Issues in Rural Nursing: A Victorian Perspective

Angela Bradley, Ralph McLean

5th National Rural Health Conference
Adelaide, South Australia, 14-17th March 1999
Proceedings
Australian rural health services and practice models have reflected some traditional notions of isolation; the image of the rural doctor and rural nurse working in difficult conditions remote from centres with major hospital or specialist services relies in part on literary and broadcast media rather than reality. In addition, rural health and rural practice as a field has only been highlighted since the holding of the 1st National Rural Health Conference in Toowoomba in 1991.

Since then, there have been three major national rural health policies or strategies and another is in preparation. Increasing national and regional attention has been paid to the importance of rural health issues and rural practice—most notably through the regular concern at the shortage of rural medical practitioners willing to work in perceived isolation from many of their peers. A major series of initiatives was taken through a national General Practice Rural Incentives Program which supported the recruitment and retention of doctors in rural and remote communities.

The position of rural and remote nurses has been less celebrated and the subject of fewer initiatives by both government and the sector. The development of health care in rural and remote Australia has, however, heavily relied on the work of nurses. For many years, nurses have provided extensive health care services without any readily available access to medical or allied health personnel other than via telecommunication.

Until the 1980s, State and Territory government support for nursing and nurse practice models relied on segmented professional advisory structures through the appointment of successive Chief Nursing Advisers to the State government and advisory structures both formal and informal to these advisers. Through the introduction of general management in successively restructured provincial health authorities, nurse roles, regulations and registration have been relaxed. Traditional hospital-based training has been replaced with university-based undergraduate courses.

Mirroring the national experience, nursing concerns and nurse leaders in Victoria have been less evident than medical ones. To address the major changes in both rural and remote medical and nursing practice and services, a Practice
Models Project was jointly established by the Department of Human Services Rural Health Services Unit and the Rural Workforce Agency Victoria. In 1998, a Senior Project Officer was appointed to work alongside nurses, allied health professionals and GPs in the rural and remote areas. An aim of the project was to assist practitioners to identify their scope of practice, education needs and any areas of overlap of roles and service provision in their health service.

An additional benefit which has emerged from this project has been the identification of the expert nurse practitioners and allied health professionals who are establishing models for best practice and innovative models of service delivery. There has also been a major increase in networking amongst the respective regions enabling more open communication and sharing of extended clinical experience and knowledge and varying models of practice. This has involved bush nursing centre nurses, collaborative nurse and general practitioner model nurses, maternal and child health visiting nurses, district nurses, visiting and community mental health nurses, community health nurses, nurse-led service staff, midwives and multi-disciplinary practice staff involving both medical and allied health professionals.

Through this project, the establishment of a collaborative clinical panel of 43 members was also established in 1998. The panel members collectively have an extensive range of experience and expertise across all professional areas and provide valuable professional advice and feedback.

The project officer also has been appointed to represent rural and remote clinical expertise on the Victorian Nurse Practitioner Task Force established in July 1998. The Task Force has selected nurse practitioner demonstration projects, is overseeing a year-long evaluation program, and will be reporting back to the Minister of Health with recommendations for legislative changes and implementation plans to enable the formalisation of nurse practitioner status in Victoria in late 1999. A rural reference group has been established which has provided valuable feedback to the project officer.

FACING RURAL AND REMOTE NURSING ISSUES

The main issues facing both practitioners and observers of rural and remote nursing practice and its models include: recognition of the nurse practitioner role by GPs, prescribing rights, formal recognition of established rural and remote nursing roles, recruitment issues for attracting health professionals into the rural and remote sector, cultural variance between rural Australia and the cities, isolation, funding and service purchasing and provision, educational standards, undergraduate nursing preparation, rural postgraduate education issues and strategies, advanced emergency clinical skills programs and education issues, and ongoing competency attainment.

Rural GP attitudes have been important in addressing, in their turn, nursing issues. Rural doctors are represented through a series of professional, industrial and sectoral organisations including the Rural Doctors Association of Australia.
(RDAA), the Australian Medical Association, the Australian College of Rural and Remote Medicine and, most established of all, the Royal Australian College of General Practitioners (RACGP).

While there has been some opposition to the formal establishment and recognition of a Nurse Practitioner role, the RACGP, for example, has acknowledged that, while there is a great diversity of practice styles and attitudes amongst their members, there is general support for the establishment of a collaborative nurse practitioner model.

Collaborative models have been developed by rural nurses, GPs and allied health professionals and submitted for consideration for funding through the Nurse Practitioner Project.

**FORMAL RECOGNITION OF ESTABLISHED RURAL AND REMOTE NURSING ROLES**

While nurse practitioners have not generally been formally recognised in Victoria, models of nursing have been in place for many years such as the Victorian Bush Nursing model, established in rural and remote Victoria for over one hundred years. The bush nurses have successfully been working in a nurse practitioner role, providing holistic care, health education to their communities and professional support to neighbouring and visiting GPs. They communicate via telephone, relaying initial assessment findings and consulting with GPs about selection of appropriate treatments. Protocols have long been established for treatment provision and support.

There are also a number of alternative nurse-led and collaborative models currently in place that have been evaluated positively by GPs, allied health professionals and community members. Where models have collaborative input in the initial planning, implementation and evaluation stages there have been a high degree of success. These new practice models have in some circumstances been the result of deliberate model and practice development instigated through work by both academic and practitioner intervention. In others, they have been a result of the process of rural health service change reflecting demographic and funding and management changes instigated by State and Territory governments as well as local communities and their leaders.

**ATTRACTING HEALTH PROFESSIONALS TO RURAL AND REMOTE SERVICE**

As previously noted, the issue of attracting and retaining rural doctors has been of increasing national, regional and local concern; early pointers to the recruitment and retention of appropriate and available rural nurses and allied health professionals have been less of a focus (CURHEV 1996).

Many of the regions without GPs have been serviced by rural nurses; however, research findings have also indicated that the predominant age of rural nurses is between 35-39 years. In addition, 31 per cent were 46 years or older and the
majority were only employed less than twenty hours per week. Unless this workforce mix changes, recruitment programs for each of the professions will be even more necessary to replace retiring and resigning nurses.

CULTURAL VARIANCE

For nurses working in rural and remote environments, the cultural differences between people living in rural and remote as opposed to metropolitan areas means that in some cases major communication barriers have to be overcome. This may be with members of the community, the local GP, nursing staff and allied health professionals who have lived within the region for their entire lives or are well accustomed to the local culture.

Some of the health services have established effective preceptorship programs for the induction of new staff. Preceptorship as a concept is more commonly used in metropolitan centres with their more established post registration clinical education programs and traditions of professional nursing networks and mentorship.

FUNDING, PURCHASING AND PROVIDING

Issues relating to the funding, purchasing and providing of services in rural and remote Victoria have become progressively more pressing since the pioneering of casemix funding for acute health services, the bundling of community and home based care through the Home and Community Care Program and the streaming of funds for aged residential care services. Through the increasing use of clearer and more uniform codes of funding and purchasing of rural health services, questions of viability and sustainability of both agencies and the care they offer has become a core rural and remote issue. Access to the range of required health services is increasingly reflected in the development of tiered community-based, bed-based and acute facilities not only in local centres but in larger regional centres and the metropolitan specialist services.

Support for the funding, purchasing and providing of nurse practitioner services is still under development. Through both the Rural Healthstreams Program and the Multi Purpose Service Program, increased flexibility for local and district management is being made possible. Specific nursing education and support has been the focus of demonstration and developmental funding and purchasing studies, projects and programs.

Specific issues which are being considered through new practice models under development in Victoria include consideration of the impact of geographical distances, travel costs, loss of salary or staff replacement costs, and additional child care expenses which have all been cited as significantly increasing the cost of attendance at education programs in the rural sector. The evolution of more community based non-acute rural health services has affected those hospitals and centres that in the past have focused on acute bed facilities and have had access to counterpart postgraduate nursing education support.
Through the development of rural health service approaches to support, education, training and research, clinical skills education requirements have been identified and begun to be met. Evaluations have shown a marked rise in rural and remote registered nurse clinical competence and confidence following attendance at an appropriate education program.

EDUCATIONAL STANDARDS

An aspect of the rural nursing workforce noted in a large number of studies was the small number of tertiary prepared nurses. Between 72.5 per cent and 82 per cent of nurses were thought to have a hospital certificate (Harris 1992, Blue 1993a). Tertiary study in the form of conversion programs from hospital certificate to university degree and higher degree programs has been estimated at between only 27 per cent and 52 per cent (Hegney et al 1997). There is, however, an increasing amount of postgraduate study being undertaken by rural and remote nurses. Further negotiation is required between nurse academics, service providers and nurses to facilitate accessible high quality rural practice oriented post graduate education programs.

The Nurse Practitioner Task Force has a mandate to consider the unique needs of the rural and remote area nurses when deciding on a suitable level of postgraduate credentialling for the status of nurse practitioner in Victoria. The recognition of prior learning will need to be considered very seriously in the establishment of nurse practitioner status particularly for experienced rural and remote nurses. Debate is also underway about whether a nurse practitioner should be qualified at a master’s level.

UNDERGRADUATE NURSING PREPARATION

Concern has been raised about the lack of ‘rural content’ in many of the current undergraduate programs. Given the broad experience that could be gained from a clinical experience in a rural setting, there is a limited amount of students who have access to this type of experience. Many of the undergraduates live in regional or metropolitan areas and have increasing living and educational expenses, often prohibiting them from the additional costs associated with ‘rural experience’. Through the development of current and new university departments of rural health, both national and provincial governments are supporting expanded rural health placements for undergraduate and postgraduate nursing and other health profession students.

A lack of knowledge about the additional benefits of the rural experience has also been cited as a possible barrier. Increased funding has been aimed at providing additional career information, along with clinical scholarships programs and rural student conferences. In Victoria, the Rural Health Services Unit has facilitated support for a range of participation in rural health professional conferences organised on a cross-disciplinary and multi-disciplinary basis. The
opportunity to discuss a wide range of professional issues and initiatives has already proved beneficial for the ongoing development of health care delivery in rural and remote Victoria.

RURAL POSTGRADUATE EDUCATION ISSUES AND STRATEGIES

Rural nursing is said to be different to metropolitan practice; one of the distinguishing factors identified in the literature is the generalist role of rural nurses who work in small rural health service district and community nursing centres. This role is often described as extended, expanded or multiskilled (Hegney et al. 1997). For these reasons, there is an urgent need for closer liaison between rural and metropolitan nursing education and services to continue to explore the quality of skillling and experience of newly graduated nurses returning to rural health settings and continue to put in place strategies for recruitment and retention into the rural and remote health sector.

The establishment of centres of rural health in the university sector based in rural regions has contributed to a greater recognition of rural health education and practice issues. Ongoing research projects are in place to establish education and practice issues, a database of post graduate study and research nursing, medical and allied health recruitment and retention issues in rural and remote Victoria.

ADVANCED EMERGENCY CLINICAL SKILLS PROGRAMS

Of particular importance to rural and remote nurse practice is the ability to perform advanced physical and psychological assessments. While assessment is now an integrated aspect of undergraduate education, there remains a large percentage of the rural nursing workforce which have not been prepared to an advanced assessment level. An urgent need to attain these skills has been identified.

Advanced emergency skills programs have been conducted across the rural and remote regions of Victoria. The New Practice Models Project has assisted in the identification of the education need, provision of funding for suitable programs, staff replacement and travel costs, to provide rural and remote-based clinical education programs. There has been a major effort to assist the regions to assist nurses to attend these courses. The focus is on providing high quality advanced emergency skills education programs throughout rural and remote Victoria which are based in their regions and are also of relevance to their current practice.

CONCLUSIONS

The consideration of nursing, practice model and workforce issues in the Victorian rural health sector has meant that there has been an increase in the collaboration between professionals, the government and service providers. Through the joint establishment of the Rural Health Practice Models Project with the Rural Workforce Agency Victoria, the Rural Health Services Unit and the
rural health sector more generally is enabling the establishment of, at the very least in a Victorian context, innovative and informed projects and programs. These are providing avenues for the testing of new ways of supporting rural health professional leadership, the provision of care and the review of models.

REFERENCES

Blue, Ian 1993 *A Critical Analysis of Postgraduate Education Opportunities for Rural Nurses Practising in the Northern and Western Regions of South Australia* Unpublished monograph University of South Australia Whyalla.


Harris, R. 1992 *Australian Rural Health: A National Survey of Educational Needs* University of Wollongong Wollongong.
