



NATIONAL RURAL
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Submission to the

NATIONAL PREVENTATIVE HEALTH TASKFORCE

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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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EXECUTIVE SUMMARY

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 and lower levels of capacity to address them, and so potentially have much to gain from such an approach.

No health and wellbeing issue in Australia is worse or more urgent than the impoverishment and appalling health status of Indigenous people. Aboriginal and Torres Strait Islander peoples should command high priority under preventative health programs.

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 people in rural and remote areas. In this work there must be meaningful engagement with people and communities most at risk.

In the Alliance’s view 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, two key principles that should underpin strategic directions and specific initiatives in the preventative health agenda are:

- 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 people 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.

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. 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.

The Alliance strongly supports the proposed establishment of a performance monitoring framework to:

- provide an essential discipline in clarifying goals and targets, timeframes and development and delivery processes; and
- act as a tool in engaging and maintaining the public, inter-sectoral and institutional commitment and interest that is essential for the major cultural change inherent in the prevention agenda.

It would also be valuable in planning, delivery, ongoing research and evaluation and in public interest and commitment if there was a locational dimension to public performance monitoring. This would enable people in each area to see and understand how various elements of the prevention agenda were performing in their own locality.

The Alliance supports the indicated future priorities of the Taskforce, to include mental health and injury. Particular priority should be given to promotion of overall mental health and wellbeing as a framework within which to consider and address the range of risk factors including obesity, smoking and alcohol misuse.

The Alliance considers that there would also be merit in considering risk and illness prevention measures in early childhood as a logical flow-on from work on obesity and on the promotion of nutrition and physical activity.

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. (A list of Alliance Members is at Attachment 1.)

The Alliance's vision is equal health for all Australians by 2020.

The health status of rural and remote Australians is substantially lower than that of people who live in metropolitan areas. Overall, the health of Australians deteriorates with increasing remoteness, and at the same time their exposure to health risk factors becomes greater¹. On average, rural and remote (hereinafter 'rural') Australians are older and experience a higher incidence of chronic illness and disability. They are also poorer than their metropolitan cousins and are confronted by higher levels of health risk factors including poor nutrition, physical inactivity, obesity, smoking, harmful levels of alcohol consumption and high blood pressure.

No health and wellbeing issue in Australia is worse or more urgent than the impoverishment and appalling health status of Indigenous people. Most indicators for poor health are worse for Indigenous Australians. Preventative health measures should form a major plank of the Government's *Closing the Gap* strategies and Aboriginal and Torres Strait Islander peoples should command high priority under preventative health programs.

Accordingly, the Alliance strongly welcomes and supports the Government's policies and priorities to pursue a comprehensive program of improving people's health and wellbeing and in reducing risks of a range of diseases. People in rural Australia, including Aboriginal and Torres Strait Islander peoples, have much to gain from these initiatives. The Alliance also acknowledges that policies and programs to address obesity, smoking and alcohol misuse generally have a strong socio-economic dimension to them, with the risk factors relating to those three being more prevalent among lower socio-economic groups.

Whatever strategies are proposed to address smoking, obesity and alcohol misuse, the specific implications for rural areas must be considered. People in rural Australia overall do not enjoy access at the community or individual level to the same range, level and affordability of facilities and services as the bulk of their urban counterparts. This lower level of access and diversity applies to health services, work, education and entertainment options, public transport, fresh food supplies and information and knowledge bases and is exacerbated by barriers of distance and affordability.

For the management and prevention of these risk factors, strategies need to be developed and funds and services provided and apportioned in a way that will ensure equity and sustainability for consumers and health professionals across all geographic locations. For example, where there is a need for staff on the ground, account must be taken of smaller population groups, smaller workforce numbers, fewer facilities, and transport, distance and other barriers to access. This will require collaborative planning among governments, local communities and individual consumer groups and those tasked with the delivery of preventative health practices. Critically, there must be opportunities for local communities to tailor programs to allow local acceptance, ownership and implementation.

The Taskforce discussion paper, *Australia - The Healthiest Country by 2020*, is encouraging in its recognition and its understanding of these issues, noting as it does:

- increasing disparities between Indigenous and non-Indigenous, between city and rural, between rich and poor;
- the need for governments, public and private sector organisations and community groups to work together to reshape consumer demand and support;
- the need to involve every community and neighbourhood;
- the merits of locally-identified mechanisms to establish and maintain partnerships and collaborations;
- the need to take account of the socio-economic gradient of health; and
- the need to respond to the ‘inverse care law’¹ and provide underserved communities with the support and resources that they need, including through tailored approaches and services to reach Indigenous and other disadvantaged groups.

The discussion paper is also commendable in its proposals to identify appropriate indicators and to monitor performance in working towards targets and, in some instances, to take into account the contextual locational and socio-economic factors.

The challenge will be to adhere to these principles and follow through on the recommendations and to implement programs at the national, local, community and individual level that specifically target areas of greatest need and counterbalance the ‘inverse care law’ tendencies. For example, national education or social marketing campaigns should be shaped and delivered to have relevance for and accessibility by risk groups in rural Australia well as by residents of Major Cities.

While this submission will make comment on some other aspects of preventative health issues of particular concern in rural Australia, its main focus is on seeking to ensure genuine access by rural Australians to preventative health measures, through programs of preventative health that achieve local ownership and local acceptance.

HEALTH STATUS AND DETERMINANTS IN RURAL AUSTRALIA

Health Status

In its March 2008 publication, *Rural, regional and remote health: Indicators of health status and determinants of health*ⁱⁱ, the Australian Institute of Health and Welfare provides a detailed picture of the health conditions of people outside Australia’s Major Cities. Of relevance to the work of the Taskforce, it reported conditions of populations in Inner Regional, Outer Regional and Remote/Very Remote areas compared to their counterparts in Major Cities in areas as follows:

- 1.2 times the reported rate of fair to poor health;
- 1.1 times the level of mortality;
- females having 1.3 times the rate of diabetes;
- males having 1.2 to 1.4 times the rates of smoking, 1.2 to 1.4 times risky alcohol consumption, (for males in Outer Regional areas 1.2 times the likelihood to engage

¹ The Inverse care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served.

in risky behaviour while intoxicated), 1.2 times the rate of injury and disability conditions;

- 1.2 to 1.4 times the reported level of sedentary behaviour;
- 1.1 to 1.2 times the rate of perinatal deaths;
- for both females and males, 1.1 times the level of overweight and obesity.

It is concerning to note that the prevalence of obesity has increased over time in all areas and that smoking levels among rural males has not changed over the past decade.

While people in rural Australia have worse health outcomes overall, it should be acknowledged that for some risk factors and health conditions their reported levels were the same or better than for people in Major Cities, including mental health and coronary heart disease (no reported significant difference), while rural Australians were 1.5 times more likely to consume five or more serves of vegetables per day.

Health Determinants

In addition to the higher overall burden of disease, Australians outside the major capital cities also have to contend with:

- lower overall socio-economic status;
- lower levels of access to GPs, specialists, dentists and allied health professionals;
- lower education levels and ‘health literacy’; and
- a more restricted range of options for population health measures (eg less access to public transport, cycle paths, the capacity benefits of larger workplaces, diversity of sporting facilities, entertainments for young people).

Socio-economic status

The rankings of the Australian Bureau of Statistics Index of Relative Socio-economic Disadvantage, 2006, by Local Government Area (LGAs), based on income, educational attainment, the proportion in unskilled occupations, unemployment, one-parent families, renting households and Aboriginal and Torres Strait Islander populations, show a preponderance of rural and remote LGAs in the most disadvantaged areas in Australia.

A Parliamentary Library analysis of socio-economic indexes at Electoral Divisional level, derived from the 2001 ABS Census, showed that the lowest 20 Electorates on the Index of Socio-economic Advantage/Disadvantage comprised thirteen rural and seven outer suburban electorates. It also found a preponderance of rural electorates at the lower end of the Index of Economic Resources and on the Index of Education and Occupation.

While there are substantial variations in ranking and some disadvantaged areas in metropolitan areas as well, the well-evidenced socio-economic gradient of health dictates that people in areas that are disadvantaged in economic and social terms have worse health outcomes as well as fewer economic resources at the individual and community level, and generally lower levels of educational attainment and health literacy to be able to respond to public health education and information.

Maldistribution of Health Professionals

General Practitioners

The AIHW survey of Medical Labour Force changes from 2002 to 2006 indicates that the investment in national medical workforce training and distribution initiatives is serving to

increase rural access to medical practitioners, as shown in the following table. In overall terms, however, the geographically skewed distribution of employed medical practitioners continues and is in fact increasing, with greater increases of health professionals per 100,000 population in metropolitan areas than in Inner and Outer Regional areas.

AREA	Total Medical Workforce per 100,000		Growth Rate in Employed Medical Practitioners	Employed Primary Care Clinicians FTE per 100,000		Employed Hospital non-specialists FTE per 100,000		Specialists/ in training FTE per 100,000	
	2002	2006		2002	2006	2002	2006	2002	2006
Metro	312	332	18.5%	105	98	29	39	154	170
Inner Regional	176	184	8.3%	90	87	14	18	65	71
Outer Regional	146	154	4.9%	80	86	15	15	43	45
Remote, Very Remote	140	191	31.2%	89	108	22	34	21	35
Overall Clinicians	271	290		101	97				
	252	272							

Note: AIHW urges care in interpreting 2006 data for Remote/Very Remote because of few numbers responding to survey.

There are similar disparities for allied health professionals, dentists, midwives and nurses, with the last-named profession having the most even distribution across different remoteness classifications.

The AIHW survey of the medical labour force also found that hours of work by primary care clinicians were 2.6 hours more in Inner Regional, 6.1 hours more in Outer Regional and 10.3 hours more in Remote/Very Remote, compared to their metropolitan counterparts. (Rural and remote clinicians are also likely to spend more time on call.) Thus it is clear that primary health care practitioners in rural Australia already work longer hours and have a broader range of demands for their services and will be significantly less well placed than their metropolitan colleagues to devote additional time to health promotion and prevention measures.

Psychologists

The National Allied Health Workforce Report (2003)ⁱⁱⁱ showed that 20.5 per cent of practising psychologists were reported as 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 to 5.92 per 10,000 head of population in major capital cities. The rural sector tended to attract the youngest and hence least experienced health professionals. Although data are scarce, there would appear to be few Indigenous people working as psychologists, regardless of whether or not they are located in rural areas.

The Alliance considers that the availability of mental health practitioners and strong programs of promoting better overall mental health and wellbeing will be important in achieving risk reduction in people with a range of related risk factors.

Dental Labour Force

The AIHW study, *Geographic Distribution of the Australian Dental Labour Force, 2003*^{iv}, reported 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 yardstick, dentists per 100,000 population were 27.7 compared to 57.6 in Major Cities, while there were 1.1 dental hygienists, compared to 3.8 per 100,000 in Major Cities.

Good oral health is vital to healthy eating. The National Survey of Adult Oral Health 2004-2006 found that 39.4 per cent of Indigenous people who were surveyed avoided some foods because of dental problems and 17.4 per cent of all ages were similarly affected.

Health Literacy

Prevention programs involving social marketing, information and provision of advice inevitably run into health literacy barriers, not surprisingly among the major target groups for prevention programs. The ABS 2006 Survey on Adult Literacy and Life Skills and its component Adult Health Literacy found that 59 per cent of people did not attain the level of proficiency regarded as the minimum required for individuals to meet the complex demands of everyday life and work in the emerging knowledge-based economy. Health literacy was defined to include five domains: ability to respond to health promotion, the ability to assess information on health protection, the ability to undertake preventative and early detection measures, the ability to seek and form partnerships with health care providers and the ability to navigate the health services system.

Not surprisingly, health literacy diminished with education levels, and with household income, unemployment and certain types of occupation. While the survey found that regionality was not itself a major factor in health literacy, the lower levels of education and household income in rural Australia imply a corresponding lower overall level of health literacy.

Summary

Overall then, many communities in rural Australia have higher levels of health need and lower levels of capacity to address them. Rural Australians therefore have much to gain from a substantial and sustained approach aimed at reducing the risk factors for chronic disease and the more immediate goals such as reducing levels of violence and accident attributable to alcohol misuse, more healthy pregnancies and early childhood development achieved through better nutrition, and reduced smoking and alcohol consumption.

Realisation of this gain requires strong priority to be given to rural Australia, along with other targeted groups, if the health inequities and higher incidence of risk factors are to be addressed and reversed.

SOLUTIONS RELEVANT TO RURAL AUSTRALIA

Proposed Preventative Measures

In this submission, the Alliance does not presume to critically analyse the efficacy of the various measures proposed to promote the goals of reducing alcohol consumption, smoking and obesity. Given the complexity of the issues, and the multiple and in some cases well entrenched barriers to the risk reduction goals, it is clearly essential that every resource from Government, community and private sector sources be applied as effectively and as efficiently

as practicable to the tasks at hand. Research and identification of the most effective and efficient approaches are therefore more appropriately the responsibility of experts in population health and in addressing socio-economic determinant issues.

The key concern of the Alliance is to ensure that clear consideration is given to strategies to engage people and communities most at risk and to allow appropriate flexibility in approach to provide equitable, accessible and effective population health measures for people in rural Australia.

In this context, the Alliance considers that two key principles should underpin strategic directions and specific initiatives in the preventative health agenda:

- engaging all sectors of Australian society in the challenge; and
- enabling people and communities to increase control over their health.

Leadership and engagement

The challenges of effecting and sustaining the major cultural change inherent in progress towards the preventative health goals would seem to require leadership, collaboration and engagement among all sectors of Australian society. In section 5 the Taskforce discussion paper acknowledges the importance of leadership and coordination and identifies the need to engage key leaders and build new partnerships. The Alliance considers this aspect of the overall strategy to be crucial. This view is well-expressed in the Business Council of Australia submission to the National Health and Hospitals Reform Commission:

“Because health is so fundamental to a nation’s social and economic prosperity, ... health is everybody’s business, including Australia’s businesses. For too long health policy decisions have been seen as a matter for governments and the health sector. But as we face new possibilities and difficult choices about the allocation of scarce resources, we all need to take responsibility for understanding the challenges and participating in the debate.”

While some of the specific proposals in the discussion paper seek to reach out to other sectors, it has not yet identified how to achieve community-wide leadership and engagement in the same detail as it has discussed more traditional health promotion and health system responses. The Alliance considers that the next phase of development of preventative health strategies warrants greater attention to achieving these goals. In particular, the concept of leadership should be taken further, to seek to include other sectors in leadership, not just to ‘engage’ them.

The proposed National Prevention Agency should have a governance framework and a charter that seek to maximize reach to sectors and communities other than health. The organisation should ideally include leadership from other sectors of government, education, business (as suppliers of goods as well as employers), sport and recreation and should certainly include strong rural as well as Aboriginal and Torres Strait Islander representation and have the capacity to connect with those constituencies.

Ownership and Control

In the further development of approaches to preventative measures, greater attention should be given to ownership and control at the community and individual level. This is particularly important for people in rural Australia who have less by way of supporting infrastructure and services in health, less by way of health literacy and, due to technical and logistical realities, more by way of costs and barriers to a range of other services and resources.

The Alliance notes the Ottawa Charter for Health Promotion definition of health promotion as:

“the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.”^v

The discussion paper rightly emphasises the importance of the social gradient of health in indicating health outcomes at the population level. The social gradient, as a determinant of health outcomes, is not just about poorer nutrition, water quality, poorer health literacy or greater patterns of risk behaviours such as smoking. The ‘Whitehall studies’ undertaken by Professor Sir Michael Marmot, and giving rise to the notion of the social gradient of health, show that another major factor in determining health outcome is the ‘locus of control’: that is, the extent of control people have in their work, in their life choices and in their social engagement^{vi}.

The ambitious goals set for the preventative health agenda in essence require environmental culture and regulatory change, health education, community development, and addressing the ever-present socio-economic gradient issues. Long-lasting action and change will require community understanding, community support, and community acceptance and action. Aboriginal and Torres Strait Islander communities also stress “community ownership and control” as essential to improving their health outcomes.

The crucial nature of the alignment of government policy with community ownership and control is reflected in the following:

“Much government policy in Indigenous Affairs reflects the failure to apply even the most rudimentary principles of social science to understanding why there are so many social problems and what should be done to reverse them. Understanding concepts like learned helplessness, locus of control, self fulfilling prophecies and attribution theory, for example, would undoubtedly assist in devising better policy. It is a concept well understood in psychology and encompasses research which shows that when people repeatedly experience unpleasant events over which they have no control, they will not only experience trauma, but will come to act as if they believe that it is not possible to exercise control over any situation and that whatever they do is largely futile. As a result, they will be passive even in the face of harmful or damaging circumstances which it is actually possible to change.” (Carmen Lawrence)^{vii}

Given the first four principles promulgated by the National Health and Hospitals Reform Commission, namely “people and family centred services, equity, shared responsibility and strengthening prevention and wellness”, it seems essential that all elements of the Australian health care system be designed to improve locus of control, health literacy and a shared sense of responsibility for healthiness.

Chronic Disease Self-Management

The principles of chronic disease self management (CDSM) would appear to be relevant. An essential element of CDSM methodology is to give people 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.

More intensive and supported approaches, akin to chronic disease self management programs, might in fact be necessary in the many cases where people endure two or more of the burdens of smoking, excessive alcohol consumption and obesity and face socio-economic gradient issues.

Overall, the social gradient of health findings, the Aboriginal and Torres Strait Islander philosophy on ‘ownership and control’ and the key components of CDSM provide a substantial body of evidence about the impact of the ‘locus of control’. Such approaches may also help to overcome health literacy barriers among target populations and to achieve more sustainable results in all areas of preventative health.

The discussion paper itself quotes a US study on community-based disease prevention measures as showing a return on investment of \$5.60 for every dollar spent in the program, indicating that there are good returns to be achieved under the right conditions.

The Australian Government has had programs of financial support for one-off projects to build healthy communities and to undertake innovative projects to help people in rural and remote areas of Australia to address key risk factors and to promote healthy lifestyles, prevent illness and manage their health. The Alliance considers that there would be merit in support for programs that provided ongoing rather than time-limited support for these initiatives and that there was concerted national effort to promulgate the lessons and the outcomes of these initiatives and build healthy community initiatives into the fabric of the Australian health system.

ACCESSIBILITY OF RISK REDUCTION MEASURES

Policies and programs to address obesity, smoking and alcohol consumption will have an inherent element of equity when they focus on individuals and communities in Australia with higher rates of such characteristics, including people in rural Australia. The targeted and progressive approach towards equity in health outcomes advocated in the discussion paper is welcomed.

Reaching regions, population subgroups, communities and individuals with higher needs and with lesser access to health and complementary service and support systems presents a number of challenges. Ideally, these circumstances need to be specifically identified, acknowledged and addressed through countervailing action appropriate to that region, subpopulation or community. This will require collaborative planning among governments, local communities and those tasked with the delivery of preventative health practices. Critically, there must be opportunities for local communities to tailor programs to allow local acceptance, ownership and implementation, recognising that needs may well be different for each community. Some of these issues are addressed below.

Overcoming Barriers in Rural Australia

Workforce Distribution

The discussion paper suggests that one measure of performance would be the uptake of the Medicare Benefits Schedule item for prevention, suggesting that service funded by MBS might constitute an important element of the prevention agenda in relation to all three risk factors.

Given the health workforce shortages in rural areas, people in rural Australia will face barriers to access and reduced equity if the selected measures depend on delivery through health professionals using current supply and funding mechanisms. There should not be too much emphasis on programs delivered through MBS payments because, as noted above, rural Australia is under-supplied with GPs compared with Major Cities, and rural doctors work longer hours and have less capacity to take on additional work in preventative health.

An evaluation of the SNAP (smoking, nutrition, alcohol and physical activity) program in two Divisions of General Practice found that the SNAP interventions fitted well with general clinical practice, especially with chronic disease programs, but were limited in their effectiveness through the lack of time within consultations and the heavy workload of general practices, including their practice nurses^{viii}. There were also problems with lack of patient access to referral services such as for nutrition and alcohol counselling, and lack of feedback from such services. All these issues are exacerbated in rural areas. If rural GPs have a choice between seeing ill patients who might have had to wait a week for an appointment, or to devote more time to preventative health initiatives, they will inevitably have no option but to choose the former.

Furthermore, adult males in rural Australia are more likely than their urban counterparts to be obese, to smoke and to misuse alcohol, but are less likely than females to visit a GP. For example, in its report on Mental Health and the new Medicare Services for the period to August 2008, the Mental Health Council of Australia shows access by males to the new mental health items at about 50 per cent of the rate for females. If, as seems likely, this pattern of low male access to MBS for mental health services is replicated in relation to risk reduction measures, it would not match the higher levels of need among men for reduction of risk factors.

As acknowledged in the Rudd Government's initiative to develop a National Men's Health policy, and in the Taskforce discussion paper's emphasis on the need to target particular at-risk groups, including men in rural Australia and Aboriginal and Torres Strait Islanders, specific approaches will be required to break down current barriers and better align service and program support with needs.

Thus, the Alliance considers that any primary reliance on fee-for-service interventions in preventative health without addressing the time, staffing and allied health referral systems would mean that people in rural Australia would have substantially more limited access than those in major cities who are relatively well-served by general practice. MBS usage statistics on preventative health services items would indicate how substantial the shortfall is in areas of lesser access to such services, while broad information is available on higher levels of need in rural Australia.

While outside the scope of the Preventative Health Taskforce, substantive, effective measures to improve health professional workforce distribution in rural Australia must remain a key focus for the future. Specifically relating to preventative health, strong consideration should be given to supplementary funding to address the inevitable shortfalls in fee for service arrangements so that, overall, the distribution of resources and services for preventative health reflects the needs of the population in each area. Such supplementary funding would enable Regional Health Services, general practices, Divisions of General Practice, Aboriginal Health Services and the like to fund the range of health workers to support the delivery of SNAP or equivalent programs in areas of particular need. This supplementary funding might also be

allocated to specific measures for outreach to groups such as men in rural areas who would be less likely to see the GP in the course of the year.

The nursing profession is currently the most evenly distributed across different regions of Australia. Even in the absence of detailed analysis of the type of specializations of nurses, or of their current levels of professional development in preventative health measures, it seems likely that they are currently better placed to play a significant role in health promotion activities in rural and remote communities, provided they are adequately resourced to do this in an effective and structured manner.

Community nurses and, in more isolated areas, remote area nurses, can play a key role in providing nutrition information and programs to teachers, students and parents and by having input into decisions about what is or is not available in school tuck shops and community stores. Diabetes educators work with local communities to provide health information about diabetes prevention, while child and family and community nurses would seem to be well placed to work with pregnant women on nutrition, management of overweight, alcohol minimization and smoking cessation for the health benefit of both mother and baby.

Workforce Development

The discussion paper notes that a skilled workforce is a key structural component of the overall capacity to support the prevention agenda, noting for example the desirability of “bringing together GPs, pharmacists, nurses, psychologists and other allied health professionals for community based training and support”. It makes specific suggestions in relation to skilling and supporting primary health care to help people make healthy choices in relation to nutrition, physical activity and management of overweight and obesity (Section 2.7) and alcohol consumption (Recommendation 4.7), and about sustainable education and training programs for health workers for pre-service and continuing professional development in relation to smoking cessation.

Alliance members consider that health professionals, particularly in smaller rural and remote communities, are important advocates within those communities and that a strong understanding of and commitment to disease prevention and health promotion is critical within this group. Preventative health should become a fully integrated element of the primary health care system. This requires the ongoing development of a comprehensive approach which ensures that preventative health and health promotion are imbedded within undergraduate curricula for all health disciplines, as well as support for postgraduate and vocational activities and continuing professional development.

Constraints on education and training opportunities, resources, time, mix of health professionals and peer support in rural Australia all indicate that measures for workforce development on preventative measures may run the risk of geographically skewed and inequitable distribution unless there are specific and effective measures to ensure professional development based on population needs. Specific resourcing should be provided to rural health education and training institutions to reduce these constraints as far as is practicable.

Models of Service Delivery

The Alliance considers that the theme of the discussion paper in bringing health professionals together for development might also be usefully extended to consideration of multi-disciplinary and coordinated approaches to support people in making major changes in life patterns. Achieving risk reduction across a range of risk behaviours would seem to be beyond

the reach of occasional or uncoordinated interventions and receipt of a single ‘health service’. There is evidence to suggest that risk factors are not independent and that there are dangers in not considering them together. Studies in the US in the mid-1990s estimated that adult patients had approximately 12 risk factors involving 24 preventative services, and had resulted in routine disease checkup visits approaching half of all medical visits in the United States^{ix}.

A coordinated multi-disciplinary team approach and a patient-centred care and support plan for an overall improved health lifestyle would seem to have more chance of improving health. This may require consideration of a range of funding models, including payments for care plans and incentives for performance and the practice or health service level, or alternatives such as salaried teams of health professionals with possibly broader remits in reaching and engaging with at-risk populations. The case for supplementary funding to compensate for shortfalls in fee-for-service arrangements might also be directed towards methodologies that provide for more multidisciplinary models of care.

The Alliance has proposed a suite of actions (see page 4 above) to take account of the health workforce maldistribution as it relates to health promotion activity.

Settings for Action

In chapter five, the discussion paper identifies a range of measures common to obesity, tobacco and alcohol. It includes ‘community engagement’ and identifies community settings for action, including schools, childcare and maternal health programs, workplaces, sports venues and local government settings.

The discussion paper proposes as a performance measure the number and proportion of workplaces with over 50 people that have comprehensive programs in place to support healthy eating and physical activity. Newspaper reports also suggest that workplaces will be funded by the Federal Government to help keep employees healthy and to boost productivity and will include support for “weigh-ins, medical checks, healthy canteens and lunchtime workouts”. Much of such support would not be relevant or possible in small and family businesses or for sole operators. The roll-out of such programs should carefully plan for and deliver a needs-based outcome rather than allow market forces to dictate and inevitably skew program distribution.

The discussion paper also identifies the value of municipal plans that include steps to tackle obesity through such measures as improving public transport, building cycle paths and footpaths and protecting open spaces. However, it should be recognised that, by dint of lower population densities and distance barriers, many rural settings such as workplaces and local government are less likely to have the scale and resource base to be able to respond in major ways to drive prevention agendas.

Often, public programs will require local community contribution in order to be eligible for government funding. Further, Federal Government funding is also sometimes contingent on the body bidding for funds not being a State Government agency. Both these sorts of approaches are likely to inadvertently discriminate against rural communities.

Further, as noted by the Productivity Commission in its draft report on its Inquiry into Drought Assistance, a range of factors has led to the long-term decline of many small towns in Australia as people and economic activity move to larger centres. Many people living in or close to these small towns are negatively affected by these changes, which can be exacerbated

by drought. The Expert Social Panel, engaged by the Productivity Commission in its Inquiry, also found that:

“when family farms are struggling with events such as dryness, the communities in which people normally spend their money and participate also suffer. Dryness negatively impacts on the ability of members of a rural community to work together for the benefit of the whole community, eroding the capacity of people to engage in community projects or do the voluntary work that keeps rural communities alive.”^x

The Alliance considers that the programs to support preventative health measures in various settings should specifically take account of local resourcing capacity, as well as of local community, business and consumer needs, and must avoid a ‘one-size fits all’ approach.

Other Scale and Supply Barriers

Access to fresh, nutritious and affordable food is an issue that has been properly recognised in the discussion paper. Compared with people living in Major Cities, people living in regional and remote Australia are significantly less likely to consume low fat or skim milk and the recommended two serves of fruit per day. This trend is worst in rural males aged 15-44 years^{xi}.

Healthy eating is dependent on the availability of good quality, fresh, affordable food and the capacity to store fresh food successfully. Some towns have deliveries of fresh fruit, vegetables and milk less than three times a week. One of the key findings in a 2006 State-wide survey in Queensland was that the cost of nutritious food in the two years from 2004 had increased significantly throughout the State in all areas except Major Cities.

Some well-known programs which promote healthy eating, shopping and lifestyle skills cannot even be started in towns with small populations, and some towns have not been able to sustain reputable weight loss programs because of not having sufficient numbers attending their sessions.

Poor internet access is still common in many rural areas and will restrict the provision of information to people affected, and limit their engagement where internet-based information and advice are concerned.

Public meetings are not always accessible, with habit, transport, distance and travel costs all providing barriers. It is important to take the message to where people go: sports events, pubs, agricultural shows, farmer updates and agricultural field days, school P and C meetings, and the Shire Office. Health promotion activities should be people-centred and will be more effective if community members are involved in their development and implementation.

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

PERFORMANCE MONITORING AND ACCOUNTABILITY

The Value of Performance Measures

The Alliance strongly supports the proposed establishment of a performance monitoring framework. This provides an essential discipline in clarifying goals and targets, timeframes and development and delivery processes. It also provides an ongoing framework for assessing performance, and casting some light on what is working at the process and output level, so that lessons can be learned and ongoing adjustments made. Given the size of the task in prevention, it is crucial that there is a strong learn-as-we-go approach.

Performance monitoring can also be an important tool in engaging and maintaining the public, inter-sectoral and institutional commitment and interest that is essential to the major cultural change inherent in the prevention agenda. It could be argued that the long-term public reporting on road accident deaths has been of abiding interest to the Australian community and has been of value in community support for a range of regulatory and policing measures to improve road safety, and for Governments themselves to invest in road accident reduction measures.

This of course requires that there are at least some aspects of performance monitoring that are public, timely and transparent. By way of example, regular reporting on crime, accidents and injury where alcohol was a contributing factor could assist in public acceptance of regulatory and taxing measures and assist in engendering the required cultural shift over the longer term. Regular public reporting on the proposed monitoring of hospital separations attributable to the three risk measures could also assist in raising and maintaining public consciousness and supporting cultural change.

Conversely, lack of public, timely and transparent information on performance could quickly lead to weakening of community and intersectoral support, and loss of momentum in the culture change. The Alliance therefore suggests that commitment to timely public access to performance monitoring is an important plank of achieving longer-term interest in and support for the prevention agenda.

Locational Focus

The discussion paper suggests that, given their different characteristics, some measures should be State or Territory-specific. It also suggests that some health outcome measures include Aboriginality. These directions are supported.

However, it would also be valuable in planning, delivery, ongoing research and evaluation and in public interest and commitment if there was a locational dimension to public performance monitoring so that people in each area could see and understand how various elements of the prevention agenda were performing in their own locality. Given the concerns that the Alliance has had over many years to improve the distribution in the health workforce, it welcomes the proposed measure to identify per capita coverage of allied health professionals engaged in selected risk reduction measures.

This locality focus should be taken much further at either the specific region or the type of region level. It is hard to see why specific locational measures should not apply wherever data collection is on a locality-by-locality basis. This approach also has the potential benefit of improving the accuracy of record keeping and reporting if local data managers can see locational benefit from their work. Location-based measures could readily apply to initiatives

in various settings such as schools and workplaces and to access to primary healthcare services.

Where measures are derived from broad surveys, eg daily levels of consumption of fruit and vegetables, it would be impracticable to do this region by region but the measures should have sufficient statistical validity to make comment about consumption patterns in outer regional areas, for example.

Selection of Indicators

The selection of performance indicators is likely to influence where health authorities and others put their efforts. This can have beneficial or distorting effect. Beneficial effects are likely where the measure has universal application eg pricing of tobacco products. By way of example of potential distortion, a measure of “recall of public education and social marketing campaigns” may have little impact on outcomes if the reality is high recall by low risk groups and low recall by high risk groups.

In relation to those areas of Australia with lesser access to GPs, especially with time and scope to expand their scope of practice on prevention, access to MBS-funded measures will inevitably be less. As noted above, other programs should be put in place to compensate for such barriers to access (population-needs based resourcing) and performance measures should be enhanced to show an overall picture of performance.

FUTURE FOCUS OF THE TASKFORCE

The Alliance supports the indicated future priorities of the Taskforce in including mental health and injury. As noted earlier, the incidence and burden of injury in rural Australia among males is greater than for major cities and health promotion related to injury would be likely to be of particular benefit in rural Australia.

Mental health overall is a large contributor to the burden of disease and has substantial co-morbidity with alcohol and substance misuse. Mental health promotion and illness prevention/early intervention measures may also be relevant to risk reduction in obesity, tobacco and alcohol misuse and could be essential in addressing these risk factors among co-morbid people. Ideally, mental health promotion measures could have been included as an integral element of tackling obesity, smoking and alcohol misuse, and of shaping an overall holistic health and wellbeing framework within which all other specific risk factors might be considered. It should certainly be given high priority and the earliest practical inclusion in the overall prevention strategy.

The Alliance considers that there would also be merit in considering the promotion of wellbeing and illness prevention measures in early childhood as a logical comprehensive flow-on from risk prevention measures in obesity and promotion of nutrition and physical activity. As with mental health, the importance of the family, with support where necessary, in early childhood health and wellbeing through role modelling and practice in healthy living, could also be an overarching theme across the range of risk factors, and an essential element in early prevention measures.

ATTACHMENT 1:**Member Bodies of the National Rural Health Alliance**

ACHSE	Australian College of Health Service Executives
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
ARHEN	Australian Rural Health Education Network Limited
ARNM	Australian Rural Nurses and Midwives
CAA (RRG)	Council of Ambulance Authorities - Rural and Remote Group
CRANA	Council of Remote Area Nurses of Australia Inc
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
NRHN	National Rural Health Network
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors' Association of Australia
RDN	Rural Dentists Network
RHWA	Rural Health Workforce Australia
RFDS	Royal Flying Doctor Service of Australia
RGPS	Regional and General Paediatric Society
RIHG	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RPA	Rural Pharmacists Australia—Rural 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

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- ⁱ AIHW, *Rural, regional and remote health: Indicators of health*, Canberra, May 2005; cat. no. PHE 59
- ⁱⁱ AIHW, *Rural, regional and remote health: Indicators of health status and determinants of health*, Canberra March 2008, cat. no. PHE 57
- ⁱⁱⁱ Lowe, S and O’Kane A (2003), cited in *Under pressure and under-valued: allied health professionals in rural and remote areas*, NRHA, Canberra, 2004, p.8
- ^{iv} AIHW study, *Geographic Distribution of the Australian Dental Labour Force 2003*, Canberra December 2007, cat. no. DEN 168
- ^v First International Conference on Health Promotion Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1
- ^{vi} Michael Marmot in *Sir Michael Marmot Interview: Conversations with History*, Institute of International Studies, UC Berkeley, <http://globetrotter.berkeley.edu> accessed 10 November 2008
- ^{vii} Carmen Lawrence, Paper presented at Fulbright Conference: *Healthy People: Prosperous Country*, July 11, 2008
- ^{viii} Mark F Harris, Coletta Hobbs, Gawaine Powell Davies, Sarah Simpson, Diana Bernard and Anthony Stubbs, “Implementation of a SNAP intervention in two divisions of general practice: a feasibility study” in *MJA*, Vol 183: No 10, 21 November 2005
- ^{ix} B Starfield, J Hyde, J Gervas, I Heath, “The concept of prevention: a good idea gone astray?” in *Journal of Epidemiology and Community Health*, 2008, accessed at jech.bmj.com on 23 November 2008
- ^x Peter Kenny, *It’s About People: Changing Perspective. A Report to Government by an Expert Social Panel on Dryness*, Report to the Minister for Agriculture, Fisheries and Forestry, Canberra, September 2008, <http://www.daff.gov.au> accessed 9 January 2009
- ^{xi} AIHW, *Rural, regional and remote health: Indicators of health status and determinants of health*, Canberra March 2008, cat. no. PHE 57