Is remote health different to rural health?

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Introduction: In Australia the ‘rural health’ rubric has been used to include a range of geographical and social settings, and services. From the mid-1990s, there has been a growing recognition of ‘remote health’, as distinct from ‘rural health’. Currently, there is a renewed policy interest in remote Australia: for example, the 2007 Northern Territory Emergency Response, which has now been redefined as the ‘Stronger Futures’ policy; and a recent publication, Fixing the Hole in Australia’s Heartland: How Government needs to work in remote Australia (2012), which describes the failure of governance in remote Australia and provides recommendations for a way forward based on a deeper understanding of local context. But what do we know about remote health?

There is very little published about the distinct features of remote health (Wakerman 2004) or remote medicine (Smith et al 2009). From the literature, Wakerman (2004) describes a context of relatively higher mortality and morbidity; higher proportion of the population that is Indigenous; and a more dispersed population. Service delivery is characterised by a relative undersupply of health workforce; poorer access to services; a very strong multidisciplinary team approach with overlapping roles; and a greater reliance on visiting service models. Distinct features of remote health practice include generally non-procedural medical practice and a high degree of GP substitution, especially utilising remote area nurses and Aboriginal health workers.

Smith et al (2009) utilise expert consensus to describe remote medical practice as characterised by a cross-cultural context; isolation; the use of telehealth; the need for increased clinical acumen; extended practice; a strong multidisciplinary approach; public health and security considerations; and predominantly non-private employment.

Empirical evidence that describes the nature and distinct features of remote health is lacking.

Methods: We interviewed and surveyed 45 Australian experts in rural and remote health. Experts were identified by the research team based on experience, tenure, reputation and at least five years’ work in rural and/or remote health. Selection was purposive to ensure coverage of four key areas: academic, policy, practitioner and advocate, as well as ensure geographical coverage. Within each category were professionals with experience in remote areas and in Aboriginal health.

Findings: Both quantitative and qualitative data were analysed to distinguish the characteristics of context and practice between rural health and remote health. Perceived differences with respect to isolation, the type of population, cultural differences, access to health care, the relative roles of GPs, nurses and Aboriginal health workers, socioeconomic disadvantage, and political power were all statistically significant. Some respondents
suggested that ‘remote is ... not well understood unless you’ve actually been there, worked there and are passionate about Indigenous health, especially in Australia.’

This paper describes in detail these and other differences, as perceived by the rural and remote health experts who participated, and draws out implications for policy and practice.