

CONTINUED NEGLECT OF RURAL AND REMOTE NURSING IN AUSTRALIA: THE LINK WITH POOR HEALTH OUTCOMES

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ABSTRACT

Difficulties facing Australian rural and remote nurses first emerged decades ago and recent Australian Federal Government rural health strategies have promised improvements in health outcomes. However closer scrutiny of the funding allocation supporting these claims reveals that although nurses provide the majority of health care, they receive only a small fraction of funding support. Successive rural health strategies have continued to overlook nurses' concerns regarding the nurse - practice environment interface. This persistent lack of political support stifles organisational support for the nursing role, resulting in frustration, resignation and diminished health care delivery. Meanwhile, rural and remote population health outcomes fail to show signs of improvement.

INTRODUCTION

The Australian rural environment is one of low population densities, poorer population health statistics and therefore, more likely to have concomitant increased and more complex health care needs (Australian Institute of Health and Welfare [AIHW] 1998a). This is coupled with substantially fewer medical practitioners (Hays et al 1998). Traditionally nurses have been meeting the health care needs in rural and remote areas in whatever manner they can with whatever resources are available (Hegney et al 1997). The complexity of attending the range of health care needs in extreme environments therefore presents specific challenges to nurses' practice (Willis 1991).

The breadth of literature spanning several decades describing difficult practice environments experienced by rural and remote nurses suggests their problems have largely been ignored (Colditz and Elliott 1978, Ormiston 1983, Klotz 1984, Cramer 1995, New South Wales Department of Health [NSW DoH] 1995, Hanna 2001). Meanwhile, Federal Government rural health strategies have concentrated on doctor ratios and systematically undervalued the role of the nurse and overlooked nurses' concerns (Australian Health Ministers' Conference [AHMC] 1994, AHMC 1996, Wooldridge 1999, Wooldridge 2000). This paper explores the impact of ignoring the significance of the nursing contribution and challenges the wisdom of this medico-centric focus to health service provision.

This paper suggests that there is a link between the lack of positive Federal Government responses to the much-published nurses' workplace difficulties and the persistent poor health outcomes of rural and remote communities. The study was conducted in order to determine whether problems reported elsewhere still persist, and to provide primary source examples of the difficulties confronting nurses. Benchmarking these working environments, as described by participants, against the current focus on *quality health care, accreditation* and *best practice*, serves to highlight the magnitude of the gulf between the

standards of health care available to metropolitan versus rural or remote communities. It also highlights discrepancies between the political rhetoric and reality.

The study described here investigated health service delivery in three diverse settings. Factors that acted as barriers to effective nursing practice were identified. Evidence presented here suggests that previously identified barriers persist across rural and remote Australia. Nurses argue these barriers significantly reduce their capacity to provide adequate levels of health care, and in so doing, create a level of frustration which forces remote area nurses to resign their posts. This further limits efficacy, as service provision is interrupted. As nurses provide most of the primary care in these areas, external impediments to effective practice therefore diminish the ability of rural and remote communities to access appropriate health care. The World Health Organisation (WHO) defined access to health care as:

Accessibility implies the continuing and organised supply of care that is geographically, financially, culturally, and functionally within easy reach of the whole community. The care has to be appropriate and adequate in content and in amount to satisfy the needs of people and it has to be provided by methods acceptable to them (WHO 1978, p.58).

Rural and remote nurses have repeatedly identified shortcomings in the Australian health care system, where barriers to practice reduce the quality of health care to below acceptable standards (Commonwealth Department of Health and Aged Care [DHAC] 2000). By constantly ignoring these messages, past and present Federal Government strategies profoundly diminish accessibility of rural and remote populations to effective health care. This strict adherence to the current medico-centric rural health policies helps to explain the poor outcomes observed in rural and remote health status.

Whereas the distinctions between rural nursing and remote nursing practice are substantial in many facets, it serves no useful purpose to differentiate for the purposes of this paper. What is relevant is here is nurses' invisibility to Federal and State Governments, and administrative bodies. The outcome of this invisibility is inadequate health care provision to populations most dependent upon nursing care.

LITERATURE REVIEW

Rural and remote area nurses report extreme levels of occupational stress stemming from a lack of organisational support (Willis 1991). Journals have published nurses' concerns regarding their practice environment since the 1970's (Colditz and Elliott 1978). Information regarding the constrained working environments confronting nurses has therefore been in the public domain for many years.

The most notable feature amongst these papers is the consistency in theme of constraints to effective practice (NSW DoH 1998).

The significant disadvantages of rural practice have been identified as: (i) restricted opportunities for continuing education; (ii) difficulty obtaining adequate locum assistance for leave; and, (iii) professional isolation (NSW DoH 1998).

Other frequently documented issues include:

- inadequate resources - equipment and facilities;
- staff shortages;
- lack of relief staff;
- absent or inadequate orientation, specifically cultural orientation;
- stress resulting from the broad range and complexity of skills required for the position, often in the absence of medical support, and compounded by limited opportunities for further education and training; and,
- lack of personal security.

(Ormiston 1983, Klotz 1984, Dawson 1992, Cramer 1995, Tattam 1995, DHAC 2000)

More than 20 years have passed since these issues were first published, yet these identical issues continue to permeate the literature, suggestive that little has changed, and despair and frustration are rife (Huntley 1995, Kennerson and Chiarella 1996, Hoadley 1998, NSW DoH 1998, Spencer et al 1998). The logical consequence of this situation is low morale and resignation. Accordingly, nursing staff retention has now evolved as a problem of such proportion that in 1995 the NSW State Government commissioned a task force to investigate the reasons. Also in NSW, a *Rural and Remote Nursing Summit* was convened to explore these issues and develop a series of strategies to address problems (NSW DoH 1998).

The Federal Government funded *National Rural Health Strategy*, developed in 1994 and updated in 1996, was designed to address the problems of poor health in rural populations. These were followed by *Healthy Horizons 1999-2003*, released in 1999. These documents promised to address rural workforce issues. Although the terminology in the strategy outlining targeted workforce groups remained vague, they were initially greeted with optimism from nurses anticipating their needs would be also addressed. However the optimism was misplaced as subsequent rural health budgets continued largely to ignore nurses (Anderson 1997, DHFS 1996, DHAC 1999a, Wooldridge 1999, Wooldridge 2000). This issue is therefore of significant concern to nurses, nursing practice, and more importantly, to the health of the Australian population.

METHODOLOGY

The specific aim of the study was to explore the efficacy of the provider - practice environment interface in rural and remote Australia. A tri-polar case study design methodology was applied to gather detailed situational information from the providers' perspective. In-depth semi-structured interviews were conducted with four senior nurses. Two were practicing as remote sole practitioners, and two practiced in a rural setting. Sampling was purposive. The study was limited to three settings as it was viewed that sufficient data had been generated to determine that, despite decades of nurses' demands for change, significant barriers to effective practice continue to exist. The intent was to explore the issue as a pilot study. In the event of finding persistent and substantial workplace problems, this pilot was to serve as a basis to support a funding proposal for a significantly larger study across all states.

As the study was limited to three settings, maximal diversity was sought. Practice environments were selected to include one Aboriginal remote, one non-Aboriginal remote and a mixed rural community. Rationale for this was to exclude the possibility that workplace issues were simply a function of one particular setting. Locations suiting these criteria were found in three states, Northern Territory, South Australia and Victoria. This strategy sought to also maximize diversity in funding mechanisms and organisational structures. One health agency received funding from the Aboriginal Medical Service, one from a church group and one clinic was dependant upon State Government funding.

All participants accepted the invitation to be interviewed, and were keen to participate in any process which might help policy makers acknowledge and rectify the situation facing them, their peers, and the communities in their care.

Cross-case analysis of the findings using grounded theory was performed to identify common themes and compare practice related features emerging across the three diverse settings. Interviewees were asked to elaborate on specific examples of negative impact on patient care only after they had nominated this as an issue. Limited information of this aspect was available from the published literature. Interviews continued until the interviewees believed they had imparted sufficient information to enable full comprehension of their practice environment.

Case study 1 - Northern Territory

This case study examined the health service in a remote community of 250 people, mostly Aboriginal, comprising three different 'skin' groups, living on the edge of a desert,

500 km by bitumen road from Alice Springs, or 250 km by 4-wheel drive track. The sole registered nurse (RN) was assisted by two Aboriginal health workers who job shared. Royal Flying Doctor Service (RFDS) retrieval could take up to five hours to get there.

Case study 2 - South Australia

The second remote clinic examined was located in a railway siding township on the Nullarbor Plain, with a population of 150 non-indigenous railway maintenance workers and their families. This township was extremely isolated, being only 100km from Maralinga, the British nuclear testing site of the 1950s. Travel time to reach Port Augusta or Kalgoorlie by train exceeded 12 hours, and the nearest highway was two to five hours away, depending on weather and condition of the road. The RFDS could arrive from Alice Springs in three-and-a-half hours, when an aircraft was available. The town and health clinic also serviced the travelling train population, many of whom were elderly with complex medical conditions, unwilling or too unwell to fly across the continent.

The clinic in this setting had six beds and one cot and was staffed by one RN. No access to a general practitioner (GP) was available, however telephone medical advice could be sought via the RFDS. Some restricted specialist services were supplied on a rotational visiting basis. The community was facing imminent closure of the church funded clinic.

Case study 3 - Victoria

The third community setting explored in this study was a northern Victorian town, near the Murray River. The population, currently almost 1000 people, is gradually declining and ageing, but swells significantly with young families during holiday periods. The state funded health care services provided are located in a small rural hospital comprising 10 acute beds and 12 nursing home type beds, serviced by a nursing staff and two GPs.

Compared to the remote area nurse clinics, staff turnover at this agency was very low, reflecting national and international trends in rural settings (Muus et al 1993, Huntley 1995). No pharmacy services existed within the facility or township. No facilities for air evacuations were available. Waiting times for a road ambulance to arrive often exceeded three hours, despite being only 50km from a Level B referral centre. Two senior RNs were interviewed from this setting.

Barriers to effective practice

Cross case analysis of working environment issues revealed consistent themes which kept re-emerging as inter-related issues across these three diverse settings.

MAJOR ISSUES FOR NURSES

- Lack of resources, inadequate equipment and facilities;
- Overwhelming sense of lack of organisational support for the position;
- Limited or absent preparation or cultural orientation;
- Diverse range of skills required - professional and some unrelated;
- Infrequent demand on specific clinical skills - maintenance of skills;
- Limited medical support, nil allied health support;
- Inability to access education and educational resources;
- Pressure to extended practice scope, varied support to do so, legal implications;
- Unmet debriefing needs and confidentiality issues;
- Lack of administrative recognition of importance/respect for role which reduced capacity for nurse(s) to authorize or implement changes;
- Insufficient relief and respite available;
- High profile position within the community - effectively 'on call' every day;
- Personal safety.

OTHER ISSUES

- Professional isolation - reduction of transference of new ideas/practice methods;
- Isolation - delay in response times - supplies, evacuations;
- Feelings of responsibility to community they serve;
- Personal and community-wide sense of abandonment.

Lack of resources

In **case study 1**, no orientation was provided and the nurse could find no resource material covering policies or protocols on arrival to her first remote placement. Also absent were procedure manuals, contact details and information regarding referral mechanisms and the process to organise RFDS evacuations. No reference texts were available, and the level of equipment and supplies was deemed to be inadequate. Supply orders were often delayed, expired or the wrong items were delivered. Cold chain facilities were severely flawed.

Patient care was further compromised by other difficulties described as 'numerous, varied and frustrating', such as the physical inability of the nurse to open the damaged rear doors of the four-wheel drive ambulance. Patient transport involving hundreds of kilometres over four-wheel drive tracks, sometimes in the dark, was the nurse's responsibility. This became an onerous task when compounded by such problems as being physically unable to get patients in or out of the vehicle.

In **case study 2**, the supply of essential resources and equipment was limited not only by the size of the clinic,

but also by the nature of the funding. Additional difficulties arose from the location of the funding agency. Cramer (1992) found that when management was based at distant locations, such as Sydney, the stark contrast in culture and distance contributed to low levels of comprehension and interest in the stress resulting from delays or inappropriate resourcing. Few of the Sydney-based management personnel involved in arranging funds or supplies had ever visited the study site. The situation had improved little from the nurse's first appointment at the clinic in the 1970s, a mere 12 months post qualification, when orientation was not provided, nor were procedural manuals available. Such conditions at this remote location persisted for at least 25 years. However, by the latest tour of duty in 1998, telephones were available as were Council of Remote Area Nurses of Australia (CRANA) publications.

In **case study 3**, chronic staff shortages meant prioritisation of care provision, and necessitated functioning on a minimalist approach. Nurses reported internal conflict resulting from external restrictions limiting the care they were able to provide. Chronic understaffing of this health care facility necessitated a reorientation of health care priorities whereby health promotion and health education were perceived as 'luxurious extras' and therefore not routinely offered. Consequently, patients were discharged with little information or advice about how to manage their condition, or how best to prevent or minimize further episodes.

Constant stress arose from the mismatch in resources versus community health needs. Absence of a pharmacy within the town created tensions as nurses were unable to dispense medications. A lack of clarity about their role in the supply of medications, and the absence of appropriate standing orders created illogical and potentially harmful outcomes in such instances as supplying asthma medications to a passing ambulance in short supply, or critical drugs (eg Dilantin) to holidaymakers to provide cover until they could attend a pharmacy in another town.

Lack of organisational support

The most significant and most alarming finding of the study was the consistency and the depth of frustration and disillusionment stemming primarily from a lack of organisational support for the role of the nurse as health care provider. This problem is widespread (NSW DoH 1998), and surfaced in a wide range of examples of unmet needs across all settings in the study. Lack of recognition of the fundamental operational needs of the role of primary health care provider was the factor ultimately responsible for the decision to resign by remote area nurses at both sites.

In despair, suffering frustration, mental and physical exhaustion, the nurses reluctantly departed in full recognition of the detrimental impact this would have on their communities. Justifying their decision to their communities, their patients, was reportedly extremely difficult.

Meeting professional needs was viewed by all participants as essential for the provision of adequate health care to occur. The absence of appropriate support, characterised by lack of response to repeated requests and demands for resources, rendered their performance less than their own professional tolerance and standards would allow. One nurse claimed:

I couldn't continue and be a party to this any longer. I was tired of banging my head against a brick wall when nobody cared what happens to these people. I couldn't do it all myself. It was as though I was fighting the system as well as all the community's health problems associated with living out here.

At no stage was lack of organisational support viewed to be related to the personal attributes of the nurse. All those interviewed reported that the situation was still endemic among their peers at other locations. This supports the findings of the NSW Recruitment and Retention Taskforce Report and other studies (Cramer 1992, NSW DoH 1995, Wolfenden et al 1996).

Cultural preparation

No cross-cultural preparation was provided prior to appointment to the Aboriginal community, so dealing with cultural issues was initially based on intuition and guesswork. The nurse considered this significantly extended the time required to develop a trusting, and therefore effective, provider relationship with community members. The health professional needs to become familiar with Aboriginal culture and the specific needs of their local Aboriginal group. Until this occurs, providers remain locked within their 'western' frame of reference, their understanding of indigenous behaviour is flawed, as cues are misinterpreted and communication is non-effective (Wakerman and Field 1998, Baum 1999). Hence the provider is often unable to enter real dialogue, accurately identify problems, predict likely responses and plan care accordingly (Willis 1991).

The nurse soon identified that clinic attendance rates were directly proportional to the level of trust in the clinic personnel. High levels of suspicion were observed initially as historically, new nurses were not expected to remain in the community for more than a few months. Turnover in remote areas can reach 400% and higher (Kreger 1991, Carruthers 1996).

The Aboriginal community demonstrated a strong resistance to being instructed to attend appointments,

follow treatment recommendations or adopt suggested lifestyle modifications. Provider ignorance of this cultural trait was initially reflected in low compliance and professional efficacy was severely reduced as the nurse's offers of service provision were refused. Over time, the flaw of taking a seemingly 'instructional' approach was realised. The nurse described her interpretation of their reluctance to comply in terms of a community almost totally dependent on welfare, which severely limited their ability to make personal life choices, and resulted in a widespread fatigue at following what is seen as 'more instructions from the white system':

In effect, the only form of choice these people can exercise when dealing with 'the system' is a decision not to attend clinic ... Over time, I changed my approach. A sense of trust was developed. Attendance rose, and some of my recommendations were adopted ... but I couldn't do much in the first few months. I felt useless. I was so frustrated, because they had so many health problems, and I couldn't help. It eventually got better in time - but it took a while.

The negative impact of high staff turnover rates can be profound and continuing, as health services and programs are interrupted while each new clinician not only arrives, but gradually gains understanding and acceptance into their new community. Communities experiencing high turnover in health workforce are spending extended periods without access to effective health care, which can persist for several months beyond the arrival of new health professional(s). In some cases, given the absence of cultural preparation, the nurse may leave before ever becoming truly effective. Meanwhile, a community fatigue develops as new faces come, struggle and leave. In this context, it can easily be seen how the process by which new practitioners earn acceptance within the community increases in complexity.

The recurring pattern is one of evaluation of each new arrival, hopefully eventual acceptance, yet the inevitable departure leads to subsequent disillusionment and growing suspicion demonstrated to the next incumbent. The chronically high rate of staff turnover in these regions is therefore a critical issue with significant impacts on population health, and must be addressed promptly (McDermott 1998).

Neither of the remote nurses were provided with preparation for life or work in remote Australia. Both RNs described their early months as being in a state of 'shell-shock'.

Variability in caseload

Another striking feature across these three diverse workplace settings was the extensive range of skills

required by these rural and remote nurses. In the absence, or shortage of medical and allied health personnel, possession of excellent clinical nursing skills is an absolute necessity to avoid extremely poor outcomes. Nurses with advanced emergency care skills maximize patient outcomes and can prevent death (Foster et al 1994). In rural and remote Australia many high acuity skills are called on, however these skills are required infrequently (Hegney et al 1997, NSW DoH 1998). This places limitations on both the development and maintenance of expertise, and accordingly, confidence to perform them. Where nurses no longer feel competent to use these skills, communities depending on those skills are disadvantaged.

Prior to first taking up her post, one remote area nurse sought three days suturing experience and also sought instruction on the techniques of performing tooth extractions and temporary dental fillings. These activities were self initiated and, where necessary, self-funded, yet the skills were frequently required.

However, despite long professional careers, excellent and broad ranging clinical skills, all interviewees reported encountering many situations which stretched their clinical repertoire. These instances were not infrequent as long delays in air or road evacuation were common, necessitating extended stabilization, maintenance and monitoring of patients. Receiving telephone instructions from the RFDS describing the technique to intubate a patient suffering severe head and neck burns was one vivid example recalled. The patient survived.

Functioning as a lone practitioner in the remote areas exacerbates these issues. Remote area nurses within the study argued their work largely involved crisis resolution with insufficient residual time to provide health education, health promotion or adequate counselling. This confirms the findings of Bell et al (1997), Sealy (1997) and Stratton et al (1995). Denial of these public health activities further disadvantages remote populations with known high levels of need in these areas.

Surgery was not performed at the rural hospital, and less than 15 births are delivered on site per annum. The small hospital carries no funded accident or emergency facilities, yet tourists not realising this, frequently seek access to services, particularly during the busy tourist season on the river. Some are urgent cases. Complex road trauma cases also present, whereby victims and their families expect the nurses to provide appropriate emergency care. While awaiting the ambulance, which can involve a delay of three hours, emergency care and stabilisation of the patient is required. The inability or failure of doctors to attend urgent cases when paged is a common stressor identified by nurses in rural areas as nurses provide what treatment they feel clinically competent, and are sanctioned to provide (Healy and

McKay 2000). Cases arise where pressure to extend their scope of practice is driven internally by a desire to assist, and externally by the relatives, friends or patient. This desire to help in a framework of legislated restrictions or hospital policy, presents a profound source of stress for rural nurses.

The range of skills generally required therefore was diverse, reinforcing the specialist-generalist nature of the rural nurse role, and the consequent imperative for clinical updates (Hegney 1996, Jones and Cooke 1996). However, the rubbery and unpredictable nature of medical and administrative expectations for nurses to extend their scope of practice, was a major issue identified at this site. Extensions of practice were not endorsed by administration. Yet doctors requested advanced practice on some occasions, while at other times, it was rejected and drew public criticism.

Lack of professional support for nurses to sustain or upgrade their skills leads to an erosion of self-confidence in their clinical ability to provide that level of complexity if required. This feature is also commonly reported elsewhere (Hegney et al 1997, Shi and Samuels 1997, NSW DoH 1998).

Access to educational needs

Realising their limitations, nurses at all study sites repeatedly called for access to educational opportunities. Geographical isolation without locum relief restricts attendance at seminars, workshops and even informal discussions with colleagues (Hill and Alexander 1996, Bell et al 1997, NSW DoH 1998). No educational opportunities were available at the time at any of the three locations. Operating as lone practitioners, the remote nurses were unable to leave the community to attend further training, or be granted formal study time, as no one else was available. Where calls for additional training are systematically refused, it can only be presumed that the first few cases encountered must be disadvantaged as practitioners learn by experience. The implication here, in the worst case scenario, is that experience is gained at the expense of the patient, where learning occurs in instances of omission or error. Whereas this unfortunate scenario may be unavoidable in some instances, it serves to highlight the potentially devastating effect of high staff turnover rates.

The small size of the rural hospital was a limiting factor in the ability of the nursing complement to adequately cover workplace industrial requirements of sick leave and holidays. Granting study leave therefore becomes a low administrative priority (Hegney et al 1997). The impact of such a policy is a reduction in applications for leave, as refusal is expected. Hospitals of this size are severely limited in their ability to attract skilled staff and maintain skills currency of specialised staff, such as midwives

necessary to attend the low numbers of births. Low turnover of staff may lead to a stagnation of knowledge, and persistence of outdated treatment modalities such as the much publicised kerosene bath incident demonstrated at a Melbourne nursing home (The Age 2000).

In the interests of providing quality, or at best *adequate* care, the rural nurses also argued that granting access to ongoing education and funding staff relief were paramount in small organisations. Nurses at this site expressed despair that current funding models, and hospital administrators, did not recognise maintenance of specific nursing skills as a valid need. They stressed patient care and the community's health was being compromised as a result.

Isolation, relief and respite

For the remote area nurses, the sense of social isolation experienced was extreme. Vast distances limited opportunities to leave the town for social contact elsewhere. Confidentiality and the sensitive nature of many issues meant that debriefing needs could not be met locally. High visibility in small communities meant they were effectively on call 24 hours a day, every day. Professional isolation was also extreme and listed as a major stressor. Travel to establish links with peers was costly in terms of time and money. However, immense gratitude was expressed for the support and empathy provided by the RFDS staff who recognised the difficulties of the remote practice environment. Both remote nurses raised the lack of support in this regard from their administering bodies.

No orientation or preparation for dealing with issues associated with living in the outback was offered at either of the remote locations. Also not available was access to professional support services, counselling or assistance with coping with personal issues arising from isolation. The nurses described their feelings with intensity of being 'emotionally traumatized by their experiences'. The nurses frequently sought this support from friends 'from home', outlining their frustrations via long distance telephone calls, and received variable tangible benefit from those who could not fully imagine their situation.

Despite being a provision of remote area employment contracts, adequate relief or respite was routinely denied, even for circumstances identified as constituting an occasion of great need, again due to the perpetual shortage of available relief nurses. Professional isolation and absence of opportunities to access education or skills updates were exacerbated by the inability to secure locum relief. The angst associated with an inability to leave was compounded by a high sense of commitment, as sole health provider, to the community. Both remote nurses eventually resigned following extended periods of rising stress levels, inability to sleep and a sense of entrapment.

On return home, one remote RN was diagnosed as being in a 'state of complete physical and mental exhaustion'.

Personal safety

An extreme example of lack of organisational support was demonstrated in the issue of personal safety. For many years Federal and State Governments have been aware that exposure to violence is a problem for remote area nurses. An Australian Nursing Federation study found that 85.8% of remote area nurses have experienced violence (Fisher et al 1996). Employers have a responsibility to provide a safe and secure environment for their employees. This is not only a significant ethical issue, but also now a legislated one. Fisher et al lamented this was not happening in a systematic way in 1996, and systems ensuring personal safety continue to remain arbitrary to this day.

The nurse in **case study 1** reported that during one Christmas period movement among groups within the community was high. Alcohol consumption increased and, during a span of several days' conflict between the different groups escalated. A riot situation eventually arose raising real fears for the personal safety of the solo nurse. The nurse's accommodation was central to the district of greatest violence. The alarm system in her home had been damaged by a previous burglary and despite repeated requests, had not yet been repaired. The only contact for assistance, should the need arise, was via telephone to the council, however this option was not available as that telephone had been disconnected to avoid nuisance calls, effectively isolating the nurse in the midst of a riot situation. This action demonstrated a disregard for the safety of the nurse, and was particularly distressing in light of a recent attempt on a nurses' life in a nearby community during a similar outburst:

This became the final straw - I resigned.

DISCUSSION

Federal Government response

Nurses have researched and published their concerns, similar to those described here, for decades. The organisational barriers to effective health care delivery described are not new. Yet the Federal Government focus *in real terms*, that is via funded strategies, remains medico-centric.

Proposal 8 of *The National Rural Health Strategy 1996 Update* describes strategies to address rural health issues (AHMC 1996). Yet the funding accompanying this rhetoric is meagre for nurses as their concerns have consistently been ignored.

Nurses presently provide 90% of the health care in remote areas, and form 87% of the rural health care workforce (AIHW 1998a), yet annually received less than 1% of rural health workforce support funding. However doctors comprise only 7% of this workforce and receive directly over 49% of the funded support (AIHW 1998b, AIHW 1999, DHAC 1999a, DHAC 1999b). Medical incentive strategies have existed in various forms since introduction of the General Practice Rural Incentive Program in 1992 (Norrington 1997), yet these millions of dollars have not achieved a reversal in medical shortfall in rural areas (AIHW 1998b, AIHW 1999).

While this bias persists, little will change, and the health of rural people will continue to suffer. Unless government policies are altered dramatically, we can expect no real improvement in rural health status. The answer to rural health problems is not simply a matter of addressing doctor shortfalls.

The task ahead - for agencies and governments

The poor health status of rural and remote Australians constitutes a significant problem, and no 'quick fix' exists. However it must be recognised that current Federal Government strategy approaches are clearly not working. The National Nursing Workforce Forum (2000) identified that professional barriers often impede optimum patient care, as examples described here provide sad testimony. Policy makers need to acknowledge the value and efforts of the existing health workforce. The most pressing task for the Federal Government, is to recognise the plight of those who are presently struggling against a disturbing plethora of organisational impediments, to bring improvements to the health of our rural and remote communities. High on the political agenda should be funding programs aimed at addressing the needs of nurses, to ensure access to education (initial orientation and training followed by regular updates), to provide adequate resources, clinical mentoring and locum relief.

Remote nurses continue to be employed as sole practitioners. The advantages of dual staffing as an absolute minimum should be recognised. Appointment of a second provider would facilitate staff development education and training leave. Having at least two providers creates opportunities for diffusion of difficult problems, and facilitates mutual support giving. It would also broaden the range of skills available, and enable comprehensive orientation of new incumbents. The additional role can then develop the health promotion and health enhancement activities which currently comprise only 1% of the functional tasks of remote areas nurses (Bell et al 1997, Sealy 1997). This strategy could truly enhance the health of the community, rather than have nurses perpetually focusing on crisis resolution (Dunne et al 1994, Hoy et al 1997). And finally, the task of attracting

locum relief may be easier if the relieving incumbent was supported by an onsite practitioner, rather than being sent alone to adopt full healthcare responsibility to an unknown community.

Continuity of care maximises the providers' knowledge of individuals' health history and idiosyncrasies, and is vital to good health care, as GPs have long testified (McMurchie 1993, Van Damme et al 1994). It is more effective in terms of clinical outcomes and more cost effective to maintain staff rather than find regular replacements (AHMC 1994). Evidence provided by this study demonstrated that chronically high staff turnover rates are crippling efforts to deliver quality health care services in remote areas.

Efficacy of health care delivery will be hugely potentiated when an educated, confident and cohesive, well-supported and *stable* provider network is established. Until this occurs, the populations most in need of quality health care are receiving marginal care where the only care available is from a highly stressed, fatigued and under-resourced health professional. This is strikingly evident where the practitioner is in a state nearing complete physical and mental exhaustion, or grappling with trying to establish themselves in a new community.

It is evident that doctors have demonstrated strong resistance to the financial incentives offered to entice them to relocate to outlying areas (Johnston and Wilkinson 2001). The political invisibility of nurses perpetuates the deep-rooted cultural belief in the primacy of medicine over nursing (Lumby 2000). However, numerous studies have now demonstrated that for many acute and chronic conditions, the care provided by skilled nurses produces outcomes equal to those provided by doctors (Chang et al 1999, Rudy et al 1998). Nurses are also well qualified to provide health education, health promotion and behaviour modification programs that have shown higher efficacy than medications in improving health outcomes for many conditions (Rowley et al 2000).

CONCLUSION

It is now well established that the health status of rural and remote populations is substantially inferior to their metropolitan counterparts. The low population densities of many communities make it difficult for these communities to attract a resident medical practitioner or for this to be a realistic option. Such communities rely heavily on nursing services for their immediate and long term health needs. Nurses provide the vast majority (87-90%) of health care in these regions, to a population whose health needs are diverse and complex. By ignoring nursing services, government rural health policies have also ignored the rights of communities to access appropriate health care.

The significance of nursing services on rural health outcomes for these communities has yet to be recognised by policy makers. Communities who receive their primary health care from nurses are presently seriously disadvantaged, not because their health service provider is a nurse, but because the nursing services are not resourced or supported. Nurses have long argued that organisational supports aimed at facilitating their role in health care delivery are continually overlooked at the expense of lucrative incentive schemes attempting to entice a reluctant medical workforce to relocate to rural and remote areas. Despite extensive public debate in the form of published literature and conference presentations testifying to the fact, the need for ongoing nursing education and skills maintenance is still not yet fully endorsed by employers and policy makers, and therefore not accorded a high priority.

Organisational support issues were described as the most pressing in this study. It is perhaps notable that extrinsic features such as working conditions, the temperatures in the outback, personal accommodation or financial rewards were not raised. The overwhelming theme behind all problems highlighted by rural and remote nurses consistently relates to lack of support for the nursing role in health care delivery. This widespread neglect made performance of clinical nursing skills and health promotion activities a daily challenge, described at times as 'impossible'.

While the Federal Government does not directly pay nurses' salaries, it is undeniably ultimately responsible for the health of rural and remote Australians. What is under dispute here is not the salary of nurses, but the calibre of health services provided to rural and remote populations. Nurses are important providers of health care across Australia, and are often the only providers in these areas where access to others is limited. Nurses have identified substantive problems in the health care delivery process, and have done so for decades, but have been systematically ignored.

The present medico-centric strategy is very much a blinkered approach which limits focus to *medical care* rather than *health care*, and access to doctors rather than access to appropriate health care services. This policy has damaged health services in rural and remote Australia, which have languished as a consequence, and has served to block access of rural and remote Australians to an effective health care source. This neglect has contributed significantly to poor rural health outcomes. The Federal Government must reorientate its present inefficient and ineffective strategy, broaden the focus, and support nursing services if their rhetoric 'to improve rural health care' is genuine. The Federal Government obligation to advance the health of rural and remote communities is not only political, in a climate of rural discontent, but moral, based on justice and a sense of ensuring a 'fair go for all Australians'.

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