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PUBLIC SEMINAR: HEALTH AND WELLBEING IN REMOTE AUSTRALIA

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***PROFESSOR JOHN WAKERMAN, CHAIR
NATIONAL RURAL HEALTH ALLIANCE:***

Facilitator: Sue McAlpin

SUE McALPIN: I'd now like to introduce the newly elected Chair of the National Rural Health Alliance, Professor John Wakerman.

John is a public health physician, general practitioner and a researcher. He is the inaugural director of the Centre for Remote Health and he's done consultancies overseas in relation to public health and health service management. He lectures in - he teaches management, he's - and a general practitioner and an experienced practitioner of remote health. So we await with interest John's presentation this morning on defining remote health.

JOHN WAKERMAN: Thanks, Sue Thanks everybody. I'll just get this technology working. Okay. Well, thank you. Thank you, Senator Joyce, for setting that very broad scene in terms of workforce issues throughout rural and remote Australia and some of the terrific check lists of what to do if you want to be successful on the political side of things. It's a pretty hard act follow, but I'll do my best. What I'm going to do is focus this right down now on remote health and talk a little bit about what we might mean when we talk about remote health.

What I do in this paper is to summarise a literature review that we did pertaining to definitions of rural health and remote health, and there is a goodly amount of literature around



rural health, particularly around rural medicine in Australia and internationally, but there isn't a clear elucidation or understanding of what we mean by remote health. And often we use the two together, rural and remote health. And there isn't a satisfactory distinction between the two and for those 3 per cent of us that live in remote areas, we think it's different and we're trying to set out to explain how it's different.

What I can say is that currently there's no satisfactory definition of - well, either of remoteness or remote health or remote health practice. But what I offer at the end of this paper is a working definition that I think is useful to us in remote areas, maybe useful to our rural colleagues and to policy-makers. So it really addresses the issue of the identity of remote health practitioners. It's about who we are and what we do. Why bother defining remote health? Well, I think there are a few reasons why. As Sue said, I am a researcher and researchers are interested in definitions for purpose of sampling. Those of us that are demographers, ethnographers, or geographers, a concept or definition of remoteness is certainly important.

We know that defining remoteness is critical for policy planning and resource allocation, and so these definitions are very important implications for policy-makers for developing appropriate models of service delivery and appropriately resourcing those services. And lastly, it does describe the discipline for practitioners, academics and other interest groups.

So on Alliance we have the Council of Remote Area Nurses of Australia. Well, what do we mean by that? I work at a place called the Centre for Remote Health and it was named before I started working there but I'm not sure the people that named it had a clear definition of what they meant by remote health. So we've had a look at the literature and I want to just briefly present the results of that to you.

First of all, it's worth noting that definitions are time and place sensitive. So this first quote on this slide is from an American demographer and he makes the point that times change, perceptions of the nature of things change and so that the frontier, which is what people in the United States call their remote areas, hasn't defined the United States for some time, although it remains a strong part of that life and culture of that country. We just have to look at the current American President to see that idea about the frontier and about cowboys, and so forth, are still very much alive. What seemed distant once may not seem distant any more, so telecommunications, and I say this with some reservation, telecommunications have



improved, certainly just in my time living in remote Central Australia, telecommunications have improved - not enough, but nevertheless, what seemed a long way away once doesn't seem so far away now.

But also when you start looking at the geographical classifications and conceptualisations of rurality, those quantitative measures, they've changed over time as well. So there's been a change from an urban rural dichotomy where rurality is defined as not urban through to a continuum where people think about urban through to rural and more remote, to something now a little bit more complex which recognises that heterogeneity of non-metropolitan areas and the distinct features in different settings and these are reflected by various sociodemographic and health indicator. And they're not necessarily continuous. It's a bit more complex than that.

And lastly, these definitions are place-sensitive as well. So I was really interested to see that there was a masters in remote health care run by the Robert Gordon University in the United Kingdom. We run a masters of remote health practice, but this one was the MSC in Remote Health Care (Polar-Option) for doctors in the British Antarctic survey. So it's a little bit different to the sort of masters that we offer. The Centre for Offshore Health in Aberdeen regards remote health as a sub-specialty of occupational health particularly concerned with the oil and gas industry in the North Sea. So as you go from country to country, these ideas about remote health might vary a little bit.

And when you look at the literature, there are different definitional approaches. So there are the geographical classificatory systems and I'll mention these very briefly. One can add to those various sociodemographic indicators and I'll mention those briefly as well. And then there are what I call practice or service focus descriptions and that's what I wanted to talk about mainly today.

So there have been various geographical classification systems in Australia, the United States, Canada and in the United Kingdom. In Australia, as elsewhere, any of these are imperfect. They become increasingly sophisticated but none of them - all of them are open to criticism.

RRMA, which many of you will be familiar with - the Rural Remote and Metropolitan Areas classification system has been around for decade. It's just recently been reviewed. We're just waiting for the results of that review. By and large, they're based on population size and the distance of a community from a major population centre or some sort of service centre.



That's what is at their core.

There's an excellent Australian Institute of Health and Welfare publication, a monograph that Andrew Phillips has authored, that has a great description of some of these main classificatory systems in Australia.

I show this slide just to say that there's a plethora of these classification systems. America seems to have quite a few of them. The interesting thing is that - and this is just an aside - that these sorts of systems are used to informed policy and resource allocation, but there's really very scant research that examines the policy implications of these definitions of rurality. So there's been a little bit of work done that disaggregates these larger groupings and shows that sometimes we miss some of the fine detail in specific populations that is really important in terms of policy and resources. And I was really happy to see that in the presentation that Andrew Phillips gave the other day to the Alliance, and he might talk about that a bit more today, he's starting to do some of that work in terms of breaking down some of these categories into finer cuts to see what's actually going on inside these broader geographical areas.

Some classificatory systems draw on a range of quantitative and qualitative sociodemographic indicators that characterise these different populations in different geographical areas. I'm not going to spend a lot of time of this because this is the sort of stuff that Andrew's going to talk about after me, but just to give you a couple of examples that relate to us and relate to remote areas. So in the USA a frontier area is characterised by six or less people per square mile. And certainly in Australia there's a population density gradient wherein large rural centres there's about 60 people per square kilometre which goes down to about point one of a person per square kilometre in very remote areas. And this population dispersion is a very salient factor for health care planning and delivery.

We know that the proportion of the Aboriginal and Torres Strait Islander population varies greatly from metropolitan areas where it's about one per cent through to remote areas where about a quarter of the population is indigenous. Socioeconomic status varies as well, while there isn't a completely consistent gradient. I think it's safe to say that the indices of socioeconomic wellbeing also show a pattern of increasing disadvantage with increase in remoteness. And so it's not a surprise then that health status is consistent with that and that there are changes in morbidity and mortality data as you go in to more remote areas. I don't



want to oversimplify what is a more complex picture, I'll leave it to Andrew to do that. But these are the sorts of indicators that we can also look at to inform how we think about remote health.

And then there are a whole lot of practice focus descriptions. These are a few Canadian definitions from different Canadian groups. Definitions of remote and isolated and basically they're based around population and distance. There are a variety of indices from Canada and New Zealand based on a number of these sorts of variables and you'll note that these definitions are very medicocentric and there's a good reason for that because a lot of these were made up to work out how to remunerate doctors that were working in more remote areas. And then we can look at other definition. Here is a definition of rural health from the College of General Practitioners, and whilst it's medicocentric, it does recognise the extended role of non-urban practitioners.

I'll give a speed reading aware to whoever can get through this slide by the time I'm finished. This is the definition of rural remote medicine from the Australian College of Rural and Remote Medicine and it's largely, but not entirely medicocentric and I think the important points to me are that it recognised the broad role of the rural and remote practitioner, the lack of other ancillary and referral services, and it mentions team building and highlights the practitioners sociological environment. Here is a definition from someone that some of you might know, a remote area nurse, and it gives a definition for a remote area nurse, from CRANA, and includes the principles of primary health care as well as emphasising teamwork.

When we look through the literature, we really couldn't find a definition that adequately reflected all of characteristics of remote health but a lot of the definitions that we looked at, and a lot of the literature, touched on many of the salient features of remote health practice: isolation, a team approach, the need for extended skills and some of the sociodemographic features of the remote Australian environment. So based on these, we've come up with a definition which we regard as a working definition so that at least we have an understanding of what we mean when we talk about remote health. And this is it. So what we say is remote health is an emerging discipline, it has distinct sociological historical and practice characteristics and in Australia its practice is characterised by a number of factors. Isolation, which isn't only geographical but professional isolation and for some us, but not all of us, social isolation.



There's a very strong multi-disciplinary approach and we think in remote areas much stronger than in rural areas and certainly much stronger than in metropolitan areas. And one of the features of that is that really the blurred boundaries between the professional roles within that team and often changing roles of team members, depending on the situation. So there may be a situation where one discipline takes the lead and another when another health professional takes the lead.

Some of my nursing colleagues don't like the term "GP substitution", but the truth is that in most of Australia the primary care system is based around GPs. In many, many remote areas it's not. In many remote areas there aren't any doctors, as Matilda has said. And it's others, remote area nurses, Aboriginal health workers, for example, that really do a lot of the work that GPs do in other settings.

And the sorts of skills that are required for people working in remote areas include an understanding of population health, because it's very difficult to understand why you've got this revolving door on your clinic unless you have some sort of population health understanding in these areas, as well as emergency skills, because you may be the only one in a remote clinic that has to deal with a motor vehicle accident or severe trauma or whatever. There isn't a trauma centre down the road. And also extended clinical skills, again, because we've got practitioners that are not trained in their undergraduate training to deal with the sort of common clinical conditions that they have to face and deal with in a remote setting.

And in terms of the environment, these skills and the health systems that we design need to be suited to working in a cross-cultural environment, so we know that there is a very high proportion, a relatively high proportion of Aboriginal and Torres Strait Islander people in remote communities, living in remote communities but it's not the only culture out there. We're also talking about mining communities, remote tourist facilities, you know, quite different cultures to those that a lot of practitioners are used to; serving very small dispersed and highly mobile populations and also working in a really tough physical environment. So people in remote areas work in tough places, in the top end, in the wet and they can be completely cut off from air and road transport. In the desert it gets pretty tough. It's hot in summer, it's hot, dusty work. It's a tough environment to work in.

So that's the working definition that we offer for remote health so that when we have a seminar like this on remote health or we call something a remote health service, perhaps we



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can have some slightly more defined way of understanding what we mean by those terms.
Thank you.
