AUSTRALIA’S RURAL, REMOTE and INDIGENOUS HEALTH 3e

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It has been nine years since the second edition of this book was published, and many things have changed and improved in rural and remote Australia during that time, which is very pleasing. This edition is therefore a considerable rewrite, with several new chapters written collaboratively with five other authors from whom I have learnt so much.

During these nine years rural turned into regional, the profile of rural health increased, the government invested more and the landmass experienced more drought and flooding rains. The First World got fatter, the Third World got thinner and diabetes and chronic disease increased. National organisations such as Health Workforce Australia and the Australian National Preventive Health Agency were birthed and then closed down along with many other health organisations as a result of the controversial 2014 budget. During this time the Australian Government intervened into Aboriginal communities in the Northern Territory, the then Prime Minister the Hon Kevin Rudd made the historic Apology to Indigenous Australians and the Close the Gap Campaign commenced to measure the impact of these initiatives. Some things, however, did stay the same: Australia’s focus on terror, fear and international events, which left floods of refugees fleeing for their lives.

Writing this third edition was a reflective and liberating process. I found myself in a privileged position that gave me time to reflect and find a louder voice about remote, Indigenous and rural health education. Many universities prescribe this book as a core text for undergraduate and postgraduate medical, nursing, pharmacy, occupational therapy, allied health and Indigenous health subjects, and I thank them for their encouragement to get on and write the third edition.

This third edition is restructured into four sections for easier accessibility and is also available as an eBook for the first time, which has been quite an educational process for me. It has two new chapters on clinical practice coauthored by an Aboriginal GP and a remote area nurse that, I am sure, will become student favourites. In addition, the eBook includes a variety of electronic links, videos, audio files, photos and colour that make it come to life. I also changed the title so that it better reflects the strong Indigenous content.

Life for me has always been a series of everyday events punctuated by moments of absolute bliss and those few critical moments that remove us from the ordinary life path that our mothers always thought we might follow. For me, undertaking a one-week student placement on Bathurst Island in the Northern Territory became one of those critical moments in my career, as it took me down a different life path – a rural, remote and Indigenous health path. For many years this path took me over completely. It challenged my values and priorities in life and my worldview. At times it made me think I was between worlds, and that I never really fitted into either. I loved it, I hated...
it and, 30 years later, I remain absolutely fascinated by it. This book brings together some of those critical moments and combines those experiences with the current literature available in the field. Once I found my voice, which was amazingly rural, the pages seemed to take on a life of their own. Rural, remote and Indigenous health work can be enormously rewarding. To make it such, the rural and remote health workforce need to be adequately prepared for the adventures and the realities that they face. This book aims to meet that need.

Enjoy and have no fear!

Professor Janie Dade Smith
FOREWORD

Before we learnt to recite the words of Judith Wright’s *A Sunburnt Country*, and before Albert Namatjira painted his ghostly gums at the outskirts of Alice Springs, remote Australia had been a permanent part of our national identity. Regrettably, this has not always flowed through to our social policies.

It must strike an outsider as strange that this part of the nation, which is so central to our national psyche, has not been central to the way health care is planned or delivered.

This can be measured with precision. The inequality of health outcomes is well known and documented. The further you live from a capital city, the more likely you are to die younger, suffer a chronic disease or suffer a serious and avoidable illness without access to medical care. It is precisely these parts of our country where health professionals are most needed and where we have struggled to attract and retain staff.

This is changing. New models of practice, a greater focus on prevention, and new schemes to train, attract and retain workers in rural and remote Australia are making a difference. We know that, to succeed in retaining staff and improving health, our health professionals need to understand and be part of the communities they serve.

In 2008, Prime Minister Rudd brought the nation together and delivered the National Apology to the Stolen Generations. It will be properly remembered as one of the great and unifying moments in Australian history and a key point on our journey to reconciling black and white Australia. Since that moment, each parliament has committed to reporting on Closing the Gap in a handful of social and health indicators – from life expectancy to employment. This Closing the Gap project serves as a reminder to the Australian Parliament and peoples about what works and what is still to be done, and is the score card of the litany of invariably failed and sometimes well-intentioned policies before it. An important factor will be Aboriginal control over Aboriginal health care to achieve a reconciled future.

This book makes an important contribution to closing this gap. It is as much a practical guide to remote and rural health practice as it is a collation of stories that bring life to the key themes. It harnesses the power of storytelling and ties together the key economic, social and political forces that have, and will continue, to shape health care in rural and remote Australia.

Hon Stephen Jones MP
Federal Member for Throsby
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Janie Dade Smith was born in rural Queensland in the year television came to Australia and has lived rurally for most of her life. Being a middle child in a large family, she developed a strong sense of ‘a fair go’ early on. This formed the foundation for a life driven by humanist values, a social justice agenda and an ability to think outside the square.

Janie is a highly experienced health educationalist and project manager who has worked extensively in national curriculum development, program accreditation, educational resource development, policy development, organisational review, Indigenous health, as a clinician and in research. She has worked across all health disciplines – medicine, nursing, pharmacy, allied health, and with Aboriginal and Torres Strait Islander health practitioners.

Janie’s passion for justice, remote and Indigenous health and plain English writing meant that she has often found herself sitting on an island by herself, struggling to fit into impractical and bureaucratic systems. Therefore, in 2004 she established her own rural health consulting company, RhED Consulting Pty Ltd, and undertook consultancies, developed curricula, and provided program evaluations and reviews for health departments, universities, professional colleges and government and not-for-profit organisations.

Since 2012 Janie has worked for the Faculty of Health Sciences and Medicine at Bond University and is the Professor of Innovations in Medical Education. Janie coordinates the Master of Clinical Education Program, leads the development of the Doctor of Medicine program and works on the Indigenous and rural and remote curriculum. She is well published and has won many awards for her work, the most recent being the prestigious 2015 Australian Office of Learning and Teaching Award for University Teaching Excellence with the Indigenous health team for their work on the Indigenous medical curriculum. Janie is the President of CRANAplus, the peak body for all remote health in Australia, and previously sat on the Council of the National Rural Health Alliance.
INTRODUCTION

Australia’s Rural, Remote and Indigenous Health continues to be one of the few books that discusses and applies Indigenous history, health and policy to rural and remote health in Australia, a subject that has now become compulsory in most undergraduate health programs. This text aims to fill this gap by providing the basic information required by any health professional to work in rural, remote and Indigenous Australia.

Australia’s Rural, Remote and Indigenous Health is intentionally different from other rural health books, as it is based on a social justice and social determinants framework. Social justice essentially means giving people a ‘fair go’, a share or a choice. It is the foundation upon which the primary health care approach to health is based. This perspective questions the important issues of human rights, equity, access to services and the appropriateness and affordability of what is provided. The very tenets of primary health care are founded in social and economic justice.

The material is also presented differently, using a variety of plain English forms of writing. These include storytelling, historical accounts, video and audio links and real-life experience, supported by the literature. These approaches apply the realities of everyday human life in rural and remote Australia to professional practice, and provide some useful teaching and learning resources. This makes it easy for the learner and the teacher.

Opposed to a medical evidence-based perspective, this book uses the evidence to support social justice and social determinants arguments. It also questions the very foundation of how we address health in Australia, and why we do not approach it from a more inclusive social justice framework.

Geographically, rural and remote Australia has many more playing fields compared to urban Australia, yet rural people have less access, fewer appropriate fields and fewer affordable ones compared with their city cousins. This affects one of their basic human rights as citizens of this great country: their right to an equal level of health, although theirs is lower on most health indicators. This is particularly so for Indigenous Australians.

This book is aimed particularly at those who are undertaking studies in rural, remote and Indigenous health – in nursing, medicine, pharmacy and allied health, as well as Aboriginal and Torres Strait Islander health professionals; those in sociology, anthropology, cultural studies and education; and at undergraduate as well as postgraduate levels. It will also be of use to those working in policy, social justice and law, and to those with an interest in the area.
What became of the bakery, the Mechanics Hall, where fiddlers played, farm families danced and kids skidded on the floor?
The general store, with yarns on the step, a school house, where ponies drowsed till the door flew open like a hen-house coop as the clock on the wall struck four.
Dusty roads, dry creek beds, sere paddocks where harsh boxthorn sports its berries and vicious spikes, and the country folk we knew have long departed.

(JEAN RINGLAND, 2005)
Australians are one of the healthiest groups of people in the world. We enjoy a life expectancy for men that is the third highest in the world after Iceland and Switzerland. Australian women have a life expectancy of 84.3 years and men can expect to live to 80 years (Australian Institute of Health and Welfare, 2014c). The number of Australians who are 65 years and older is projected to double by the year 2055, with an escalating number of centenarians from approximately 5000 in 2015 to 40 000 by 2055 (Australian Government, 2015). There is also a trend among these ageing populations to retire to regional and coastal areas in search of cleaner air, fresher food and a healthier lifestyle. Australians can therefore generally expect to live out their long and healthy lives walking by the seaside and carrying their thongs in their hands. However, not all members of the Australian community can have this expectation.

Many inequalities exist, depending upon where we choose to live and our cultural grouping. Those who have lived their lives in rural areas die about four years younger than other Australians, and this increases with greater remoteness and lower socioeconomic status (Australian Bureau of Statistics, 2011a). When we add Indigenous to the equation this increases dramatically. Consequently, the average remotely living

**HEALTHY AUSTRALIANS**

Why are rural and remote Australians dying younger than their city counterparts?

Why are Indigenous Australians dying a decade younger than other Australians?

Why does the area where we live and our cultural grouping have such an impact upon our health?
Indigenous Australian may never reach the age of retirement, nor draw on their superannuation, as old age is considered to start at about 45 years.

In this chapter I will examine the health status of rural Australians, using data mainly from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare. I will then draw out the marked inequalities by comparing the health status of rural Australians with the National Health Priorities for Australia. It should be noted that the first report on the health of rural and remote Australians was only produced in 1998 (Strong, Trickett, Titulaer, & Bhatia), and few national rural-specific reports have been produced since that time, apart from those found on state government websites. Hence, it is difficult to draw a national picture.

THE HEALTH OF RURAL AUSTRALIANS

When imagining rural Australians one automatically thinks of a farmer or, these days, a miner. However, most workers in rural and remote Australia are in the retail, health, education, government, manufacturing, processing and transport sectors (Phillips, 2009). They make up about seven million people or about 31 per cent of the overall Australian population, when we include those in outer regional, remote and very remote communities (Australian Institute of Health and Welfare, 2014b). And while some live on farms most live in regional cities and rural towns.

The current picture of a rural Australian is typically someone who is overweight, more likely to smoke and drink alcohol, has high blood cholesterol and who is not very active (Phillips, 2009). These rural Australians have unique health concerns that relate directly to their living conditions, social isolation, socioeconomic disadvantage and distance from health services. They have neonatal death rates that are double the urban rate, four times the death rate due to injury and road accidents, and double the death rates due to diabetes (National Rural Health Alliance, 2011; Australian Institute of Health and Welfare, 2014b). Yet rural people have poorer access to health care compared with their metropolitan counterparts because of distance, time factors, costs and transport availability. This is compounded by shortages of health facilities and health professionals, and rural people's perceptions of health. Figure 9.1 describes the significant differences in death rates by remoteness.

THE TRIPLE WHAMMY

There are three major factors that impact upon a person's health – their age, their culture and their geographical location. When we add the three together it is like the 'triple whammy', as we will see in the following section.

**PAUSE AND THINK**

What does it mean for rural Australians when we put these three factors together?
FIGURE 9.1 Age standardised death rates by remoteness area, 2012.

Deaths per 1,000 population

Note: Rates have been age-standardised to the 2001 Australian population.


Age discrimination
Older people

Australia’s population generally is ageing. Just over half of those who are over 65 years of age have some form of chronic disease or disability. Older people are less likely to live in major cities, though the two-thirds who do experience a longer life expectancy than those who live rurally (Australian Institute of Health and Welfare & Department of Health and Ageing, 2007). The remaining third of Australia’s older population have taken a sea change or tree change. About a quarter live in inner regional areas and 11 per cent live in outer regional areas. The remaining 2 per cent live in remote and very remote areas (Australian Institute of Health and Welfare & Department of Health and Ageing, 2007). This varies by state and region with just over 17 per cent of all older Australians living in Tasmania and only 6 per cent living in the Northern Territory (Australian Institute of Health and Welfare, 2014b). On the mid-north coast of New South Wales one-quarter of the population are over 65 years of age; hence there is a greater need for aged care services in that region. However, there is some anecdotal evidence that many are moving back to the city of Canberra in their 70s as their health care needs change. Additionally, dementia is now seen as a national health priority due to its increased incidence (Australian Institute of Health and Welfare, 2015a).
Young people

Lower health status also discriminates for young rural people. Infant mortality rates in remote centres are double those found in city areas and 3–5 times the rate for very remote areas (Australian Bureau of Statistics, 2011c). Young rural and remote people aged between 12 and 24 years also have considerably worse health compared to their city counterparts. The death rates of young rural and remote people are double the urban rates and injury rates are 3 times the national rate (National Rural Health Alliance, 2011). The rates for hospital separations for transport accidents were 3.2 times higher and the rates for assault were 5.7 times higher for remote areas (Australian Institute of Health and Welfare, 2011). Rural and remote young people are more likely to experience violence, have higher rates of alcohol and substance abuse, are less likely to meet the minimum standards for reading, writing and numeracy, are more likely to have dental decay and are less likely to access a GP (Australian Institute of Health and Welfare, 2011). The leading cause of death for young Indigenous people is suicide, which is 4–6 times the non-Indigenous rate, and the assault rate is 6 times the non-Indigenous rate (Australian Institute of Health and Welfare, 2011). Same sex attracted young people in rural and remote areas experience much higher rates of isolation, discrimination and suicide (Rosenstreich, 2013). All of these factors multiply with socioeconomic disadvantage and remoteness.

An important factor, which we must examine here, is the age structure of Australia’s youth due to the links between age and culture in rural and remote communities. In 2009 there were four million young people in Australia and they represented 20 per cent of the total Australian population (Australian Institute of Health and Welfare, 2011). Of these young people, a little over 3 per cent were Indigenous. These 3 per cent, however, make up 27 per cent of the total Australian Indigenous population, which has a much younger age profile generally (Australian Institute of Health and Welfare, 2011). Health factors such as obesity incidence have a greater impact upon this population group. What this means is that, when resources are distributed and programs are developed for Australia’s young people, governments need to consider the much higher young Indigenous population and develop programs based on the age and cultural distribution that target these groups, and not apply the urban models to remote Indigenous populations.

Figure 9.2 demonstrates the age structure and population distribution between Indigenous and non-Indigenous Australians. It illustrates the much higher proportions of Indigenous babies, children and young people, and the much lower population of Indigenous older people.

Cultural discrimination

Health status also discriminates according to culture. Indigenous Australians have the worst health status in this country, and on some health indicators they rank worst in the world (Australian Institute of Health and Welfare, 2014a). The life expectancy of an Indigenous boy born in 2011 was 69 years and 73 years for an Indigenous girl,
which is about 11 years less than non-Indigenous Australians, hence the lower number of older people seen in Figure 9.2 (Australian Institute of Health and Welfare, 2014b).

On almost every indicator, Indigenous Australians are disadvantaged compared with all Australians. The largest differences are in smoking status, psychological distress and cardiovascular conditions, which affect one in eight (Australian Institute of Health and Welfare, 2014a). Infant mortality rates are double the non-Indigenous rate; ischaemic heart disease is double for men and four times higher for women; and the incidence of diabetes doubles with remoteness, and is up to 30 per cent of the population in some remote communities (Australian Institute of Health and Welfare, 2014b). While recent research indicates some improvement in health status, there are significant state differences, and evidence of improved health outcomes was found where systematic chronic disease monitoring and prevention strategies and measures were being implemented (McDermott, Tulip, & Schmidt, 2004).

**Geographical discrimination**

Seventy per cent of the total Indigenous population live outside major cities, and those living in remote and very remote communities make up over a quarter of the total Indigenous Australian population (Australian Bureau of Statistics, 2011a). We know that health status worsens significantly with remoteness; therefore the health
concerns raised have a much greater significance for young Aboriginal and Torres Strait Islander peoples as one population group, for they make up 18 per cent of the total remote population.

**Diabetes and the triple whammy**

Let us examine what happens when we put the triple whammy together – age, culture and geographical location – with a chronic health condition such as diabetes.

- **Diabetes incidence**: diabetes has doubled in the Australian population over the past two decades. Today over 4.6 per cent of the total Australian population suffer from diabetes, mostly type 2 diabetes (Australian Bureau of Statistics, 2011b). Diabetes is associated with long-term circulatory and eye conditions, and it significantly increases the risk of developing coronary heart disease, stroke and peripheral vascular disease. Diabetes mellitus, or type 2 diabetes, is strongly linked with obesity, diet and exercise.

- **Now let’s add age**: diabetes mellitus was often called maturity onset diabetes as it was usually only found in those over 40 years of age. However, it is now escalating in younger people due to the increase in obesity in the Australian population and other First World populations.

- **Now let’s add culture**: Indigenous Australians were more than four times as likely as non-Indigenous Australians to report some form of diabetes and have one the highest incidences in the world (Diabetes Australia, 2013; Indigenous HealthInfoNet, 2013). Diabetes affects up to 39 per cent of those aged over 55 years (Indigenous HealthInfoNet, 2013). Diabetes hospitalisation rates are 3–5 times higher for Indigenous Australians than other Australians (Diabetes Australia, 2013). Indigenous Australians are almost 7 times more likely to die from diabetes than other Australians (Diabetes Australia, 2013).

- **Now let’s add geographical location**: almost one-third of all diabetics live in the most disadvantaged areas. Young females in regional areas were 30 per cent more likely to be overweight or obese than those in the city. Indigenous Australians living in remote areas are almost twice as likely to have diabetes – 9 per cent in remote areas, 5 per cent in non-remote areas (Australian Institute of Health and Welfare, 2014a).
What these figures tell us is that being young and living rurally is a health disadvantage. An even greater health disadvantage is being young and living in a remote area, as demonstrated in Figure 9.3 above. The greatest health disadvantage of all is to be young, to live remotely and to be Indigenous. I examine this more closely in Chapter 7.

RURAL CULTURE

There is a strong feeling in rural communities that they are different from, and have special qualities not found in, city communities. Rural people see themselves as having a different world view and a different set of values and priorities from city-living Australians. Rural people are generally close-knit, supportive of one another, fiercely independent and self-reliant; their emphasis is on getting their work done and being productive. Ironically, they are also renowned for their higher levels of risk-taking behaviours, such as smoking, drinking and driving for long distances after a night out on the town. These factors have consequently added to their perception of health as ‘the absence of disease’ and their ‘she’ll be right mate’ attitude to minor health ailments; as a result they tend to delay attending to their health issues (Strasser, Hays, Kamien, & Carson, 2000).

Providing rural health services

In this rural culture of self-reliance and independence, rural GPs reportedly see more patients than do their metropolitan counterparts, but see them less often because
their patients’ primary concerns are those of illness, not of wellness, and because of their limited ability to access a doctor (Strasser, 2002).

Many Australians, especially those living and working in rural and remote areas, would agree that ‘it’s different in the bush’ compared with urban areas. Those who provide health care services also understand that their roles differ compared with those of their metropolitan counterparts, and know that they need advanced and additional skills to work rurally. This, however, is not generally recognised by those who fund rural health, research it, lobby for it and govern it.

It is fair to say that many outsiders question the validity of some of the rural and remote initiatives, and cannot see why rural health services are not just a part of mainstream services. Of course, these people are working from their own urban understanding of ‘mainstream’. For example, researchers might ask: ‘How different is rural health?’ and ‘Where is your evidence?’ Economic rationalists might say: ‘Is it different enough to demand a separate policy, separate budgets and separate training?’ and ‘Why does it cost more than if we ran it in Sydney?’ Health care providers would want to know: ‘Are the people sick enough to warrant special attention?’ and ‘Just how sick are they?’ Humanists would argue: ‘The people, irrespective of where they live, should have equal access to health care services – it’s a matter of equity.’ The Australian Government would say: ‘That’s a state responsibility.’ And the state government would respond: ‘But the Australian Government doesn’t give us enough money to adequately support these programs.’ In the meantime, the rural and remote people would probably shout: ‘Fair go mate, I’ve got a family to support and a business to run. Just sort this bloody mess out!’ A number of reviews and initiatives have occurred over the past decade to do just that (National Heath and Hospital Reform Commission, 2009).

**Government blame-shifting processes**

A factor that specifically impacts upon rural health services is our peculiar, inherited three-tier system of government with its Commonwealth, state and regional levels, which jointly provide funding for health services. This poorly coordinated system creates a situation whereby many rural and remote programs are conducted using a cost-splitting device, with investment from both the state and Commonwealth governments. Frequently, in rural areas, where the costs for travel, recruiting or providing services are considerably higher than the base amount allocated, there is a discrepancy between the state and Commonwealth government contributions. Yet the Commonwealth often sees the discrepancy as a state responsibility, and the states see it as insufficient provision of funds by the Commonwealth. One only has to read the paper or watch the news on television to hear the blame shifting going on between the state and federal governments, particularly to do with health and education (National Heath and Hospital Reform Commission, 2008). This blame-shifting syndrome has a direct impact on the provision of health care services and has led to many recruitment exercises for rural medical trainee positions not being filled, leaving those communities most in need without services. An example is the rural specialist trainee
workforce in the Kimberley region of Western Australia, where the state and Commonwealth governments jointly fund rural specialist training positions. Attracting a specialist to this area will cost more than placing someone in, say, Bunbury in the south-west corner’s wine-growing country, which is another rural specialist training post. The additional cost lies in the extensive travel a doctor has to undertake to provide clinical services across thousands of square kilometres, the additional specialist resources needed and the usual necessary incentives such as housing, study leave, adequate locum relief and a car. However, the Commonwealth Government provides the same amount for this rural training position as it does to support a specialist in Bunbury, which is a two-hour drive from Perth. Therefore, many training positions in areas of workforce need are not being filled; and rural people are not being provided with adequate specialist services.

Let us examine the health of rural Australians using Australia’s National Health Priorities, both as a basis for determining the health status of rural and remote people and in an attempt to answer some of the questions above.

PRIORITISING RURAL PEOPLE’S HEALTH

The National Health Priority Areas (NHPA) initiative focuses on the nine biggest causes of morbidity* and mortality† in the Australian population. These include those chronic diseases that pose a significant health burden and those conditions that have a potential for health gains and improved outcomes for Australians – asthma, arthritis, cardiovascular health, cancer control, dementia, diabetes mellitus, mental health, obesity and injury prevention and control (Australian Institute of Health and Welfare, 2015a). It is interesting to note that obesity was only added in 2008 and dementia was only added in 2012, due to their increasing incidence in the population. Table 9.1 compares, for the nine National Health Priority Areas, the morbidity and mortality experienced by rural and remote Australians to that of all Australians.

Note: Many people may believe that the reported health status of rural people is due to the poorer health of Indigenous Australians, who largely live in rural and remote areas. This is not the case, for two reasons. First, there continues to be limited data about the health status of rural and remote Australians. The Australian Institute of Health and Welfare published the first and only national report in 1998 (Strong et al.). Second, the Indigenous data sets are incomplete in most reports. What Indigenous data that do exist are taken from usually only four or five Australian states. Rural health disadvantage is therefore not a result of poorer Indigenous health; it reflects the health disadvantage of all rural Australians.

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* Morbidity is the rate of incidences of disease or impairment.
† Mortality is the rate of deaths.
Asthma

- Over 2 million (10%) of Australians have asthma – that is 14–16% of children and 10–12% of adults. This rate has plateaued recently, although 37 500 Australians are still admitted to hospital each year due to asthma (Australian Institute of Health and Welfare [AIHW], 2015a)
- The prevalence of asthma in the Indigenous population is almost double (18%) compared with the non-Indigenous population (AIHW, 2015d)
- The risk of dying from asthma increases with age. Up to 60% of asthma deaths may be avoidable (AIHW, 2015a)

Cancer control

- Cancer accounts for 30% of all deaths registered in Australia. One in two men and one in three women could be directly affected by cancer by their 85th birthday (AIHW, 2015a)
- The five most common cancers are prostate cancer, bowel cancer, breast cancer, melanoma of the skin and lung cancer (AIHW, 2014d, 2015a)
- Indigenous people have 2.8 times the liver cancer rate, 2.3 times the cervical cancer rate and 1.7 times the lung and uterine cancer rates of other Australians (AIHW, 2014b). Aboriginal men are 50% more likely to die from prostate cancer (Cancer Council, 2015)
- The incidence of cancer is highest in inner regional areas and lowest in very remote areas (AIHW, 2014b). Remote areas have the highest incidence for cancer of unknown primary site and bladder cancer (AIHW, 2014b). However, death rates from all cancers combined were highest in very remote and remote areas, with the highest incidences being lung cancer, prostate cancer and kidney cancer (AIHW, 2014b)
- Men living in rural NSW were found to be 32% more likely to die from prostate cancer than urban men (Yu, Luo, Smith, O’Connell, & Baade, 2014). Rural and remote people have to travel to major centres for cancer treatment and often chose surgery over radiation so that they could return home earlier

### TABLE 9.1 National Health Priority Areas: Health status for all Australians compared with rural and remote Australians

<table>
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<td>- The prevalence of asthma is highest in inner regional areas. The urban and rural incidences of asthma are about the same (AIHW, 2015d)</td>
</tr>
<tr>
<td>- The prevalence of asthma in the Indigenous population is almost double (18%) compared with the non-Indigenous population (AIHW, 2015d)</td>
<td>- Asthma mortality rates are higher for people living in more remote areas and those of lower socioeconomic status (AIHW, 2015d)</td>
</tr>
<tr>
<td>- The risk of dying from asthma increases with age. Up to 60% of asthma deaths may be avoidable (AIHW, 2015a)</td>
<td>- Asthma is higher in the Indigenous population and their death rates from asthma are more than double those of non-Indigenous people (AIHW, 2015a)</td>
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<td></td>
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### CHAPTER 9 RURAL PEOPLE’S HEALTH

**Table 9.1 National Health Priority Areas: health status for all Australians compared with rural and remote Australians—cont’d**

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<tr>
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<tbody>
<tr>
<td><strong>Cardiovascular health</strong></td>
<td><strong>Cardiovascular disease causes more deaths annually than any other disease, accounting for 33% of all deaths in 2009 (AIHW, 2015a). Males have higher death rates from cardiovascular disease than women and this reduces with improved socioeconomic status</strong></td>
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<tr>
<td></td>
<td><strong>Rural people experience higher levels of cardiovascular disease and it is higher again for remote males. Death rates from cardiovascular disease in remote and very remote areas were 1.4 times as high as in cities (AIHW, 2015a, 2015c)</strong></td>
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<td></td>
<td><strong>Indigenous death rates from coronary heart disease are 1.8 times higher than in the non-Indigenous population</strong></td>
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<td></td>
<td><strong>Rural and remote people are more likely to be smokers, drink to dangerous levels, be obese and have much higher blood pressure than city people (AIHW, 2015a)</strong></td>
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<td></td>
<td><strong>Much of the burden caused by cardiovascular disease is preventable. The main risk factors are obesity, poor diet, smoking, excessive alcohol consumption, hypertension and high blood cholesterol</strong></td>
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<td><strong>Dementia</strong></td>
<td><strong>Dementia was added as a National Health Priority in 2012 due to the increased incidence in the population. In 2011 1 in 10 Australians aged over 65 years had dementia and 3 in 10 over age 85 years. It is estimated that the number of affected people will double by 2050 (AIHW, 2015a)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No specific data on rural or remote distribution could be found</strong></td>
</tr>
<tr>
<td><strong>Diabetes mellitus</strong></td>
<td><strong>Diabetes has doubled in the past 2 decades. In 2012 about 1 million Australians had diabetes, of whom 84% had type 2 diabetes. Northern Territorians experience twice the rate of diabetes (excluding remote) (AIHW, 2015b)</strong></td>
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<td></td>
<td><strong>Rural and remote people experience almost 2–3 times the incidence of diabetes and twice the hospitalisation and death rates. Indigenous Australians suffer 3 times the incidence of diabetes and were 7 times more likely to die from diabetes (AIHW, 2015a)</strong></td>
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<tr>
<td></td>
<td><strong>Diabetes is more prevalent in overseas born people and is increasing in younger people. Over three-quarters of people with diabetes were aged over 45 years with a higher incidence in men than women (Australian Bureau of Statistics [ABS], 2011b)</strong></td>
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<td></td>
<td><strong>The incidence of Indigenous people with diabetes in very remote areas is twice the incidence of those living in cities (AIHW, 2014a)</strong></td>
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*Continued*
Diabetes is the second most common cause of kidney failure, eye damage, ulceration and gangrene; its complications contribute significantly to ill health, cardiovascular disease, disability and premature death in Australia (AIHW, 2015b).

Indigenous Australians have one of the highest prevalences of diabetes in the world, which is up to 30% of the population in some remote communities (Diabetes Australia, 2013).

Injury prevention and control

Injury is the fifth leading cause of death in Australia and is more common in men. The main causes of injury in Australia are falls, half of which occur in the 65+ age group, followed by transport accidents and self-harm (AIHW, 2015a).

Indigenous people are twice as likely to be admitted to hospital for injury and have twice the rate of self-harm as other Australians (AIHW, 2013).

Men die from suicide at 4–5 times the rate of women (ABS, 2012).

The rates of hospitalised injury and transport injury are double in remote and very remote areas (AIHW, 2013).

Rates of assault and intentional self-harm increased with remoteness and were highest in very remote areas (AIHW, 2013). Men in remote areas are 3 times more likely to suicide than urban men, most commonly by hanging. Rural men also have better access to guns and are less likely to seek support for depression and financial issues. Two-thirds were older farm owners or managers (Alston, 2012).

Mental health

45% of Australians aged between 16 and 85 years have experienced a mental disorder at some time in their life (AIHW, 2014e). One in 5 Australians experienced a mental disorder in the previous year. These are mostly anxiety disorders (14.4%), mood disorders (6.2%) or substance abuse disorders (5.1%) (AIHW, 2014e).

Females are more likely to suffer from mental disorders, particularly anxiety, and men are twice as likely to experience substance abuse disorders (Slade et al., 2009).

Mental ill health is the fourth most common reason for seeing a GP, and depressive illness is the fifth most common.

Indigenous Australians have one of the highest prevalences of diabetes in the world, which is up to 30% of the population in some remote communities (Diabetes Australia, 2013).

The stress associated with drought, unemployment and poverty contribute towards the health and wellbeing of rural and remote people. Rural and remote people were slightly more likely to have a mental disorder at some point in their life than urban people (ABS, 2013).

However, they were 34% less likely to report very high levels of psychological distress (ABS, 2013).

Suicide rates are almost double in rural areas and up to 6 times higher in very remote areas (National Rural Health Alliance [NRHA], 2009).

Younger rural Australians are almost twice as likely to suicide as their urban counterparts (NRHA, 2009).
TABLE 9.1 National Health Priority Areas: health status for all Australians compared with rural and remote Australians—cont’d

<table>
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<tr>
<th>ALL AUSTRALIANS</th>
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<tr>
<td>• Same sex attracted Australians are 4 times more likely to experience major depressive illness and twice as likely to experience very high levels of psychological distress (Rosenstreich, 2013)</td>
<td>• Rural and remote same sex attracted Australians are estimated to have suicide rates of up to 14 times those of other Australians (Rosenstreich, 2013). They also have less access to the internet to access health information and were more likely to report feeling unsafe, isolated and discriminated against (Hillier et al., 2010)</td>
</tr>
<tr>
<td>• The death rate due to mental disorder has increased significantly over the past decade. Expenditure on mental health services has increased by 5.7% over the 5 years to 2011 (AIHW, 2014e)</td>
<td>• The prevalence of arthritis is highest for those living outside cities, particularly for males, Indigenous Australians and those of lower socioeconomic status</td>
</tr>
<tr>
<td>• Mental disorders accounted for 7% of the disability adjusted life-years lost worldwide in 2013</td>
<td>• Indigenous Australians in rural and remote areas are 1.45 times more likely to have osteoarthritis and 1.92 times more likely to have rheumatoid arthritis (NRHA, 2014)</td>
</tr>
<tr>
<td>• Arthritis and musculoskeletal conditions are the most prevalent diseases and conditions among the National Health Priority Areas, with almost 6.1 million, or 28%, of Australians estimated to have arthritis and musculoskeletal conditions long term (AIHW, 2015a)</td>
<td>• Rural and remote Australians have limited access to preventative, diagnostic and specialised care services (NRHA, 2014)</td>
</tr>
<tr>
<td>• Back problems (14%), osteoarthritis (8%), osteoporosis (3%) and rheumatoid arthritis (2%) are the most prevalent forms in Australia (AIHW, 2015a)</td>
<td>• Between 2003 and 2013 there was a 47% increase in knee replacements and a 17% increase in total hip replacements (AIHW, 2015a)</td>
</tr>
<tr>
<td>• Arthritis and musculoskeletal conditions mostly affect women and are a significant cause of disability</td>
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</table>

*Continued*
### CONCLUSION

Australians generally have exceptional levels of health based on world standards. Rural Australians have unique health concerns that relate to their culture, their living conditions, socioeconomic disadvantage and social isolation. They also relate health to their ability to be productive, and see themselves as dissimilar to their urban counterparts. This concept of difference places them in a different category from other Australians where health is concerned. Compounding this situation is their limited access to health care and transport, shortages of health facilities and professionals, and poorly coordinated government processes.

Rural health is not an issue that can be addressed in one government portfolio. It crosses into many other areas such as employment, education, housing, transport, social security and reconciliation. Yet governments continue to maintain narrowly defined departments, even when the issues require a whole-of-government response (Humphreys, Hegney, Lipscombe, Gregory, & Chater, 2002). While there has been some improvement in the past decade there is a need for a consistent, nationally coordinated approach that considers the uniqueness of our country and the needs and diversity of its populations.

The above snapshot, showing a comparison of health status between urban and rural Australians, demonstrates marked inequalities in almost every National Health Priority Area based on geographical location, age and culture. It shows why different health approaches, based on rural understandings of health, are needed. While this picture provides an image of inequity and social disadvantage, it also raises an important question. Should rural people expect the same level of health as their metropolitan counterparts?

With the increasing trend in the baby-boomer generation to move to smaller regional areas to retire, where does this leave this higher health maintenance

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**TABLE 9.1** National Health Priority Areas: health status for all Australians compared with rural and remote Australians—cont’d

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<tr>
<td><strong>Obesity</strong></td>
<td>Over 30% more people living in rural and remote areas are obese than their city counterparts (AIHW, 2015e)</td>
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<tr>
<td></td>
<td>Indigenous Australians are twice as likely to be obese as non-Indigenous Australians (Obesity Australia, 2013)</td>
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<tr>
<td>Three out of every 5 Australians is overweight or obese – over 12 million people. One in 4 children are overweight (AIHW, 2015e). This is a fourfold increase in the past 30 years</td>
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<tr>
<td>Obesity is a risk factor for diabetes, cardiovascular disease, kidney disease and other chronic diseases (Obesity Australia, 2013)</td>
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</table>
population, who are used to immediate quality health care, when there are fewer services and people to provide them? Can they still expect to live out their long lives, walking on a level playing field, carrying their thongs in their hands?

Discussion Points

1. Discuss the different value systems operating in rural communities that contribute towards rural people viewing their health differently from city people.

2. Using the National Health Priorities as a guide discuss the differences in health status between rural, remote and city-living Australians. Why do these differences exist?

3. Should rural people expect the same level of health as their metropolitan counterparts? If so, why? If not, why not? Discuss.

4. How do you think health services could be changed to better meet the needs of rural and remote people? Discuss.

5. If rural people are living in environments where there are open spaces and where food is grown, why are they not leading the way in giving up smoking, decreasing alcohol consumption, increasing exercise and eating healthily? Discuss.

References


