

National Human Rights Consultation Submission

AGWW-7PB63U

Organisation: Charles Sturt University

Submission Text:

The following letter sets out an approach to conceptualising and providing human rights based rural health care. Please accept this document as a submission to the National Human Rights Consultation.

On December 18, 2007, health researchers from Charles Sturt University (CSU) in NSW met to develop a blueprint for rural health. The blueprint is being developed to provide a positive direction to address what are very clearly poorer health outcomes currently being experienced by rural Australians. It also will provide a framework to guide the provision of services into rural areas. To date, rural health services have been based upon a negative or deficit model of health. They have also mostly been provided on the basis of services that a community has historically had, or for which they have successfully lobbied, not against any standard of what services are to be delivered or what they are intended to achieve. This has produced marked differences in the services provided between apparently similar communities.

To address this, we propose a set of principles, developed from a human rights standpoint, to address the underlying issues associated with rural health and with the provision of healthcare. If good health is enshrined as a human right, communities will be able to ask whether they have what they need to ensure good health. If these principles are acted on by governments and communities then rural health will necessarily improve.

We would argue that rural Australians have a right to expect health chances and health experiences similar to those of their urban counterparts.

Australia is a signatory to the UN Declaration of Human Rights which includes the right to:

A standard of living adequate for health and well-being of self and of family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.¹

It has also signed the International Covenant on Economic, Social and Cultural Rights. This covenant includes the statement:
The States Parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health²

The World Health Organisation defines health as:
A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity³

In line with the International Federation of Social Workers Policy on Health⁴, we also note that two key dimensions of health, chances and experience, both shape rural health consequences –
Health chances – a person's chances of being ill or staying well, of living a long life or having their life cut short, are a product of economic, social, political and environmental factors.
Health experience – a person's experience of living with and combating illness, is a product of the resources they can access for preventing, treating or alleviating illness and promoting health.

Key Principles underlying the Blueprint

These principles frame government, non-government, community and individual responsibilities for addressing rural health. Acting on all of these will immediately improve health chances and experience.

1. promote socio-economic well-being through the provision of education, employment and cultural activities and opportunities allowing people to achieve their potential;
2. provide regular and accessible services for screening, monitoring and development at appropriate life stages;
3. provide physical access to culturally appropriate, effective services (including outreach) without compromising the financial, emotional and interpersonal well-being of rural people;
4. ensure service providers in regional and rural settings are adequately staffed with a suitable range of services, equipment and communications technologies (including adequate working conditions, leisure, professional development and resourcing of staff) and develop more flexible rural practice models;
5. ensure services are community managed and resourced to assess local needs.

The Blueprint team continue to work on case studies that demonstrate the health chances and experiences that would be available to all rural and remote Australians if the principles are upheld. We are developing a checklist tool that will help communities identify what resources and services they require and promote cross sector collaboration to access them. A recent letter to the Editor of Rural and Remote Health noted the paucity of solutions to health disadvantage⁵. Our approach promotes solutions rather than the continuing commentary of deficits.

We call on others to work with us in defining the practical elements of the Blueprint principles.

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