Action Now To Improve Rural Health Outcomes Soon

A Winter Manifesto
from the
National Rural Health Alliance

Canberra

June 1995

FOREWORD

This 'Winter Manifesto' has been prepared immediately before the Australian Health Ministers are due to meet in Alice Springs on 15 June 1995.

Its purpose is to report on the National Rural Health Alliance's (NRHA's) highest priority requests of those Ministers. There could be no better place than Alice Springs, the best-known 'totem' of inland Australia, for Health Ministers to agree to renew a vigorous attack on the problems facing health consumers and providers in rural and remote Australia.

The Manifesto is based on the NRHA's work over the past eighteen months, including in particular those Recommendations from the 3rd National Rural Health Conference which have been endorsed by the NRHA's fifteen member bodies and judged to be of the highest priority.

The fifteen members of the NRHA are the Association for Australian Rural Nurses Inc, The Rural Interest Group of the Australian Community Health Association, Australian College of Health Service Executives (rural members), Australian Nursing Federation (rural members), Australian Rural and Remote Allied Health Taskforce, Aboriginal and Torres Strait Islander Commission, Council of Remote Area Nurses of Australia Inc, Country Women's Association of Australia, Faculty of Rural Medicine of the Royal Australian College of General Practitioners, National Association of Community Controlled Health Organisations, National Association of Rural Health Training Units, Rural Doctors' Association of Australia, The Australian Council of the Royal Flying Doctor Service of Australia, Rural Pharmacists Australia, and the Rural and Remote Consumer Health Network.[1]

These fifteen groups work together in the NRHA to improve the health of rural and remote people. All fifteen have agreed that their number one priority is the development for all rural health professions of a package of supports and incentives which have the same broad aim as the Rural Incentives Program has for doctors: to recruit and retain more health care providers to country towns and remote communities, and to ensure that they are suitably trained, accredited, oriented and then supported once there. Given all of these things, there will be more rural health care providers in rural areas, they will be more effective, and they will stay longer. Rural people will then be closer to their city cousins in terms of having equivalent access to healthcare services for equivalent health needs.

[1]The Isolated Children's Parents' Association (ICPA) and Services for Australian Rural and Remote Allied Health (SARRAH) were admitted as new members on 27 May 1995.

We commend this document to all those in any position to help to convert the recommendations it contains into action, and so to help translate the Manifesto's principles into better health for rural Australians.

Sabina Knight
Chairperson

Gordon Gregory
Executive Director

INTRODUCTION

The 3rd National Rural Health Conference was held at Mt Beauty in February 1995 and led to the production of fifty-seven Conference Recommendations. Fifty-five of those recommendations have been formally endorsed by the fifteen member bodies of the National Rural Health Alliance (NRHA).

At its Council Meeting in Darwin on 26-27 May 1995, the Council of the NRHA selected twenty-seven recommendations as those it regards as being of the highest priority: twenty-five from the 3rd National Rural Health Conference, one directly from the National Rural Health Strategy, and one from the NRHA's policy statement on Rural Health Training Units. These twenty-seven are those which have been formally endorsed by all of the NRHA's member bodies and which it wishes to promote immediately, given their importance as means of improving the health status of rural people.

They are grouped by topic below. In many cases the NRHA has endorsed the relevant recommendations from the 3rd Conference without change. In other cases the NRHA has endorsed a revised or expanded Conference Recommendation. In all cases, reference is made to the number of the original 3rd Conference Recommendation which is the basis of the NRHA's request for action. Wherever applicable, reference is also made to the Proposals from the National Rural Health Strategy (NRHS, adopted by Ministers in March 1994) to which the particular recommendation for action relates.

A. Further development of an integrated program to enhance the recruitment, retention and support of all health professionals in rural areas

A1 An overall strategy

1. An overall education strategy for rural and remote area health practitioners should be developed by governments in consultation with all stakeholders in rural and remote health. AHMAC should direct this work, which should be undertaken in conjunction with the professional bodies representing rural health workers and consumers, health educational institutions, and peak bodies with an interest.

   In this overall strategy, education and training for rural nurses, remote area nurses, and rural allied health professionals should be a high priority, given that progress has been made with such support for GPs.

   Core competency and curriculum development should proceed urgently and should include training in child and adolescent health. In particular, a core curriculum for remote area nursing should be developed and implemented immediately.

   Retraining and re-certification should be available to all rural health professionals. Undergraduate courses for all health professions should offer quality units in rural health care.

   [Based on 3rd Conference Recommendation 36. Compatible with Proposals 2, 5, 6, 7, 8, 9 and 11 of the National Rural Health Strategy (NRHS), March 1994.]

A2 Incentives programs for all rural and remote health workers

2. A key component of this integrated support strategy should be a program offering to all rural health professions a range of incentives according to the needs of the particular profession concerned. The Rural Incentives Program provides a general model, as it consists of five elements designed to provide what is required to have doctors go to, stay in and be effective in smaller rural communities. However, because they are the major employers of nurses, allied health professionals and Aboriginal Health Workers, the States and the N.T. should take the lead in the development of these support and incentive programs for members of these three professional groups.

The Rural Incentives Program (RIP) itself should also be continued and expanded by the Commonwealth for GPs. The guidelines of the RIP should be further amended so that the Program can provide assistance more readily to GPs working in the public sector as well as in private practice.

This public/private sector issue should be accounted for in the new programs for other health professionals, because in some remote areas all health professionals are employed by a State or the Northern Territory Government and it is in these areas that some of the greatest needs for the improvement of services exist.

The suitability of various models of Continuing Practitioner Education (CPE) for nurses and allied health professionals should be examined.

[3rd Conference Recommendation 38. NRHS Proposals 5, 6, 7, 8, 9, 11, 12 and 13.]

A3 Aboriginal Health Curriculum for medical practice

3. The NRHA fully endorses the Aboriginal Health Curriculum for medical practice developed under the auspices of the NACCHO/RACGP Joint Consultative Committee and supports its implementation as soon as possible. The NRHA also hopes that the RACGP will endorse the curriculum, and that the Commonwealth Department of Human Services and Health will finance its implementation as a matter of urgency.

[3rd Conference Recommendation 5. NRHS Proposals 2, 10 and 11.]

A4 Study leave

4. State and Territory Governments should ensure that all rural nurses have a minimum of ten working days paid study leave per year and that funding for relief staff is provided to ensure that nurses can be released. The NRHA points out that relief staff have to be equipped with the skills to enable them to fill the positions professionally, effectively and in a culturally appropriate fashion.

[3rd Conference Recommendation 40. NRHS Proposals 5 and 8.]

A5 Orientation programs

5. A 2-4 week orientation program should be established for rural and remote area nurses and allied health workers, as a matter of urgency. State and N.T. Health Departments should set aside funding specifically for orientation and continuing education programs for nurses and allied health workers.

[3rd Conference Recommendation 47. NRHS Proposals 2, 5, 8 and 11.]

A6 Training and accreditation for remote area practice

6. Priority should be given to the establishment of a Centre of Excellence for Remote Area Practice. Remote area health workers should be represented on the group which works on this proposal in proportion to their numbers in remote area health practice. The Centre should work to improve the recruitment and retention of remote area health professionals who are suitably trained for their work, with improvement of the health status of remote people being the underlying purpose.

The Centre should be responsible for the development and co-ordination of a nationally accredited education program which has multi-disciplinary common core components, single discipline streams, and which is based on a Primary Health Care approach.

[3rd Conference Recommendation 37. NRHS Proposals 2, 5, 6, 7, 8, 10, 11 and 12.]

B. Institutions which can contribute to the integrated program of support referred to in A.

B1 Rural Health Training Units

7. The NRHA believes that because of the importance of RHTUs to the health of people in rural and remote areas, Commonwealth, State and Northern Territory governments must ensure that adequate funds continue to be made available to maintain and develop them.

Many of the elements of the continuing education, orientation and support programs referred to in A will be best undertaken within or under the auspices of the nearest regional Rural Health Training Unit. This is one of the main reasons why the NRHA would like to see the 'gaps' in the coverage of operational RHTUs (eg. the N.T. and the Kimberleys) filled as quickly as possible.

[3rd Conference Recommendation 39 and 49. NRHA Policy Statement on RHTUs. NRHS Proposals 5, 6, 7, 8, 9, 10 and 11.]

B2 An Office of Rural Health

8. The NRHA supports the establishment by the Commonwealth of an Office of Rural Health as a matter of urgency. The Office should increase the level of co-ordination of rural and remote health policy and programs at the Federal level, with the overall aim of reducing the unacceptably high morbidity and mortality rates among rural and remote people.

   One of the priority tasks of the Office should be to work with other organisations to improve the quality, collection and dissemination of health data on rural and remote people and communities. This should be done on both a national basis as well for the variety of non-metropolitan regions and communities in rural Australia.

   [3rd Conference Recommendation 15. NRHS Proposal 4.]

B3 A multi-professional College of Rural Health

9. Consideration should continue to be given by all relevant bodies to the establishment of a multi-professional College of Rural Health.

   [3rd Conference Recommendation 51. NRHS Proposals 5, 6, 7, 8 and 9.]

C. Aboriginal and Torres Strait Islander Health

C1 Funding

10. The NRHA calls on the Federal Government to take the lead in urgent action over the appalling situation of Aboriginal health in Australia. This should be done through an immediate review and adjustment of Federal health spending to provide equity of health service delivery to Aboriginal people. Such funding increases should be directly linked to equity of health outcomes, and these outcomes should accord with Aboriginal people's interpretation of 'health'. Aboriginal health is not simply about measurable mortality and morbidity rates; it is about total well-being, and only Aboriginal communities themselves can determine what well-being is for them.

    [3rd Conference Recommendation 1. NRHS Proposals 2, 6, 7, 8, 10 and 13.]

C2 Environmental initiatives

11. Action to improve the status of Aboriginal health should include initiatives to improve the environments of Aboriginal people, where these have a proven detrimental effect on their health. These environmental initiatives will include consideration of work and income security; the quality and cost of housing, water, air and food; community development initiatives; and access to and ownership of land.

[3rd Conference Recommendation 3. NRHS Proposals 2, 4, 10, 11 and 12.]

C3 Aboriginal Health Workers

12. Funds for the training of Aboriginal Health Workers should be made available directly to Aboriginal and Torres Strait Islander training providers as part of a decentralised training structure. Formal training and accreditation should be offered to such Aboriginal and Torres Strait Islander providers. A national registration process should be set up to allow for formal recognition of the qualifications and service of Aboriginal Health Workers.

[3rd Conference Recommendation 34; NRHS Proposals 2, 6, 8 and 10.]

D. Equity in funding for rural and remote places

D1 "Equal access for equal need"

13. There should be a re-examination by Commonwealth, State and the Northern Territory Governments of the principles and mechanisms which currently underpin the funding of rural and remote health services.

The primary principle governing funding decisions for health services should be equity of access for equivalent need.

Equity should not be continually subjugated to the pursuit of fiscal efficiency. Funding should be linked to outcomes and needs. Equity of health *outcomes* is also a relevant criterion but, given a wide range of existing health status and needs, and the difficulties involved in measuring health outcomes, it is not as important as the principle of equity of access for equivalent need.

[3rd Conference Recommendation 16. NRHS Proposals 2, 9, 11 and 13.]

D2 Geographic definitions

14. There is a need for a redefinition of 'urban', 'rural' and 'remote' places. The new definition should account for local and regional variations in distance, population and culture, and include recognition of specific local anomalies which affect access to high quality health services.

[3rd Conference Recommendation 19. NRHS Proposals 1 and 2.]

E. Consumer participation and self-determination

E1 The principle

15. The NRHA strongly supports consumer involvement in all areas of rural and remote health policy and program development, implementation and evaluation.

[3rd Conference Recommendation 13. NRHS Proposals 1, 2 and 13.]

E2 The practice

16. In particular, rural and remote communities should be assisted to develop mechanisms that will allow them to plan, implement and manage appropriate access and levels of care required to meet their local health care needs.

This assistance should include access to a full range of information and, whenever possible, other resources which will facilitate planning of their own local health service. This information and other resources will also help small rural communities in their struggle to survive.

Both local and national data should be used when determining the health needs of a local community.

[3rd Conference Recommendation 8. NRHS Proposals 1, 2 and 13.]

E3 Regional and local Boards

17. Health service Boards (Hospital, District and Regional) should be made up of people who represent the population characteristics of the community they serve, in terms of gender, race, ethnic background, age, disability and needs.

[3rd Conference Recommendation 7. NRHS Proposals 1, 2 and 13.]

F. A Charter of Rights for Health Consumers

18. A national charter of rights for rural and remote health consumers should be developed. Such a national charter should be consistent with the United Nations Charter of Human Rights, to which Australia is a signatory, so that those human rights are not diminished in a rural or remote setting.

It is important at the same time to understand that the health rights of consumers cannot be guaranteed without a properly resourced health system, giving them access to a full range of health professionals.

It is also important to recognise that the guarantee of rights to consumers goes hand-in-hand with the acceptance by consumers of a number of responsibilities in and for the healthcare system. Also, a Charter of Rights in the health area should also recognise and guarantee the rights of healthcare providers. If this is not the case, the problems which contribute to health professionals not being willing and able to stay in rural areas will be compounded. As examples, rural healthcare providers have rights to professional support, to privacy, and to some free time.

[Based on 3rd Conference Recommendation 9.]

G. The establishment of a greater number of multi-purpose services

19. The establishment of Multi-Purpose Services in rural and remote areas should be encouraged. Community development techniques - such as consumer participation in needs-based planning - should be used to strengthen such services. Services such as ambulance and pharmacy should be included in Multi-Purpose Services. Disability services and mental health services should also be integrated in MPSs, and access to them for disadvantaged groups should be encouraged. The flexibility in service delivery that is present in Multi-Purpose Services should be more widely available to rural and remote communities.

The key principles for MPSs are that local people should want one for their area and that it be controlled by them and reflect their local culture. As is the case with the Nganampa Health Service, an Aboriginal community controlled health service may determine that it wishes to be deemed an MPS and therefore be considered for funding available to MPSs. The value of a successful MPS is that administration costs are cut to the bone and health services are maximised.

[3rd Conference Recommendation 22. NRHS Proposals 2, 3, 9 and 13.]

H. Support for the development of innovative programs and services, through the continuation of RHSET or a similar program

20. Because of its great value to the improvement and maintenance of rural health services, the level of funding of RHSET should be maintained in real terms.

The NRHA places a very high value on the innovations in rural health services that RHSET has allowed to be tested.

The NRHA supports the moves to a more strategic approach to the use of RHSET funds and hopes to be able to continue to contribute its views on both the Program as a whole and on specific grant applications.

[Based on 3rd Conference Recommendation 50. NRHS Proposals 2, 9, 11 and 13.]

I. Model health plans

21. The NRHA supports the Proposal in the National Rural Health Strategy for model health plans:

"Health Authorities, in conjunction with the community and non-government agencies, should further pursue the development of frameworks, such as model health plans, as examples of how services might best be delivered to rural communities. Initial attention should focus on developing models that identify the level and mix of health services appropriate for different sizes and types of rural communities.

"Among the factors such models will reflect are health status, the social and economic composition of the resident population, the nature of population change, geographic location and the distance of the community from major service centres.

"Model health plans should be sufficiently flexible to cover the broad range of needs which characterise rural communities, and should maximise community participation and involvement in the planning process. A priority should be given to meeting the needs of people in remote areas.

"Funding for this activity should be sought under the RHSET program with the Commonwealth establishing a steering group, including representatives of State Health Authorities, to commission and oversight the progress of the activities."

[NRHS Proposal 2.]

It is important to recognise that model health plans for rural areas must be adequately resourced, to match both the expectations of the local consumers, the enhanced abilities of rural health professionals, and their need for support (such as locums) to enable them to avail themselves of continuing education and 'a spell'.

J. Data

J1 Data quality

22. There is a priority need to improve the quality of national health data on rural and remote people and communities. The Australian Institute of Health and Welfare and the Australian Rural Health Research Institute should address this issue, and the proposed Office of Rural Health should oversight the task.

[3rd Conference Recommendation 19. NRHS Proposals 12 and 13.]

J2 A national minimum data set

23. The development of a national minimum data set for non-in-patient care should be a priority for the Australian Institute of Health and Welfare in 1995.

[3rd Conference Recommendation 29. NRHS Proposal 13.]

J3 Workforce data

24. AHMAC should devise mechanisms to develop and maintain workforce data for all health professions not currently being maintained by the Australian Institute of Health and Welfare.

[3rd Conference Recommendation 45. NRHS Proposals 6, 7 and 13.]

J4 Data to assist local health consumers

25. Rural and remote communities should be assisted to develop mechanisms that will allow them to plan, implement and manage appropriate access and levels of care required to meet their local health care needs. This assistance should include access to a full range of information and, whenever possible, other resources which will facilitate planning of their own local service.

Both local and national data should be used when determining the health needs of a local community.

[3rd Conference Recommendation 8. NRHS Proposals 1 and 13.]

K. Professional indemnity

26. The NRHA recommends that, to the greatest extent possible, professional indemnity for rural obstetric services should be based on vicarious or institutional liability, in order to minimise the additional cost of such indemnity to individual practitioners, and to help overcome problems in the suitability and affordability of available cover.

This would also avoid 'double insurance' of the same risk. Options which achieve this should be developed to accommodate the range of people who are involved in obstetric services in rural areas (including Remote Area Nurses and Aboriginal Health Workers), and to take into account the cultural needs of mothers. The Review of Professional Indemnity Arrangements for Health Care Professionals should reflect these requirements for rural areas in its final report.

[3rd Conference Recommendation 28. NRHS Proposals 7 and 8.]

L. Farmsafe

27. A comprehensive national program of education of farming families about accident risk and risk reduction is needed to make farming a safer occupation. AHMAC should therefore commission a review of the operation of Farmsafe Australia. If the review shows Farmsafe to be a successful operation, the Commonwealth, States and Territories should consider as a matter of urgency how to increase the resources available to it. A the same time additional means of improving occupational health and safety in rural and remote areas should be investigated by the AHMAC review.

[3rd Conference Recommendation 27. NRHS Proposals 2, 9 and 12.]