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Commentary

Rural Proofing Policies for Health: Barriers to Policy Transfer for Australia

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Abstract: A 'rural proofing' framework, which offers assessment of the potential impacts of policies on rural and remote communities, has been advocated for by state governments and interest groups throughout Australia. It is argued that rural proofing can be used to redress health inequities between urban and rural and remote communities. While implementation of rural proofing in some countries shows promising results, there are many social and spatial contexts that should be considered prior to its adoption in Australia. Rural proofing is not the best option for rural health policy in Australia. It has been imported from communities where the urban/rural divide is minimal. It is based on a rigid urban/rural binary model that targets disparity rather than accommodating the diversity of rural communities. Rural proofing concentrates on tick-the-box activities, where rural communities are not sufficiently consulted. There is no unified federal ministry in Australia with responsibility for rural and remote affairs. Considering potential shortcomings of rural proofing for health policies, it is imperative for Australia to have a specific rural health policy at both federal and state levels.

Keywords: rural proofing; health service; healthcare; health policy

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1. Introduction

Rural proofing for health policies is defined as a systematic approach to safeguard that the needs of rural communities are meaningfully embedded into government health policies (Swindlehurst et al. 2005; Shortall and Alston 2016). It assesses potential impacts of health policies on rural communities and adjusts the policies to ensure their relevance to rural contexts (Swindlehurst et al. 2005; Walker 2019). Rural proofing emerged due to recurring challenges faced by rural communities in addressing ongoing health inequities and service sustainability. Contemporary approaches to redress these issues have been dominated by the urban models which often fail to accommodate diversity in rural and remote communities (Swindlehurst et al. 2005; Sherry and Shortall 2019).

The concept of rural proofing is not new. The term 'rural proofing' was first coined in the UK in the mid-1990s to ensure that government policies would consider the specific needs of rural communities (Atterton 2008). In 1998, Canada's Rural Secretariat introduced the 'rural lens' to help governments in designing their policies (Hall and Gibson 2016). It was then adopted by various OECD countries which include New Zealand, Sweden, Norway, Finland, and Northern Ireland (OECD 2005, 2011). Rural proofing for health policies has also been introduced and implemented in South Africa (RHAP 2015). The WONCA Working Group on Rural Practice has acknowledged the importance of rural proofing for health (WONCA Working Party on Rural Practice—Health for All Rural People Planning Committee 2003).

There are growing calls from some state ministries (Regional Development Victoria 2012) and Australian advocacy groups to start implementing rural proofing in Australia.

For example, from the National Rural Women's Coalition (National Rural Women's Coalition 2016), Rural Doctors Association of Australia (Rural Doctors Association of Australia 2018), and National Rural Health Alliance (National Rural Health Alliance 2015). These growing pushes to adopt rural proofing are motivated by genuine intention to improve access equity and health outcomes for rural and remote communities across Australia. Implementation of rural proofing for health in England and South Africa shows promising results (Swindlehurst et al. 2005; RHAP 2015). However, there are many social, political, ideological, economic, and spatial contexts that should be considered prior to the adoption of rural proofing for health in Australia. In this commentary, we describe four key considerations prior to adopting rural proofing for health policies in Australia. We argue the need for a coherent rural health policy at both federal and state levels to meaningfully promote health equity for rural and remote communities.

2. Why Might Rural Proofing for Health Policies Fail in Australia?

The implementation of rural proofing for health could contribute to redress inequity between urban and rural communities. However, we argue that the implementation of rural proofing is not the best policy option for Australia because of four fundamental reasons.

First, rural and remote communities in Australia are heterogeneous with great diversity in cultures, wealth, geographical challenges and isolation, and lifestyles. Different types of rural and remote communities may have socioeconomic characteristics and health needs that are unique. Such characteristics should be considered in planning for appropriate health services. The premise of rural proofing in England and the Northern Ireland for instance, rests on the similarities of urban and rural areas rather than the differences (Shortall and Alston 2016; OECD 2005). This is clearly not the case for Australia, with diverse spatial contexts ranging from major cities, inner regional, outer regional, remote areas to very remote areas. For example, in the Australian context, the term 'rural' might be closely linked to 'regional areas' but it does not adequately represent remote and very remote areas. We argue that recognition of geographic disparity is necessary but not sufficient to adequately create relevant policy tools for meaningful local outcomes, especially for remote and very remote communities in Australia. By concentrating on the geographical disparity alone, rural proofing will likely discount the processes of social changes and social determinants of health taking place in remote and very remote areas. There are various social, economic, cultural, environmental, and political forces operating in remote and very remote areas which contribute to the accessibility of health services, health outcomes, and wellbeing of the population.

Second, rural proofing for health policies assimilates rural and remote communities into a single undifferentiated aggregate with urban communities as the comparison. It assumes that rural and remote areas require additional considerations to achieve health aspirations of urban areas—to 'catch up' but not 'aspire beyond'. For example, the Rural Mainstreaming Policy in England, the Urban Rural Need Act in the Northern Ireland, the Rural Health Advocacy Project in South Africa, and the Rural Lens in Canada are designed to safeguard the needs of rural communities so that they are not disadvantaged relatively to urban people (Shortall and Alston 2016; Atterton 2008; Hall and Gibson 2016; RHAP 2015). In so doing, it imposes a disparity-based policy logic and promotes a rigid urban/rural binary and the categorical disadvantage model into policy formulation (Saraceno 2013). It leads to simplification of rural and remote health issues and its diversities. Consequently, we argue that rural proofing for health policies will only address abstract needs and neglect the actual needs of rural and remote communities (Sherry and Shortall 2019). By systematically ignoring the complexities and diversities across remote and very remote communities, rural proofing for health policies will marginalise further the health needs of these communities.

Third, we contend that the rural proofing framework is a processes-oriented policy and concentrates on tick-the-box activities with poorly articulated policy goals and objectives. It focuses on auditing the proposed health policies using an impact assessment tool

performed by government officials. In so doing, rural communities are not sufficiently consulted. Additionally, the use of generic impact assessment tools is also problematic because different contexts do respond to health policies differently. Specific needs of different population groups who reside in remote and very remote areas, especially Indigenous Australians and migrants, cannot be accommodated by a single impact assessment tool.

Finally, although there are existing local champions at the state level (Walker 2019), in many countries that implement rural proofing, there is a federal body or agency that functions as the rural proofing champion. For example, the Rural Secretariat (Canada), or the Department of Environment, Food and Rural Affairs (England and Northern Ireland) (Shortall and Alston 2016; Atterton 2008; Hall and Gibson 2016). This is not the case in Australia where there is no federal ministry with responsibility for rural and remote affairs. However, there is a strong network of national bodies that can function as the federal champion for example the National Rural Health Alliance (NRHA) which is well connected with local and national policy makers and universities (e.g., rural health forum/symposium). Similarly, the key roles of the Minister for Regional Health in Australia can also be expanded as a government agency that functions as the rural proofing champion.

3. Alternative Approach

Considering potential shortcomings of rural proofing for health policies, it is imperative for Australia to have a specific rural health policy at both federal and state levels. Rural health policies at both federal and state levels would be a more appropriate policy option for Australia to accommodate rural diversities. This would facilitate the formulation of rural health policies that are sensitive to the different needs of rural and remote communities by addressing health service delivery issues and social determinants of health simultaneously. A comprehensive rural health policy must go beyond the current rural health workforce strategy to include: (a) ensuring high quality, comprehensive, and accessible primary health care for local communities; (b) ensuring sustainability of these services locally; (c) ensuring a spatial dimension to health budget and infrastructure both at local and federal levels to ensure redistribution across rural communities; and (d) ensuring the social and economic needs of rural communities are met through meaningful consultation (Wakerman and Humphreys 2019). Furthermore, these health system responses must be placed within the broader contexts of many social and economic determinants affecting health outcomes of rural and remote communities.

A rural health policy at both federal and state levels provides the basis for the coordination of coherent actions across different levels of government. It will encourage active participation of rural and remote communities to ensure responsiveness to changing community needs over time and space. It has the potential to link vital social and economic factors in rural and remote communities with the provision of effective and sustainable health services to redress health inequities and to promote sustainable livelihood for rural and remote communities across Australia.

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