

■ Programs would be monitored for the development of drug resistance (a problem already present in veterinary practice where related drugs are used⁸).

Two critical factors for the success of such a program are political will, and a will on the part of the communities themselves, together with local healthcare providers, and government and Indigenous health organisations. While the cost of the drugs is not the major barrier to the implementation of such programs, the positive publicity gained by two pharmaceutical companies from their leadership in donating ivermectin and albendazole to the WHO-sponsored filariasis program could have some local lessons. Leadership in Australian parasite elimination programs should come from both the Indigenous and medical communities through an alliance of Indigenous people and public health, infectious diseases and paediatric practitioners.

James S McCarthy

Associate Professor of Tropical Medicine and Infectious Diseases
School of Population Health, University of Queensland, Herston, QLD

Stuart C Garrow

Director, and Public Health Physician, Kimberley Public Health Unit, Derby, WA
(currently, General Practitioner
North Peterborough Primary Care Trust, St John's, Peterborough, UK)
j.mccarthy@sph.uq.edu.au

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Rural health: why it matters

Australia needs a distinctive "rural health" approach that recognises the valuable role played by the "outback" in our economy and our national psyche

THE YEAR 2002, THE "YEAR OF THE OUTBACK", is an opportune time to reflect on why rural health matters and why it continues to be important for Australia. It is the culmination of a decade of initiatives and activity by governments, health organisations and communities seeking to address the "problem of rural health".

Rural health emerged in the 1990s as an identifiable field of activity focusing on improving the health status and meeting the specific health needs of people living "out back" of metropolitan areas. The key rural health issues are medical workforce supply, including appropriate training and education; transport and access to appropriate services; funding and costs to patients; and the health status of Aboriginal and Torres Strait Islander peoples in particular, which remains a national shame.¹

Under strong pressure from the rural electorate and from advocacy bodies such as the National Rural Health Alliance, there has been a positive government response to rural health issues in recent years. This has included a policy framework that coordinates different levels of government;² support for advocacy groups and rural professional associations; a significant investment in rural and remote academic infrastructure through the university departments of rural health and rural clinical schools;³ and increased funding for regional and Aboriginal health services. As it is too early to fully evaluate the outcomes of Commonwealth investment in rural health, a sustained effort is required.

Rural health issues warrant specific and ongoing attention for a number of reasons. Firstly, outback Australia is different from metropolitan Australia. While the defining

characteristic of rural health remains its geography (and related issues of access to healthcare services), rural and remote Australia is also sociologically, culturally, economically and spiritually different from metropolitan areas, as well as internally diverse. It is these characteristics that define the health behaviour of its residents, determine their health status and influence the way health and medical care is provided.⁴ Nowhere is this more evident than in dealing with the healthcare needs of Aboriginal and Torres Strait Islander peoples in rural and remote regions.

Secondly, rural health matters because of health differentials between the city and the outback. Nationally, there is a trend towards a higher mortality rate with increasing remoteness, mostly attributable to the higher proportion of Aboriginal and Torres Strait Islander peoples in remote and very remote regions.⁵ Given the right of all Australians to optimal health and equitable access to health services, the significantly poorer health status of people in outback Australia remains a fundamental concern.

Thirdly, improving rural health is integral to rural and regional development in Australia. Currently, outback Australia fares worst in statistical comparisons of the underlying social determinants of health — namely, housing, employment, income level, education, transport, and social security.⁶ Good health does not result from access to health services alone. Without a comprehensive regional develop-



ment policy that focuses on a healthy rural economy, many outback communities face a bleak future — a future characterised by continued poor health status of rural dwellers. Complementary local initiatives based on community empowerment will also be required to address specific problems.

Lastly, rural health matters because of the valuable lessons to be learned from the many innovative solutions that have arisen in response to the problems of rural health in Australia. The tyranny of distance, the deficit of resources and the passion of a number of dedicated practitioners to cater for the diverse geographical circumstances of non-metropolitan Australia have resulted in many innovative health sector responses, including the Royal Flying Doctor Service, multipurpose and regional health service models, and telemedicine. Nurse practitioners (a concept currently being trialled in several States) have been working effectively in Australia's remote communities for decades. Australia is a world leader in rural health education, particularly medical education.^{7,8} Implementation of a true primary health care approach has long characterised the way healthcare is practised and delivered in many small outback communities, particularly by Aboriginal community controlled health services.⁹ In summary, innovation born of both local need and community action is a hallmark of much rural and remote healthcare practice.

Strong rural and regional representation in setting national policy is imperative. Moreover, improved coordination between government departments and between different levels of government on issues affecting rural areas is required. Metropolitan-based clinicians, educators, policy-makers and those responsible for implementing health programs should at the very least have an awareness of the geographical, economic and cultural diversity of their constituents and patients. We in the medical profession can

collectively continue to press for appropriate health infrastructure, improved access to education and economic opportunities for rural and remote communities.

The issue of how the "outback" is defined (whether in terms of "rural" or "remote" areas) is likely to be an ongoing debate, if for no other reason than its significance in terms of resource allocation and monitoring of health outcomes. What should not be in dispute, however, is the need for a distinctive "rural health" approach and national recognition of the valuable role in the Australian economy and psyche played by a healthy "outback" in all its diversity.

John Wakerman

Director, Centre for Remote Health (a joint centre of Flinders University and Northern Territory University), Alice Springs, NT

John S Humphreys

Professor of Rural Health Research, Monash University School of Rural Health
Monash University, Bendigo, VIC

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Child sexual abuse revisited

Notification of abuse should trigger initiatives to prevent further abuse and ameliorate adverse consequences

THERE HAS BEEN CONCERN recently in Australia about the sexual abuse of children by those in authority. Clearly, we expect such people to behave better. However, child sexual abuse is much more likely to involve the ordinary people comprising a child's family and their friends.

In 1990 the World Health Organization Global Burden of Disease project¹ identified 10 risk factors that, if averted, would reduce the burden of disease by a third (eg, malnutrition, poor sanitation, unsafe sex). For the next revision of the risk estimates, the WHO Collaborating Centre at St Vincent's Hospital, Sydney, was asked to prepare a report on the prevalence and impact of child sexual abuse on health status around the world.² Here, we comment on the situation in Australia.

Child sexual abuse can be subdivided into three levels of severity. Non-contact abuse includes sexual solicitation or exposure by an older person; contact abuse involves genital touching or fondling; and penetrative abuse includes oral, anal or vaginal intercourse by an older person.

Prospective studies of the prevalence of child sexual abuse are ethically and legally difficult. Thus, all data are from retrospective reports of men and women asked about their experience of unwanted sexual activity before the age of 18 years. However, establishing the validity of retrospective

