Opening the Gates on Farmer Health

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Thanks to the National Rural Health Alliance and the Australian Institute of Health and Welfare

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Rural Life: Mortality and Morbidity

Before we 'open the gates', let's have a look 'in the paddock'!

Almost 1/3 of Australians live in regional, rural and remote communities (National Rural Health Alliance, 2009).

Health inequalities are well-documented, if not well advertised. Health service inequalities are also evident, exacerbating the problem rather than ameliorating it (AIHW, 2010, 2008).

Life expectancy is approximately 4 years lower (the more remote, the shorter the life expectancy). The death rate is 8% higher.

Aboriginality, motor vehicle accidents, and suicides are major contributors to the difference in life expectancy.

Rural and remote communities are ageing faster than the general population (due to higher death rate and out-migration of youth).

Self reported health and subjective wellbeing are lower among people from rural and remote communities.

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Physical Health Inequalities

Australians living in rural and remote communities experience higher rates of disease than 'metro-livers' with respect to several of the main WHO 'burden of disease' conditions.

In particular, higher rates of coronary heart disease (CHD) and other circulatory diseases, cancer, and diabetes have been found. Lower survival rates are associated with each of these conditions as well.

Higher rates of perinatal death are associated with rural and remote living.

Higher rates of injury and disability are also associated with rural and remote living.

Higher rates of 'risk behaviour' have also been found with 24% more smoking and 32% more over-use of alcohol in rural and remote communities.

More sedentary lifestyle/behaviour has been associated with rural and remote living as well. (Caveat: These studies generally do not include work activity in their analyses. More work is needed.)

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Mental Health Inequalities

In general, the prevalence of mental ill-health is estimated to be similar in metropolitan, regional, rural and remote communities. However, some particular differences have been found.

Depression is higher among middle-aged males (45-64 years) living in rural and remote communities.

More males (20% more) from non-metro communities have reported very high levels of 'psychological distress'.

Anxiety is lower among middle-aged females (45-64 years) living in rural and remote communities.

People living in rural and remote communities are 10% more likely to have a lifelong mental illness and 30% more likely to have a lifetime substance abuse disorder.

Higher rates of suicide are reported within rural and remote communities as well.

Note an association between mental ill-health and physical ill-health.

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Health Service Inequalities

The health workforce is not well distributed throughout Australia.

Rural and remote communities have below average concentration of every health profession (25% below national average per 100,000 population). GP shortages are well documented. Psychiatrists, psychologists, dentists, pharmacists, and allied health professionals are also in severely short supply. This is a longstanding condition.

There are proportionately fewer community health services, hospitals, and mental health services as well with greater distance and poorer public transport.

Reduced access to Medicare-funded services has also been cited with attendant distance issues complicating sparsity.

The example of mental health care: Less than 60% of those in need Australia-wide actually receive care. GPs provide 75% of care. Fewer GPs in rural communities. Use of psychologists by 'rural livers' is half that of 'metro-livers' (8% vs 15%).

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A Way Forward for 'Farmer' Health

Improving Health Literacy – ensuring that health information is not trapped in GP and Health Services offices, free testing and info in public places, public seminars and workshops, etc.

Promoting Lifestyle Change – changes in food availability, promotion of active recreation activities, development of amenities, etc.

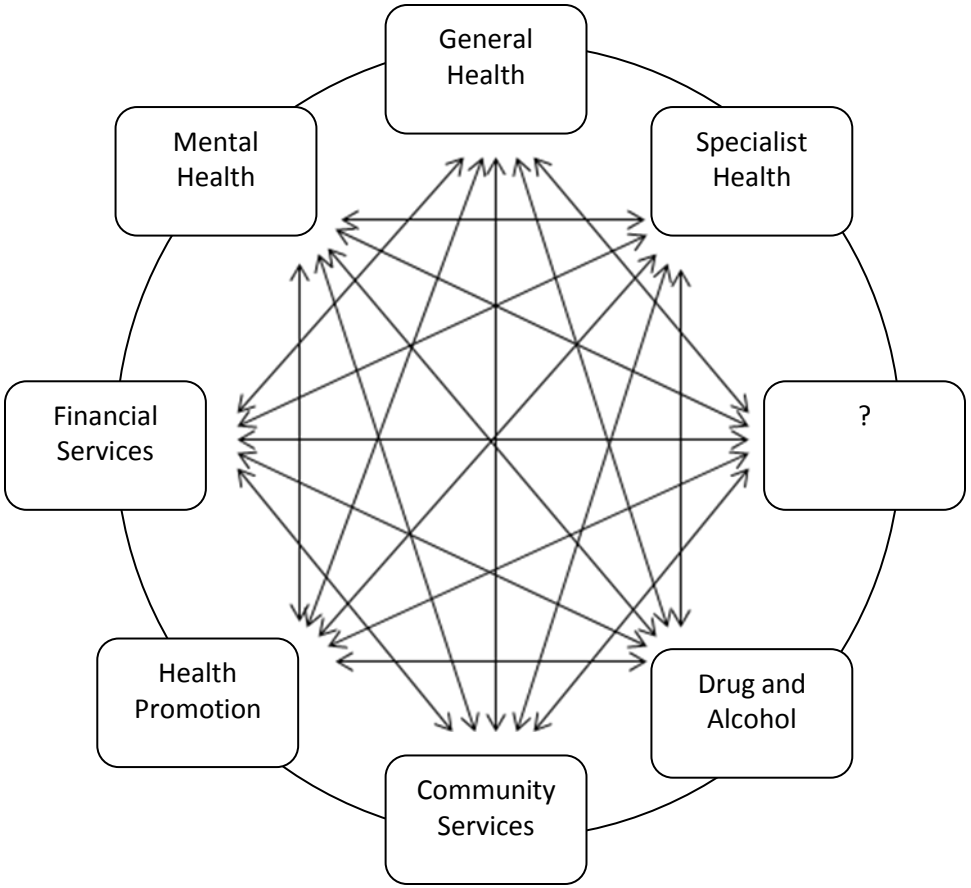
Directly addressing Health Service Inequalities – improved analysis and awareness of local conditions, lobbying government with facts ($9.9 billion announced for regional/rural Australia); make it health.

Addressing specific 'rural health issues' such as farm and motor vehicle accidents, depression/suicide, and 'other' (local-specific).

Adopting a 'whole of community' approach to health promotion.

A systemic perspective is needed. This involves adopting an 'ecological' approach – health is a complex set of interacting variables. This includes the person, social relations, material conditions, health and community services, and community as one.

Opening the Gates on Farmer Health: Local Area Health Hubs



Deakin – Community Partnerships for Health

Centre for Rural Emergency Medicine – Established as a joint initiative of state government, Portland District Health, South West Healthcare, Alcoa, and the School of Medicine at Deakin to specifically address the emergency medical management in SW Victoria.

RuraLife – A centre for alcohol and other substance abuse and gambling research in rural communities.

Deakin Health Online – Commencing in 2012, this e-learning service will link health services, practitioners, and educational institutions for clinical training of health professionals.

FeeL Deakin – Commencing in 2011, this multi-mode of course delivery will allow highly interactive university study from community located delivery sites.

Deakin Institute for Health Research (DIfHR) – Commencing in 2011, DIfHR brings together five of the university's Strategic Research Centres and includes a full range of health discipline research.

Deakin Health Precinct – Plans are underway to develop a health precinct on Waurn Ponds Campus including a Regional Community Health Hub (REACH) and Epworth Healthcare's plan to build an acute care and rehabilitation hospital. Dept of Health is considering its new Barwon Health community hospital on campus.