Action on Rural Health

Proposals for the Review and Revision of the National Rural Health Strategy

Canberra

June 1997

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Foreword

The National Rural Health Strategy ('the Strategy') is the key framework document for work to improve health outcomes in rural and remote Australia.

The Rural Health Alliance welcomes the opportunity to contribute to the major review and revision of the Strategy being undertaken by State, Northern Territory and Commonwealth Governments.

'Action on Rural Health' was originally prepared for a meeting between the Alliance and the Forum of Rural Health Policy Units. It therefore assumes a good understanding of the existing Strategy. The current Strategy comprises two documents: 'National Rural Health Strategy - Issued by the Australian Health Ministers' Conference, March 1994' and 'National Rural Health Strategy Update - Issued by the Australian Health Ministers' Conference, July 1996'.

In February 1997 the 4th National Rural Health Conference was held in Perth. It attracted over 750 participants. Many of the ideas in this paper flow directly from the recommendations produced at that Conference. That, coupled with the breadth of the constituency of the Rural Health Alliance, provides the authority for the views in this paper.

Since February 1997 there have been significant developments affecting rural health and many of them are reflected in this paper. Some of the developments in 1997 in rural and remote health in the States and the Northern Territory are summarised in Section 1. Major developments at the Federal level, including those announced in the 1997 Federal Budget, are also summarised in that Section.

The 1997 Federal Budget was significant for rural and remote health, as much for the considerable emphasis it gave to regional, rural and remote issues as for the particular new policy proposals which were announced in it.

Two specific issues picked up in the recommendations from the 4th Conference in Perth reflect well on the vision and commitment of those who attended that Conference. At the time of writing (June 1997), both the Wik Decision and the structure of Australia's taxation system are squarely on the political agenda.

The Alliance intends to give this paper wide circulation. We believe it will help achieve the high level of discussion and public awareness to which the Alliance aspires for issues affecting rural and remote health.

Sue Wade
Chairperson

Gordon Gregory
Executive Director

June 1997

Executive Summary

PURPOSE

The purposes of this paper are:

- to propose some key ***principles*** that the National Rural Health Alliance (NRHA) believes should be considered in the 1997/98 review of the National Rural Health Strategy (NRHS);

- to recommend the adoption of a revised ***process*** for the NRHS, using a two-tiered reporting strategy, based on models of existing Commonwealth/State agreements and strategies in the health area (one such model is summarised at Attachment 1);

- to summarise key issues and recommendations, including those arising from the 4th National Rural Health Conference, which the NRHA considers to be the main priorities for ***content*** for inclusion in the revised NRHS; and

- to provide views for a ***review of progress*** with the Proposals agreed by governments and listed in the 1994/1996 NRHS.

The National Rural Health Strategy is a fine example of intergovernment co-operation, of strategic planning and of focusing on matters of high priority. It is a document which should be accessible, in all senses of the word, to rural people as well as to those who are professionally involved with health outcomes and health services. For this reason, the Alliance suggests that it is important for the revised Strategy and Plan to be written in plain language.

STRATEGY AND PLAN

In developing the way forward for the National Rural Health Strategy (NRHS), the Alliance proposes a three-step approach:

- the existing NRHS policy document should be revised and updated, setting out the agreed priorities for funding, reform and future development of rural and remote health services. That document would provide the major policy framework and would continue to be referred to as the National Rural Health Strategy;

- a 3 year strategic plan for the NRHS should be adopted and would be referred to as the National Rural Health Plan ('the Plan'); and

- Federal, State and Northern Territory Governments should report annually and openly on progress with specific elements of the agreed Plan.

The Plan will translate the aims of the NRHS into recommendations for action and measurable outcomes, within specific target areas. Using the language of the 1994/1996 Strategy Update, this three-step approach will move the document from "an operational framework" to an operational plan of action.

The Plan should be endorsed by Australian Health Ministers' Council (AHMC) and should be reviewed annually, possibly by a working group comprising members of the State/Territory and Commonwealth Forum of Rural Health Policy Units, the National Rural Health Alliance and consumers. To ensure compliance by all jurisdictions, the main health outcomes in the Plan should be included in the Medicare Agreements (due for renegotiation by June 1998) and linked to future Commonwealth funding.

This proposal is in line with a major recommendation coming out of the 4th National Rural Health Conference, which called on the Commonwealth, States and Territories to agree to national targets for the provision of services in six priority areas.

The proposed Plan should focus on the following areas:

- priority areas for action;
- the roles and responsibilities of the Commonwealth, the States/Northern Territory and local government;
- the needs of special groups;
- consumer rights and customer focus;
- intersectoral collaboration;
- data collection, collation and dissemination;
- flexible funding strategies and best practice service provision; and
- the development of performance indicators, monitoring, evaluating and reporting mechanisms, including an annual review of progress.

It will clearly be necessary for the non-government sector to be accountable for actions in the Plan, as well as Governments. As the peak non-government body in the area, the Rural Health Alliance will meet its obligations in this respect.

In particular the Alliance will commit itself to the following actions in relation to the revised Strategy and the proposed National Rural Health Plan:

- to disseminate outcomes and related reports;
- to play a leadership role in primary health care;
- to provide leadership in community involvement in discussing rural and remote issues and in developing and implementing a rural health strategy; and
- to collate information and to report to policy makers and government, including to the Forum of Rural Health Policy Units.

REVIEW OF 1994/1996 STRATEGY

Analysis of progress with the thirteen Proposals in the 1994/1996 Strategy shows patchy progress.

Overall, health jurisdictions and the consumers they serve are suffering the negative effects of 'downsizing' and of almost constant organisational change. The morale of health managers and other workers in many areas is low, particularly in the public sector which is so crucial for rural and remote areas.

On the positive side, there has been progress with the rural medical workforce, despite uncertainty about how the Federal legislation on provider numbers will affect the situation in the immediate future. Training for rural general practice has become a contentious issue.

The moves to establish seven University Departments of Rural Health (including those in Tasmania and the Northern Territory) have been widely welcomed.

Apart from these new University Departments, issues of recruitment, education, training and retention of the non-medical workforce are still seen as being largely unaddressed. This is still a matter of major concern for the Alliance and those with whom it is working.

Flexibility of funding for health and community services has been given a shot in the arm by Victoria's Healthstreams Program and by movement towards more Multi-Purpose Services. These locally integrated services need to be established after genuine consultation with all interest groups, otherwise some will feel threatened by the perceived takeover of facilities that were established independently by local people. This negative situation still exists with proposed Multi-Purpose Services in some areas.

The 4th National Rural Health Conference resulted in recommendations in six main areas:

- multi-professional health workforce;
- intergovernment relations and the allocation of resources;
- Aboriginal and Torres Strait Islander health;
- aged care, mental health and health promotion;
- community participation and education; and
- transport.

CONTENT PROPOSALS FOR REVISED STRATEGY

These are some of the key recommendations the Alliance would like to see included in the Revised Strategic Plan with, in each case, the problem to which they relate. They are dealt with in more detail in Section 5 of this paper.

- Government agencies should work urgently to make more information available on the status of health in rural and remote areas. This may require new work to collect, collate, analyse and disseminate, in consumer-friendly forms, data on rural and remote health, on rural health services, and on the rural health workforce.

Problem 1: *there is still very little 'simple' information available to the public and the media to show just how bad rural health and the distribution of the health workforce are, and how much worse they are in rural than metropolitan areas.*

- Government leaders and agencies should take the steps necessary to have rural and remote health recognised as a high priority area for research attention.

Problem 2: *rural and remote health issues in Australia do not attract their deserved share of attention from elite research institutions and individuals.*

- The Tripartite (or Quadripartite) Agreements on Aboriginal and Torres Strait Island Health Services should be signed and implemented in all States and the Northern Territory. If acted upon quickly, they will provide many of the requirements for indigenous health and health-related services which will lead to improved health outcomes for indigenous people.

Problem 3*: it is a matter of the greatest urgency for the Australian Nation as a whole to meet this most serious and damaging issue facing it and its indigenous people.*

- Governments and training institutions should actively collaborate to make the total system for recruitment, education, training and retention of rural and remote health professionals more strongly vertically integrated and better resourced. Additional resources for this workforce system are urgently required in four areas:

  * for incentive and support programs for health professionals other than doctors;
  * for curriculum work, training, professional development and a greater number of funded positions for Aboriginal and Torres Strait Islander Health Workers;
  * for definition and correction of the unmet needs of <u>remote</u> area health workers; and
  * for management training for staff of rural and remote health services.

Problem 4*: rural and remote areas do not have an adequate and fair supply of health professionals, and those who do work in those areas cannot yet be assured of safe, effective and happy working lives.*

- The Federal Government should mount an information campaign on its new regulations for aged care facilities and investigate the conflicting interests of the operators of those facilities and their potential new clients.

Problem 5: *there is currently a great deal of uncertainty about what the aged care changes are, what they mean for individuals and services, and whether the new requirements can be met by small services without prejudice to their very existence.*

- Selected rural people in non-health occupations should have training on mental health.

Problem 6*: it is likely that there will never be enough mental health specialists to meet the needs of rural areas, so people in other 'helping services' and the families of patients must be equipped to play a major role.*

- A new grant program should be established by the Federal Government to provide incentives to support community public health activities in rural areas. This will help with what was described on page 17 of the 1994/1996 Strategy as "a critical issue is how to reduce people's dependency on curative care and encourage them to take greater responsibility for ensuring that problems of ill-health do not arise". The following page of the 1994/1996 document called for an "Increase in primary health care and public health activities owned by the community and supported by changed funding arrangements".

  Problem 7: *the capacity of rural communities to design and run their own local public health programs is currently under-utilised.*

- All relevant Federal and State/Territory Departments (including Health and Community Services, Aboriginal Affairs, Veterans' Affairs, Primary Industries and Agriculture, Regional Development and Small Business, Employment and Youth Affairs) should report annually to the public through their Ministers on the work of their organisation which affects the targets in the National Rural Health Plan.

  Problem 8*: intergovernment and inter-departmental collaboration are fertile areas in which to work for improved health outcomes. However a smaller number of public servants are now expected to do more with less, making collaboration with other agencies even harder for them. Political and managerial leadership are therefore required on the matter now more than ever before.*

- State and Territory Governments should provide adequate resources and structures for their health managers to communicate with consumers frequently enough and effectively enough to ensure that the services provided are customer-focused.

  Problem 9*: calls for community participation and control of health services are caused by experience that, without it, there is a real risk that services actually delivered do not fit the bill for local requirements.*

- There should be a national review, in which Federal, State and Northern Territory Governments are involved, of the Patients' Assistance Travel Scheme (PATS, or its equivalent). In this review special consideration should be given to patients from remote (cf rural) areas, including Aboriginal and Torres Strait Islanders from such areas.

  Problem 10: *the PATS is failing to meet the needs for which it was originally designed; difficulties with travel are becoming a major and pervasive problem for rural and remote people.*

STRATEGY AND PLAN: REASONS FOR OPTIMISM

The status of indigenous health is appalling by overall Australian standards and, on some measures, is getting even worse. There is an excessively high rate of organisational change in health administrations which is causing serious damage to the morale of their workers. Travel in rural and remote areas is becoming more difficult for many; public transport services continue to be 'rationalised' and many families have a reduced capacity for private travel due to unemployment and reduced incomes. Nothing, not even the best services delivered through interactive technology, can take the place of face-to-face services.

There is still a shortage of doctors in rural areas (as is fairly well-known) and an equally serious shortage of nurses in certain specialties and allied health professionals (facts that do not seem to be well known). There is still an over-emphasis on, and a community expectation for, acute care services. This works against the adoption of more cost-effective approaches like health promotion and illness prevention. And the challenges of inter-government and inter-Departmental collaboration still appear to be insurmountable in some quarters.

Despite all of these challenges, there are good things happening in rural and remote health.

The Agreements on Aboriginal Health contain all the required processes and content to make a real improvement: they now have to be acted upon. Governments are showing signs that they understand the special needs of rural and remote areas: all that is required is the follow-through to sustained action. Governments are also showing greater willingness to pool resources and have them used for the creation of flexible services for health and community well being. Training institutions are improving their focus on rural health matters.

These positive developments require leadership and a continued commitment to action.

In terms of the excessive rate of organisational change, a 'decade of stability' in health service management and structures would be a real boon to health services and outcomes. It would enable health targets to be pursued without the distraction of organisational change.

Work to improve health outcomes will be assisted by recognition of the fact that social and economic status are significant determinants of health. In the 1994/1996 Strategy there is a reference (p 19) to the "economic impact of the recent drought". There is always a current or recent drought somewhere in rural Australia and it appears that there may well be another bad one in the coming eighteen months. If it eventuates it will be yet another reminder that cash incomes in rural Australia are notoriously variable and frequently low.

The presence and status of employment, transport, health and community services play a large part in determining the well-being of rural and remote communities. In turn, the health of rural communities is a significant determinant of the health of people who live in them.

Notwithstanding the litany of challenges to be met, there are grounds for optimism. At least the challenges are well-known, even if information about them is often still descriptive and anecdotal, rather than well quantified.. The impediments to overcoming them are also well-known. The National Rural Health Strategy itself and the proposed Plan have the capacity to galvanise government and community action. Finally, it will always be the case that (1994/1996, p.19) "many rural and remote communities continue to offer opportunities, challenges and a quality of life that remain unsurpassed".

1. DEVELOPMENTS IN THE STATES, THE NORTHERN TERRITORY AND AT FEDERAL LEVEL

THE NORTHERN TERRITORY

The Northern Territory and the Federal Government have funded the Central Australian Remote Health Training Unit. A Clinical School has been established, through Flinders University, in Darwin.

There is a very welcome commitment by Commonwealth Government to a new University Department of Rural and Remote Health for the Territory.

The Aboriginal Cultural Awareness Program running in Central Australia has been extended to the Top End. The Council of Remote Area Nurses of Australia (CRANA) has been funded for remote area mental health counselling and support for the health workforce throughout remote Australia. The Program began in February 1997.

RHSET has funded allied health student placements in the Barkly region and a health services managers' continuing education project through the Territory.

WESTERN AUSTRALIA

As with other States, the announcement of a Department of Rural Health has been warmly welcomed. A consortium of the three West Australian Universities will establish new Training Units at Port Hedland in the Pilbara, at Kalgoorlie in the Goldfields, and at Geraldton.

Another twelve communities in the State are now developing multi-purpose service facilities. The Ministerial consultations held in the summer of 1996/97 boosted the development of these new facilities.

The State Department of Health has begun work to recruit nurses, particularly in those specialties such as midwifery and perioperative nursing in which there are serious shortages. This work will continue alongside the activity of the new Department of Rural Health.

Guidelines have been completed for the practice by rural general practitioners of obstetrics and a policy is being prepared. It is hoped that this will allow obstetrics to be undertaken wherever it is safe, rather than having the situation in which obstetrics practice may only be undertaken if a certain number of births is maintained each year.

VICTORIA

The Healthstreams Program is soon to get off the ground. This will allow the pooling of State funds for all activities related to health and result in flexible local programs which can meet local needs. Healthstreams should enable small hospitals to be converted to effective integrated service centres. The Program will also shift the focus of health expenditures away from acute care towards public health.

The Ministerial Advisory Group on Rural Health has been revamped and given more 'teeth' with a Member of Parliament as its Chair.

The intended establishment of the new Victorian University Department of Rural Health has been very well received.

SOUTH AUSTRALIA

In July 1996 the seven new Regional Health Service Boards received their first annual funding allocations and have moved on to develop strategic and capital plans to meet the population health needs within their Regions.

The Rural Health Enhancement Package has been introduced at a full year cost of $6m. This package significantly increases remuneration for country fee-for-service doctors and is the most generous package available in rural Australia.

A Rural Health Policy Unit has been established within the new realigned structure of the South Australian Health Commission and a multidisciplinary State-wide Rural Health Training Unit was opened by the State Minister for Health.

QUEENSLAND

Of primary importance for rural health in Queensland has been the establishment of a Rural Health Council reporting directly to the Minister for Health. This Council comprises interested parties including representatives from the different health professions, universities and other key groups.

The Council meets regularly in different locations around Queensland and is managed by the Office of Rural Health based in Roma. The Council has planned for closer integration of the State's Rural Health Training Units, which will be facilitated by the Office of Rural Health. It has also prepared an allied health workforce review. The Council has also proposed that recruitment and retention issues be advocated more strongly by the Office of Rural Health and by its own members.

Queensland Health has supported the Commonwealth in establishing a Rural Health Unit at Mt Isa and has successfully offered further scholarships to help undergraduate health students interested in rural practice.

Queensland Health has established regular forums with the AMA and the RACGP to improve links between the public, private and community sectors. Finally, to further illustrate the Queensland Health commitment to rural and remote communities, a key objective for Rural Health is to "Improve the provision of, and access to, integrated health care services appropriate to the needs of rural and remote communities".

NEW SOUTH WALES

Special initiatives have been taken in a number of areas including in multi-purpose services, continuous quality improvement education, better practice guidelines for rural hospitals, Telemedicine, and through a pilot 'Hospital in the Home' program.

A range of measures has been taken to improve the recruitment, retention and support of nurses in rural New South Wales.

Women's health has been given a high priority and the Department of Health has collaborated with other NSW Government agencies to provide a 'one stop shop' in selected rural communities.

Considerable capital investment continues in rural health areas with major works in a number of locations throughout the State, and funding has been provided to upgrade health technology in hospitals and to improve home dialysis services.

In 1996 the Department of Health produced the Rural Health Workforce Strategy Report in response to concerns about the recruitment and retention of health professionals in rural NSW. A number of the recommendations have now been costed, assessed for feasibility, and incorporated in a draft Rural Health Workforce Strategy Implementation Plan. They will be considered in terms of funding bids for the 1997/98 year.

Funding was continued for Rural Health Training Units and further initiatives were taken on rural trauma triage and remote radiology operators.

The Ministerial Community Advisory Group on Community Participation in Rural Health Services was established; community participation mechanisms, determined after discussions with the local community, will be implemented during 1997/98.

TASMANIA

Following the restructuring of the Department of Community and Health Services, a Division of Community and Rural Health has been established which includes a Rural Health Unit responsible for policy and planning initiatives in rural health.

The changed structure has been well received as it provides a focus on rural health which had not previously existed.

The establishment of the University Department of Rural Health is seen as a complimentary initiative as it will use existing State infrastructure as training sites and will incorporate the functions of the Rural Health Training Unit. All the equipment and intellectual property of the Training Unit has been transferred to the Department of Rural Health. It is anticipated that the Department will be operational before the end of 1997.

The Tasmanian Department of Community and Health Services, and, in particular, the Division of Community and Rural Health is closely involved with the establishment of the University Department and it is planned to co-locate the newly established State Rural Health Unit with it.

Capital redevelopment of the Beaconsfield MPS commenced in June 1997 and a number of rural communities are now developing integrated health services with community management models.

The next twelve months will see considerable developments in addressing a number of rural health issues within the State. The Government's 'New Directions' statement has provided the impetus for a telehealth project.

FEDERAL DEVELOPMENTS

The most important recent developments related specifically to rural health at the Federal level have included the Agreements on Aboriginal and Torres Strait Islander Health, establishment of the new University Departments of Rural Health, evaluation of the General Practice Rural Incentive Program, the first awards under the John Flynn Scholarship Scheme, and work on remote area nurse competencies. A major review of the General Practice Strategy is being undertaken. The Rural Health Support, Education and Training program has continued to fund critical programs in its area of responsibility. The work of the Public Health Division on many fronts is also underpinning a focus on rural and remote issues. Mental health also remains a high priority at the Federal level.

A development with which the Alliance itself is involved is the National Rural Public Health Forum to be held in Adelaide in October 1997. This has strong support from the public health and rural health areas of the Federal Department of Health and Family Services and from the Department of Primary Industries and Energy.

It was clear from the Federal Budget that the Government recognises the needs and circumstances of rural communities. Regional, rural and remote areas received special mention in the proposed use of the National Heritage Trust Fund and the Federation Fund.

Given that $1 billion was cut from health spending overall in that Budget, including $700 million from the PBS, rural and remote areas fared well in respect to health.

Existing rural and remote health programs were not cut. In several of the areas in which there were modest new initiatives or extra resources for health, rural and remote areas were highlighted. Extra money was provided for innovative models of health care delivery in remote areas and the Alliance welcomes such specific recognition of remote area needs.

The Budget also announced increased numbers of medical specialist training places for rural areas.

Given the uncertainty many feel about the Council of Australian Government (COAG) processes and other intergovernment negotiations, it was good news for rural areas that the Commonwealth is to remain directly involved (at least for the foreseeable future) with mental health work and women's health programs.

An extra $1 million a year was provided in the Budget for Aged Care Assessment Teams. This is a very modest amount to cover the whole nation, and is put in perspective by the $1 billion for the Federation Fund. However, it was gratifying to see that this extra $1 million "will predominantly be given to teams in country areas".

2. The 4TH National Rural Health Conference

Delegates at the 4th National Rural Health Conference, held in Perth from 9-12 February 1997, called on governments, professional health bodies and rural communities to work together urgently to bring about vital improvements in health and health services in rural and remote areas.

More than 750 people attended the Conference from all parts of Australia. This made it the largest public meeting ever held in Australia on rural health. It was organised by the National Rural Health Alliance.

The key conclusions and directions for future action from the Conference were as follows.

- If the current downgrading and withdrawal of health services in rural Australia continues - together with general rural decline - sickness and avoidable illness will increase and the gap between rural and city health status will widen still further.

- The problems in rural and remote health, and the way to fix them, have been known for years. Instead of ducking the issues and hiding behind artificial arguments about who is responsible, Governments and others with responsibilities such as universities and professional organisations should declare 1997-1999 the triennium in which they will rejuvenate country health services. A National Rural Health Plan should be developed and reported on annually. Where targets are not met the annual report should identify what special measures will be taken to get back on track.

- Governments, business leaders and the wider Australian community must recognise that reducing services and closing down operations in rural Australia is degrading the social, economic and environmental fabric of country areas. It is inevitable that this will lead to depopulation and a continued drift to regional and capital cities, exacerbating the already major problems in providing infrastructure to rural and remote areas. It follows that, apart from social justice and equity considerations, it is in the national interest to maintain and enhance the viability of rural Australia.

- The state of Aboriginal and Torres Strait Islander health is scandalous. Initiatives are blocked by petty bickering and hiding behind agreements which are yet not delivering the goods. The lessons of history in Aboriginal health services must be learned and must inform future action.

- While there are many specific health services which are grossly under-resourced in rural and remote areas, special and immediate priority should be given to multi-professional workforce issues, Aboriginal health, Commonwealth-State/Territory collaboration, community involvement, transport, aged care, mental health and health promotion.

These priority issues are those affecting the most vulnerable members of Australian society. The Commonwealth and the States and Territories should agree national targets for the provision of these services, agree performance indicators and report annually on the progress they have made towards achieving their goals.

The current measures aimed at recruiting and retaining health professionals, including doctors, nurses and allied health practitioners, are fragmented and poorly integrated. The long-term shortages of these health care providers in country Australia will worsen unless a more co-operative and co-ordinated approach is adopted. If steps are not taken now, rural Australians will be further disadvantaged.

Much could be achieved within existing health and related funding levels simply by re-allocating existing resources. Many of the proposals for action from the Conference could be implemented within existing programs by changing priorities and acknowledging that urban-based criteria are not practical. Relatively little new funding would be needed to make real improvements in the availability, range and quality of rural health services.

The priority areas in which specific proposals for action were developed at the Conference were:

- multiprofessional health workforce recruitment, retention, training and support;
- Commonwealth-State/Territory relations and the allocation of resources;
- Aboriginal and Torres Strait Islander health;
- specific services and communication (including aged care, mental health, health promotion, and the availability of infrastructure for and the development of telehealth);
- community participation and education;
- transport within rural areas and between them and larger service centres; and
- other recommendations, including two directed at the National Rural Health Alliance.

3. Progress with the Proposals in the 1994/1996 Strategy

The numbered headings in this section are synopses of the thirteen Proposals from the 1994/1996 Strategy.

Views in this section were obtained from Members of Council of the Rural Health Alliance.

(1) Development by the States/NT of strategic frameworks or regional plans for each of their rural regions.

Overall there has been considerable progress with this Proposal.

There are now some good examples of regional or district health plans, but the situation is not uniform across the whole nation. There is still insufficient recognition of the realities of rural communities by some planners and managers based in the capital cities.

In several jurisdictions there have been significant structural changes over the last two years. This means that many sub-State areas do not yet have in place a detailed district health plan.

The high rate of organisational change has resulted in very significant personnel problems in several rural health jurisdictions. The morale of workers in these public health sectors is very low and this is imposing a significant constraint on major improvement to rural health services and outcomes.

(2) The development of flexible frameworks, such as model health plans, as examples of how services might best be delivered.

Overall there has been some progress with this Proposal.

Western Australia is active in this area with twelve new Multi-Purpose Service sites being developed this year. There have also been surveys of needs, a number of community consultations and some service delivery plans developed at Area level.

In South Australia there are three Multi-Purpose Services. One rural hospital has taken an active role in community primary health care work.

There is still uncertainty about the reporting mechanisms related to the area health plans, where they exist.

Given the reference to MPSs in the 1994/1996 Strategy ("the central plank in the development of flexible approaches to the funding of aged and health care services in rural communities" - page 4) it is critical that there be good progress made in this area in all health jurisdictions.

(3) The expansion of flexible approaches to funding and management arrangements between the Commonwealth and the States for rural aged care and health services.

There have been mixed reports on this Proposal, with the balance of opinion being that little progress has been made.

The new regulations (now due for implementation on 1 October 1997) seem to place extra imposts on the aged for entry to aged care facilities and there have been very few additional resources provided for aged care in rural areas. The $1 million announced in the Federal Budget for Aged Care Assessment Teams is welcome but will obviously be thinly spread.

The Nganampa Multi-Purpose Service in South Australia is regarded as a significant success story.

The Institute for Aboriginal Development in the Northern Territory is also engaged in aged care training and the Central Australian Remote Health Training Unit is now operational. On the other hand the reduction in funds for remote women's centres has been a backward step.

There is some unfortunate suspicion among interest groups involved with local aged care facilities concerning the possibility of 'takeover' by an integrated local service.

There is great interest in the Co-ordinated Care Trials being operated by both the Department of Health and Family Services and the Department of Veterans' Affairs. The outcomes of these trials are awaited and will determine the attitude of rural people to the phenomenon. Currently there is some fear that this style of health service delivery will not benefit rural consumers, particularly if the services provided are overly-centred on medical and acute care.

(4) The establishment of a Commonwealth Office of Rural Health.

The fact that the Office has been established is welcome but there is uncertainty about the extent to which, in its present form, it is able to "assume a functional role in promoting better co-ordination and integration of existing programs relating to the provision of rural health-related services …" (1994/1996, page 5).

(5) "Health Authorities should continue initiatives aimed at improving the recruitment and retention of the rural health workforce".

Overall there has been considerable progress in this area, particularly for general practitioners. For nursing and allied health there is still insufficient recognition of the problem.

In the 1996 Strategy Update, a considerable amount of activity for non-medical health professionals was listed at page 5. Despite this the Alliance is still not satisfied that enough is being done for those professionals.

The network of Rural Health Training Units is now more comprehensive than it was two years ago and it is clear that they play a critical role in issues related to this Proposal. The Alliance looks forward to the results of the other 'Best for the Bush' report and to continued strengthening of the work and network of Rural Health Training Units. Given the valuable national role of Rural Health Training Units, the Alliance is pleased that the functions of the Tasmanian Rural Health Training Unit are to be incorporated within the University Department of Rural Health.

The Alliance also looks forward to the results of the Review of the General Practice Rural Incentives Program (GPRIP). One particular concern is that the various elements of the GPRIP should accommodate the special needs of remote areas.

On a related issue, the Alliance believes that Shire Councils and Hospital Boards should work closely together more often to recruit health staff.

(6) The Commonwealth should introduce arrangements for tertiary health education institutions to take more rural students, have more rural placements, and to have curricula with a primary health care approach and cross-cultural training.

Overall there has been some useful progress in this area. In particular there has been a very warm welcome given to the coming establishment of the seven University Departments of Rural (or Remote) Health.

There are now rural sub-quotas in some health disciplines. Despite this, curriculum change is still slow. Also, the new fee structure under HECS is likely to have an adverse impact on undergraduate intake to health sciences. The Alliance's concerns revolve around access to health science courses and disincentives for institutions to arrange clinical placements. The Alliance questions the extent to which DEETYA has fulfilled the expectations of it referred to on page 21 of the 1996 Strategy Update.

The HECS changes are likely to have major impact in the Northern Territory where there is a considerable number of students on placements at Alice Springs Hospital.

There is an urgent need for the cross-cultural training referred to in this NRHS Proposal to be provided to health professionals in all jurisdictions working in and heading for rural and remote areas. RHSET has funded some allied health student placements and Territory Health has funded cross-cultural training which is planned to be compulsory for all Territory Health Service staff. However there is no 'mainstream' funding program for this important work.

The Rural Health Undergraduate Clubs are a beacon of hope in the area of this 1994/1996 Proposal. They are providing enthusiasm, training and political sensitisation for future leaders and they are embracing multi-professional undergraduate activity, particularly of the allied health professions.

(7) "All Health Authorities" to have specific initiatives for specialist support for rural GPs, for "increasing the availability of allied health personnel and managers in rural areas", for additional specialists, and for training for rural GPs in surgery and mental health.

Overall, this Proposal received a fairly negative report card from Members of the Alliance Council, particularly for allied health personnel and managers.

The South Australian Government has provided $6m for incentives for rural GPs to stay in country areas. Surgical placements are still scarce in that State. There is some mental health work being undertaken there, as in other States, by video-conference.

In Western Australia, surgical and mental health services are provided to remote areas through 'fly-in, fly-out' teams. Teaching hospitals still need to be encouraged to provide more specialist support to rural general practitioners.

(8) Action on roles of rural nurses and Aboriginal and Torres Strait Islander health workers, alternative models of practice for rural nurses and Aboriginal and Torres Strait Islander health workers, and an education and training strategy for remote area health care providers.

Overall, there has been some useful progress on this Proposal.

The South Australian Rural Health Training Unit has been providing education and training for rural nurses but there is no policy in place for role changes for rural nurses or allied health workers.

There are programs for the training of Aboriginal Health Workers in the Kimberley which have been favourably evaluated.

The Federal, State and Northern Territory Governments are involved in important work on Advanced Nursing Practice and the Alliance is pleased to be supporting this. The 1994/1996 Strategy included references to AHMAC's action on nurses working in designated areas, including remote communities. Despite this focus there are still concerns about the legal and educational background and support for remote area nurses.

The Rural Health Education Foundation has demonstrated its capacity to provide training and other support by satellite to rural and remote health professionals and is investigating the feasibility of moving more strongly into work with non-medical professions.

(9) Action by all Health Authorities on best practice models to maximise multiskilling and multidisciplinary activities.

Overall, progress on this Proposal has been disappointing.

Compulsory Competitive Tendering is leading to some good examples of best practice activity and has the capacity to lead to more benchmarking for elements of rural and remote health services, including for such things as catering, laundry and cleaning.

It seems that this Proposal is not well understood and that developments relating to it are not apparent. This is one area of the National Rural Health Strategy which will benefit substantially from being described more simply so that non-health people can understand it. It is apparently an important area but one in which the technicalities and language used have the effect of mystifying people. By more clearly describing what is involved in 'multiskilling' and 'multidisciplinary activities', health service providers and consumers will be more positive in pursuing them.

(10) Mainstream programs to better meet special rural needs, especially those of indigenous Australians and in the mental health area.

There has been significant effort put into these two major challenges and some good progress has been made on both. It requires hard work by health managers and staff on the ground: a good relationship between mainstream and community controlled health services depends on open communication and a degree of give and take.

All State, Northern Territory and Federal Governments have specific Sections or Strategies for Aboriginal and Torres Strait Islander Health. This reflects the importance of the issue and the historical difficulty of improving outcomes in the area.

Several of the jurisdictions also have specific sections or strategies for mental health and there has been a high level of focus on rural issues in this area.

The Youth Suicide Prevention Initiative and related activities have had a particular rural focus. The Alliance and the Australian Rural Health Research Institute have both been involved with this work and regard it as essential that the rural focus in the area is maintained.

There are obviously still major difficulties in attracting mental health specialists to rural and remote areas.

The current proposal for there to be a new peak body for mental health is supported by the Alliance, as long as its controlling Board has sufficient and well-resourced consumer members.

(11) For isolated communities, a greater focus on Medicare funding, primary health care, training in public health, investigation of mobile or outreach services, and commitment to the primary health care approach.

Progress on this Proposal has been disappointing.

The continued emphasis on acute care and medical model approaches to health services can be partly attributed to the attitudes and expectations of the public. However, the benefits of alternative approaches are so great that it is imperative that there be a continued emphasis on primary health care, public health and early detection of illness.

The funding of health services in remote areas is a complex issue because church groups, the RFDS, mining companies and Railway Departments are all involved, as well as 'mainstream' health services and community controlled Aboriginal Health Services. This complexity should not be used as a reason for avoiding the important work entailed in this Proposal of the 1994/1996 Strategy. As pointed out in that document, people in many remote areas have no access to services funded by Medicare.

It is not apparent that there are as yet sufficient means of "facilitating greater activity by GPs in health promotion and illness prevention programs" (1996, page 9) Presumably this challenge will be taken up in the Review of the General Practice Strategy; the Better Practice Program may be one way to make more progress on the matter.

(12) Health Authorities to give special priority to implementing primary health care and public health programs, including through a review of Medicare funding arrangements.

This Proposal is related to No 11 and progress has been disappointing.

The changes confirmed in the 1997 Federal Budget to the Pharmaceutical Benefits Scheme, the use of Pharmacies as Medicare agencies, and electronic claiming through Medicare will all impact on this Proposal.

The States and the Northern Territory are heavily involved in various aspects of Public Health and are being supported by the Federal Department, including through the formulation and implementation of strategic plans in a number of population health areas.

(13) "Suggested that AHMAC supports the development and adoption of national and local indicators" in order to measure performance and health status, monitor health outcomes, provide communities with information, and help develop indicators for specific rural issues.

The Alliance is aware of the work being undertaken by AHMAC on these matters. The results of this work made available so far have provided only partial answers. The early release to researchers of new survey data from the Australian Bureau of Statistics remains an issue.

4. Principles for Revision of the National Rural Health Strategy

PURPOSE

The purpose of this Section is to propose some key *principles* that the NRHA believes should be considered in the 1997 revision of the National Rural Health Strategy.

BACKGROUND

The National Rural Health Strategy (NRHS) is a critical policy document relating to rural and remote health. It is endorsed by the Australian Health Ministers' Council (AHMC), and it provides a co-ordinated national approach and framework for providing health services to rural and remote areas of Australia.

The NRHS has played a major role in identifying the priority issues facing rural and remote Australia and in raising the profile of rural and remote health issues, particularly at the government level. Notwithstanding this success, there remain a number of major concerns which continue to face rural and remote Australia, including the downgrading and withdrawal of health services, the major health problems and poor health status of Aboriginal and Torres Strait Islander communities, and the shortage of health care providers.

Dr Steve Clark and Ms Angelita Martini have recently undertaken a study of the themes of the four biennial National Rural Health Conferences held since 1991. Their analysis shows that, generally speaking, the issues covered in the main Conference themes (which comprise education and training, local management, service delivery, research, public health, Aboriginal and Torres Strait Islander health, and health organisations) have remained fairly constant between 1991 and 1997.

It could be concluded that, despite the progress made as a result of introduction of the NRHS, the activities being undertaken under the Strategy need to be redefined to ensure that it remains a relevant, strategic and outcomes-focused policy up to and beyond the year 2000.

The NRHA is proposing some broad principles to guide this comprehensive review.

BROAD PRINCIPLES FOR THE REVISION OF THE NRHS

There is a real need to operationalise the NRHS to ensure that improvements in rural health planning, service provision, and the education of rural health professionals can be properly measured.

In its current form the NRHS articulates the major priorities and concerns of rural and remote communities. However it is not in a format which is conducive to governments measuring and reporting progress towards meeting key rural goals, except in a general way.

To overcome this problem it is proposed that a three-step approach be adopted:

- the existing NRHS policy document be revised and updated, setting out the agreed priorities for funding, reform and future development of rural and remote health services. This document will provide the major policy framework and continue to be referred to as the 'NRHS';

- a 3 year strategic plan for the NRHS be adopted: the National Rural Health Plan. The Plan will translate the aims of the Policy into recommendations for action, within specific target areas; and

- Federal, State and Northern Territory Governments should report annually on progress with the Plan, preferably through a report to their respective Parliaments.

Both the revised Policy and the Plan should be endorsed by Health Ministers.

The revised NRHS has to continue to be sufficiently flexible and wide-ranging to meet the diverse needs of rural and remote communities, and to accommodate different State priorities, planning processes and timeframes for implementation. At the same time, monitoring of the Plan will ensure that all jurisdictions are able to report progress on achieving real outcomes.

The revised NRHS and the Plan should be drafted in a way that makes them understandable to a wide audience, not just to policy makers. Plain language should be used. This will ensure that the documents have an influence far beyond the national, State and Territory Governments which take the lead in developing them and which sign off on them.

The NRHS should be revised with an eye on all possible ways to encourage collaboration in health work between different government agencies, and between them and non-government bodies, including local government and local communities. The 1996 Strategy Update reported (with some understatement) that "the need for intersectoral co-operation remains considerable" (p. 11). The extent to which this was (and remains) the case can be judged by the fact that 8 of the 13 'impediments' to progress listed in the 1994/1996 Strategy relate to intersectoral or interprofessional issues, or to other demarcation matters.

Health services need to be redesigned so that delivering a customer-focused service becomes the highest priority. Work to achieve this could range from getting feedback from those using the health service to establishing, including through market research, what types of services customers would most value.

Practical ways to increase community participation and control, such as customer focus groups, customer satisfaction surveys and customer focus staff training, need to be instituted. Therefore, in developing the revised NRHS, it is essential that genuine consultation strategies with the local community, consumers and relevant organisations, such as the Consumers Health Forum and professional bodies, be included.

The revised NRHS should place a priority on reducing duplication and cost-shifting in the health services sector, and on increasing the flexibility of funding arrangements to ensure that the special needs of communities are met, including Aboriginal communities. The three co-ordinated care trials announced in the Commonwealth 1997-98 Budget for Aboriginal communities in the NT, WA and NSW, which will pilot new approaches to funding and delivering the full spectrum of health care needed by these communities, are strongly supported.

The revised Strategy should put an emphasis on developing benchmarks for adequate health and community services for rural and remote communities, and providing examples of 'best practice' which could form the basis upon which States and the Northern Territory could improve their service provision to rural and remote communities.

There is a strong and urgent need for governments to collect, collate and disseminate in useable form a range of rural health and workforce data. The development of a Plan with specific performance indicators is likely to highlight once again the current inadequacy of data collection and dissemination on rural and remote health. It is therefore imperative that, as a result of the review of the NRHS, additional resources are allocated to improving the availability of data on the health status of rural and remote communities, workforce data, access to services, impact of different models of service delivery and the evaluation of best practice initiatives. There need to be special efforts to make the data accessible to rural people and useable by them.

The revised Strategy should recognise Australia's international obligations in relation to social and economic rights. For example, Australia signed on to the international objective of primary health care which flowed from the Alma-Ata Declaration of 1978 of 'Health for All by the Year 2000'. Proposals for service delivery in the NRHS should, therefore, be based on a primary health care approach and be multidisciplinary in focus. They should support the work of the primary health care infrastructure that delivers health services at the local level, including community health services, non-government organisations and local government programs.

KEY FEATURES OF PROPOSED NATIONAL RURAL HEALTH PLAN

It is proposed that a three year strategic plan for the NRHS (the NRH Plan) be adopted for the years 1998-2000 inclusive. The Plan will translate the aims of the NRHS into specific strategies and recommendations for action, within defined target areas and timeframes, linked to performance measures, to achieve the objectives of the NRHS.

This proposal reflects the recommendation on the matter from the 4th National Rural Health Conference. Where progress falls short, governments should identify special measures to be taken to get back on target.

The new Plan, including its proposed reporting and monitoring arrangements, should be modelled on similar Commonwealth/State Agreements, such as the National Mental Health Policy and Plan, and the Agreements on Aboriginal and Torres Strait Islander Health. Selected details of the Queensland Agreement on Aboriginal and Torres Strait Islander Health are included at Attachment 1 to this paper.

While it is true that dedicated resources have been allocated for the implementation of the National Mental Health Plan, this is not the case for the Agreements on Aboriginal and Torres Strait Islander Health, and is not a necessary precondition for the development of a separate implementation plan.

The National Rural Health Plan will clearly articulate State, Territory and Commonwealth Governments' commitment to rural health, and clarify Commonwealth and State Governments' roles and responsibilities as a basis for a national approach to service delivery in rural and remote areas. It should also identify the roles that local government does and can play in health and community services.

Local Government should be invited more frequently by other Governments to be properly involved in planning and decision making, including on community services and health issues.

In summary, the proposed Plan will focus on the following areas:

- priority areas for action;
- roles and responsibilities of the Commonwealth, the States and the Northern Territory, and local Councils;
- the needs of special groups;
- consumer rights and customer focus;
- intersectoral collaboration;
- data collection and collation;
- flexible funding strategies and best practice service provision; and
- monitoring, evaluating and reporting mechanisms, including an annual review of progress and the development of performance indicators.

The advantages of the proposed National Rural Health Plan are:

- it will clearly identify who is responsible for action in each of the priority areas, set out agreed performance indicators and provide a clear timeframe for action, for both short- and long-term priorities. By providing a much clearer link between strategies articulated under the NRHS and improved health outcomes, it will make it easier to determine whether outcomes are attributable to the NRHS or to other programs;

- it will specify how the involvement of the community will occur, through the inclusion of genuine 'customer-focused' consultation strategies with consumers and relevant consumer organisations;

- it will ensure that the special needs of disadvantaged groups, such as Aboriginal and Torres Strait Islanders, are clearly recognised, and that services are planned and delivered in a way which meets their needs and expectations; and

- it will provide a mechanism for the continual monitoring of health needs and workforce requirements, and for evaluating progress. This will enable governments to identify more clearly those areas where progress is slow, to isolate the reasons for this, and to propose solutions.

The Plan will also provide a way of more closely linking and integrating the NRHS with related Commonwealth and State/Territory programs and strategies, such as the Agreements on Aboriginal and Torres Strait Islander Health and the Mental Health Policy and Plan. The National Rural Health Plan will also need to take account of recent changes in public policy, including the move towards the broadbanding of Special Purpose Payments and the development of new public health agreements.

Following a reassessment of the health needs and priorities of people in rural and remote communities, the 4th National Rural Health Conference called for special and immediate priority to be given to the following six areas:

- multi-professional health workforce recruitment, retention, training and support;
- Commonwealth-State/Territory relations and the allocation of resources;
- Aboriginal and Torres Strait Islander health;
- specific services and communication (including aged care, mental health and health promotion, and the availability of infrastructure for and the development of telehealth);
- community participation and education; and
- transport within rural areas, and between rural areas and larger service centres.

Section 5 provides further details of recommendations in each of these areas which the Alliance proposes should be incorporated into the revised Strategy and Plan.

5. Recommendations on Content for the Revised Strategy

5.1 WORKFORCE ISSUES

Workforce issues are those which need to be progressed in order for rural and remote areas to have an adequate number of suitably motivated, educated, trained and supported health care providers. The issues involved concern recruitment and retention; and education, training and support.

The Alliance is concerned with these matters as they relate to all health professions.

The issues concerned can be listed in the chronological order in which they affect individuals:

- incentives for school students to consider rural health practice, and promotion to rural families (including at major country shows and field days) of the positive aspects of such work;

- flexible entry requirements to tertiary training in health sciences (including Medical Schools), and positive discrimination by the training institutions in favour of rural entrants where necessary;

- measures to encourage and enable tertiary level undergraduates to experience rural and remote area practice (including through direct rural and remote placements);

- learning and vocational training systems which are based on the practical skills needed for solving problems, and which include effective orientation to rural and remote area work;

- measures to ensure that those in rural and remote practice have an appropriately high level of access to continuing education opportunities and other support measures to ensure that they and their families are safe and happy; and

- the need for locum relief for all rural health professionals to provide them with cover for sickness, holidays and continuing education (the situation, although still problematic, has been improved in recent years for rural GPs but little progress has been made on this for other health professionals).

This group of issues has received considerable emphasis in the recommendations produced at the four National Rural Health Conferences held to date.

The total system for recruitment, education, training, support and retention of rural and remote health professionals needs to be vertically integrated and well-resourced.

Additional resources for this total system are urgently required in four areas:

- for health professionals other than doctors (the States and Northern Territory should work collaboratively with the Commonwealth on recruitment, education, training, support and retention training programs for non-medical rural health workers);

- for Aboriginal and Torres Strait Islander health workers;

- for definition and amelioration of the unmet needs of remote area health workers. These include certain issues still outstanding for nurses who work in areas where there are no resident doctors and who have to deal with the full range of emergency and clinical practice procedures, in addition to those required of nurses in areas where they do work with doctors and other health professionals; and

- for management training for those who are required for effective administration and operation of rural and remote health services.

There is an urgent need for the Department of Employment, Education, Training and Youth Affairs (DEETYA) to play a leading role in the development of national competencies for Aboriginal and Torres Strait Islander Health Workers. With uniform national competencies agreed, DEETYA and the Office of Aboriginal and Torres Strait Islander Health Services (OATSIHS) should then make available the resources for vocational training in this area.

Improvements to this workforce system will, in the long-run, go a long way towards improving health services and outcomes in rural and remote areas. However some of the changes sought will take years to have their full effect. In the meantime there are urgent and serious problems to be met in relation to many rural health professions, including in certain nursing specialties and in many allied health professions, as well as in relation to the better-known issue of the shortage of rural doctors.

In the next few years the mal-distribution of GPs is likely to be worsened by the restrictions on provider numbers and on temporary visa doctors. These doctors currently provide much of the desperately needed locum support for practising GPs. The ‘Register of Opportunity’ doctors will be insufficiently trained and under-skilled in other respects for successful rural practice. This increases the urgency and importance of getting, by other means, adequately trained doctors, including those on temporary visas, to work in rural and remote areas.

5.2 INTERGOVERNMENT RELATIONS AND THE ALLOCATION OF RESOURCES

BACKGROUND

Governments should recognise that health care is an essential element of the social and economic rights of Australian people. They should also be aware of their international obligations in relation to social and economic rights. It is the responsibility of governments to reduce the inequalities within Australia, some of which relate to low incomes and poor access to health services in rural and remote areas.

Historically there has been a lack of local control over health service funding and activities in rural and remote Australia.

Community control of health services is preferred by people in rural and remote areas and leads to the best use of scarce health dollars. However, there is concern about whether and how local or regional control of health services can be achieved. The focus should be on health service managers engaging in communication activities with their clients to ensure that the services provided are customer-focused.

There is currently duplication and cost-shifting in the health services sector which act against the development and operation of appropriate services for rural and remote communities and the achievement of best health outcomes for their people.

Small communities have to compete with larger centres for funding and services. To the extent that they are unsuccessful in this competition there are inequities between their residents and those of larger centres. Given equal health need of individuals in the Kimberley and Sydney, a health care system funded predominantly through Medicare is inherently inequitable.

There is the problem of contestability of funding between health service areas, such as mental health, the hospital sector, community health and aged care.

PROPOSALS FOR ACTION

The Commonwealth and States should increase the flexibility of funding arrangements to enable the special local needs of communities to be met by focused health authorities.

The Commonwealth and States should simplify and clarify the arrangements for Multi-Purpose Service and other pooled funding structures.

Funding for Multi-Purpose Services needs to be negotiated with the local communities concerned, and based around the health and community service needs of each community.

Actions by the Commonwealth and States should become more transparent and they should be directly accountable for expenditure and funding to rural and remote health services. The required high level of funding transparency needs appropriate data to be collected and analysed.

There is a need to re-examine funding formulae used for allocating health and related dollars, including the Rural and Remote Areas (RARA) classification, to appraise the social justice and equity effects of their use. The definition of remoteness should be further delineated and clarified, including in the RARA indexes, in order to better identify the true nature of resources and needs in rural and remote communities.

The cost disadvantages experienced in delivering services in rural and remote areas should be allowed for in all the programs of the State/Territory and Commonwealth governments.

The Commonwealth and States should support programs which deliver the most effective primary health care services and ensure that there is equitable access by these services to appropriate funding.

There should be formal recognition of rural and remote health as a field of priority research by peak bodies in health and medical funding such as the NHMRC and the Australian Research Council, and for attention to be given to improving the translation of research into practice.

The Commonwealth should develop benchmarks for adequate health and community services for rural and remote communities, including Aboriginal and Torres Strait Islander communities. The scope for flexibility in services should be maintained.

5.3 ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

BACKGROUND

The problems with indigenous health, and the way to overcome them, have been known for years. Lack of progress has been due to the absence of a strong national will to resolve the problems, and to insufficient intergovernment and inter-departmental collaboration.

Rapid improvement therefore depends on actions to achieve a high level of inter-departmental co-operation at all three levels of Government. This requires strong and direct political support from the Ministers in charge of relevant Departments and an unceasing public demand for success in the matter.

This public demand for progress is enhanced by the support of credible and high profile individuals. The current support of the Governor General, Sir William Deane, is a pre-eminent example.

Governments could encourage this public demand for improvement through public relations and promotional campaigns which might include radio and television advertisements.

The existence of a revised National Rural Health Strategy and of a new National Rural Health Plan will provide support for the National Aboriginal Health Strategy. The Plan will help provide the high level of transparency which is desirable for the actions taken under the umbrella of the two Strategies. The Plan will specify the measurable actions to be taken.

Governments should encourage other relevant agencies, such as training institutions and professional associations, to set their own annual targets which, when met, will contribute to meeting the national targets for improvements to the status of indigenous health.

Where targets are not met by Governments or other bodies, annual reports should identify the reasons and what special measures will be taken to get back on track.

PROPOSALS FOR ACTION

Resources

The resources devoted to any particular issue include current and capital expenditure, political and public support, and human skills and energy.

Given this definition, there are many specific health services which are under-resourced in rural and remote Australia. By far the most urgent of them is the range of services related to the status of indigenous health.

Extra resources for indigenous health services are required in all areas with which the National Rural Health Strategy is concerned.

These areas include:

- greater local community involvement;
- improved intersectoral linkages and collaboration;
- increased primary health care and public health activity;
- more information and the better targeting of services which results;
- improved access to mainstream health services;
- increased flexibility of funding and service delivery models;
- further use of outreach services and interactive technology;
- additional health workforce measures; and
- improved means of measuring the effects of interventions.

Decisions of Governments relating to land, the environment and health should be informed by recognition of the influence on health status of the relationship between indigenous people and their land.

The Agreements on Aboriginal and Torres Strait Islander Health must be signed and implemented as a matter of urgency in all States and the Northern Territory. These involve the Commonwealth, individual States/Territories, ATSIC and NACCHO (or its State/Territory affiliate) as direct signatories, and NACCHO is also formally involved in the joint planning processes which are the subject of the Agreement. These Agreements have the capacity to provide the visibility and accountability which will lead to better governmental contributions to indigenous health outcomes.

Commonwealth, State and Northern Territory governments should work together to identify the current level of funding for environmental and public health for Aboriginal and Torres Strait Islander communities. The work should identify both the functional areas and localities in which additional resources are most urgently needed. The functional areas considered should include housing, water, food, air, employment, income security, substance abuse programs and health education. This work should be co-ordinated through AHMAC and a report provided to the Australian Health Ministers' Council.

The Commonwealth Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS) and State and Territory authorities should be adequately funded to establish and maintain comprehensive health care facilities for Aboriginal and Torres Strait Islander people. These facilities should provide comprehensive coverage of rural and remote indigenous communities with core primary health care and treatment services.

Commonwealth, State and Northern Territory Governments should ensure that existing Aboriginal and Torres Strait Islander community controlled health services are adequately funded and should continue to establish new community controlled services. The goal should be to provide people in all significant indigenous communities with access to a community controlled health service.

Services

Research should be commissioned through AHMAC to collate information on existing primary health care models which work well in rural and remote Aboriginal and Torres Strait Islander communities. The results of this research should be made available to all indigenous communities and health services.

State and Northern Territory Ministers for Health need to ensure that the senior managers of their Departments are actively encouraging collaboration between the services they provide and community controlled indigenous health services, as well as the services and activities of other agencies which affect indigenous health outcomes. This leadership will provide stronger links between mainstream health services, community controlled Aboriginal and Torres Strait Islander health services, and related activity.

Workforce and Training

One of the priority proposals in the 1994/1996 Strategy was that "Attention should be given to methods of recruiting more indigenous students into all health science programs, including medicine" (1996 Update, page 17). This is one of the key challenges to be met in order to improve indigenous health.

All rural and remote health service education and training initiatives should incorporate a specific component to maximise the involvement of Aboriginal and Torres Strait Islander health workers and to ensure that their contributions are appropriately recognised and valued. Specifically, Aboriginal and Torres Strait Islander people must be involved in the training and education of all non-indigenous rural and remote health professionals. Rural and remote Aboriginal and Torres Strait Islander communities should be funded to develop these culturally-appropriate education and training programs for non-indigenous health workers.

State and Northern Territory Governments should establish programs to provide incentives, training and support for Aboriginal and Torres Strait Islander health workers. These should include training in environmental and mental health.

State and Northern Territory Governments should fund a greater number of positions for Aboriginal and Torres Strait Islander health workers.

There should be consistency in salaries and conditions for Aboriginal and Torres Strait Islander health workers nationally, and the Commonwealth should develop and fund a national career structure for them.

5.4 AGED CARE, MENTAL HEALTH AND HEALTH PROMOTION

Aged Care

BACKGROUND

Like the overall population, the people of rural Australia are ageing. This raises a number of particular issues for elderly people, their families and the system of care for them in rural and remote areas.

Attempts to have as many people as possible stay in their own homes are welcome, but in rural areas it is even more difficult to achieve this satisfactorily because of the relative shortage of domiciliary care and other 'at home' services which are needed to support an independent home lifestyle for the aged.

It is most desirable that elderly people in small country towns should have the option of staying in those towns even when they are frail and have the need for full-time nursing care. It is therefore welcome that the new regulations for aged care facilities will result in a greater number of nursing home type beds in country towns which are not in hospitals. However, there are significant problems for smaller aged care facilities in meeting the new regulations in one fell swoop.

PROPOSALS FOR ACTION

Considerable concern has been caused for aged people in rural areas and for the rural aged care sector by the Federal Government's changes to the financing system and other regulations for aged care facilities. The following specific recommendations are proposed by the Alliance.

- A detailed information campaign should be mounted in rural areas by the Federal Government to explain the new regulations now due to come in force on 1 October 1997. This campaign should continue past that date because of the need for many people to have a clear understanding of the changes. Currently some of those involved in the aged care sector and some aged people and their families themselves have a poor understanding of what the new situation will be.

- The Federal Government should undertake further investigation of the competing interests of the aged care facilities in rural areas and their potential new clients. The proposal for the accommodation bond to be payable six months after an individual's entry to the aged care facility has significant negative implications for the cash flow of those institutions (which, in rural areas, are small and usually lacking in capital), and raise the undesirable possibility that such institutions will have to act as 'debt collectors' from deceased estates.

It would help small aged care facilities if those entrants who can pay the accommodation bond up front did so. However, if such a policy decision were to be made it would be important to establish its impact on the financial affairs of the elderly people involved.

- The Federal Government should gather information on the difficulties experienced by aged care facilities in rural areas of meeting the intended new requirement that 27% of all their residents should be 'concessional residents' (pensioners). In small communities where there are fewer elderly people it is obviously more difficult to maintain a set ratio of patients of certain types. There is therefore a strong objection to the proposal that any aged care facility which does not meet this 27% target is penalised $26 a day.

- It is asserted that the rebate offered to the institutions of $5 a day for each concessional resident does not cover the real costs of care for such residents, which is claimed to be $11.80 a day. These matters should be clarified and the particular circumstances of smaller aged care facilities, many of which are in rural areas, should be accommodated in the new regulations themselves and in the timing of their introduction.

- It will also be very difficult for small rural aged care facilities to find the additional running costs to upgrade their staff to the level required for accreditation for the care of nursing home type patients. While the Alliance supports the move to a higher level of training for staff, there should be special consideration given to the costs this will impose on small institutions and the time it will take them to achieve full coverage.

- The Alliance has always supported the notion of Multi-Purpose Services and it still does. These have the capacity to overcome some of the problems alluded to above. For instance if there is full integration of a small local hospital with domiciliary services and local aged care institutions, some of the financial problems can be eased. The upgrading and accreditation of staff can be undertaken using the existing training systems of the hospital and, through the judicious use of staff with different levels of skill, it is possible to reduce the need for retraining in the integrated Multi-Purpose Service. Also an integrated service has the capacity to save money through combining resources for such things as laundry and catering.

- However, in some small country towns where there is a frail aged lodge there is opposition to the establishment of a Multi-Purpose Service. This is because the local Council or some other local organisation has contributed significant resources to the establishment and operation of the frail aged facility and perceives its amalgamation with the hospital and other services as being a takeover which would result in a significant loss of control for the Council.

- The lesson from this is that it is important to involve all stakeholders in health, aged care and community services in the establishment of a new integrated service. This should not be seen merely as a desirable principle but should continue to be an operational guideline for all levels of government and all individuals involved in the establishment of new Multi-Purpose Services and similar structures.

- Local integrated services should be free to use whatever name they choose, without prejudice to their benefiting from the flexible financial policies for MPSs.

Mental Health

BACKGROUND

Mental health tends too frequently to be defined in terms of specific conditions such as schizophrenia or a propensity for suicide. Just as important is its definition as a reflection of the spiritual well-being of individuals and their communities. Substance abuse is often due to low self esteem, alienation and anomie which are signs of poor mental health.

PROPOSALS FOR ACTION

It is vital that the revised National Rural Health Strategy (and the new Plan) should continue "to articulate closely with … the National Mental Health Policy".

The Alliance supports the establishment of the proposed new peak body for mental health. It is important that the representatives on the Body include an adequate number from rural and remote areas, and that consumers also be adequately represented on it.

Given the sparse services dedicated to mental health in rural areas, it is even more important for them than the major cities to have individuals and agencies alert to and trained to varying degrees for dealing with mental illness. It is frequently the case that the front line workers in the area (the mental health workers, where there are any, and the counsellors and community development workers) are professionally and physically exhausted by their standard daily work. This means that outside normal working hours the onus for first contact and referral of people with mental health illness falls on the police, church people, community groups and others in the non-government sector.

It is therefore important that these non-health workers in rural areas have sufficient training about mental health to be able to manage safe referral work and to know something about how to deal with emergencies when they arise.

The Alliance strongly welcomes the decision in the 1997 Federal Budget for the Commonwealth to maintain a direct role in mental health services. The Alliance also welcomes the emphasis given to rural issues in the National Mental Health Strategy and the range of programs directed at suicide prevention. As is well-known, youth suicide is a particularly common phenomenon in rural areas and it is important that the work underway on this in rural areas is completed as soon as possible and is followed up by programs of action which will make a real difference.

In remote areas especially there is a need to give consideration to the mental health problems in Aboriginal and Torres Strait Islander communities. These problems are often compounded by their inter-relationship with issues related to drugs and alcohol. The programs to combat these need to be community-driven and to be well enough resourced to enable them to employ local workers on their programs.

Health Promotion

BACKGROUND

The 1994/1996 Strategy referred to the importance of "refocussing resources from acute care to prevention and early detection" (1996 Update, page 11). This remains a critical challenge.

The sorts of health promotion activity which might be regarded as standard in cities and regional centres is harder in small country towns where there is no local radio station and few, if any, other local media outlets which can be used to spread health promotion messages.

This means that health promotion successes in smaller country towns are frequently dependent on the enthusiasm, continued activity and leadership of key individuals which can lead to a community-wide effort taking off. One such successful campaign was the anti-smoking campaign at Warren in NSW. Billboards were painted by local people, the campaign was supported by local community groups and the media, and large parts of the community were eventually behind the activity.

PROPOSALS FOR ACTION

The Alliance would like to see be a grant program established to provide incentives and some cash resources to support such community activities as this.

Another key element in successful health promotion activities in rural and remote areas is genuine collaboration between all of those Departments and agencies whose activity affects health outcomes. In the Northern Territory the Health Infrastructure Planning (HIP) program provides a model of such collaboration. It involves the Territory Departments of Health, Transport and Works, and Public Housing and Environment.

The Alliance recommends that such active interdepartmental collaboration as this be mandated by the Ministers responsible for individual Departments and that there be incentives for staff of those Departments on the ground to engage in active joint work designed to plan for and lead to better health outcomes. The Ministers in portfolios affecting health should be required to report annually on the work of their Departments towards the targets in the National Rural Health Plan.

The Alliance recommends that Rural Divisions of General Practice fund projects to establish interdepartmental working groups on environmental and other aspects of health, and that such projects include resources for the employment of local people to work as project officers to ensure that the ideas of the interdepartmental groups are put into action.

5.5 COMMUNITY INVOLVEMENT FOR CUSTOMER-ORIENTED SERVICES

BACKGROUND

The situation regarding genuine community participation in health services varies across States and Territories. Overall for the past few years it has been a case of two steps forward, two steps back.

The 1994/1996 Strategy acknowledged throughout "the importance of community consultation", especially to take account of local and health priorities (1996 Update, p 3). It is certainly not yet the case that "In all instances, the planning process incorporates mechanisms which provide for widespread community consultation in determining health care priorities and appropriate planning responses" (1996 Update, p 4).

All Governments should explore options for facilitating more direct participation by communities likely to be affected by planning and policy changes. These options need to accommodate the diversity of rural and remote communities.

The purpose of community participation is to ensure that health services are customer-focused; for this to be the case they need to be customer-driven.

Service planning and delivery should be based on the health needs of the community or client group. The process of assessing needs requires:

- statistical data;
- geographical and social information; and
- credible community consultation.

Planners and policy makers should allow communities to decide what 'health' is to them and allow them also to decide what services are required to meet the defined needs.

This will be brought about by:

- encouraging and recruiting community leadership and participation;
- polling the community to identify health service needs and issues;
- providing appropriate education, training and information on planning, consultation, decision-making and models for the provision of health services;
- health agencies working in partnership with communities and consumers;
- the provision of appropriate resources for community involvement; and
- implementing the provisions of the Ottawa Charter at the local level.

PROPOSALS FOR ACTION

Government and non-government agencies must provide adequate time and access to information and participation in the decision making process so that rural and remote communities can take the initiative in exploring options for managing their own health care and health promotion services.

Obtaining comments on discussion papers from people in rural and, especially, remote areas takes more time than it might do in a capital city. This has to be allowed for in processes of planning and consultation. Two of the things that anger rural people about token consultations are speedy visits by 'fly-in and fly-out experts', and receiving an important discussion paper about a week before the deadline for comment.

Communities involved in consultations and research should receive, as a matter of course, information and advice resulting from those local exercises.

All of those involved in consultation should be adequately and appropriately skilled for the job. There needs to be feedback from decision makers to the community about why and how specific decisions were made

Those involved in consultation will frequently need to have their costs covered for such work. The involvement of people in meetings, especially if they come from remote areas, takes time and money.

State and Territory Governments should provide adequate resources and structures for their health managers to communicate with consumers sufficiently to ensure that the services provided are customer-focused.

There must be equitable community representation on health service boards and their equivalent. The current trend in some States towards less community participation is regrettable and will be counter-productive in terms of health outcomes and health services.

Governments must make available resources to complement and acknowledge community input into health services. For example, adequate investment in the development and support of a Hospital Board is a prerequisite for its success.

By all possible means governments should involve people in genuine community participation in health service planning and policy making. Resources and structures for this participation must be built in to funding agreements.

5.6 TRANSPORT

BACKGROUND

Transport has a pervasive effect on access to services and on overall quality of life in rural and remote areas.

As acknowledged in the 1994/1996 Strategy, "Adequate transport and communications remain imperatives in delivering effective health care throughout rural and remote Australia and in ensuring access of rural and remote inhabitants to services".

The transport situation has become worse for some people, particularly those who are not well off due to unemployment or other causes of low income. Public transport services within rural and remote areas, and between them and major regional centres and capital cities, have continued to be 'rationalised'. In many isolated areas there are only bus services on intermittent days or air services which are very expensive for private individuals. Country fuel prices remain high despite some continued fuel freight subsidy.

For these reasons transport is identified surprisingly frequently by patients and consumer advocates as the number one priority with respect to access to health services. This is not sufficiently well recognised by funders and policy makers.

There is a lack of co-ordination of the public transport services that do exist, leading to ineffectiveness and insufficient flexibility to deal with local transport problems.

There are some positive community activities in transport in rural areas, including for health purposes. However there are difficulties with the recruitment, training and support of drivers of community vehicles, many of whom are volunteers.

There is also difficulty in obtaining and servicing vehicles, even in the public sector, particularly when they are used extensively on dirt roads and when the people using them are expected to maintain the vehicles themselves.

Allied health, dental and other non-medical services are not covered by Patient Assistance Travel Schemes (PATS, titled Isolated Patients' Travel and Accommodation Schemes, IPTAAS, in some jurisdictions).

The administrative and regulatory details of these patient assistance schemes vary across States and the Northern Territory. There are or have been recent reviews of these Schemes in some health jurisdictions but, given the importance of the matter, an overall national review is necessary and should be undertaken as a matter of urgency.

The high cost and scarcity of transport also affect health through their impact on the cost of all goods and the quality of perishable items in more remote areas. Fresh food at affordable prices is an important input to good health, but in remote communities a cabbage may cost $5.00 and two litres of fresh milk $8.00.

PROPOSALS FOR ACTION

Given the importance of the issue, State, Territory and Commonwealth governments should give a higher priority to the allocation of resources for operational and capital funding of health transport services, especially those provided for outreach and other mobile services.

There needs to be sufficient standardisation of policies in relation to PATS/IPTAAS to ensure equity, flexibility and efficiency. Specific issues to be considered include eligibility criteria, escorts, return travel, cross-border issues, pre-payment, and access to allied health and other non-medical professions. This standardisation could be accomplished through AHMAC and the Health Ministers' Council.

Appropriate funding should be allocated in health budgets to hospitals and health services in rural and remote regions to ensure that they engage in good discharge planning. These resources should also be used to provide appropriate support for people returning home, especially when they have a long distance to travel.

The case for giving a higher priority to rural and remote transport services would be strengthened by an analysis of the comparative levels of subsidy of public transport in urban, rural and remote areas. Such a study should be commissioned by the Commonwealth Government.

Federal, State and Northern Territory Governments should adopt an inter-departmental approach to examine more flexible and efficient models of transport service for all rural and remote areas and functions.

ATTACHMENT 1

THE TRI-PARTITE AGREEMENTS ON ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

BACKGROUND

A major development in health services for Aboriginal and Torres Strait Islander peoples is the existence of a number of Quadripartite (or Tripartite) Agreements between the Commonwealth Government, the State or Territory Government, the Aboriginal and Torres Strait Island Commission (ATSIC), and the National Aboriginal Community Controlled Health Organisation (NACCHO), through its State affiliate.

The Agreements for Tasmania and the Northern Territory are not yet signed. It is to be hoped that they will be signed as soon as possible.

It is a matter of extreme importance that all the Agreements be fully implemented as quickly as possible.

The Agreements for individual jurisdictions are based on a uniform approach, amended following detailed negotiations between the parties involved in each case.

Given their content, these Agreements offer great hope in relation to improving the health status of indigenous peoples. They contain many of the elements regarded as being necessary to improve community and government actions on this critical issue.

The agreements are signed by the individual State or Northern Territory Minister for Health, by the Commonwealth Minister for Health and Family Services, by the Chairperson of ATSIC, and (in most cases) by the Chairperson of the NACCHO affiliate. Their personal signatures recognise the key roles for them as leaders, as well as the roles of their agencies.

SPECIFIC CONTENT

The elements of the Agreements which provide encouragement include the following (all the following quotations are taken from the Queensland Agreement).

They are “underpinned and informed by the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody”.

They recognise the need to improve access “to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs”.

They recognise the need for "increasing the level of resources allocated to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples, including within mainstream services, and transparent and regular reporting".

They work through joint planning processes in which the National Aboriginal Community Controlled Health Organisation (NACCHO), its State affiliate (in this case the Queensland Aboriginal and Islander Health Forum - QAIHF) and substance misuse services are heavily involved.

They propose the development of model service contracts which are outcome and output oriented and "contain clear operational service principles which ensure control of these services by Aboriginal and Torres Strait Islander peoples in these communities, and set out how Aboriginal and Torres Strait Islander involvement in design, delivery and the evaluation of Aboriginal and Torres Strait Islander health and health related services is to be implemented".

They support "a viable and independent Commonwealth funded NACCHO" and "a viable and independent QAIHF which represents the community controlled health sector".

They propose regional plans which will identify gaps, opportunities and priorities.

They propose "Community health plans designed in consultation with those communities".

They lay the basis for "action to improve access to mainstream health and substance misuse services which are culturally sensitive".

They refer to the need for "public accountability against enforceable written standards of service that are reported on".

They refer to "programs and strategies to improve the status of Aboriginal and Torres Strait Islander Health Workers and to achieve agreed employment and training outcomes" for them.

They propose "to establish culturally sensitive and ethical privacy and confidentiality protocols for the routine collection of standardised data on Aboriginal and Torres Strait Islander health. These protocols are to recognise Aboriginal and Torres Strait Islander ownership of the data including clarity about the use of data".

Most importantly, the Agreements refer to development of "a mechanism to report specifically on health outcome indicators".

They clarify the respective roles of the Commonwealth, the State or Territory, ATSIC and community controlled health and substance misuse organisations.

The Agreements also have substantial and encouraging reference to the critical role of intersectoral collaboration, between those involved in "agriculture, local government, land, animal husbandry, socio-political, cultural, food, industry, education, communications and community infrastructure such as housing and public works".

In the context of this last point, the Agreements refer to “the establishment of cross government processes” and “exploring innovative options for better intersectoral collaboration”.

“The State of Queensland and the Commonwealth of Australia agreed to report on progress in implementing commitments under this Agreement and the action planned at each Australian Health Ministers’ Conference.”

“Reporting under this Agreement is to occur regularly (on a six monthly basis), publicly and be transparent.”

ATTACHMENT 2

MEMBER BODIES OF THE NATIONAL RURAL HEALTH ALLIANCE

There are 18 members of the National Rural Health Alliance, all of which are national bodies in their own right or the rural special interest groups of national bodies. They are:

AARN	Association for Australian Rural Nurses Inc
ACHA	Rural Interest Group of the Australian Community Health Association.
ACHSE	Australian College of Health Service Executives (rural members)
AHA (RPG)	Rural Policy Group of the Australian. Hospital Association
ANF	Australian Nursing Federation (rural members)
ARRAHT	Australian Rural and Remote Allied Health Taskforce of the Australian Council of Allied Health Professions
ATSIC	Aboriginal and Torres Strait Islander Commission
CRANA	Council of Remote Area Nurses of Australia Inc
CWAA	Country Women's Association of Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NARHTU	National Association of Rural Health Training Units
RDAA	Rural Doctors' Association of Australia
RF of RACGP	Rural Faculty of Royal Australian College of General Practice
RFDS	The Australian Council of the Royal Flying Doctor Service of Australia
RPA	Rural Pharmacists Australia - Rural Interest Group of the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia
SARRAH	Services for Australian Rural and Remote Allied Health

You don’t need a man with a brick in his hand
Or a glass in your face so you know where you stand
Lift up your heads from out of the sand
You might see what a state we’re in

You don’t need the papers to tell you all the news
If you stand by the reds or you’re true unto the blues
Lift up your eyes instead of looking down at your shoes
You might see what a state we’re in

And I’m alright Jack - pull up the ladder
Alright Jack - I’m safe on the wall
Alright Jack - and if you climb just a little bit higher
But the higher you climb the further you fall

You don’t need a number instead of a name
If you don’t like the smoke then don’t fan the flame
And if you look in the mirror you might see who is to blame
You might see what a state we’re in

You don’t need a salesman to rattle and to pose
If you buy one of these you get a free one of those
He could sell you a ring to put right through your nose
You might see what a state we’re in

You don’t need the queues for assistance and for dole
Taxation inflation population control
If you listen to the tills you can hear the bells toll
You can hear what a state we’re in

And I’m alright Jack - pull up the ladder
Alright Jack - I’m safe on the wall
Alright Jack - and if you climb just a little bit higher
But the higher you climb the further you fall

J Tams (Hobson’s Choice Music)

ATTACHMENT 3

PUBLICATIONS FROM THE NATIONAL RURAL HEALTH ALLIANCE:

1. **A Fair Go For Rural Health**, Proceedings of the 1st National Rural Health Conference, Toowoomba, 14-16 February 1991; Department of Health, Housing and Community Services, Canberra, 1992.

2. **A Fair Go For Rural Health - Forward Together**, Proceedings of the 2nd National Rural Health Conference, Armidale, 12-14 February 1993; University of New England, Armidale, 1993.

3. **The Politics of Rural Health: How Far Have We Come?** Proceedings of the 3rd National Rural Health Conference, Mt Beauty, 3-5 February 1995; NRHA, Canberra, May 1995.

4. **Action Now to Improve Rural Health Outcomes Soon**, A Winter Manifesto summarising the priority recommendations from the 3rd National Rural Health Conference; NRHA, Canberra, June 1995.

5. **Submission on the National Rural Health Strategy Mid-Term Review**; NRHA, Canberra, December 1995.

6. **Strategies for Change**, A Summer Statement to Shareholders; NRHA, Canberra, December 1995.

7. **Communique and Recommendations**, from the 4th National Rural Health Conference, NRHA, Canberra, February 1997.

8. **The Journey to Rural Health**, NRHA, Canberra, July 1996.

9. **Position Papers from the NRHA**, NRHA, Canberra, forthcoming.

10. **Proceedings from the 4th National Rural Health Conference**, NRHA, Canberra, forthcoming.

The NRHA now has a home page on the Web: www.ruralhealth.org.au Included on that page are details about the NRHA as well as copies of the papers presented to the 4th National Rural Health Conference in Perth in February 1997.