Over the past year, I have travelled to about 40 communities in all States and Territories, from large regional cities like Cairns and Bunbury, to small towns like Bourke and Peterborough, to remote communities like Papunya and Yuendumu. My travels have been part of the Human Rights Commission’s Bush Talks program. We set out at the beginning of 1998 to learn about the human rights concerns of people outside the capital cities. They told us loud and clear: health care, education, jobs, access to services, a future to hope in and live for. In this article, I will elaborate on the first of these concerns: health as a human right for people in rural towns and remote areas.

HUMAN RIGHTS

Human rights belong to every person by virtue of birth. They are not only for majority groups or for minority groups but for everyone equally and without discrimination.

Human rights are also not granted to us by others or by the government. They are ours to be enjoyed simply by reason of our common humanity and innate dignity as human beings. For that reason, we cannot agree to give them up and they cannot be taken away from us.

Most people are aware of their civil and political rights: for example, the right to freedom of expression and the right to vote. These are, of course, fundamental human rights. But matters relating to people’s social, economic and material wellbeing are equally matters of human rights. These include the right to adequate food and nutrition, health and medical services, in addition to the right to work, to social security and education. They impose an obligation on government to give assistance and support to families in need.

These rights are often overlooked by governments because they raise issues of public welfare and public spending. In a climate of fiscal restraint, governments are reluctant to face issues that require more spending. In a climate of economic rationalism, governments reject many spending options that, in purely economic terms, are not cost-effective. However, Australian Governments have made solemn promises to the Australian people that oblige them to uphold these rights and ensure that the basic needs of every person are satisfied.

One of the most important human rights treaties is the International Covenant on Economic, Social and Cultural Rights. Australia is a party to this treaty.

It is perhaps not as well known as the International Covenant on Civil and Political Rights, but it is no less important. These two sets of rights are not mutually exclusive. For example, a society that promotes and respects individual rights is more likely to be well placed to enjoy economic growth and good standards of living. At the same time, where there is economic inequality and poverty, where health is neglected and education denied, civil and political rights often suffer.

Many will argue that these rights (social, economic and cultural) are difficult to measure or attain. Unlike the right to vote, it can appear impossible for governments to guarantee the right to work. Consistently high unemployment, especially in rural Australia, has taught us that there is no quick solution to extending these rights to everyone.

However, the International Covenant on Economic, Social and Cultural Rights is a means of getting governments to measure their achievements or failures and to commit to progressively attaining realisable goals. Unlike the Covenant on Civil and Political Rights, it commits each State party to achieving the rights progressively, but this does not mean that they are not achievable. Impor-
tantly, governments must guarantee that these rights are protected and enjoyed without discrimination of any kind.

**BUSH TALKS**

Having travelled to many parts of rural and remote Australia, I have no doubt that we are failing to protect and promote economic, social and cultural rights in the bush as we should. In many respects, the bush comes off second best to the city.

People in the bush should not be excluded from the enjoyment of human rights simply because they make up less of the population or live outside metropolitan centres. As one person in the country said to me ‘we pay the same taxes; so we should get the same services’.

The infrastructure and community of many rural, regional and remote towns have been slowly pared away. It was described to me by a woman in Port Augusta as the ‘dying town syndrome’, a downward spiral of de-servicing, de-resourcing and de-populating. People are moving out of towns where they can no longer make a living or find a job.

The smaller the population, or the more geographically isolated, the more difficult it is to get access to a necessary range of services, whether government or non-government services. These are not luxury services that people are asking for. Remote and isolated communities are still waiting for the basic means of survival and well-being.

As one submission to *Bush Talks* put it:

Governments must acknowledge the fact that people live in rural communities and need to be recognised as being a part of society rather than part of an economy.¹

To a certain extent, those who live in a rural area, and especially a remote area, expect to have reduced access to a full range of services. I did not find that people’s wishes were extreme or unreasonable.

It is false to argue that people should up and leave a farm or a town where they were born, or in the case of Indigenous people, where their traditional land and people are, just to get the basic essentials for life. Regardless of where one lives, all Australians should have access to basic health facilities, good education, decent housing and access to a reliable supply of safe water.

**HEALTH PROBLEMS IN THE BUSH**

Certainly, the poor state of rural health has been the focus of media attention for several years. Despite research, conferences, meetings and national strategies, in a number of areas the health of rural and remote Australians continues to fall well below that of people in the cities.

Death rates from all causes are higher in rural and remote areas than in capital cities. Rural Indigenous people die on average 15–20 years earlier than their fellow Australians. In coronary heart disease, asthma and diabetes, rural Australians are more likely to suffer than city dwellers. Deaths of males from road accidents are 100% higher in remote areas than in capital cities.² Suicide, especially of young males, seems endemic in many communities.

Not surprisingly, while the level of health need increases, the level of health care drops dramatically as we move from capital city to regional city to a rural or remote area. Yet instead of increasing services, it seems that many are being pared away.

In Geraldton, Western Australia, *Bush Talks* was told that the hospital had recently closed 29 beds, reducing the total to 60 beds. The average number of patients is 60 but the peak to date has been 73.

In one town in south-western New South Wales, a woman collapsed in a supermarket. When the ambulance was called the paramedic decided she had to be taken to hospital and so asked bystanders whether someone could drive the ambulance while he travelled in the back to look after the patient.

The shortage of general practitioners in the bush is well known. Last year, there was an estimated shortage of 445 doctors in the country compared with an oversupply of 2400 doctors in all metropolitan regions, except Darwin.³ In many towns we visited, we heard of long waits for appointments with general practitioners (GP), towns without a GP for lengthy periods and towns in which not one GP would bulk bill, in some instances not even for Health Care Card holders.

One man from Mudgee told us how all the medical centres in town had refused to bulk bill and how his wife had been turned away for a regular prescription of heart medicine because she could not pay for the consultation, even though she offered to pay on next pension day. Moreover, the pattern is inconsistent. Travelling across north-west New South Wales in March this year, I found that all doctors in Bourke, Brewarrina and Walgett bulk bill but not a single doctor among the 12 in nearby Moree, by far the largest town in the region. Perhaps it is time that the Australian Competition and Consumer Commission had a look at whether there are any collusive or restrictive trade practices at work here.

Almost everywhere we went, lack of services for mental health was raised as a really pressing issue: counselling, psychiatric, hostel, inpatient, especially services
Many choose to die rather than leaving family, community and land. When they do go, they see it as a life sentence, for they can never come back except to die. Support in the towns for those on dialysis is almost non-existent. Many live in the river beds or, if they are given accommodation, their families who accompany or visit them are not.

Indigenous people also raised with us the common ignorance about Indigenous cultures among health professionals, which results in culturally inappropriate and often inadequate treatment. In Cairns, Queensland, *Bush Talks* was told that it was often difficult for Indigenous patients from outlying areas to understand the medical terminology and language of doctors at the Cairns hospital. The information could be about critical issues such as medications and treatment.

Services for the elderly and frail are also particularly in demand in rural and remote areas. Small towns have lost, or are losing, their young people, which leaves towns to age dramatically. The health needs of older people mean that it is increasingly difficult for them to maintain an independent lifestyle. In Burnie, Tasmania, *Bush Talks* was told that there is a 6-month wait for nursing home care.

Problems of distance obviously greatly affect the health and wellbeing of the communities. For people on low incomes, those who do not have family and friends to support them, people with disabilities, young people, parents with young children, travelling long distances to see a medical practitioner, go to hospital or visit the dentist can be near impossible. Although there is a federally funded and State-administered travel and accommodation assistance scheme, this was criticised as inadequate by some of the rural people we spoke to. Because of restrictions on eligibility, *Bush Talks* was told in Bathurst of cancer sufferers ‘taking the risk’ rather than finding the money to go for treatment. In Geraldton, we heard of a spinal injury patient having to pay her own airfare because she was only in a full body cast and not a wheel chair.

The problems were very different according to which region we visited; some towns have plenty of access to GPs but no services for the mentally ill. Others have a doctor but no hospital. There are also differences in the state of rural health depending on whether you live in a remote area or in a rural town, what the economic situation is like in that area, or whether or not you are Indigenous. The ‘bush’ is by no means homogeneous. However, overall, the range of problems and shortages in rural health is somewhat overwhelming.
GOOD NEWS

I want to make the point that Bush Talks did not hear all bad news. In our Bush Talks consultations, we came across plenty of good stories: stories of communities banding together and thinking creatively of solutions, instances of individuals with a remarkable sense of responsibility and drive who were looking around for solutions, and some government programs which are beginning to make a difference for the community.

I was continually impressed by how people working together could make a difference, especially when they have a little outside support and some more flexible, less bureaucratic government responses.

For example, in Yeoval, New South Wales, the Yeoval District Hospital was about to be closed due to funding shortages. The community got together to try to work out ways of saving it and formed a cooperative. The State Government agreed to make the funds available and the Cooperative Development League in New South Wales guaranteed bank loans to get the project going, funded a feasibility study and prepared a business plan. Almost $100,000 was raised through local charities and the Cooperative’s 250 shareholders. The Cooperative also lobbied the Federal Government, which agreed to provide more than $300,000 under its Aged and Community Care Program, provided that accommodation and care for older people were part of the hospital priorities. The Cooperative now provides a range of health and aged care services at one site, a doctor’s surgery, hospital, physiotherapy, ambulance, X-ray unit, nursing home, hostel and self-care units, as well as community services such as Meals on Wheels and a volunteer driver service.

Another approach to two familiar problems was taken by the Remote and Rural Training Unit in Dubbo. The problems were the departure of young people from country towns and the inability of these towns to attract and retain health-care workers. The unit decided to conduct a week long health-care career options program for 20 Year 10 students from high schools in surrounding towns. It is hoped that this will encourage local young people to train in health-care work and to remain in their own communities.

These initiatives are perhaps well known to some. But I suspect that many of the communities we visited are not aware of some of the successful community initiatives in health which are being implemented in other rural communities. The Commission has planned a project to share this information with rural communities.

The project will identify some of the successful community initiatives and the factors contributing to their success. It will also publicise these initiatives to the wider community so that others can be inspired to address their own concerns. We aim to place the delivery of health services within a human rights framework.

CONCLUSION

Openness to creative ideas and determination to survive may be the best resources a local community has.

Professor John Humphreys at the 1998 Worner Research Lecture in Bendigo, Victoria, spoke some inspiring words on rural and remote area health.

Whereas history looks backward to reflect on what has happened and why, vision is forward looking about what is possible and how. How optimistic we are may well depend on the perspective from which we perceive the world and what we believe is possible even in the face of seemingly insurmountable odds. Often it is easy to succumb to resignation and pessimism. However, I recommend that we model our future approach on examples of pioneers who battled in the face of daunting impediments and whose achievements and legacies grew from small initiatives.¹⁷

Health is a human right. We can create a society where all Australians, regardless of where they live, have adequate access to appropriate and responsive health-care services and thereby lead longer and more active and happy lives. All it takes is commitment on the part of government, business and the community. That is the challenge.

REFERENCES