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EDITORIAL

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What progress can the *Australian Journal of Rural Health* celebrate on its thirtieth anniversary?

Abstract

Thirty years ago the first edition of the *Australian Journal of Rural Health* (AJRH) was published. Following reviews published in 2002 and 2012, it is again time to review what progress has been made in bringing about improved health outcomes for residents of rural and remote Australia over the past decade. Compounded by the Covid-19 crisis that has affected the health and health care system throughout Australia, this review notes the significant lack of progress over the past decade in ameliorating ongoing problems of poor access to primary health care and associated avoidable hospitalisations, persistent poor health of Indigenous Australians, and the greater prevalence of a range of health risk factors. Following the findings of the recent New South Wales enquiry into rural health, this review highlights what is needed to implement the many recommendations that have emerged from the wealth of evidence-based research published in journals such as the AJRH to improve health outcomes and increase the parity and equity in health between metropolitan and non-metropolitan Australians.

1 | INTRODUCTION

Thirty years ago, the *Australian Journal of Rural Health* (AJRH) was conceived as a repository for the most up-to-date research evidence on the state of rural and remote health. Since then, it has become Australia's leading academic journal reporting rural and remote health research, policy formulation, program development, and clinical practice. In 2002 and 2012, the journal reviewed progress in the two decades following the journal's inception.[1,2] Both papers concluded that, despite innumerable government "rural and regional" health initiatives, much remained to be done to improve rural and remote population health outcomes and achieve greater parity with metropolitan counterparts. As the AJRH celebrates its 30th birthday, it is again time to review what more needs to be done to improve the health of remote and rural residents.

2 | REVIEWING THE STATE OF RURAL AND REMOTE HEALTH FROM THE "COVID-19 BUBBLE"

Undoubtedly, the past 10 years have been disappointing with respect to progress towards improving rural and remote health outcomes. Significant differences in the health status of rural and remote Australians and metropolitan counterparts persist.[3] These disparities include higher mortality and poorer health status, especially for Aboriginal and Torres Strait Islander people and remote area residents; lower socio-economic status; greater exposure to and prevalence of a range of health-risk factors; the increased need for patients to travel for medical care; poorer access to primary health care (PHC) services; and more potentially avoidable hospitalisations.

In terms of rural and remote health education, training, research, and policies, the past decade has been characterised by "more of the same"—existing *University Departments of Rural Health* and *Rural Clinical Schools* have been subsumed under the *Commonwealth Rural Health Multidisciplinary Training* program; rural health stakeholders continue to hold regular meetings exhorting governments to do more; academic conferences and publications highlight the latest research findings; Commonwealth, State, and Territory government meetings regularly discuss how best to resolve ongoing problems of workforce supply and distribution; and governments have launched rural health strategies to great fanfare. But what has really changed?

The Covid-19 pandemic has resulted in an unprecedented demand for health care services and highlighted deficiencies within the existing complex and fragmented health care systems in Australia.[4] Considerable unmet

needs were apparent as demand for PHC resulted in burgeoning pressure on hospital emergency departments. Most hospitals were overwhelmed with Covid-related patients, such that waiting times for standard care and surgery waiting lists became unmanageable. Inadequate government funding for health services (in particular the indexation freeze on Medical Benefit Scheme items) soon became manifest, with significant consequences. Health worker burnout, inadequate remuneration (especially for bulk-billing general practitioners), border closures and restrictions on travel, and lack of recognition of the key roles and conditions under which health professionals were operating resulted in increased workforce turnover and difficulties in recruiting new workers. The desperate cycle of workforce shortage and turnover exacerbated the daily pressures characterising already under-resourced health services and ambulatory care as health workers sought to meet local health needs.

Whilst hospital staff have suffered under these systemic strains, the consequences of these stressful times have been particularly apparent in small rural and remote communities. Significant numbers of PHC services and remote clinics were forced to close as they could no longer offer a safe and sustainable service,[4] a scenario that was flagged 20 years ago.[5] Services that depended on locums from interstate or overseas had their supply chain curtailed when borders closed, or saw "fly-in, fly-out" locum fees triple from $1000 per day to unaffordable levels, highlighting both their fragile workforce situation and financial precariousness. The closure of local health services exacerbated the longstanding problems of accessibility and affordability as country residents were forced to travel even longer distances to seek alternative health care. In addition, the increased demand for mental health services could not be met due to inadequate mental health services and overburdened GPs. In summary, the problems characterising many small rural and remote communities today, so poignantly highlighted by the recent New South Wales government enquiry into rural health,[6] are reminiscent of those of nearly 50 years ago.[7]

3 | THE WAY FORWARD—ACTION NOT WORDS

While Australia's health care system remains world-class in aggregate, this status disguises long-standing flaws with respect to policy, service delivery, funding, and monitoring of quality in the health system.[8] Persistent national inequities distinguishing rural, remote, and metropolitan communities reflect ongoing neglect by governments and authorities charged with ensuring an efficient, effective, and sustainable health care system for all Australians, regardless of their place of residence.

Since the AJRH was first published in 1992, considerable research evidence has been amassed, increasing our understanding of how to improve local health care availability and quality. So, given our somewhat pessimistic assessment of progress over the past decade, what more is needed to overcome existing remote and rural health problems? Or is rural and remote health destined to remain one of Rittell and Webber's insoluble "wicked problems"?[9]

We suggest the following foci in combination warrant greater attention.

1. Fundamental to improving rural and remote health care in Australia is the need to adopt and implement a *national strategic approach* to rural and remote health which ensures genuine inter-connectedness between primary, secondary, and tertiary care. Such an approach would simultaneously address the need for *regionalised provision of integrated health services* that maximises access to appropriate and affordable local health care at times of need. The pre-requisites for such a comprehensive rural and remote health strategy were outlined recently in the *Medical Journal of Australia*.[10]
2. Renewed emphasis on implementing *accessible, affordable, acceptable, and sustainable PHC services*. While the PHC strategies developed by the Rudd Government highlighted the value of a strong PHC system,[11] health expenditure since then has largely remained disease-focused and on hospitals, rather than on improved public health literacy, preventive services, and timely access to core PHC services. Greater attention to the socio-economic determinants that underpin poor health outcomes is needed—housing, employment, education, transport, and so on—and increased emphasis on the chronic disease would certainly help to meet the needs of an aging rural and remote population.
3. Implement an *integrated, multidisciplinary rural, and remote workforce training pipeline*. A wealth of evidence now supports the value of rural student selection, rural-based undergraduate and post-graduate training, and immersion in increasing the probability of take-up of practice in non-metropolitan communities.[10] Aside from serious ethical issues associated with importing overseas-trained health workers to remedy the undersupply in rural and remote areas, Australia needs a supply chain that provides an appropriately trained, fit-for-context, and sustainable workforce.
4. Ensuring *equitable resourcing* of the rural and remote health system is vital for reducing geographical health disparities. From 2006 to 2007, the National Rural

Health Alliance (NRHA) demonstrated that non-metropolitan health services suffered a shortfall of $2.1 billion.[12] The most recent figure is $4.0 billion.[13] Recent research has highlighted this shortfall at a jurisdictional level,[14] and shown how greater funding equity can result in increased availability of, and access to, the primary health care services needed to meet local needs in rural and remote areas.[15]

5. Prioritise policies that address the persistent unacceptable state of *Indigenous health*. Recent positive developments, namely the acceptance by the national government of the *Uluru Statement from the Heart* and the proposed *Voice to Parliament*, should result in more appropriate policies across sectors that will improve the socio-economic and health status of First Nations Australians. The Aboriginal Community Controlled Health Services provide exemplars of effective comprehensive PHC service provision in remote areas.
6. Rural and remote health researchers need more *effective knowledge translation*. No longer is it sufficient to publish in eminent academic journals. Researchers need to become more proficient in embracing all forms of knowledge exchange, including social media which are arguably more effective in disseminating knowledge, influencing human behaviour, and guiding important decision-making. Researchers must work within the important political arenas where key resource allocation decisions are made to ensure equitable funding, hold governments and authorities to account in terms of timely program implementation, and evaluate their effectiveness in delivering appropriate, accessible, affordable, and sustainable health services. In short, they need to assume greater prominence in the policy arena.
7. *National leadership* is essential in providing the vision, impetus, and commitment necessary to ensure programs bring about lasting improvements in rural and remote health care. Over the past 30 years, the greatest improvements have occurred when strong leadership has been provided by Health Ministers. Independent academic researchers must also lead in their advocacy of rigorous evidence-based recommendations and show how they should be implemented—including who should take carriage and responsibility for the activities, resources required and likely costings, priorities, community involvement, and timeframe.[16]
8. *Routine rigorous program evaluation* in terms of service effectiveness in delivering appropriate, accessible, and affordable health care to all Australians is long overdue. Many rural and remote health programs have been consigned to the scrapheap without any substantive evaluation of what difference they made. Rigorous empirical evidence of changes, based on good baseline data which control for confounding influences, should be mandatory for every program, together with a sound economic evaluation of the resulting costs and benefits.[17]
9. *Physical and digital infrastructure* in rural and especially remote areas needs to be fit-for-purpose and ensure that staff can be adequately housed locally, digitally connected globally, and able to derive real-time data on service quality and effectiveness.

4 | CONCLUSION

Considerable progress is still required to achieve the prospective "bright stars" outlined by Lipscombe & Gregory in this journal in 2000.[18] Evidence-based research has been ignored, and prevailing neo-liberal government priorities that regarded health expenditure as a burden on the budget rather than an investment in productivity and quality of life, have had a negative impact on rural and remote services. This year, community dissatisfaction with a decade of inaction resulted in a change of national government. Newly-elected leaders have a once-in-a-generation policy window to implement both the macro health system changes and specific remote and rural health policies required to put Australia on the path to becoming the best health system in the world. The evidence about what is required already exists.[10] With researchers and consumers working more closely with key decision-makers in governments and health authorities to implement and evaluate what we know works, hopefully, the AJRH will be able to report a glowing testimony of a robust and effective local PHC system, interconnected with high-quality regional secondary and tertiary health services in 10 years' time.

KEYWORDS
health services, primary health care, remote, research, rural

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