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.

The development and establishment of policy is necessary to facilitate the achievement of goals defined by stakeholders. Policy development occurs at a number of levels. These include the broad values on how the health system defines its goals; for example, the representation of key groups in specifying these goals, or the accountability of those charged to deliver them.[2] Without policies, decision-makers will be engaged in repeated debates over the same crucial issues. Policy constitutes authorisation for an agent to act in a particular way whenever a particular situation exists.[3]

The evolution of 'primary health care' in recent decades has recognised the pivotal role that policy may have in determining the outcome of better health. The fundamental principles underpinning the primary health care approach were garnered from the diverse experience of small rural-based community programs.[4] The success of this approach will only be seen when its implementation is both derived from and embedded in the domain of its target group. It follows, then, that for policy to lead to an improvement in health and social conditions in the rural sector, it must be born and driven within those communities.

This is supported by my personal experience. For a number of years, I was privileged to work in a small and remote community in the Kimberley region of Western Australia. In response to enormous adversity in social circumstances, this community set about re-building itself, outlining its vision, and showing a determination that it could fulfil its plans to achieve its goals. The success of the community in doing so became a valuable catalyst for other communities to address their issues in a similar way. Policy makers within the social sectors were willing to be challenged, and development–adaptation was achieved accordingly.

The issue of the misuse of alcohol is a good example. The community determined a raft of measures to address the social disruption caused by the excessive consumption of alcohol.[5] One such action was to restrict the availability of alcohol. This was met with opposition from the liquor industry, which further fuelled the eagerness of the community to determine the nature of their own environment. A landmark decision by the Director of Liquor Licensing in Western Australia pronounced a range of restrictions on the licensees of Halls Creek. The restrictions included a reduction in trading hours; delayed take away trading (that is, not before noon); and a limit of one flask of wine per person per day. This decision provided the community with both a sense of achievement and subsequent benefits that were measurable. This, and similar cases in other jurisdictions, have provided a good foundation for the development of policy at national level. The case demonstrates how a small community is able to influence its own destiny; share that experience with nearby communities; and, with the added and subsequent experience of other communities, collectively influence the formation of national policy. Importantly, the regional and state senior health personnel provided strong advocacy for local public health action.

As my personal circumstances required a move to the eastern states of Australia, and to a larger centre, I reasoned that if I could not work in close contact at a 'grass roots' level, then the next best thing may be to remain as an advocate of health gain for disadvantaged groups working at a level where policy decisions were cast. With this ambition, I accepted a position as director of a public health unit in western NSW, which afforded regional decision making capacity and linkages to statewide debate on policy matters. I was to learn that, in adopting such a position, I was no longer a part of the community that I aspired to serve, but rather had become one who provided advice *to* communities, with very limited capacity to be an agent of change. The policy environment was largely one of imposition; and, in my own enthusiasm for change, I became one of the central agents making decisions *for* communities. My cherished principle of health for the community by the community had somehow lost its way.

The lessons from this example should not suggest that regional or state policy makers do not have a place. Quite the contrary. Communities, and their health care providers, need guidance and a robust mechanism for sound policy development. Policy-makers have a responsibility to fulfil this task. Where there is little capacity for the foundations of policy to emerge from isolated and remote communities, 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. Public health practitioners are necessary, and are potentially rewarded, as energetic advocates of better health for disadvantaged groups.

It remains that policy in the health sector in rural Australia is largely determined by a 'top down' approach. Policy research agendae frequently reflect the interest of the producers of research, rather than a strong relation to the assessment of need. Funding allocations are made centrally. State or Commonwealth jurisdictions are substantively the policy makers of today, and the rural community is most commonly the passive recipient of their decisions. International and Australian experience has indicated the benefits of community input into their health and social welfare systems, the premise behind the Declaration of Alma Ata. 'Bottom up' development of policy, particularly in the rural sector, can be effected, and will almost certainly provide a greater opportunity for better health. The challenge remains in engaging

communities, and bringing forward a health system to be proactive in determining the rural health agenda. Opportunities exist and to a limited extent, are being exploited. Community 'health councils', rural health training, and an evolving level of rural health research are all signs for optimism.

The further groundwork for change must be laid. Ongoing recognition of stratified indicators of rural health is necessary. Most importantly, however, is the need to listen to and work with communities. Disadvantaged groups should be encouraged to actively participate in developing policy, and implementing measures intended to improve their situation.[4] These programs and interventions must be implemented in a way that supports equity and group problem solving. Regionally based, and central policy-makers need to encourage and facilitate rural communities that advocate for change. While early steps have been taken, and have provided some measure of optimism, in order to achieve a more equitable and focused policy framework to develop better rural health, a deepening of understanding and a greater willingness to be 'with' rural communities in their plight remains a priority.

REFERENCES

1. Lawson H. Faces in the Street (1888). Wright DM (editor). *In the days when the world was wide: the poetical works of Henry Lawson*. Melbourne: Lloyd O'Neill: 1970.
2. Reeves PN, Coile RC. *Introduction to Health Planning* (4th edition). Arlington, Virginia: Information Resources Press, 1989.
3. Kerr DH. The logic of Policy and Successful Policy. *Policy Sciences* September 1976; 7 (3): 351–363.
4. Werner D, Saunders D. *Questioning the Solution: The politics of Primary Health Care and Child Survival.* Palo Alto, California: HealthWrights, 1997.
5. Douglas M. Restriction of the hours of sale of alcohol in a small community: A beneficial impact. *Aust N Z J Public Health* 1998; 22: 714–9.

THE EXPERIENCE OF THE *WELL PERSON'S HEALTH CHECK* IN THE FAR WEST AREA HEALTH SERVICE

Lisa Jackson *

NSW Public Health Officer Training Program
NSW Department of Health

Darren Mayne and Hugh Burke
Far West Area Health Service

The Far West Area Health Service (FWAHS) sought to develop a new, or implement a modified, community screening methodology to assist in assessing the health needs of remote Aboriginal communities living within its area. Following a review of the literature, it was decided to examine the North Queensland *Well Person's Health Check*, which is run in collaboration between the Tropical Public Health Unit (TPHU) in Cairns and the Apunipima Cape York Health Council, a community-controlled indigenous health organisation in Far Northern Queensland. This article describes the process by which the FWAHS adopted its own Far West *Well Person's Health Check* (Far West WPHC).

THE *WELL PERSON'S HEALTH CHECK* IN NORTH QUEENSLAND

The original *Well Person's Health Check* was developed in Far North Queensland following the publication of the *National Aboriginal Health Strategy* in 1988. Findings of the Strategy confirmed that many undiagnosed and untreated diseases such as sexually transmitted infections, diabetes, renal, cardiovascular and respiratory disease contribute substantially to excess mortality and morbidity in indigenous populations. Treatment of these diseases in the early stages can result in a cure or a reduction in morbidity. Unfortunately, because many of these diseases are initially asymptomatic, diagnosis usually occurs at a later stage.

To promote community-based primary health care, a unique partnership was formed during 1997 with the Apunipima Cape York Health Council and the TPHU. One of the outcomes of this partnership was the development of the Far North Queensland *Well Person's Health Check*. This intervention, originally targeted at remote communities, was an endeavour to:

- establish the extent of certain diseases in remote communities;
- provide early treatment and referral;
- use the data collected to inform service delivery and address local health issues.

The program is planned and implemented in conjunction with local community members and service providers. The *Well Person's Health Check* is conducted in conjunction with a community event in order to attract interest and optimise participation. *Well Person's* screening is offered together with health promotion activities, advice, treatment, and healthy food. There are protocols for consent and confidentiality, and referral and follow-up treatment are provided.

* *Currently Epidemiologist at the South Eastern Sydney Public Health Unit.*