Rural Health

Policy Position Statement

Key messages:

Rural communities have poorer health outcomes than non-rural communities, due in part to a range of barriers to accessing health services and to differences in social determinants of health. Access barriers are due mainly to insufficient numbers of health professionals across medicine, dentistry, nursing, and allied health disciplines, and demand that exceeds supply. Access barriers to comprehensive health care for rural residents across Australia and inadequately funded rural health services contribute to rural health inequities. However, rural communities have many strengths, and fit-for-purpose rural models of care offer solutions to address rural health challenges.

Key policy positions:

1. Rural communities differ from non-rural communities and from each other. Health problems facing rural areas are complex and require long-term solutions. Rural and non-rural researchers, clinicians, policy-makers and community should work together to address rural health issues.
2. Intersectionality is important to consider in rural health, such as, but not limited to, the intersections between Aboriginal and Torres Strait Islander health, ageing and disability.
3. Equitable and affordable access to primary health care must be provided to people, regardless of where they live.
4. Voices of rural communities must be included in decision and policy making in relation to rural health, at all levels of government.
5. Rural communities need to lead, drive and co-design best practice, evidence based, sustainable and needs-based initiatives and models of care to improve rural health, with adequate resourcing and support.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Diversity, Equity & inclusion Special Interest Group

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Policy position statement

This position statement should be read in conjunction with the existing PHAA policies on *Health Promotion and Illness Prevention*, *Health Equity*, *Oral Health*, *Primary Health Care*, and *Aboriginal and Torres Strait Islander Health*.

PHAA affirms the following principles:

1. Every human being has a fundamental human right to the highest attainable standard of health without distinction of economic or social condition, race, religion, or political belief,[(1)] or place of residency. People living in rural[(1)] areas have a right to equitable opportunities for good health.

2. The diversity of people residing in rural areas should be recognised, as should the diversity of rural communities, and the intersectionality of rural health, Aboriginal and Torres Strait Islander health, ageing and other personal characteristics.

3. Although prevalence of mental health conditions may be similar in rural and non-rural areas, suicide and self-harm are more common and access to mental health professionals is typically more restricted *(See PHAA Suicide Prevention Policy Position Statement)*

4. Primary health care should be equitably and affordably accessible, with adequate support for access to other, more specialist services where required.

5. Health promotion and prevention strategies for rural people require investment in a dedicated health promotion and preventative health workforce, the integration of health promotion and disease prevention with medical, dentistry, nursing, and allied health practice, and a commitment to build the public health capacities of local government, healthcare services, and non-government organisations.

6. The PHAA affirms the need for high quality, and sufficiently granular data to monitor key health indicators, social determinants of health, and workforce distribution across Australia. PHAA supports the need for increased rural health research funding,[(2)] as the relative lack of rural health research is considered to contribute to persistent rural health inequities.[(3)] PHAA supports research priority areas including rural health workforce recruitment and retention, access to health services, and effective models of care.

7. Policy making should recognise the principle '*Nothing about us without us*', the active involvement of rural people in decision and policy making in issues that impact rural communities. Rural communities have rich histories of adaptability, resilience, and innovation that can be drawn upon to develop novel approaches to improving public health.

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[1] Terminology: For the purposes of this document the term 'rural' is used to incorporate non-metropolitan areas, and is considered inclusive of rural, regional and remote areas. Regions of Australia have been categorised in a variety of ways, including the Australian Standard Geographical Classification (ASGC) system used by the Australian Bureau of Statistics and the Modified Monash Model (MMM) system used to address maldistributed health workforce. ASGC defines an area's remoteness as RA1 - Major Cities. RA2 - Inner Regional, RA3 - Outer Regional, RA4 – Remote and RA5 - Very Remote. MMM uses seven categories from MMM1 (major city) to MMM7 (very remote) and incorporates remoteness and town size.

PHAA notes the following evidence:

8. Approximately 7 million people in Australia (28% of the population) live outside of metropolitan areas.[4] Forty-four per cent of all Aboriginal and Torres Strait Islander people live in inner and outer regional areas.[5] The proportion of Aboriginal and Torres Strait Islander people in the total population increases with remoteness, from 1% in major cities to 32% in remote and very remote areas.[5] Rural and remote areas have a higher prevalence of people with disability.[6, 7]

9. Inequities in access to health services, health promotion and preventative activities, along with social determinants of health, contribute to higher rates of avoidable mortality, poorer life expectancy and preventable hospitalisation in rural areas.

Strengths/positive attributes:

10. Rural areas typically have cleaner air, access to natural spaces, community participation, stronger social capital, and innovative models of health services that are matched to their communities' health needs.[8, 9]

11. Key features of successful rural healthcare models include locally controlled funding, accountability, engagement of relevant agencies, evaluation, are place-based and include lived experience expertise and local leadership.[10] There are strong examples of models that address local need, and co-operation between health services and Aboriginal Controlled Health Organizations with locally elected boards of management.[11] Partnerships that include local government and non-government organisations can improve rural community health outcomes.

Social determinants of health:

12. Differences in rural, remote, and metropolitan health status can partially be explained by avertible inequities in socioeconomic status, which affect health service usage, participation in health screening, and health-related behaviors.[12, 13] Rural areas also tend to have higher proportions of people aged over 65 compared to metropolitan areas.[14, 15]

13. There are social and economic disadvantages in rural areas including fewer education and employment opportunities, difficult working conditions, more social isolation, larger distances from services and service access barriers including issues of acceptability and availability, and more difficult conditions for transport.[16]

Access to services:

14. In rural areas, long distance travel and transportation challenges present barriers to accessing resources required for health.[13]

15. Access to safe and nutritious food, education and employment can also be limited in certain rural and remote areas.[17, 4, 18] Resulting in often lower income but higher prices for goods and services, resulting in higher socioeconomic disadvantage.[4, 18]

16. Multiple barriers to healthcare access also exist as rural and remote areas continue to be under-resourced.[19] This under-resourcing has been estimated to be as large as a $4 billion shortfall for non-metropolitan health services.[20]

17. Poorer access to primary health care means lower use of primary health care.[4] People in rural areas are less likely to have a regular GP compared with major cities.[21] Rural areas have an estimated up to

50% fewer health providers per capita compared with major cities.[22] Affordable access to dental services is particularly fraught given oral health is largely excluded under Medicare, the public dental services, are under-funded and the nature of dentistry relies on in-person visits. There are fewer dental practitioners providing clinical care in rural areas compared to non-rural areas.[23]

18. Rural areas have a markedly lower per capita rates of medical specialists, dental practitioners[2], pharmacists and other allied health professionals compared with non-rural areas.[4]

19. Multiple barriers to healthcare services have been linked to lack of preventive and screening services and unmet health care needs.[21]

Injury and risk:

20. Agriculture, forestry, and fishing, are major industries in rural and remote areas and have the highest industry-specific fatality rate for young workers in Australia.[24] Rural environments also contain hazards that increase the risk of injury, road accidents, and zoonotic disease.[13, 25] Children are also at increased risk of injury in rural and remote areas through farm-related injury.[26]

Risk factors:

21. Modifiable risk factors such as alcohol misuse, tobacco use, excess sugar intake are more prominent issues in rural areas than in metropolitan areas.[4]

22. Rural environments present higher risk factors than metropolitan environments for developing adverse health outcomes – including comparably lower walkability,[27] poorer access to whole food[28] and affordable health foods.[29]

23. People living in rural areas typically have poorer oral health than people living in non-rural areas due in part to limited or no access to community water fluoridation and oral healthcare.[23, 30]

Mental health:

24. Prevalence of mental health conditions may be similar in non-rural and rural areas, but access to mental health care and outcomes are poorer in rural areas. Suicide rates and rates of self-harm are higher in rural areas.[31]

25. High levels of distress can be experienced by groups of people in rural areas facing other challenges including unemployment,[32] chronic ill health, disability, or isolation.[31]

Mortality and hospitalisation:

26. There is higher premature mortality, higher prevalence of chronic conditions and lower life expectancy in rural areas compared with metropolitan areas.[4]

27. Rural areas have higher rates of potentially preventable hospitalisations compared with major cities.[4] Use of hospital emergency departments as a source of primary health care can be linked to lower availability of health providers and poorer access to non-hospital primary health care.[33]

Inclusion:

28. In rural areas, there is evidence of complex patterns of social inclusion-exclusion and discrimination affecting persons living with chronic illness[34] or disability,[35] and those belonging to minority groups in relation to sexuality,[36] and ethnicity.[37] Social exclusion is also commonly experienced amongst

[2] Includes dentists, dental specialists, dental therapists, dental hygienists, oral health therapists, and dental prosthetists.

newcomers to rural locales,[38] lack of cultural safe healthcare services,[39, 40] and discrimination towards Aboriginal and Torres Strait Islander Peoples can be pervasive, particularly in remote areas and townships.[41]

Climate change:

29. Rural communities are typically on the front-line of natural disasters and bear a disproportionately high burden from the impacts of climate change, including impacts on physical and mental health, economic prosperity and the natural environment.[42] While all Australians will be affected by extreme heat from climate change, people living in rural communities will be the worst affected as health services are already under pressure and many rural communities are poorly equipped to deal with health impacts of higher temperatures.[42]

Data:

30. While Australia has good area-level data by remoteness, most Australian health datasets and longitudinal studies have insufficient observations for rural areas. This prevents disaggregation by rurality for detailed or causal analysis of relationships between health and social determinants of health or other drivers of health inequities.[43]

PHAA seeks the following actions:

Access to health services:

31. Tailored solutions are required to ensure equitable access to primary health care for rural people, and support for access to more specialised services when required.

32. Health workforce shortages and maldistribution must be addressed, across medicine, dentistry, nursing and allied health.

33. There should be sustained and increasing investment in telehealth, but as an adjunct to, rather than a replacement for, local, in-person rural health services.

Policy and decision making:

34. A comprehensive Rural Health Strategy needs to be supported, led by peak bodies such as the National Rural Health Alliance.[44] This strategy should be inclusive of mental health.

35. Rural health solutions must be adequately and sustainably resourced. Effective rural models of care should be co-designed, assessed and resourced, as highlighted in the Rural and Remote Multidisciplinary Health Teams approach of the Ngayubah Gadan Consensus Statement.[45]

36. Continued support for the Office of the National Rural Health Commissioner to provide policy advice to the Rural Health Minister.

Other:

37. Better collection of data and improved data linkage to underpin analysis of drivers of rural inequities. Further investment in data collection to meet the needs (available and accessible data at local level) identified in the National Preventive Health Strategy.

38. Greater recognition that rural communities are on the front-line of climate change. Efforts to mitigate climate change also present opportunities to enhance population health through the promotion of healthier and more sustainable diets and active transportation.

PHAA resolves to:

39. Advocate for rural people to consistently have a voice in decision and policy making.
40. Advocate for equity of healthcare access across rural and remote Australia.
41. Advocate for sustained and enhanced rural health leadership in government
42. Support the development of a minimum dataset to track health outcomes, healthcare workforce, health behaviours and social determinants of health with sufficient granularity and quality to be useful to rural communities.
43. Maintain inclusive practices at all PHAA events to support participation by rural and remote members.

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