NSW Public Health Bulletin

Volume 12, Number 6
June 2001

NSW HEALTH
Better Health *Good Health Care*

ISSN 1034 7674
State Health Publication PH 010067

RURAL HEALTH IN NSW

GUEST EDITORIAL

Charles Kerr
Sub-Dean of Rural Health
Faculty of Medicine
University of Sydney

During the 1990s, rural health became more prominent on the political agenda. Through the 20th century, the NSW Department of Health and its antecedents contributed to subsidies raised by local communities to attract and retain doctors; progressively increased its rural workforce; and, especially in the period following the Second World War, constructed many small rural hospitals. In the 1970s, the NSW Health Commission took the initial structural steps to decentralise health service administration to the regions. Yet, by the end of the 20th century the fundamental problems of rural health remained:

- an increasingly well-documented excess burden of injury and disease (especially among remote and rural indigenous people);
- the inability to constantly maintain an effective workforce of health professionals;
- difficulties with creating a sustainable service infrastructure.

Several promising initiatives were made by the Commonwealth and State governments during the 1990s. Some of these are described in the following articles, along with other aspects of the contemporary rural health scene.

Drawing on his experience in the Kimberleys and the Far West of NSW, Michael Douglas provides a personal view on developing health policy in the rural sector. Douglas is a public health consultant who believes that little in the way of health gains will be achieved without the active involvement of rural communities in the initiation and development of policy. Observing that health sector policy in rural Australia is largely determined by a 'top down' approach, Douglas writes that regional centres 'have an important role, both in feeding up the reality of life in a rural community to a central level, and then massaging the shape of policy that may be best developed centrally'.

continued on page 150

CONTENTS

149 **Guest editorial—Rural health in NSW**

150 **Policy development in the rural sector: a personal perspective**

152 **The experience of the Well Person's Health Check in the Far West Area Health Service**

155 **The health of the people in agriculture and its interdependence with the health of rural communities**

159 **Building Capacity in Rural Health**

162 **Rural medical education: Helping to solve the rural workforce crisis**

165 **NSW Lead Management Program in Broken Hill**

167 **NSW Health becomes a registered training organisation**

170 **Tinnitus awareness kit for health professionals**

171 **Fact*Sheet*: Giardiasis**

172 **Epi*Review*: Notifications of Q Fever in New South Wales, 1991–2000**

175 **Communicable Diseases: June 2001**

175 Trends

175 NSW Influenza Surveillance

175 Arbovirus activity

176 The National Notifiable Diseases Surveillance System

The principle of active community involvement is clearly demonstrated in the article that follows, which describes how the Far West Area Health Service successfully modified a community screening program, the *Well Person's Health Check*, to improve service delivery to an indigenous community in its area. This program was conducted by Lisa Jackson, who is proud to be the first Aboriginal person to complete the NSW Public Health Officers Training Program.

Lyn Fragar, Head of the Australian Centre for Agricultural Health and Safety, clearly outlines the pressures (such as income reduction, among others) that influence the health of people working in the agricultural sector. Essentially, due to the forces of globalisation and policies of economic rationalism, farmers have lost control over many of the factors that influence their livelihood, and hence their health and wellbeing. So mental health is an important issue along with relatively higher rates of serious injury, cardiovascular disease and some cancers. Fragar believes that the capacity building approach to health service delivery would benefit farming communities.

Capacity building is the focus of the next paper by David Lyle, Professor of Rural Health, and Charles Kerr, who emphasise new initiatives for education and vocational training in remote and rural Australia. They regard these continuing developments by Commonwealth and State governments as important investments in infrastructure that have the potential—within a capacity building framework—to improve the availability, quality and flexibility of workforce resources.

Mohamed Khadra, Director of the Greater Murray Clinical School at Wagga Wagga—the first of 10 intended rural clinical schools throughout Australia—concentrates on this initiative to attract and retain more doctors in rural practice. The intention is for substantial numbers of medical students to complete at least half their clinical education in a rural setting. Khadra presents a strong case that such arrangements can meet their objectives.

Finally, David Lyle and colleagues from the Far West Area Health Service summarise 10 year's experience of the NSW Lead Management Program in Broken Hill. Over a century of mining operation had left a persistent environmental lead hazard, manifested as relatively high blood lead levels in a proportion of children. The program, based on public health principles of minimizing harm from an environmental hazard, has been highly successful; but it needs to be maintained due to the irremedial nature of widespread lead sources.

There is much more that could be written about rural health. Nevertheless, it will be evident from this series of articles that many of the realities of rural health are being firmly addressed; and there is a cautious optimism that the people of rural and remote parts of NSW will eventually benefit from more determined and better supported efforts to improve their health.

POLICY DEVELOPMENT IN THE RURAL SECTOR: A PERSONAL PERSPECTIVE

Michael Douglas
Public Health Consultant
michael.douglas@bigpond.com

'I wonder would the apathy of wealthy men endure
Were all their windows level with the faces of the Poor.'[1]

Although a century has passed since Henry Lawson penned these words, the truth they express still holds. The most influential determine the fate of all. This perception is not lost in the experience of the rural populations of Australia, whose livelihoods are built on conditions vastly different from those of the metropolis; and yet their opportunities are frequently determined by those who live in the metropolis.

This paper presents an opinion of policy development in rural Australia. It holds that, in spite of encouraging steps that seek to involve the rural population in the development of relevant policy, centralised decision-making remains the norm. Although international developments around the issue of meeting the needs of target groups have been achieved—and are available to policy makers—an element of maintaining the familiar practice and efficiency of systems has limited the potential for the greater involvement of rural populations in decision-making.

Also, the differentiation between rural and urban populations is commonly and inappropriately simplified. The adverse health status and other health differentials in the rural populations are not uniform across all rural areas, while sectors of the urban population also have poor health status. A set of values may be assigned to one or other group that frequently depicts an adversarial relationship; however, urban and rural populations are not as distinct as these simplifications may suggest.