

Revisiting the well-being of remote communities twenty years on – a time for celebration and reflection

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Chair, Ladies and Gentlemen.

I would like first to acknowledge the Aranda people as the traditional owners of the land on which this conference is being held.

Thank you for the opportunity to address the 8th National Rural Health Alliance Conference. This biennial conference has become a landmark on the rural health calendar because of its importance in bringing together such a diverse group of people united by their common concern to improve the health and well-being of rural and remote Australians and its role in informing the policy agenda of governments and rural health stakeholder organisations. I feel privileged to be invited to address this auspicious gathering of friends and colleagues.

My talk this evening will be brief as I do not want to limit the time available for you to network with colleagues and friends who have gathered together here from all parts of Australia. I shall take my cue on how long to talk not from the chair but the expressions of delegates sitting furthest away from me. As our church Minister says to the congregation “You have to be early the get a good seat at the back”!!

This evening I would like to focus on two issues. First I want to take the opportunity to celebrate some of the achievements that have resulted since the first National Rural Health Alliance Conference was held in Toowoomba in 1991. Secondly, I would like to use the occasion to reflect on what more is needed in our quest to ensure optimal health and well-being for residents of the many rural and remote communities throughout Australia.

A TIME FOR CELEBRATION

This 8th biennial National Rural Health Alliance Conference follows previous gatherings at Toowoomba (Queensland), Armidale (NSW), Mt Beauty (Victoria), Perth (Western Australia), Adelaide (South Australia), Canberra (ACT), and Hobart (Tasmania), so all states and territories have now experienced the benefits of hosting of Australia’s premier rural health conference.

This conference in Alice Springs is undoubtedly an exciting occasion. Since the first NRHA Conference in 1991 many people who are passionate about rural and remote health have attended, presented papers, initiated recommendations, and assumed a key role in their implementation and the subsequent formulation of policies and programs designed to improve the health and well-being of non-metropolitan Australians. Now that the national conference circuit is complete, it is timely to consider what has been achieved over the past 14 years – achievements which are attributable in part to the impetus provided by this conference as the interface between practice, communities, education and training, research, health providers and government.

- **Rural Health Policy:** Today almost every state government has a specific health policy unit devoted to addressing the specific needs of rural and remote health communities, and to ensure consistency of their programs with the strategic directions outlined in **Healthy Horizons**.
- **Rural Health Programs:** In an attempt to redress the significantly poorer health status of non-metropolitan Australians and their lack of access to primary and secondary health care services, numerous specific rural health initiatives and programs have been implemented by Commonwealth, State and Territory governments. Significant funding now underpins numerous workforce incentives programs and new models of service delivery, including telehealth initiatives for both education and clinical services. These initiatives represent a response to quite specific needs that are unlikely ever to be met through mainstream health programs.
- **Rural and remote health advocacy:** The National Rural Health Alliance has become the peak body for rural and remote health, and one cannot but admire and commend the marvellous work undertaken by its Director (Gordon Gregory) and his energetic and enthusiastic team. At the political level, organisations such as the Rural Doctors Association, the Association for Australian Rural Nurses, the Council of Remote Area Nurses of Australia, and Services for Rural and Remote Allied Health all now play an indispensable role in ensuring that governments do not become complacent in their concern for the health of rural and remote communities.
- **Rural and remote health research:** The **Australian Journal of Rural Health** (under the initial Editorship of Desley Hegney and now of John Marley) has become the national and international voice of Australian rural and remote health research, augmented recently by the electronic journal of **Rural and Remote Health** (under the Editorship of Paul Worley). University Departments of Rural Health set up in every State are collectively driving a research program focused on significant rural and remote health issues.
- **Rural and remote health education and training:** New organisations and agencies now exist in every state with a key role in providing education, support, and training to the many health professionals who work throughout rural and remote Australia. Rural Clinical Schools have developed new curricula and devolved the education and training of students from capital cities, thereby ensuring greater exposure to life and practice in rural and remote areas. More students are now supported by specific rural scholarships. Rural Workforce Agencies not only play a leading role in workforce recruitment and retention, but also their continuing professional education and providing support for spouses and families.

In short, rural and remote health is now firmly on the map – a far cry from 1993 when Des Murray and I travelled the length and breadth of Australia in the process of drafting the first National Rural Health Strategy. I vividly recall some of the meetings and workshops, and the **cries de coeur**, passion and commitment of people like Jack Shepherd, Col Owen, Bruce Chater, Paul Mara, David Mildenhall, Bruce Harris, Desley Hegney, Sabina Knight, Roger Strasser, Michael Bishop, John Wakerman and many more.

Today I would particularly like to single out the work of John Wakerman and his team here in Alice Springs. John has been unflagging in his passionate commitment to bring about improved health outcomes for the residents of remote communities. He has directed and overseen the establishment of the Centre for Remote Health here in Alice Springs, he made a major contribution at the Regional Australia Summit held in Parliament House in 1999, and he continues to advocate the cause of remote and Indigenous health through his ongoing research publications.

Nor should we forget the enormous influence of many Canberra-based bureaucrats who have been so important in guiding the process, people such as Joan Lipscombe, Des Murray, John Anderson, Bob Wells, Margaret Norrington, Linda Holub, Jan Bennett, Kim Snowball and many more, together with government advisors such as Jack Best.

Acknowledgment should also be made of the many other individuals who have contributed so willingly behind the scenes to advancing the health needs of rural and remote Australians – university students through their rural health clubs; Indigenous Australians such as the late Puggy Hunter, Ian Anderson, Pat Anderson and many others through the National Aboriginal Community Controlled Health Organisation; and consumer organisations and their leaders such as Marg Brown. These groups especially play a critically important role in providing advice to government and validation of the need for, and wisdom of, many of the ideas that emerge from such gatherings such as this.

The Conference represents time both to celebrate these achievements as well as to thank the many people, some of whom are with us today, who have contributed to putting rural and remote health on the national health landscape. Many of these initiatives have resulted from the dedication, enthusiasm, energy, initiative and resourcefulness of the champions of rural and remote health, who have often pursued their goals in circumstances that are poorly supported, resource-deficient, frustrating and stressful. We owe an enormous debt of gratitude to all these ‘champions’.

A TIME FOR REFLECTION

While the next three days provide a wonderful opportunity to celebrate these considerable achievements, they also provide an opportunity to reflect on the measure of their success in bringing about improved health outcomes.

The theme for this conference is **“Central to health: sustaining well-being in remote and rural Australia”**. Rural and remote health may now be on the national health landscape, but it is timely to ask “what is needed to maintain it there?” Perhaps the key question that should guide our deliberations throughout this conference is “What difference have these initiatives made to bringing about improvements in the health status and life chances of Australians living in rural and remote communities?”

Nearly 30 years ago, a report by the Hospitals and Health Services Commission noted that

Many country people find it difficult to obtain adequate health care. There is a shortage of doctors, dentists and other health personnel, and difficulties in maintaining health facilities in many districts ... even where an adequate range of services is available, access may be impeded by lack of public transport or poor roads... (1976, 2).

As we sit in heartland Australia over the next few days and consider how best to improve the health and well-being of rural and remote Australians, it is timely to reflect on what has changed since 1976.

While governments are keen to publish statistics showing increases in workforce supply in rural and remote Australia and in the expenditure on new health services, it is clear that many communities across Australia, particularly the smaller ones, continue to experience real difficulty in obtaining and maintaining appropriate health services and in recruiting and retaining an adequate health workforce.

The concerns expressed by many non-metropolitan people that we are still failing to meet the fundamental health and well-being needs of rural and remote Australians is not without some foundation. Consider, for example, the following:

- the appalling health status of Indigenous Australians has again been highlighted by the recent Productivity Commission report (SCRGSP, 2005);
- lifestyle and mental health problems in rural Australia continue to increase significantly;
- the problems associated with ensuring an adequate and equitable distribution of health practitioners across rural Australia have become ever more urgent;
- the loss of many 'invisible' carers as economic restructuring has forced these people either to seek employment locally or to migrate to larger centres, thereby increasing pressures on local health services; and
- the failure of the private sector to assume a greater role in providing health services at a time when governments seek to reduce public expenditure is obvious.

In light of the many specific achievements that I have just discussed, why is progress in improving health outcomes so slow? What do we need to do to attract an adequate workforce and to ensure sustainable health care services in rural and remote communities? What obstacles continue to impede our quest for better health outcomes in these areas?

Certainly the field of health care is rapidly changing — driven by such processes as changing demography (ageing and migration), increased chronic disease, escalating costs, the problem of fiscal constraints, increased use of technology in the form of diagnostic and invasive procedures, de-institutionalisation in favour of home and community care, and increased consumer expectations as people become better informed about health and health care. Many of these changes have impacted particularly acutely on rural communities and rural health services.

Of course some would suggest that it may be too early to make a definitive assessment of the impact of these initiatives on the health status of rural Australians because many have a long lead-time.

I think that the problem is much more deep-rooted than this, for our ability to ensure equitable and accessible health care services designed to improve health outcomes must be seen against a backdrop of bigger picture social, economic, demographic, environmental and political changes taking place in our society. Underpinning these changes is the combination of increased reliance on the market forces, neo-liberal government policies, the diminished role of the state and of public expenditure, and an attempt to increasingly devolve responsibilities to the individual. Collectively these processes have exacerbated the trend towards rural demographic decline and spatially uneven development.

Consider what is happening currently to the settlement system throughout remote Australia (Table 1).

Table 1 Population characteristics of small communities in Australia

Population size	# of communities	Population	# and % losing population	% declining communities in RRMA 5 and 7
2500–4999	169	578 334	54 (32.1%)	90.7%
1000–2499	349	543 597	121 (35.3%)	80.1%
200–999	994	483 660	383 (44.7%)	83.7%
Rural balance	na	1 994 298	na	na
Total	1512	3 554 889	558 (37.0%)	85.1%

Table 1 shows that communities with fewer than 5000 residents are the home to a population the size of Sydney. Almost three-quarters of these 1512 communities lie in RRMA zones 5 or 7 – that is predominantly in remote rural areas. More than one-third of these small communities are losing population, and of these more than 85 per cent lie in RRMA zones 5 and 7. Moreover, many of these are the very communities in which disadvantage is concentrated and life opportunities most limited (Vinson, 2004; Rural and Remote mental Health Services Working Party, 2003; Humphreys, 1998).

What does this settlement pattern and performance mean for the provision of health care services? Recognising that health service delivery is enhanced by rural settlement nucleation, the problems confronting the provision of health care in remote areas where population density is low, settlements small, and distances large are aggravated by problems of isolation, population transience and the high capital costs of constructing infrastructure. Given the higher costs of delivering service, lack of economies of scale, and difficulties of staffing services, the question becomes one of how best to provide health care – whether to deliver services to people or people to services.

In 1984, I attended the CSIRO conference on remote communities here in Alice Springs. At that time I argued that the fortunes of rural and remote communities, and the health and well-being of their inhabitants, predictably reflect the demands and mobility of capital which owe little or no allegiance to place. Because, by its very nature, the market place generates, perpetuates, and legitimates inequalities, a natural tension must inevitably exist between, on the one hand, the requirements and free movement of capital and the well-being of communities on the other. When policy goals are designed principally to engineer outcomes consistent with the needs of capital, the needs of rural and remote communities, such as improved health outcomes and equitable access to society's scarce resources, are unlikely to be met.

Since that time, I would suggest that little has changed. In fact the process of economic globalisation (a process which transforms the spatial organisation of social relations and transactions) has continued apace. Today global capital exercises the decisive influence over the organisation, location and distribution of economic power and resources while increasingly governments operate to nurture and reproduce the forces of economic globalisation. The result is a fundamental contradiction between the adoption of neo-liberal policies (characterised by the rule of the market, cutting public expenditure, deregulation, privatisation, and eliminating the concept of the 'public good' or 'community' and replacing it with 'individual responsibility'), and the real health and well-being needs of regional communities (Healy & McKee, 2004). The notion of the regional public good is reconfigured within the context of the broader global domain (Temple, 1995).

Gone too are the economic subsidies, based on equity considerations that once characterised the provision of small town health services. Today, equity is little more than rhetoric in policy documents, and has even less place in the cost-benefit analysis undertaken by government Treasury Departments, which view expenditure on health and education services as

'consumption' rather than 'investment'. In their place the notion of economic benefits from a vibrant and affluent economy 'filtering down' through the social and settlement system espoused. Rural and remote communities are exhorted to 'build up social capital', and not to 'wait for the cavalry'. For many communities, unable to compete solely on the basis of the marketplace, advocating local initiatives and the benefits of some filtering down mechanism are poor substitutes for the basic infrastructure now lacking. In the absence of good public transport, telecommunication infrastructure and financial assistance for persons located some distance from the larger centres, people either forgo using services when they are needed or are compelled to travel considerable distances, thereby incurring all the associated hidden household costs.

In short, my argument is that many of the changes determined by these global economic imperatives and a desire for minimalist government, rather than principles of good health or a desire to address the real health needs of the population, are unlikely to result in noticeable improvements in health status of rural communities, nor enable them to cope with the dramatic social and economic readjustments that are required in order to remain attractive and viable alternatives to metropolitan locations.

Governments, guided by free market advocates, argue that people want less government, lower taxes, and more freedom to make decisions. What they are in danger of forgetting is the need for, and the national benefits resulting from, a vibrant, productive, diverse, and healthy rural sector to underpin today's largely metropolitan knowledge-based economy. Nor do they appreciate fully the real costs associated with the unnecessarily high incidence of mental illness, accidents and injuries, obesity, diabetes, and cardiovascular disease – a morbidity profile that might be significantly different in circumstances where people's life chances are maximised through readily available and accessible primary health care services.

So what can we (the 'rural health mafia') do to influence these macro-scale processes that are so dominant in their impact, both directly and indirectly, on the health status of rural communities?

Hugh Mackay recently wrote that

In our desire to create the kind of world we want, many of us have narrowed our focus down to such local and immediate concerns that we've managed to exclude the big picture.

The danger of focusing on our immediate personal world is that we are distancing ourselves from the very issues that determine the healthy rural communities that we want to maintain – communities that are characterised by available, accessible and appropriate health services. Unless we recognise the political, social, demographic, social and environmental forces that operate at the macro-scale, and seek to influence government philosophy and policy directions, the health status of rural and remote individuals will continue to reflect the inequalities and inequities that result from unfettered market forces operating in an environment characterised by a minimalist role for the state. To quote Hugh Mackay again "The idea of nice, safe, friendly communities, detached from the social and economic realities that surround them, is both a delusion and a time bomb."

So my message is this. Do not get so caught up in the local issues that we neglect the real bigger picture determinants. Many of the problems and issues with which we are confronted on a daily basis reflect inequalities, divisions and tensions that result from national and international issues – globalisation, privatisation, deregulation, the impact of financial reform, unemployment and so on. Rural communities are part of a larger settlement pattern, a system characterised by an intricate degree of interconnectedness and interdependence. The quest for equity in terms of health outcomes can only be obtained by focusing more on these macro-scale processes. Unless we want to risk exacerbating spatial inequalities and social fragmentation,

we must focus our attention beyond our own community to consider the larger context in which all rural and remote communities exist (see Haslam McKenzie et al., 2004).

What contribution can the residents of Australia's diverse remote communities make in this business? Small rural communities have a lot to offer – while they share the disadvantages of isolation and geographical remoteness that impact on the life-chances of their residents, they are united by a common concern for equity, problems of access to services, and they epitomise the enormous value of family, community and social capital advocated most recently by Jane Jacobs (2004) in her latest book. In health care they illustrate in practice the very things that current policies such as **Healthy Horizons** advocate – innovative health services based on teamwork, multi-disciplinarity, extended practice, and a primary health philosophy. What rural communities must do now is to demonstrate how the value of these attributes in the provision of health care is reflected in improved health outcomes. At the same time, they need to highlight the deleterious geographical consequences of increasing corporatisation, unfettered market control, and the rolling back of state activities.

In this regard the need for an ambitious program of research to build up the evidence base of what works where in bringing about improved health outcomes, and which at the same time highlights the social and spatial impacts of the processes associated with a global society. According to Wakerman

The primary problem in rural and remote primary health care service development is not lack of innovation. The problem appears to be the failure to garner knowledge through appropriate evaluation of initiatives, in order to enable the establishment of evidence-based primary health service delivery models, and to sustain and systematise these initiatives over time and transfer successful programs to other jurisdictions (2004, personal communication).

Let me conclude with a few words on what I think is necessary and possible if rural and remote health is to achieve its goal of optimal health for all. Individually we may lack the clout that is required to bring about a change of direction, but collectively much is possible. Genuine collaborations of people sharing similar aspirations, combining their various skills, expertise and experiences, and evidencing a real fire-in-the-belly desire to improve the health status of disadvantaged groups can overcome the impediments to progress and hasten change.

From my perspective, some degree of collective political mobilisation is long overdue. The issue that I have raised is undoubtedly a political one for all governments. No longer does the National Party act in the real health and well-being interests of rural and remote constituents, something that the former One Nation Party sought unsuccessfully to capitalise on. In a recent review of the book **Accessing health care: responding to diversity** in the Bulletin of the World Health Organisation, it was noted that “The principal reason for the lack of adequate and equitable access to the health-care system, irrespective of where, is the political environment in which it is embedded” (Kassak, 2004:882). We need modern day rural and remote health champions in the political arena more than ever.

I want to suggest, too, that the most important outcome that could emerge from this National Conference is a collective manifesto enunciating a national vision for remote Australia underpinned by a strategic approach empowering residents of remote communities to maintain appropriate and viable health services designed to bring about improved health outcomes.

The importance of a shared vision for rural and remote communities cannot be underestimated. Australia can no longer drift along without a systematic and strategic approach to rural and remote communities. It was remarked recently that people are able to cope with change if they can see a future. The current lack of a national vision for rural communities and rural development has undoubtedly impeded sustainable economic and

social development in non-metropolitan Australia. In the absence of any national vision and without an integrated national settlement strategy and regional development policy for small rural and remote communities, initiatives confined to the health sector, no matter how innovative, seem destined only ever to achieve limited success in meeting the health needs of rural and remote Australians, whether Indigenous or European.

My own vision, enunciated in the 1998 Worner Lecture, has not changed over time:

My own vision ... is one based on diverse, sustainable communities, varying in size, location, economic base, and social composition. That is, a settlement system that caters for a pluralistic population, in which the health status of rural Australians would match that of metropolitan dwellers and in which rural residents would have the skills and capacity to maintain healthy communities. All citizens, regardless of where they live, would have access to health care services which are responsive to the specific needs of all population subgroups, a health care system that integrates health promotion, restorative services and continuing care, and one which maximises the scope for collaboration of health workers in multidisciplinary teams and co-ordinating the activities of health care services. Entry points into the system and pathways for care would not disadvantage any Australian on the basis of their place of residence, be it in an urban, rural or remote location, and would enable continuous and co-ordinated patient care. Ready access to information and programs relating to health promotion and the prevention of ill-health would enable citizens to adopt and maintain healthier lifestyles, thereby reducing the need for curative care treatment and resulting in improved health status of rural and remote communities. In turn, healthier individuals contribute to healthier communities.

At the same time, we need to use this conference to assume a greater advocacy role and to take a more active role in setting agendas. This will require us to initiate a debate about what sort of society we want for Australia. If we really do believe that people matter, why do we so readily embrace the philosophy of minimalist government and favour indiscriminate market forces as the means for resource distribution? Why are we surprised that there is so little private capital investment in rural health care? After all, capital knows no allegiance to people or place but instead orients towards locations which provide maximum profits and market share, and minimum risk.

When banks and telephone companies are deregulated and privatised and the focus of attention is continually oriented to shareholder benefits, why should we be surprised that the losers are invariably those social groups and geographical regions least able to compete within the rules set by the marketplace? Led by the Bendigo Bank, several rural communities throughout Australia have implemented community banking as a means of facilitating economic revitalisation and the enhancement of local services and infrastructure through enhancing their control over the community's capital and ensuring more money stays in the district for local investment.

After all, the consideration of human needs and social justice (key elements of any health strategy) is not part of the market place equation. On the contrary, inequality and inequity are an inevitable consequence of the free market in capitalist economies. From where I sit, the supposed benefits of cheaper goods and services trickling down to the least able (the often espoused mechanism for bringing about improvements in the health and well-being of individuals) seldom seem to eventuate. Invariably public intervention by the state is required to provide some form of 'safety net' or bale out those groups who suffer the negative consequences of unfettered market activity. In short, my plea to each of you is to precipitate the debate that is so long overdue but which might set the principles upon which the priorities and allocation of resources to health will become evident, together with the required organisation and structure of health services. Without such a debate it is inevitable that we shall continue to witness the loss of hospital services, including procedural activity and obstetric care, in small communities.

Rural and remote health professionals need to become important advocates for rural communities on matters of education, employment, transport and the other key determinants of health and well-being. Rural health is not an issue that can be addressed within one portfolio. Sustainable health services depend on sustainable communities, the determinants of which include a broad range of policies that affect taxation, employment, education, housing, environment, transport and social security. Assuming a greater advocacy role will serve to inform and activate rural communities, with the result that they are more likely to make electoral decisions that better serve their interests and that are better able to keep those who are elected true to their commitments.

At the present time, a major problem in dealing with 'whole-of-health' and 'whole-of-community' issues as the basis for sustainability is the current 'silo' mentality characterising governments. Governments continue to maintain departments and offices with responsibility for narrowly defined jurisdictions even when the issues affecting their constituents require a whole-of-government approach. Despite government endorsement of national rural health policy recommendations to foster a cohesive government approach to address rural and remote health needs issues, all too often little effort has been made by ministers to put the interests of their rural constituents above those of their respective portfolios.

The health and well-being benefits associated with sustainable rural and remote communities are immense. Economic sustainability and adequate services enable families to remain and provide informal care support to other members of the community, reducing the sense of isolation. The critical population mass enables the economic base to diversify and grow, to support transport out to other communities where residents can pursue interests not available locally. Vibrant rural communities dispel images of 'doom and gloom' and become magnets for attracting population and economic activity.

Realistically then, what are the options for achieving this 'promised land'? The contradictions between the social and spatial impacts of existing neo-liberal government policies and the equity and access goals sought in **Healthy Horizons** as the means for bringing about improved health outcomes are clear. In the absence of any interventions and changes, we can expect more of the same. Inevitably many more small rural and remote communities will be triaged, by default rather than design. So what can we do?

Let me flag a few of the alternative options that might be considered, some of which may not be palatable.

- In terms of **workforce**, we could investigate measures to ensure that all health professionals upon graduation undertake some practice in rural or remote communities. We might consider increasing the number of salaried staff working in rural and remote communities (whose packages include guaranteed infrastructure, support and relief), and measures to train professionals with extended skills, including nurse practitioners and physician assistants.
- In terms of **service provision**, we could investigate different options for delivering services to people and people to services. The success of alternative models of service provision (such as multi-purpose services and regional network models) has not been fully evaluated. Against a backdrop of loss of hospitals, procedural activity and obstetric care in many small communities, the scope for initiatives such as small-scale birthing units (staffed by midwives with full obstetric back-up) might be investigated. For residents without locally available health care services, travel costs associated with accessing health care services could be reimbursed. Adequate telehealth infrastructure could be made available to each remote area household as a means of increasing their access to distant services.

- In terms of **infrastructure**, investment in a comprehensive quality road network and IT communications system remain pre-requisites for remote regional development and a matter of priority for enabling residents to access the full range of health services so important to ensuring equitable life-chances.

To bring about the important changes that I am advocating requires that we cast our eyes upward to the processes and forces which are operating at the macro-scale and which determine the environments in which people conduct their day-to-day lives. Failure to 'think big' and to concentrate solely on dealing with the immediate local problem may fulfil immediate needs but is unlikely to change the life chances of rural and remote residents, or affect the health differentials that distinguish city from country Australians. Similarly, while recognising the enormous importance and benefits of local community activities undertaken to support local health services and community developments, the health of rural communities will ultimately be determined by decisions and processes operating at the national and global levels. We cannot afford not to be involved in influencing those forces.

Thank you for your attention.

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