Primary Health Care

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The state opts out, the people opt in

Following the withdrawal of government funding from a small rural hospital in New South Wales, Australia, the people have formed a community cooperative through which they are organizing their own primary health care.

As in other developed countries the health care budget in Australia has been continuously rising, yet only marginal reductions in morbidity and mortality are being secured. Consequently, spending is now subject to severe controls. In New South Wales, many rural communities that have been targeted for cuts are isolated and have a vital need for local access to health care. Yeoval, for example, is 69 kilometres from a base hospital. The rail link to Yeoval has been closed and there is no bus service between towns in the area.

Rural communities argue that their very existence is threatened by remoteness, poor roads and the risks associated with primary production. They draw attention to the unequal distribution of doctors between urban and rural areas: in Sydney, for example, there is one doctor for every 200 people, whereas some rural centres covering up to 6000 people are unable to attract even one doctor.

Mounting evidence suggests that much of the health care in New South Wales is delivered to the wrong places. A study on premature mortality indicated a wide disparity between rural areas and the large city areas of Sydney, Newcastle and Wollongong. The rural area of Cobar had a comparatively high prevalence of cancer, producing the highest premature mortality among men. Mortality caused by leukaemia was highest in the rural areas of Boorowa, Murrumbidgee, Bingara and Cootamundra. The highest premature mortality for women as a result of heart attack was in the rural areas of Bourke, Brewarrina, Junee, Bingara and Crookwell. Death from asthma was highest in the rural area west of the Great Dividing Range between Narrabri and Balranald (1).
Clearly, the rural communities in New South Wales are disadvantaged in terms of access to health education and health facilities. If more attention were given to disease prevention and the promotion of health and wellness in the rural areas, premature mortality could be dramatically reduced. Research is needed on causal relationships and risk factors. The vast area of New South Wales, the distances between towns, and the distribution of the population make the allocation of public funding for health care facilities in rural communities particularly difficult. Governments have to work within strict budgets, which are often influenced by a powerful medical lobby having little sympathy with the demands of people in remote rural areas.

Community response to hospital closure

In October 1988, Yeoval’s eight-bed hospital, serving some 2000 people, was closed when state funds were withdrawn. Long-term and elderly patients were transferred to centres many kilometres away from their relatives and friends, and much unhappiness was thus brought about.

In January 1989 a public meeting was called and the local Member of Parliament was invited. After lengthy debate and consultation the people decided to establish a community cooperative. A constitution was drawn up and a new primary health care service was inaugurated, based on a multipurpose health centre.

The transition from reliance on the Department of Health to a high degree of self-reliance in health matters was not easy. Many people were ambivalent in their attitude towards the new development. On the one hand they felt empowered and liberated from a situation demanding little in terms of decision-making and responsibility; on the other they were anxious and confused on suddenly assuming power, control and accountability in health care.

Many residents, including the former hospital’s nurses, joined the board of the cooperative, while others became members of fund-raising and steering committees. They had to learn about meeting procedures and government legislation pertaining to the policies and responsibilities of cooperatives and private registered charities. In order to conform to the fire regulations, the community had to find 8000 Australian dollars (US$ 6060) for a sprinkler system in the health facility. The total amount of money spent on bringing the hospital up to the legal standards for private health facilities was 100 000 Australian dollars (US$ 75 757).

Financial support has come mostly from the hard work of the local people. Finances were boosted by the purchase of cattle, which were fattened by farmers in the area and sold at a substantial profit. Other money has come in the form of Commonwealth grants, and there has been some assistance from the state government. Money management has been very sound, the 1991 end-of-year financial statement indicating a small profit.
A successful initiative

The health services provided by the Yeoval community are already substantial. A meals-on-wheels service supplies elderly and other dependent people with a three-course meal every day for a charge of 2 Australian dollars (US$ 1.50). Each meal is prepared in the hospital kitchen, which obtains vegetables from its own garden.

Central to the project is the principle that all activities are driven by the people at a level they require and can afford, under conditions of equitable access.

Nursing care is available at all times of the day and night. If the nurses are particularly concerned about certain patients, these can be referred to the local doctor, who receives supplementary payment from the cooperative. Twenty-four registered nurses live in the area, some working full-time, others part-time. They are actively involved in many health projects, for instance in health education for schoolchildren.

The cooperative employs a part-time diversional therapist who runs a day centre, mainly for people who need rehabilitation and activities. Also employed on a part-time basis are a physiotherapist, an audiometrist, a general practitioner, an optometrist and a nutritionist. These visiting professionals are paid according to the numbers of consultations given.

A hostel, connected to the former hospital by a covered walkway, has five rooms for the elderly, two for disadvantaged individuals, and one respite room. The hostel is well furnished and its amenities include bathrooms, a kitchen, and television.

Within the area of the former hospital there are an acute care section and a nursing home section, each with seven beds. This complex also contains a doctor’s surgery and X-ray facilities. Five self-contained units are available for frail or physically disadvantaged people who can, nevertheless, look after themselves. An ambulance is being acquired which will facilitate access to larger centres for tertiary professional care.

The project demonstrates what is possible in the field of primary health care when a community has an opportunity for creative thought and action and takes responsibility for its own well-being. Furthermore, it has helped to reduce government expenditure. Central to the project is the principle that all activities are driven by the people at a level they require and can afford, under conditions of equitable access.

Reference


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