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Alliances and evidence: Building the capacity and effectiveness of rural health advocacy in Australia

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Abstract

This article describes two strategies that have strengthened the capacity and effectiveness of rural health advocacy in Australia over the past nearly three decades. The first is the development of the National Rural Health Alliance, an organisation that grew from strategic efforts to develop relationships between rural and remote health practitioners and organisations. The second is the development, organisation and use of data and evidence to highlight rural health needs. There has been important synergy between these two streams of activity, with research and evidence providing the tools and the National Rural Health Alliance providing the strategy and techniques to influence the rural and remote health care agenda.

KEY WORDS: *advocacy, leadership, policy, rural health research.*

Background

People who live in rural and remote areas have limited local opportunities for education and employment, compared with those who live in Australia's major cities.[1] The health disadvantages of these limitations are compounded by lifestyle[2] and environmental risk factors,[3] combined with reduced access to health services and infrastructure.[1] Aggregate health status and life expectancy in rural and remote areas are also affected by the higher proportion of Aboriginal and Torres Strait Islander residents,[4] whose continuing poorer health[5] constitutes, in the authors' opinion, an ongoing national shame and challenge. Despite all of this, living in Australia's rural communities has many advantages, with rural people often declaring a higher level of life satisfaction than city people.[6]

The disparate and unique characteristics of ill health and wellness in rural Australia, as well as the design of services that are appropriate for dealing with them, are not always well understood by those responsible for decisions about the provision of health care, many of whom have not directly experienced life in rural areas. Practitioners and patients who do have such experience therefore have much to offer and, through their advocacy, can help ensure that better decisions about services are made.

The article focuses on the development of the rural health sector over the past three decades. It describes two strategies that, combined, have been very effective in strengthening the capacity and effectiveness of rural health advocacy in Australia. One has been strategic activity to build collegial relationships between people and organisations that 'know' rural and remote health care into a powerful and effective body imbued with the wisdom of experience: the National Rural Health Alliance (NRHA).

The second has been the rural and remote health sector's development, organisation and use of data and evidence to analyse health status, its causes and consequences, and to develop practical proposals for how the situation can be improved. There has been important synergy between these two streams of activity, with research and evidence providing the tools and the NRHA providing the strategy and techniques for engaging in political activity.

The article begins with a very brief historical account of the establishment of the NRHA. It then moves to a commentary on how data and targeted research have influenced governments and strengthened the authority of the NRHA in improving systems and services. It concludes with a brief analysis of why this has been successful.

Establishment of the National Rural Health Alliance

In 1991, the federal government and a small number of clinical leaders in rural and remote health, particularly

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rural doctors, shared an appetite for identifying particular needs and opportunities in the rural health sector. A small group of clinicians, health service managers, public servants and rural health consumers came together to organise the first National Rural Health Conference, devoted to consideration of the perceived 'separateness' of rural health concerns. The success of this event led to a second conference in 1993.

In policy terms, the most significant outcome of the first and second National Rural Health Conferences was a National Rural Health Strategy. It was conceived and supported by both the governments at that time and the growing group of practitioners who were active in their particular disciplines and who were also devoted to the collegial political activity which, it became clear, was necessary to effect change.

In organisational terms, the most significant outcome of these two conferences was the creation of the NRHA. It was conceived to manage the conference and as the means for prosecuting the ideas in the National Rural Health Strategy. However, once established, it also picked up a range of other work in the area. In cultural or political terms, in our judgement, the most significant outcome of those early meetings was the appreciation of the fact that rural and remote health and health services were different from metropolitan ones and that there were legitimate reasons for fashioning a sector around this distinction. Evidence for this was the eagerness demonstrated by those present to meet again and regularly into the future.

The NRHA began with 13 national bodies (it now has 34) and, from its very beginning, was a mixture of consumers, clinicians, managers and researchers. Importantly, its clinicians were from a variety of professions, with all of them given equal rights and responsibilities within the organisation. This has remained a key determinant of the organisation, its operational style and the scope of work with which it has been involved.

Once the NRHA had demonstrated success in representing the interests of the newly conceived sector without favouring any one discipline over another, its growth was assured. No professional interest group with a legitimate interest in rural and remote health outcomes was excluded from its work, with all of them sharing in decisions about what the organisation worked on and the positions taken on the selected issues.

As the organisation became larger, it was forced to develop a range of appropriate operational protocols and practices. The organisational challenges stemming from increased numbers of member bodies were more than offset by the greater strength and authority of its voice. The authenticity of this voice is underpinned by the fact that its views are selected and shaped by the combined opinions of all of its member organisations. The key to this is the NRHA's Council, which meets regularly and on which each of its members has one representative. Each member of Council had (and still has) the demanding task of representing their member organisation's views within what becomes the agreed position of the NRHA on a particular matter.

From time to time, it might be impossible for an agreed position to emerge and, in those cases, individual member organisations are free to take their own stance and advocate independently. But, when an agreed position does emerge, the NRHA's position is strong and is of interest and value to policy-makers, politicians, researchers and the media.

The inclusive and egalitarian culture within the organisation has also been reflected in its relationships with governments and others it needs to influence in order to be effective. The NRHA learned to respect politicians and policy-makers, their contributions and achievements, as well as limitations. It learned to work with them effectively by focusing its demands on solutions, rather than problems.

Contribution of evidence, data and research

Rhetoric alone was insufficient to achieve improvement, so data from the sector's research and development activities became critical to the NRHA and its political effectiveness. Central agencies, such as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW), had always assisted, but with the emergence of the NRHA, their perception of the demand for, and value of, a rural focus was sharpened.

The synergy between the NRHA's political activity and the sector's research work was expedited because many researchers were also members of the NRHA through their role in organisations, including University Departments of Rural Health (UDRH). These were 11 separately funded outreach entities of urban or regional universities that began in 1996. Funded by the Commonwealth, they formed academic units in rural areas that delivered multidisciplinary education for health professionals living and working locally. Their initial goal was to support rural and remote placements as an incentive to students to take up rural practice after graduation. Initially, they had limited support from the parent institutions, with no resources allocated to research and informational activity.

Over time, there was an increase in the quantity and calibre of rural and remote health research and researchers coming from these departments.[7] This led to competitive grants being awarded to fund high-quality rural health research undertaken in rural areas.

Universities and others began to recognise the importance and uniqueness of this contribution.

This rural and remote health research effort has grown more rapidly over the last decade, with the majority of it being related to rural and remote communities. Staff of these UDRH are now frequently trained in research, many locally, and their directors are not only educational leaders but also researchers frequently leading studies of national and international importance. For example, researchers were able to show a significant increase in peer-reviewed published papers from UDRH directly addressing applied rural remote research and related topics, with 220 published in 2013 alone.[7]

A number of targeted research activities have helped to inform policy-makers, who have quite often been involved with this research from the outset, helping to ensure its relevance to real challenges faced by health service leaders. Many of the most influential of these researchers focus their work on systems, rather than diseases.[8–11] This research has helped inform, justify and support the shared agenda of the NRHA.

By improving the rural health system and quality of care delivered, disease treatments or even preventative measures can be more effective. High-quality, politically relevant research produces evidence that is valuable in several contexts. It enhances advocacy at a national level and can be used 'politically'. It also strengthens the reputation and funding of the agencies that undertake it. It also helps to build collaborative teams, both within Australia and internationally, and to generate shared agendas among rural health leaders. Opportunities to train in research have improved, with increasing numbers of doctoral graduates from rural areas now trained and employed rurally.[8,11] Finally, and often most gratifyingly, is the fact that local research builds the capacity for local service improvement directly[7] through its contributions to training, clinical service provision and leadership. Local evidence leads to better local decision-making, as evidenced in the Northern Territory, for example, with caseload care introduced and maintained for Aboriginal women transferred to town for birth based on National and Medical Research Council-funded studies.[9] Another example is improved quality of services in rural and particularly in remote Australia, based on continuous improvement research; for example, studies led by Professor Ross Baillie, now heading the University Centre of Rural Health in Lismore, NSW.[12]

The *Australian Journal of Rural Health* has been an important adjunct to the growing effectiveness and maturity of Australia's rural health research activity. It is a peer-reviewed journal that commenced in 1992, providing a high-quality, prestigious option for the publication of scholarly articles of relevance to rural and remote health. Responsibility for its management was passed to the NRHA in 1999. The success of these rural health research efforts has been assisted by an increasingly collegial relationship between national agencies (AIHW, ABS) and the researchers themselves. The NRHA has been a major contributor to this closer working relationship. Existing data have been well used and new data sets and explanations are developed usually with insights provided by cross-disciplinary teams.

Discussion

The success of the twin strategies, a strong national organisation and generation and use of data, that have strengthened the capacity and effectiveness of rural health advocacy in Australia, can be attributed in part to the characteristics of the organisations and individuals involved. These characteristics have included collegiality, openness, persistence and hard work. The strong synergy between the two streams, and indeed between almost all of the agencies involved with them, has been founded on what the authors of this article describe as 'perceptions of sameness and difference'.

The rural and remote health sector has emerged and prospered because of an appreciation among its consumers and practitioners that, despite their heterogeneity, all rural and remote areas have something in common that makes them different from the major cities. This view has been strengthened by pride in 'being rural' and a determination to overcome challenges like distance and other natural phenomena. We also see a human resilience that appears to us to be based on our extensive experience of the sector, born of the lack of access to many 'props' available in big cities. The NRHA's activities have shown, time and again, that rural people are quick to recognise and warm to others who face the same challenges as themselves. While city people are not 'the enemy', they are seen as 'different'.

These human traits have resulted in rural and remote organisations of great robustness and shared goodwill. Where research is concerned, these traits have resulted in a determination to succeed, and be seen to succeed, as distinctly rural enterprises. The very best research and development for rural challenges is undertaken with rural people, by rural people, in rural areas and this is now possible in ways not previously conceivable.

Shared goodwill has been instrumental in fashioning a consensus on complex issues that has been taken to meetings with politicians and policy-makers. It has enabled the rural health sector to overcome many of the differences between the various disciplines and helped the sector's leaders to generate authority within the sector and nationally. For example, when over 30 organisations talk with the Minister of Health with one voice about rural and remote issues, they appear to be taken very seriously and have no problems obtaining an audience.

The sector's research interests have come together partly because of the value of collaboration but also due to the self-interest of researchers who need research teams with credibility and 'spread' in order to win grants to undertake work on highly valued national priorities. High-quality evidence has been produced and has been promoted through the advocacy system described here, changing rural and remote health systems and outcomes for the better. Local entities and people have sometimes been brought together through research to achieve regional vested interests and better outcomes. This has taken precedence for many researchers over conventional disease-focused health research agendas. A tailor-made journal has helped to disseminate findings and communicate data that have been transformed into evidence and explanation.

Despite the successful development and growth of both arms of the sector, rural health status is lower and services in rural and remote Australia remain inferior to those in major cities. Now, though, there is much to build on and a great deal has been learned. Succession planning is almost inadvertent, rather than structured: Council members watch and learn from others, sometimes for a number of years, before taking on executive roles within the Board, being voted into the positions of authority or as spokespeople. The sector will need to remain strong, with good leaders who are skilful enough to influence political and policy agendas through the application of evidence that makes it difficult for governments to not act.

Disclosure statement

Lesley Barclay is an Emeritus Professor in the Sydney Medical School, University of Sydney. She was the Director of the University Centre for Rural Health North Coast 2009–2015 and led the research in the Northern Territory attached to Charles Darwin University and the Menzies School of Rural Health Research in 2004–2009. Gordon Gregory was the first Executive Director and then the CEO of the National Rural Health Alliance from 1993 until 2016.

Author contributions

GG led the description of the development of the National Rural Health Alliance while LB led the description of the role of evidence. Both authors contributed to the analysis.

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