HEALTH AND HEALTH PRACTICE IN RURAL AUSTRALIA: WHERE ARE WE, WHERE TO FROM HERE?

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ABSTRACT

This paper provides an overview of rural health discourse in Australia highlighting contemporary rural health practice, models of care and the challenges experienced in recruiting and retaining an effective workforce. Socioeconomic difficulties, inequitable access to services including education and health, lower employment levels, harsher environments, occupational hazards, and geographic and social isolation are factors identified as contributing to rural disadvantage. These concerns are described by health professionals when asked if they would consider rural practice as a career option. New initiatives designed to improve the recruitment and retention of health practitioners including nurses to “the Australian bush” are explored.

INTRODUCTION

Australia is often described as the "lucky country" yet evidence suggests that many Australians are disadvantaged and have poor health (Best 2000; Australian Institute of Health and Welfare AIHW 2003). Cheers (1990; 1998) argues that people who live in rural and remote Australia have poorer life chances than their urban counterparts, while Phillips (2002) concludes that health status decreases with increasing remoteness. The Human Rights and Equal Opportunities Commission found that.

The health of populations living in rural and remote areas of Australia is worse than that of those living in capital cities and other metropolitan areas. Mortality and illness levels increase as the distance from metropolitan centers increases. Relatively poor access to health services, lower socioeconomic status and employment levels, exposure to comparatively harsher environments and occupational hazards contribute to and may explain most of these inequalities. Also, a large proportion of the population in the more remote parts of Australia are Aboriginal and Torres Strait Islander people, who generally have poorer health status (AIHW, Australia’s Health 2000, p. 223).

The provision of an equitable health service is seen as a human right, yet health service delivery in rural and remote areas in Australia are more limited in range than in urban areas (Francis et al. in National Review of Nursing Education 2002). The Rural, Remote and Metropolitan Area (RRMA) classification system defines "rural" communities as those with a population of 5,000 - 99,999 and "remote" communities as those with populations less than 5,000 (Australian Government 2005).

Rural and remote communities desire and need the services of a range of health professionals yet recruitment of health professionals to these areas is problematic. It is proffered that there is reluctance by many health professionals to work in small rural areas and an inability by health services to employ the range of health professionals

required to meet community needs (Australian Medical Workforce Advisory Committee, 'AMWAC' 1996; Francis et al. in National Review of Nursing Education 2002; Hegney, 1997; Larson, 2002). This paper explores the socio-political, economic and professional concerns underpinning health professional's decision making when considering career opportunities that include practice in the "bush" and highlights the nature of rural health practice as it is currently experienced in Australia. Finally, recruitment strategies developed by government and rural communities to attract health professionals are described.

RURALITY

Handley (1998) suggests defining "rural" is difficult because rural environments are diverse and must include a range of seemingly unrelated usage of land geographically distant from urban centers such as dairy farming areas, forestry, wheat and sheep country, seaside tourist resorts, horticulture and fruit growing regions, mining districts and industrial areas. Humphreys and Rolley (1991 in Handley 1998, p.2) consider rural Australia "… characteristically encompasses large distances, sparsely distributed populations, often harsh environments, extensive land uses and social and economic diversity." While the term "rurality" has been used to describe behavior or lifestyle in a context which is not urban, Gray and Lawrence (2001), believe rurality refers to "… the distinguishing features of rural life and the condition of possessing them, which make differences apparent between urban and rural situations." They further contend that a "rural ideology" pervades the discourses focused on rurality. This ideology embraces dogma which views farming as a noble endeavor because those engaged in such business are hardworking, are characteristically persevering and they epitomize the Australian image of family. This ideology is embraced by rural communities, politicians and other Australians and has traditionally been linked to the myth that living in the country equates with a healthy lifestyle. Humphreys and Rolley (1991, p. 19), in Handley (1998) explain that a number of methods have been used to arrive at an unambiguous definition of rural. They argue that there is no agreed consensus as definitions are developed in response to the research being undertaken. These definitions describe rural as being "… synonymous with anything which is non-urban in character to positive attempts to specify important elements of rural identity" (Humphreys and Rolley 1991, p. 19), in Handley (1998).

Hegney and McCarthy (2000) and Humphreys and Rolley (1991, p. 1) suggest that people who live in rural and remote Australia experience many health disadvantages. These include higher mortality and morbidity rates for some diseases, higher exposure to injury in the workplace, socioeconomic disadvantage, and inequitable access to health services in comparison with urban counterparts (Simmons & Hsu-Hage in Wilkinson & Blue, 2002; McMurray, 2003). This description echoes the situation in New Zealand, Canada and the United States of America (Bushy 2000; McMurray, 2003).

CONTEMPORARY AUSTRALIAN RURAL COMMUNITIES

Contemporary Australian rural communities are characterized by diverse populations that include indigenous and non-indigenous Australians and immigrant

peoples (Smith 2004). Rural people see themselves as different from city people; they are proud of their heritage and the type of lives they live. However, life in the bush has changed. Rural communities are declining and there is a net movement of people from the bush. Jensen (1997 in Smith 2004) describes these changes as the "rural crisis" indicating that this phenomenon is attributed to "new managerialist" practices, years of drought and a government policy that has embraced centralization as an efficiency strategy (Francis et al. in National Review of Nursing Education, 2002). As a result rural communities are faced with many social, economic and cultural challenges, all of which impact on the viability of the community. Globalization has indirectly resulted in the decline of the rural sector, a net loss in circulating money and changed community demographics. Young people move from rural communities out of necessity to more populous centers that offer greater opportunities for education, employment and career development (AIHW 2003). This experience, coupled with community inability to match opportunity available in urban and larger centers, acts as a recruitment and retention disincentive for rural professionals.

THE RURAL HEALTH WORKFORCE

The rural health workforce includes nurses (who represent 65% of the total health workforce), medical doctors, indigenous health workers, allied health staff, pharmacists and others, with the diversity and the number of health professionals inversely related to remoteness (Francis et al. in National Review of Nursing Education, 2002). Vacancies are reported for all health professional groups, with the level rising the more remote the setting (AIHW 2003).

Best (2000) acknowledges that the shortage of rural doctors has been a government priority for many years. He claims that a range of strategies have attempted to address the rural doctor crisis including financial incentives, recruitment of overseas trained doctors and the establishment of Rural Workforce Agencies (RWA). Research demonstrates that some doctors consider rural communities to be socially and culturally under-resourced and question the financial viability of rural practice. Doctors also name poor collegiate support, limited access to locum relief and reduced career opportunities as factors that negatively influence their choice to practice in the bush (Best 2000).

Alexander (1998) believes that national and state initiatives have failed to address the personal issues identified by doctors such as family education, housing and resourcing needs. The issues and support structures required by doctors are similar to those reported by nursing and allied health professionals. Unfortunately there has been little consideration of the needs of these members of the rural health workforce (AMWAC, 2000; Bishop, 1998; Malko, 2001; Hegney, 1997)

The Australian Institute of Health and Welfare (AIHW, 2003) report that the rural nursing workforce is in crisis. In 1999 alarm was raised in all Australian states and territories that nursing graduate numbers were insufficient to maintain the workforce (Smith, 2004) and that the shortages were most critical in rural areas. The profession of nursing has endeavoured to draw attention to the issues underpinning this crisis; however, government has been slow to recognize and accept responsibility for addressing nursing matters (Handley 1998). Recently a national nursing workforce taskforce (National Nursing and Nursing Education Taskforce) was established, with a remit to investigate

and develop strategies for addressing nursing concerns identified in the National Review of Nursing Education (2002) and the Senate Inquiry into Nursing (www.aph.gov.au). It appears that a situation of crisis must be reached before nursing issues are acknowledged by the Australian government.

RURAL HEALTH PRACTICE

Blue (in Wilkinson and Blue, 2002) argues that rural health professionals have common practice characteristics that are different to urban counterparts. He believes that rural health professionals have a broad scope of practice and diverse practice skills, are professionally isolated, and find it difficult to access professional development programs but have more autonomy in their practice. He concedes that the rural health workforce is aging, practitioners have high workloads and often live a "fish bowl" existence (Blue in Wilkinson and Blue, 2002, p. 200).

Rural practice, maintains Best (2002), requires practitioners to be highly skilled, have a broad well-developed knowledge-base and be capable of working in resource-poor environments with little collegiate support. While many studies argue that rural health professionals should have specialist training before they begin to practice in these environments (Blue in Wilkinson and Blue, 2002; Cramar 2000), Hegney maintains that rural nursing practice must remain generalist in nature. There is however ongoing debate about the level of skills and knowledge required by nurses for rural practice.

Australian governments at all levels (Commonwealth, state/territory) are being forced to focus on addressing the rural health workforce shortfalls, and it appears that the preparation for rural practice programs at the undergraduate and postgraduate levels is one area being targeted as part of a recruitment and retention strategy. Many Australian universities have included in undergraduate health programs rural health issues and related clinical exposure, and have taken advantage of incentives provided by the Australian government to support such programs (Dunbabin & Levitt 2003; Francis et al. 2004; Strasser in Wilkinson & Blue 2002). There is a growing body of evidence that indicates that students who are recruited from rural communities and educated in rural universities are more likely to practice in the bush after graduation (Smith 2004; Dunbabin & Levitt 2003; Strasser in Wilkinson & Blue 2002).

Rural health professionals report that maintaining currency of their skills and knowledge-base is difficult. They cite an inability to secure locum relief and backfill positions as inhibiting factors (Francis et al. in National Review of Nurse Education 2002). The need for many rural health practitioners to travel to access professional development, training and education is identified as limiting their ability to access educational opportunities (Smith 2004).

The issue of professional isolation is reported in the literature as a key factor impacting on health professionals' decisions to work and/or stay in rural practice (Wilkinson and Blue 2002; Smith 2004; Francis, Bowman, & Redgrave 2002). Best (2000) argues that the expectation that rural practice is a life commitment has been a disincentive for many graduates to take up the challenge of rural practice. Recently, issues including personnel safety and security have been raised as issues of concern that are reportedly impacting on recruitment and retention of rural health professionals (AARN 2004).

RECRUITMENT AND RETENTION

The recruitment of health professionals is a key concern for all levels of government in Australia. In an attempt to increase the number of undergraduate health students to consider rural practice, a number of incentive schemes have been implemented. The Australian Government has funded scholarship programs including the John Flynn Medical Scholarship Scheme, the Rural Australian Medical Undergraduate Scheme (RAMUS), the Undergraduate and Postgraduate Rural and Remote Nurses Scholarship Scheme (CURRNS) and the Undergraduate Allied Health Scholarship Scheme (CRRAHS). In addition, a bonded rural medical scholarship program has been introduced to increase the number of graduate medical students practicing in rural Australia (http://www.sarrah.org.au/NRRAHAS/summary_of_scholarship.pdf). The Australian Government has supported the establishment of University Departments of Rural Health who are charged with supporting and facilitating multidisciplinary education, training, and professional development including the clinical placement of students and the establishment of rural medical clinical schools to increase the exposure of medical students to rural practice (Strasser, 2002). Funding has been made available to a number of professional organizations to support rural and remote practice such as Association for Australian Rural Nurses (AARN), Council Remote Area Nurses Australia (CRANA), Council of Aboriginal and Torres Strait Islander Nurses (CATSIN), Rural Doctors Association of Australia (RDAA), Australian College of Rural and Remote Medicine (ACRRM), Services for Australian Rural and Remote Allied Health (SARRAH). More recently the Australian government has announced changes to the Medicare rebate scheme and increased funding to aged care services (Australian Government 2003). Under the Medicare changes Divisions of General Practice receive additional funding including rebates for practice and nurse initiated interventions. Additionally, incentive programs have been made available to support general medical practice development in rural areas. The majority of these initiatives, however, have focused on supporting medicine with little consideration of nursing and allied health.

The potential attractiveness of rural practice is complicated by high levels of vacant positions that remain vacant due to non-appointment and poor recruitment strategies. This leads to gaps in service, frustration and increasing workload by incumbent practitioners. The frustration experienced by disenfranchised staff becomes known and may result in some practitioners seeking alternative employment, choosing urban-based practice or simply leaving the health workforce in general (AIHW 1996; Francis et al, in National Review of Nurse Education 2002).

Many local governments in rural Australia have responded to the critical shortage of health professionals and developed policies and practices designed to attract staff. It seems obvious that a multi-sectorial approach to recruitment and retention is needed if the workforce issues are to be tackled.

While governments have implemented recruitment initiatives there has been limited consideration of long-term retention strategies, although it is acknowledged that the Australian government is supporting "rural mentorship" projects for undergraduate student nurses and more recently the incumbent rural nursing workforce to limit professional and social isolation (Mills et al. 2005). However, addressing the workload issues, safety, and access to education and providing incentive and appropriate level

remuneration packages for all health professionals, particularly nurses and allied health professionals, remain the dream with little evidence that long-term planning is occurring.

MODELS OF SERVICE PROVISION

Health professionals practice in environments and in a manner reflective of contemporary thinking. McLean (1998, p. 1) points out that in rural Australia there has been an increasing emphasis on "… primary care and health promotion and illness prevention has been commonly supported even if not put in place in every rural community." Meeting the needs of rural communities by providing quality health services is a priority. The challenge facing all governments is how to fund equitable, quality services that provide the range and diversity of health expertise in rural areas that urban people take for granted. Models that are currently used to supplement and/or replace existing services include:

- Integrated services, e.g., multi-purpose centers, regional health services
- Discrete service providers, e.g., general practice, nurse practice models, case management
- Outreach arrangements, e.g., mobile services (Royal Flying Doctor Service, 'RFDS'), visiting medical specialists, oral health services
- Information Technology, e.g., telehealth, oral health education and training (Humphreys in Wilkinson and Blue 2002, p.286)

Many rural health services have experienced successive reformation of service delivery models generally in response to changing governments. Health indicators for rural and remote populations, however, remain unchanged (AIHW 1996; 2000; 2003). Sustainable, effective models of service provision that are integrated and multidisciplinary in nature will only be achieved if there is collaboration between rural communities, rural health practitioners and the health bureaucracy.

CONCLUSION

All Australians have a right to an equitable range of health services. It is recognized that with increasing remoteness the diversity of services that can be provided is limited when economies of scale underpin funding mechanisms. This approach to management is endemic in all industries including education, health, policing and banking and has resulted in the rationalization and centralization of many services that once were diversified throughout Australia. The impact on rural communities has been a down turn in many rural economies and an associated leakage of human capital to centers of higher population in search of educational and career opportunities.

The popular portrayal of rural communities as crippled by adversity such as that described reduce the potential for these communities to attract and retain health professionals. Rural practice is challenging and rewarding but must be sold if these communities are to be serviced equitably. Government initiatives including incentive and remuneration initiatives must be coupled with local government and industry strategies to promote rural living and rural practice if health professionals are to be recruited and

retained. In addition, the number of students undertaking health education programs must be increased and rural practice preparation included in all health curriculum if workforce needs are to be met.

REFERENCES

Alexander, C. (1998). Why doctors would stay in rural practice in the New England Health Area of New South Wales. *Australian Journal of Rural Health, 6*(3), 136-139. [MEDLINE]

Association for Australian Rural Nurses. (2001). *Association for Australian Rural Nurses submission to the National Nursing Education Review.*

Association for Australian Rural Nurses, (2004). *Project.* Retrieved August 21, 2004, from http://www.aarn.asn.au]projects\mental_health.htm

Australian Government, Department of Health and Ageing. (2003). *Medicare: protecting and strengthening medicare.* Retrieved August 19, 2004, from http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicare-yr2003-t

Australian Government, Department of Health and Ageing. (n.d.). The rural, remote and metropolitan Area (RRMA) classification system. Retrieved August 16, 2004, from http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-workforce-bmp-rr

Australian Medical Workforce Advisory Committee. (1996). *The medical workforce in rural and remote Australia.* Retrieved August 31, 2004, from http://http://www.amwac.health.nsw.gov.au

Australian Medical Workforce Advisory Committee. (1998). *Annual Report.* Retrieved August 1, 2004, from http://www.amwac.health.nsw.gov.au

Australian Medical Workforce Advisory Committee. (2000). p. 223. Retrieved July 1, 2004, from http://www.amwac.health.nsw.gov.au

Australian Institute of Health and Welfare. (1996). *Health and community services labour profile.* Canberra:Author. Retrieved July 21, 2004, from http://www.aihw.gov.au/publications/health/hrra/index.htlm

Australian Institute of Health and Welfare. (2000). *Australia's Health 2000.* Canberra: Author. Retrieved November 10, 2004, from http://www.aihw.gov.au/publications/health/hrra/index.cfm/title/5742.html

Australian Institute of Health and Welfare. (2003). *Australia's Health.* Canberra: Author. Retrieved August 21, 2004, from http://www.aihw.gov.au/publications/health/hrra/index.htlm

Australian Institute of Health and Welfare. (2003). *Rural, regional and remote health, a study of mortality.* Canberra: Author. Retrieved August 21, 2004, from http://www.aihw.gov.au/publications/health/hrra/index.html

Best, J. (2000). *Rural health stocktake*. Commonwealth Department of Health and Aged Care, Canberra.

Bishop, M. (1998). How many? An analysis of some allied health professional service planning approaches in rural Australia. In *4th Biennial Australian Rural Remote Health Scientific Conference Proceedings, Infront Outback, 27-28 August*. Retrieved August 17, 2004, from http://www.ruralhealth.org.au/nrhapublic/publicdocs/CRROM/data/catalogue/T_SCION.pdf

Blue, I. (2002).Characteristics of Australian rural health care professional practice. In D. Wilkinson & I. Blue, (Eds.), *The new rural health* (pp.190-203). South Melbourne: Oxford University Press.

Bushy, A. (2000). *Orientation to nursing in the rural community*. Thousand Oaks, CA: Sage.

Cheers, B. (1998). *Welfare bushed: Social care in rural Australia*. Ashgate: Aldershot.

Cheers, B. (1990). Rural disadvantage in Australia. *Australian Social Work, 43*(1), 5-13.

Cramar, J. (2000). The extended role: Implications for nursing in isolated practice settings. In *5th Biennial Australian Rural Remote Health Scientific Conference Proceedings, Infront Outback, 24-26 Feb* (pp.29-36).

Dunbabin, J.S. & Levitt, L. (2003). Rural origin and rural medical exposure: Their impact on the rural and remote medical workforce in Australia. *Rural and Remote Health, 3*. Retrieved August 13, 2005, from http://rrh.deakin.edu.au

Francis, K., Bowman, S., & Redgrave, M. (2002). *National review of nursing education: Rural nurses: Knowledge and skills required to meet the challenges of a changing work environment in the 21st century: A review of the literature.* Retrieved August 22, 2005, from http://www.dest.gov.au/archive/highered/nursing/pubs/rural_nurses/1.htm

Francis K., Burley M., & Cross M. (2004). *Preparation for rural practice: an innovative approach to undergraduate nursing education.* Paper presented at the 5th National Canadian Rural Health Research Society Conference and Fourth International Rural Nursing Conference, Sudbury, 21-23 October.

Gray, I.W., & Lawrence, G. (2001). *A future for regional Australia: Escaping global misfortune*. Cambridge, UK: Cambridge University Press.

Handley, A. (1998). *Setting the Scene: Rural nursing in Australia* (Vol. 1.). AARN Monograph Series. Royal college of Nursing. Canberra, Australia.

Hegney, D. (1997). The differences of rural nursing practice. In *5th National Conference of the Association for Australian Rural Nurses, "Rural nursing: celebrating diversity" Conference Proceedings, 1-3 Feb.* (pp.9-24).

Hegney, D., & McCarthy, A. (2000). Job satisfaction and Nurses in Rural Australia. *Journal of Nursing Administration, 30*, 347 – 350. [MEDLINE]

Humphreys, J., & Rolley, F. (1991). *Health and health care in rural Australia: A literature review*. Armidale, NSW: University of New England.

Larson, A. (2002). Health services and the workforce. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 58-76). South Melbourne: Oxford University Press.

McLean, R. (1998). *Approaching rural health service changes: Rural health streams in Victoria.* Paper presented at the 4th Biennial Australian Rural and Remote Health Scientific Conference: Cultures *in caring. Conference Proceedings, 27-28 Aug. Toowomba, Qld.*

Malko, K. (2001). Nursing specialization and rural practice. *Rural Nurse, 14*(3),1.

McMurray, A. (2003). *Community health and wellness: A sociological approach* (2nd ed.). Marrickville: Mosby.

Mills J., Lennon D., & Francis K. (Submitted). The Association for Australian Rural Nurses' Mentor Development and Support Project: Contributing to a Culture of Learning. *Australian Journal of Advanced Nursing*.

National Nursing & Nursing Education Taskforce. (n.d.). [Website]. Retrieved August 7, 2005, from http://www.nnnet.gov.au

Phillips, A. (2002). Health status and utilisation of health services in rural Australia: A comparison with urban status and utilization using national datasets. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 44-57). South Melbourne: Oxford University Press.

Senate Inquiry into Nursing. (2002). *The patient profession: Time for action.* Retrieved September 3, 2005, from http:www.aph.gov.au

Simmons, D., & Hsue-Hage, B. (2002). Health status and utilisation of health services in rural Australia: A comparison with urban status and utilization using national datasets. In D. Wilkinson & I. Blue (Eds.). *The new rural health* (pp. 79-93). South Melbourne: Oxford University Press.

Smith, J.D. (2004). *Australia's rural and remote health, a social justice perspective.* Croydon: Tertiary Press.

Strasser, R. (2002). Preparation for rural practice. In D. Wilkinson & I. Blue (Eds.), *The new rural health* (pp. 204-220). South Melbourne: Oxford University Press.

Wilkinson, D., & Blue I. (Eds.). (2002). *The new rural health*. South Melbourne: Oxford University Press.