prices in very remote areas are 1.15-1.20 times those in major cities).¹⁰

Employment in rural towns is more exposed to market forces than in major cities. A change of job because of redundancy, business failure or for career advancement will frequently mean moving town and a consequent impact on the family, schooling, social networks and spouse's work.

Education

Access to education in rural areas tends to be poorer for a number of reasons. The demand in rural and remote areas for highly educated workers is less than in major cities. This tends to limit the expectations of youth attending schools in rural and remote areas, which acts as a disincentive to high school completion. Ironically, a well-educated workforce is a key to attracting more sophisticated industry to rural areas.¹⁷

Most teachers, like other professional groups, prefer to work in major cities or in coastal regional areas than in inland regional or remote areas. Currently, some State Education Departments offer incentives, whereby new teachers can eventually 'earn' a position at a school in a 'desirable' area by serving time in regional and especially remote areas. Consequently, schools outside major cities may be less likely to have experienced and capable teachers than those in major cities.

Schools in smaller regional and remote areas tend to face greater challenges in terms of the 'critical mass' of educational skills required to offer a wide range of quality educational opportunities for children.

A lower prevalence of role models in specialised employment (ie employment requiring further education) also reduces the motivation for children in rural and remote areas to further their education. Also, it can be difficult for children in rural and remote areas to go on to higher education because while students whose parents live in major cities can 'live at home', those whose parents live outside major cities are unlikely to be able to do so, and will need to pay for accommodation – a very real economic impediment to young people from rural and remote areas attending university. Recent Budget changes to eligibility for Youth Allowance

¹⁷ <http://www.ers.usda.gov/AmberWaves/May07SpecialIssue/Features/Policy.htm> 'Policy Options for a Changing Rural America', Amber Waves, May 2007. Economic Research Service, US Department of Agriculture.

may have exacerbated these financial barriers, at least for the transitional period during which the new system – and new family expectations and behaviours – are being bedded down.

Furthermore, young people from rural and remote communities face major challenges in the long transition to successful living without their support networks of the local culture and environment and the companionship and support of family and friends.

The Alliance is a member of Rural Education Forum Australia (REFA) which brings organisations together to promote policies and cultures which will overcome some of these rural and remote educational deficits.

Indigenous Australians

Aboriginal and Torres Strait Islander people constitute over 40 per cent of the population in very remote areas, and 2-5 per cent of the population in regional areas.

Foetal death rates tend to be 1.6 times higher in remote areas than in regional areas and major cities, while neonatal death rates tend to be 1.2 to 2.0 times those in major cities. Much of this is a reflection of poorer Indigenous health.

The health and welfare of Australia's Indigenous people would be well served by a range of programs, but of central importance is the opportunity for Indigenous people to have good housing and decent access to law and order, health services, education and jobs.

Challenges for industry

Rural economies do not rely entirely on farming and mining. The bulk of the workforce in rural and remote areas is employed in other industries (eg government, retail, service, etc). However, a downturn in agricultural production or in commodity prices has a large impact on the viability of many of the businesses in rural areas, and on the welfare of people living in those communities.

Further diversification of the rural and remote economy will bolster the welfare of people in rural and remote areas against the uncertainties of climate, especially in a time of climate change.

However poorer access to internet and broadband limits the opportunities for people in rural and remote areas to diversify their income base, as well as reducing access to education, information and services. The development of new infrastructure and industries in rural and remote areas (such as renewable energy power stations, carbon sequestration plants, fast rail, broadband internet, and so on) would strengthen the resilience of the economy outside major cities.

While such industry development may be outside the scope of the National Women's Health Policy, improvement of health services in rural and remote Australia can also contribute to resilience within communities and provide excellent opportunities to actively promote participation of women in health decision-making and management

Risk factors

Rural women have a higher rate of a range of risk factors that make them more likely to experience worse health outcomes compared with their major city counterparts. These are discussed below.

Personal health risk factors

A large proportion of the mortality due to diseases and injuries mentioned above is potentially preventable. Assisting rural women to quit tobacco, drink more moderately, better protect themselves at work, and seek and accept help when they need it could measurably improve their health outcomes.

Table 1: Self-reported risk factors for women and in rural/remote areas versus major cities, 2004/05

	MC	IR	(OR+Rem)	Reg+Rem
Behavioural risk factors	Age standardised prevalence ratio			
Tobacco smoking	1.00	*1.20	*1.37	*1.26
Hazardous/harmful alcohol consumption	1.00	1.12	1.16	1.13
Sedentary levels of physical activity	1.00	1.02	1.10	1.05
Consume reduced fat milk	1.00	0.96	*0.81	*0.91
Consume 2+ serves of fruit per day	1.00	0.96	*0.91	*0.94
Consume 4+ serves of vegetables per day	1.00	*1.33	*1.44	*1.37
Experienced food insecurity in past 12 months	1.00	1.24	1.28	*1.26
Personal risk factors				
High blood pressure	1.00	1.13	1.18	*1.15
High cholesterol	1.00	0.91	*0.77	*0.86
Obese/overweight	1.00	1.08	1.11	*1.09
Changes (1995-2004/05)				
Smoking	*0.84	0.96	1.09	1.01
Alcohol	*1.69	*1.73	*2.29	*1.91
Sedentary	0.97	1.05	1.04	1.04
Obesity	*1.13	*1.12	1.09	*1.11

Source: Derived by NRHA from AIHW¹⁸

Table 1 shows that women in regional and remote areas are more likely to smoke than those in major cities. Furthermore, while the rate of smoking amongst women in major cities has declined appreciably over the past decade, this has not been the case amongst women in

¹⁸ AIHW, 2008. Rural, regional and remote health indicators of health status and determinants of health. Rural Health Series no. 9. Cat. No. PHE 97. AIHW, Canberra.
<http://www.aihw.gov.au/publications/index.cfm/title/10519>

regional and remote areas. Also of note is the fact that the rate of hazardous/harmful alcohol consumption by women has essentially doubled in all areas over the past decade.

Women in regional and remote areas are less likely to consume reduced fat milk and adequate fruit, and were more likely to have experienced food insecurity in the previous 12 month.

The prevalence of self-reported hypertension amongst women in regional and remote areas is 1.15 times higher than amongst women in major cities, but the prevalence of self-reported elevated cholesterol is lower.

Women in rural and remote areas are about 1.1 times as likely to be classified obese than women in major cities, while all women are about 1.1 times as likely to be classified as obese than they were a decade previously.

It is critical that the proposed focus on prevention in the National Women's Health Policy takes special account of ensuring that health promotion strategies reach and address the specific needs of rural women.

Access to services

Rural and remote areas have ageing populations with high rates of chronic disease, health workforce shortages, and extensive drought and other problems affecting the social economic and environmental sustainability of their communities.

There is an acute shortage of health related infrastructure, personnel and services in many rural and remote areas. There is also a tendency for policies to be predominantly city-centric.

The Alliance is promoting the development of a National Rural Health Plan, building on the success of *Healthy Horizons* and including more specific performance indicators and accountability.

The Alliance recommends that the new National Women's Health Policy should be compatible with and support such a plan for rural and remote health services. The piecemeal approach to rural health challenges is not delivering adequate or fair levels of care to rural women.

Lower access to primary health care services

Access to integrated primary health care services for both males and females in regional and remote areas is worse than in major cities.

As discussed by the Alliance in its submission to the consultation on the national primary health care strategy,¹⁹ while rural access to medical practitioners is starting to improve, primary health care practitioners in rural Australia work longer hours and have a broader range of demands for their services. Nurses are relatively evenly distributed across metropolitan, regional, rural and remote areas.

¹⁹ National Rural Health Alliance, 2009. Submission to the Australian Government - Towards a national primary health care strategy.

<http://nrha.ruralhealth.org.au/cms/uploads/publications/towards%20a%20national%20primary%20health%20care%20strategy%20-%20for%20final%20submission%2026%20feb%202009.pdf>

Distribution of allied health professionals is becoming an increasingly significant issue with trends to more multidisciplinary models of care and focus on priorities such as early childhood, preventive health and care for people with chronic disease. The availability of all allied health professionals is above the Australian average in major cities. For example, the National Allied Health Workforce Report 2004 showed that 20.5 per cent of practising psychologists were working in rural and remote regions. This equates to 0.83 psychologists per 10,000 head of population in Very Remote areas and 3.44 in Inner Regional centres compared with 5.92 per 10,000 in Major Cities. The AIHW study, *Geographical Distribution of the Australian Dental Labour Force, 2003*, reported a better distribution of dental therapists in regional, rural and remote Australia but far worse distribution of dentists and dental hygienists. Taking Outer Regional Australia as a yard stick, there were 27.7 dentists per 100,000 head of population compared to 57.6 in major cities, while there were 1.1 dental hygienists compared to 3.8 per 100,000 in major cities.

This means that women outside major cities have lower levels of access to social workers, mental health professionals, counselling, and dieticians as well as to support groups and sharing with others facing similar health challenges, exacerbated by difficulties with transport and events occurring at home as well as lack of easily accessible health-care services.

The Alliance is finalising a position paper on e-health as preferential investment in e-health capacity and implementation in rural and remote communities may be an important part of addressing current inequities in health care and ensuring full participation in the e-health strategies that underpin health reforms and innovative service delivery for rural women.

Although there is little hard evidence, it is very likely that retrieval times for victims of trauma (eg injury and heart attack) are greater in rural and remote areas simply because of the distances involved and the time required to 'raise the alarm', find the patient and then transport them to appropriate care.

Lower levels of access to hospital procedures

It is unclear from the published data whether females in regional and remote areas have lower rates of hospital procedure compared with females in major cities. However, people in rural and remote areas are between 0.6 and 0.9 times as likely to have a coronary artery bypass graft and coronary angioplasty as people living in major cities.²⁰ As stated earlier in this paper, death rates due to coronary heart disease are appreciably higher outside major cities. This suggests that for females, as well as males, living in regional and remote areas reduces the opportunity for life-saving surgery.

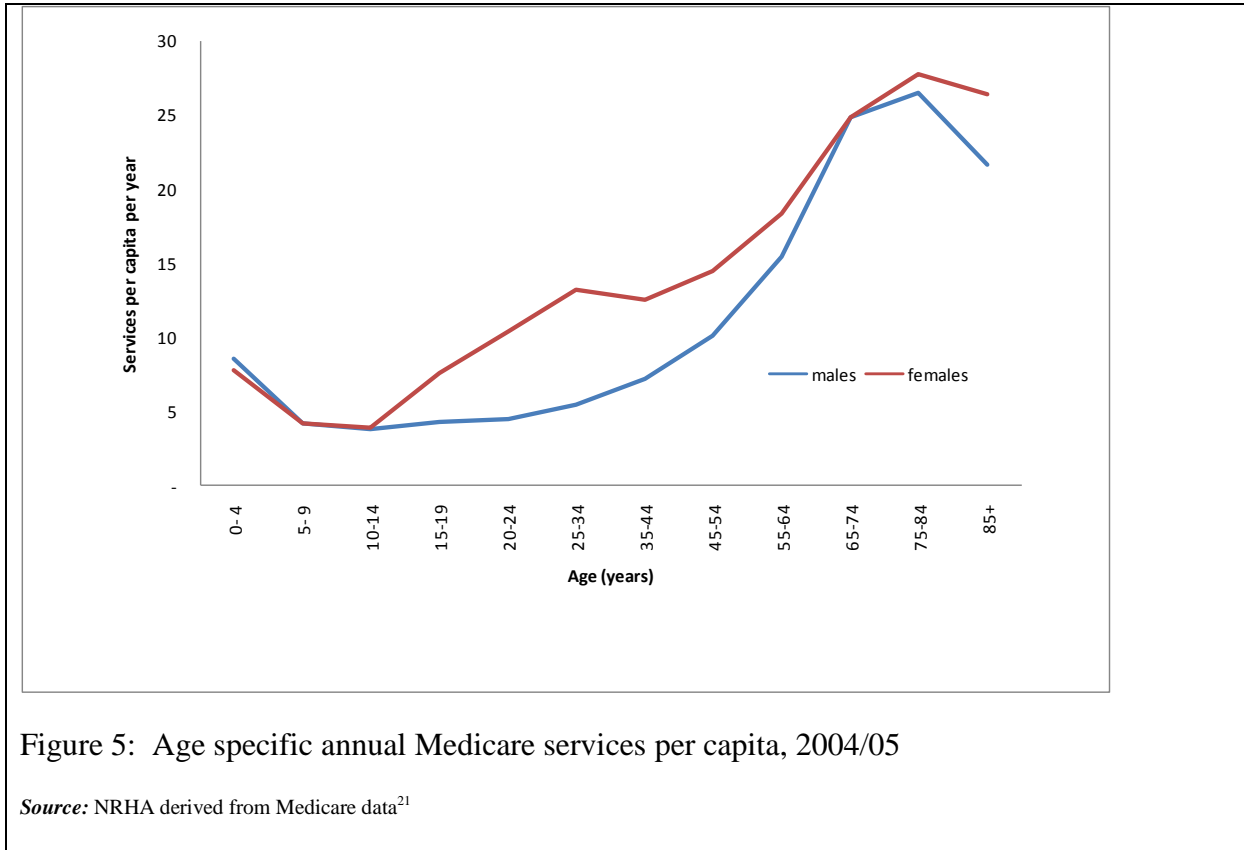
Lower use of Medicare

Females access Medicare more frequently than males (Figure 5).

The Alliance has been unsuccessful in accessing Medicare data in a format suitable for comparing the use of Medicare services in major cities, regional and remote areas, and consequently is unable to comment on the effect of remoteness on women's use of Medicare services. However it can be assumed that use is significantly less because medical

²⁰ AIHW 2008. Rural, regional and remote health: indicators of health status and determinants of health. Rural Health Series no. 9. Cat. no. PHE 97. <http://www.aihw.gov.au/publications/index.cfm/title/10519>

practitioners are less prevalent in regional and remote areas. We are hopeful that AIHW (or another statistical agency) may be successful in accessing Medicare data and be permitted to publish their findings in the future so as to inform debate.



Lower access to Medicare mental health items

Women in rural and remote areas of Australia have lower levels of access to the new MBS mental health services.

Late in 2008 and under the COAG Mental Health Reform, the Mental Health Council of Australia reported²² that:

“Distribution of services remains an issue, with people not living in urban areas facing real disadvantage in terms of access to care under the new MBS items. Per capita service figures reveal the extent to which Australians not living in cities have less access to the new measures.”

From this report, the rate of access in regional areas is 0.4 to 0.9 times that in major cities, while in remote areas, it is 0.11 to 0.3 times the rate in major cities. The report also

²¹ Australian Government Department of Health and Ageing. Historical publications. Medicare Statistics - December Quarter 2005. <http://www.health.gov.au/internet/main/publishing.nsf/Content/medstat-dec05-tables-d>

²² Mental Health Council of Australia 2008. Mental Health and the new Medicare Services: 2nd Report November 2006 – August 2008.

<http://www.mhca.org.au/documents/publications/COAG%20MBS%202nd%20Report%20Sept%202008.pdf>

comments that “women are twice as likely as men to have received some care under the Better Access Program. This trend tends to mirror the pattern of total GP presentations and may reflect broader patterns of help-seeking behaviour across genders but seems more exaggerated for these mental health items.”

ACHIEVING GENDER EQUITY FOR RURAL WOMEN

Reproductive health

Living in a small community may limit a woman’s actions to seek professional advice and support for reproductive and sexual health issues. Her GP may be known to her personally, and may be male (when she may find a female GP easier to talk to). Or it may be that the local GP is culturally distinct from them, or is rotating through on a rural placement.

Sexually transmitted infections can also be more common in rural and remote areas than in major cities. For example, rates of syphilis are over 12 times as high in remote areas as in major cities. While the pattern in previous years has been similar, the absolute rates and regional differences have declined substantially since the early 1990s.

Rates of Chlamydia were 4 times higher in remote areas than in major cities in 2001. This pattern of higher rates outside major cities is typical of the pattern in previous years.

Higher prevalence of STIs in rural and remote areas provides a source of infection or re-infection for women and, and importantly, their children.

Sexual orientation may cause particular challenges in a small town due to a lack of anonymity.

Fertility tends to be higher in rural and especially remote areas, and maternal age (at the birth of the child) tends to be younger for women who live in rural and especially remote areas. For example, in regional and remote areas, fertility rates are 1.1 to 1.4 times those in major cities. Specifically, the rate of birth for 15-19 year old women increases steadily with remoteness, such that it is 7 times in very remote areas that for similar aged women in major cities. This is symptomatic of the rural environment (poorer economy, education and opportunity) and is likely to reduce health status and quality of life for both mother and child.

Services that better meet the needs of women

The Rural Flying Doctor Service Rural Women’s General Practitioner Service Program provides an important example of the sort of service that is designed to meet the needs of rural women and goes well beyond reproductive health services. Rural women are responsive to and attend health education sessions conducted by female GPs on issues specific to their needs. Sessions conducted outside the health service at schools, community health services, or community and club meeting venues are well attended and result in greater uptake of primary health care services, including for hard-to-reach groups of women including young people.

Patients’ travel and accommodation assistance schemes that recognise the needs of families and carers as well are critical elements of integrated services for rural women.

The National Women's Health Policy should encourage women to participate in engaging their communities in health, including delivery of local health services by, for example, encouraging women into positions on community boards, ensuring policy direction comes from the local level, resourcing and recognising volunteer community groups and supporting creative community partnership programs to provide health care that works for rural women.

A LIFECOURSE APPROACH

The Alliance supports the principle of a lifecourse approach to health care. The path from birth through childhood, maternity, ageing and end of life includes a number of distinct challenges for rural women. The Alliance positions on maternity services and on ageing for rural women are summarised in this section. The discussion in the sections on prevention and on achieving equity in health for rural women in this submission also includes important issues for equity of health care for rural women across the whole lifecourse.

Maternity services

Investment in maternity services²³ yields returns for individuals, families and the nation. Women everywhere should have birthing options, with the health and wellbeing and safety of mother and child being the overriding determining factors.

A healthy pregnancy, a birth that is managed with appropriate care, and an optimum beginning to life are key determinants of the longer-term health of the child. The obverse is that poor prenatal and birthing experiences impose costs for life, and are likely to involve many in the health care sector who are not directly involved in maternity services.

The fact that rural birthing options are becoming increasingly limited is of great concern to rural families and communities.

Equity and choice are also affected by financial means and family circumstances. People with private health insurance and/or with good income are better able to afford to travel and stay away from home if there are no local birthing facilities. Many people in rural and remote areas cannot readily afford such travel and accommodation costs. For those people the absence of local birthing services imposes particular costs and logistical difficulties, and may actually increase the health risks of the pregnancy and birth. Currently pregnant women who experience a 'false alarm' may be airlifted to the capital city and then left to return by whatever means they can.

Everyone should welcome the Government's commitment to the principle that women in rural Australia should have access to good management and support for a healthy pregnancy, safe delivery and good post-natal care,²⁴ and as close to home as possible.

The key challenge is not just to maintain the current level of maternity services in rural and regional areas but, rather, to reinvest substantially in such services so that greater proportions of women have local access to high-quality, safe, women- and family-centred, culturally

²³ 'Maternity services' are an integrated sequence of services including antenatal care, childbirth, parenting skills, post-natal services and specialised services needed by very young babies.

²⁴ NRHA, 2008. Birthing in the bush. Submission to the Maternity Services Review.

<http://nrha.ruralhealth.org.au/cms/uploads/publications/submission%20to%20maternity%20services%20review%20finaloctober.pdf>

secure and holistic maternity services. Preservation of the existing service capacity and a firm, well-funded commitment to reinvest and rebuild maternity services is therefore a top priority for immediate action.

Currently, poorer obstetric outcomes for rural women (in terms of morbidity and mortality) arise due to a lack of access to care, rather than the quality of the care given. There are specific challenges relating to the ageing workforce and, for Indigenous women, limited Indigenous health workers supporting birthing. There needs to be strong support for midwifery, including for retrieval. If services are based on the ‘hub and spoke’ model, the hub must be well-resourced and well-staffed. Many people argue that all rural nurses should have some skills in midwifery. It may be necessary to invest in local upskilling of staff in small hospitals that do not have maternity units, so that personnel are comfortable to accept real emergencies. Currently people in these circumstances often feel unsupported. In Western Australia in the past, guidelines relating to the flying time to Caesarian section were used to put pressure on some small services to be closed, with assertions that some GP obstetricians might have been working outside their safe scope of practice.

The emphasis in maternity services should be on teamwork, with good relationships between the GP, the mother and the midwife, good communications and connectivity. There should be ‘integrated services’, with good communications – especially if some members of the team are not on-site and transfers take place to other environments where necessary.

Patients’ travel and accommodation assistance schemes are critical elements of integrated services for maternity services. Expectations are high for significant augmentation and improvements in such schemes.

Specific proposals on maternity services

On maternity services the NRHA has agreed as follows.²⁵

1. In the case of women and their families in rural and remote Australia in particular, it is time for all Governments to agree to the proposed National Maternity Services Plan.

Specifically, governments should agree that:

- women have the fundamental right to maternity services that maximise health and wellbeing outcomes for themselves, their babies and their families;
- maximum health and wellbeing for all will be achieved by allowing for women to give birth in or as close as practicable to their own communities, supported by their families and to have continuity of care, as far as is practicable, by their own local health care professionals;
- women’s choice as to their options for giving birth in a safe and healthy environment should be supported by person-centred care and good information on the risks and benefits of various models of care;

²⁵ These are the detailed recommendations from the Alliance’s October 2008 Submission to the Maternity Services Review.

- the large majority of women for whom childbirth is a safe and clinically uncomplicated experience should not have their options reduced or have to incur additional risks and costs themselves through extensive travel and dislocation in order to maximise the safety of those who experience substantial risks;
 - the Plan should provide for accounting annually for any diminution in the provision of local maternity services;
 - the Plan should identify and share at a national level the examples of good practice and enhancement of services; and
 - the Plan should provide for national workforce planning as well as immediate measures to boost an interdisciplinary maternity services workforce in rural Australia.
2. Such governmental agreement would be consistent with the general principles espoused by the National Health and Hospitals Reform Commission, especially those related to people- and family-centredness, equity, strengthening wellness and providing for future generations.
 3. The Australian Government should back the efforts of the States and Territories on maternity services and provide additional funding to build and rebuild maternity services in rural Australia.
 4. There should be a moratorium on further closures of maternity services in rural hospitals. Maternity services should not be treated as a commodity, subject to provision at lowest possible short-term transaction cost. Nor should the focus on safety and risk for the small proportion of pregnancies that require higher level care result in higher risks for the majority of local women for whom birthing is relatively uncomplicated.
 5. In view of the poorer access to the broad range of health services available to them, women in rural Australia should be offered continuity of care services, to provide for prevention and early intervention of both prenatal and postnatal health issues.
 6. Information kits should be provided to expectant women on the nature, scope and availability of various models of care available to them both locally and wider afield.
 7. Funding should be made available to support:
 - clinical placements for GPs and midwives in rural services providing quality maternity services at both primary practice and rural hospital levels;
 - a range of education, training and support initiatives to build the supply of midwives where there is demand by individuals for their services; and
 - clinical placements for all professions involved in the maternity services team in an interdisciplinary environment.

Older women and ageing in rural Australia

Thirty five percent of Australians aged 65 and older (referred to as elderly) live outside the major cities. Twelve percent of the population in major cities are elderly, compared with 14 percent in regional and 7 percent in remote areas.

Internal migration contributes to these proportions. Many young people from the country move to the city for education and work opportunities; retirees shift from urban areas to the country and it is believed that people from remote areas – particularly if the need regular access to more specialised services – will move to less remote places if they can.

Access to aged care, health care and ancillary services such as transport, carer respite, emergency respite, aids and supports etc) is more limited in country areas and the scope of the services that are locally available is often less comprehensive than in the cities. It is important that programs are available for the elderly in rural areas to help keep them healthy by preventing disability and maintaining function and independence. Aboriginal and Torres Strait Islander people utilise aged care services at a younger age, consistent with poorer health status and lower life expectancy and require particular attention.²⁶

As women make up a larger proportion of the elderly and of carers for the elderly than men, the National Women's Health Policy will need to consider strategies for addressing the special needs of rural women as they age and/or care for the elderly. The Alliance has made the following proposals for achieving more equitable outcomes for aged care in rural areas that should be considered in developing the policy framework:

1. Governments should work collaboratively with both public and private aged care sectors to make the special provisions that will overcome economic viability and sustainability issues for residential facilities in rural areas.
2. A range of flexible models of aged care should be available that are tailored to meet the needs of local communities. Research and development grants are needed to support the adoption of information and communications technology (ICT), networking, alliances and resource management arrangements that will enhance the economic sustainability of aged care services in country areas.
3. The Australian Government should develop a national aged care workforce strategy giving high priority to addressing the wage differential between the acute and aged care sectors and further addressing:
 - increased investment in patient transport and accommodation assistance schemes to provide better access to care for older people in rural and remote communities;

²⁶ National Rural Health Alliance, 2009. Ageing in rural, regional and remote Australia. Fact sheet 3. <http://nrha.ruralhealth.org.au/cms/uploads/factsheets/fact-sheet-03-ageing.pdf>

- specifically, there should be improved funding arrangements for ambulance use to enable universal free-to-end-user access for people in rural and remote communities.^{26,27}

PREVENTION

The Alliance strongly supports an emphasis on ‘preventative health’, being policies and programs to promote good health and reduce risks of a range of diseases. Many communities in rural Australia have higher levels of health needs as outlined in this submission and lower levels of capacity to address them, so potentially have much to gain from such an approach.

The key concern of the Alliance is to ensure that the perspectives of rural Australia are highlighted and that sufficient resources are allocated, in a flexible system, to ensure a needs-based approach and equity in access to population health measures for all people, including the women, who live in rural and remote areas. In this work there must be meaningful engagement with the people and communities most at risk. Aboriginal and Torres Strait Islander peoples should command high priority under preventative health programs.

This key concern is consistent with the principles and values outlined in the discussion paper for the National Women’s Health Policy including increased participation by women in health decision making and management as a key way of making the health system more responsive to the needs of women, especially those with the highest risk of poor health.

In its submission to the National Preventative Health Taskforce²⁸, the Alliance argued that there is a strong case for leadership of the national preventative agenda that goes beyond mere ‘engagement’ with sectors other than health to their full inclusion in the leadership structure. There is also a strong case for high levels of community and individual ownership and control in the prevention agenda. This case derives from theories on the social gradient of health, from Aboriginal and Torres Strait Islander philosophies and from the principles of chronic disease self management.

Accordingly, the Alliance recommends that the National Women’s Health Policy should also support two key principles to underpin strategic directions and specific initiatives in the preventative health agenda:

- a governance framework and a charter that seek to include sectors and communities other than health in leadership on health promotion and illness prevention, including strong representation from rural Australia and from Aboriginal and Torres Strait Islanders; and
- enabling women to increase control over their health. In this context, further development of preventative measures could warrant greater attention to ownership and control at the community and individual level.

²⁷ Further information is available in ‘Older people and aged care in rural, regional and remote Australia’ (2005) jointly produced by the National Rural Health Alliance and Aged & Community Services Australia, available at [http://nrha.ruralhealth.org.au/cms/uploads/publications/older_people_and_aged_care_july04.pdf#search="aged community services"](http://nrha.ruralhealth.org.au/cms/uploads/publications/older_people_and_aged_care_july04.pdf#search=)

²⁸ National Rural Health Alliance, 2009. Submission to the National Preventative Health Taskforce. <http://nrha.ruralhealth.org.au/cms/uploads/publications/preventative%20health%20taskforce%20final%20submission%207%20january.pdf>

This is particularly important for people in rural Australia who have less by way of supporting infrastructure and services in health, and less by way of health literacy. The Alliance considers that there would be merit in consideration of programs that provide ongoing support for community-based initiatives to build healthy communities in rural Australia. Such initiatives should be an essential part of the fabric of the Australian health system.

Despite greater need in rural Australia, there are a number of circumstances in which 'standard' population health measures are less likely to reach people in rural areas as readily as they reach urban populations which have already been discussed in more detail in the current submission. These barriers to prevention measures include less access to a range of health professionals, lower levels of health literacy, less supporting infrastructure through community and work settings, and more technical and logistical barriers to true community participation. These circumstances should be explicitly acknowledged and countervailing action taken to enable better alignment of prevention programs with areas and communities of greatest need.

Overall, health promotion and prevention programs for people in rural areas should take account of the special characteristics, challenges and diversity of Australia's rural and remote communities, and be planned and implemented in ways that will make them effective in those areas.

The Alliance suggests that:

- primacy be given to needs-based funding by location, within a mix of funding methodologies, to support better distribution of health professionals and their delivery of services in the community;
- where current workforce distribution and funding mechanisms result in serious shortfalls at the regional level, supplementary funding should be provided to achieve needs-based funding levels; this supplementary funding could be used, for example, to increase the availability of practice nurses and allied health professionals, and for innovative services to support 'hard to reach' groups such as men;
- priority be given to the development of models of care and funding that support patient-centred integrated care and multi-disciplinary approaches at individual or community level, rather than to interventions focused on episodic care and single risks;
- work should be undertaken to imbed preventative health and health promotion at undergraduate, postgraduate, vocational and continuing professional development levels for all health professionals, so that preventative health is fully integrated into the primary health care system in Australia;
- since the nursing profession is currently the most evenly distributed across different regions of Australia, they be considered for a significant early role in health promotion activities in rural and remote communities, and be appropriately trained and resourced to do this in an effective and structured manner; and
- emphasis and funding support be given to rural health education and training institutions to provide preventative health inputs at undergraduate and postgraduate

levels, to support continuing professional development on preventative measures in rural Australia, and to undertake research on the most effective measures in preventative health in rural communities.

Programs to support preventative health measures in various settings should not assume equal capacity for resourcing at the local level. Instead, they should specifically take account of local resourcing capacity, as well as local consumer needs, and avoid a ‘one-size fits all’ approach.

The Alliance would support measures to reduce the cost of fresh fruit and vegetables in rural areas where access to these products is severely limited. It also recommends that rural barriers on uptake be considered in other policy areas and compensatory measures put in place to promote equity of access.

A STRONG AND EMERGING EVIDENCE BASE FOR RURAL WOMEN’S HEALTH

The Alliance has long argued for increased funding to improve the availability of statistical information about the health of people in rural and remote areas. Key strategies would include ongoing funding for key data agencies (eg AIHW) to continue their work on rural health, the formation of a rural and remote health research institute (a strategic approach to rural health research), and regular, independent evaluation of the effectiveness of government rural health programs.

The present submission has highlighted a number of areas where the evidence base for rural women’s health outcomes and effective health services is limited. For example, a life-course approach to women’s health with a focus on prevention will include MBS based approaches, delivered through GPs or GP directed nurses or allied health professionals, especially in early intervention, screening programs and in promoting risk reduction in people with chronic conditions. Yet as discussed, the Alliance has been unsuccessful in accessing Medicare data in a format suitable for comparing the use of Medicare services in major cities, regional and remote areas, and consequently is unable to comment on the effect of remoteness on women’s use of Medicare services.

Community initiatives are equally part of the primary health care system and have benefits in giving women a greater sense of their capacity to manage their lives and their health conditions: to set goals for themselves, to solve problems, to manage their emotions and to strengthen their adherence to treatment and lifestyle regimes. The importance of building community capacity and cross sectoral engagement within the community is recognised in a number of programs and projects including Sharing Health Care, Rural Chronic Disease Initiatives and Building Healthy Communities in Remote Australia. These programs have been in operation for many years. While they have been the subject of evaluation, assessments of their levels of effectiveness and cost-effectiveness in health promotion are not readily available. The drawback with these initiatives is that they have been location limited, time limited and application driven rather than universally needs-based in their distribution.

The Alliance recommends that the new National Women’s Health Policy identifies the need for urgent evaluations to identify current program and project initiatives that warrant community-wide and ongoing adoption for rural women. Reporting on the impact of preventive health measures on women’s health should occur at national and regional levels to monitor progress towards health equity for all women.

The Alliance in its submission to the Review of Rural and Remote Health Service Programs valued the strategic framework and goals of *Healthy Horizons* in complementing its vision of good health and wellbeing for people in rural and remote Australia.

It is the view of the Alliance that special health programs for rural and remote areas should be effective, flexible, adaptable, innovative, accountable and strategic in their distribution of benefits and should help achieve equitable health outcomes for all Australians. The recent review of rural classification systems is important in its capacity to contribute to achieving equity.

The importance of Commonwealth-State partnerships in improving health outcomes in rural and remote areas and the many complexities involved in a health system being co-managed by two levels of government, means that cost-shifting must be avoided and that relocation of responsibilities between governments must result in net gains to communities in terms of services and outcomes. Other complexities relate to workforce shortages, funding arrangements, business viability, sparse populations, and linkages between rural and metropolitan health services. The Alliance advocates a broad concept of partnership which includes governments and other health organisations, professionals and individuals in order to best address this complexity of issues.

The Alliance has recommended the development of a National Rural Health Strategy, agreed by the Commonwealth and State/Territory governments, to give greater certainty and visibility to the intentions of all jurisdictions and be a basis for coherent planning and service provision. The Alliance advocates a National Rural Health Plan as a component of such a strategy, which would allow actions, timelines, resources and outcomes to be more precisely and more openly measured and evaluated. The Plan should include goals and strategies relating to national health priorities, Indigenous health, primary health care, mental health and preventative health. Its provisions would encompass both private and public provision of services, needs-based funding, compensation for additional costs of rural services and local access to basic primary health care.

Accordingly, the Alliance recommends that the new Women's Health Policy should be compatible in its rural and remote aspects with a national rural health plan.

THE FUTURE FOR THE HEALTH OF WOMEN LIVING IN RURAL AUSTRALIA

The appointment of a Minister to the Indigenous and rural health portfolio has been widely welcomed and augurs well for the immediate future. The earlier establishment of the Office of Rural Health has also been welcomed as a means for improving the focus on the health outcomes of people living in rural, regional and remote Australia.

The National Health and Hospitals Reform Commission has recognised the need for a much stronger rural focus.²⁹ The adoption by government of the reforms it might propose would enhance women's health in rural areas.

²⁹ NRHA, 2009. Submission to the National Health and Hospitals Reform Commission interim report – a healthier future for all Australians.

<http://nrha.ruralhealth.org.au/cms/uploads/publications/interim%20report%20-%20final%20response%2020%20march.pdf>

Climate change provides both threats and opportunities for rural economies, and how governments approach climate change will have a major impact on the health of both women and men in these areas.

Women's health remains a current, key issue in rural and remote Australia. Attachment 2 includes a range of recommendations relating to improving rural women's health that emerged from the 10th National Rural Health Conference in Cairns in May 2009.

Attachment 1: Member Bodies of the National Rural Health Alliance

ACHSE	Australian College of Health Service Executives (rural members)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Rural Sub-Committee of the Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association of Australia
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Members Network
APS	Australian Paediatric Society
ARHEN	Australian Rural Health Education Network
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia
CRHF	Catholic Rural Hospitals Forum of Catholic Health of Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
RDAA	Rural Doctors' Association of Australia
RDN of the ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Australian Council of the Royal Flying Doctor Service of Australia
RHWA	Rural Health Workforce Australia
RIHG	Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
RPA	Rural Pharmacists Australia - Special Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

Attachment 2: 10th Conference recommendations

The National Rural Health Conference was held in Cairns, 17-20 May 2009. Around 1000 delegates attended the event. The following recommendations relating to women's health were among those generated at the conference.

Recommendations:

Early intervention

55. The Federal Department of Health and Ageing should continue to recognise the importance and value of Community Point of Care Early Intervention Health Checks conducted by nurse practitioners/practice nurses and trained health workers to support better health outcomes/compliance and referrals to doctors with supportive evidence for primary/chronic care and medication. Both men and women benefit from this process. Point of care testing allows for greater participation rates with results processed into client records for the doctor and allied health workers' follow-up/recalls.

Indigenous health (smoking cessation)

125. Culturally sensitive, evidence-based smoking cessation programs should be made available to Aboriginal communities and all Indigenous smokers. They should be comprehensive and sustainable – not just brief interventions. They need to acknowledge individual, household and community factors driving the high rates of smoking in Indigenous populations, and address psychosocial and historical elements of trauma and current stress. These programs must be well-resourced. Pregnant women (and their families) should be given highest priority in such programs.

129. Following the success of the Give Up The Smokes (GUTS) course, others aiming to develop culturally-appropriate smoking cessation courses should include evidence-based approaches, discussion about the Indigenous history of tobacco use, targeted information about prevalence of smoking and the health and other effects of smoking in Indigenous smokers. The program should have a high level of interactive and visually stimulating activities. Exploration of women's views on smoking allows a greater understanding of both the reasons for continued smoking and the complex array of factors affecting behaviour.

Maternity services

139. It should be recognised that the lack of specific policy in rural maternity care has a constraining effect on government action in this area. While rural birthing services continue to close, the policy goal of equitable access to care is not being achieved. The centralisation of services which results from rural maternity unit closures has given rise to a number of financial, personal and social barriers to rural residents' access to care.

140. The Australian Government should establish a National Maternity Health Centre to lead the process of improving maternal/pregnancy outcomes by translation of evidence into practice – particularly clinical practice, consumer information and models of caring. The body should be modelled on the National Breast and Ovarian Cancer Centre. It would use evidence and consensus to achieve nationally-agreed resources and models for shared antenatal care, for example, and guidance for practitioners. This would significantly improve

on the current situation in which there is a plethora of such resources developed by different hospitals and maternity units.

141. Scholarships should be offered for midwives to undertake education for MBS and PBS accreditation.

142. The development of rural maternity services should be on the basis of evidence, including about the needs of individual communities.

143. Any proposal to downgrade or close a rural maternity service should include a current social impact statement and analysis of the social and economic risks attached to closure or downgrading.

144. The Government should act on the proposals in the recent maternity services review for the development of collaborative care guidelines by rural paediatricians, midwives and GP and specialist obstetricians.

Social determinants

244. The adoption of multi-disciplinary models of care would enable the social determinants of health to be better addressed and lead to better care and health outcomes. Such models would include youth workers, homeless support workers, men's health workers, women's health workers, school welfare and mental health staff, speech pathologists, early childhood workers and many more.

Women's health

246. The National Women's Health Policy should acknowledge women's roles in the health of families and communities and so should specifically promote education and health literacy in girls.

247. The National Women's Health Policy must include goals for equity in health services and outcomes for women in rural and remote areas.

248. The ability of nurse practitioners, physician assistants and practice nurses to provide Well Woman Checks should be recognised, encouraged and promoted by the medical community and the public sector. Consensus should be reached by health professionals regarding the components of the Well Woman Check, based on the evidence provided by current literature. Practice guidelines for Well Woman Checks in Australia should be developed to ensure uniformity of health delivery for women and improved education. Health professionals involved in Well Woman Checks should be encouraged to provide information to patients regarding the procedures being performed, the implications of positive and negative findings, and the follow-up of results.

Workforce

249. The SOLS model of locum relief should be extended to include midwives and paediatricians, as a core component of the plan to improve rural maternity care.