AAARRRGGHH!! ….CAN'T DO PRIMARY HEALTH CARE!

Trudy Yuginovich RN,RM, PhD, FRCNA
Associate Dean Faculty of Sciences
University of Southern Queensland, Fraser Coast Campus
161 Old Maryborough Road
Hervey Bay, QLD 4655
0741206121
Email; www.yuginov@usq.edu.au

Lyn Hinspeter RN, RM, B.H.Sc.(Nur), MRCNA
3 Undara Ave.,
Cranbrook, Townsville,
Phone; 07 47791910
Email; lyn.hinspeter@bigpond.com

ABSTRACT

Social Justice demands all people have a health service they can trust, provided in the best possible manner by the health team. In remote communities it is no secret that it is difficult to maintain a stable, qualified workforce. Nurses in these areas are so overworked and under-supported that they are unable to provide the level of primary health care required by people dwelling in these isolated communities. This study has identified major concerns of RANs endeavouring to provide such care with limited ability due to their location in single nurse clinics in remote Australia. RANs identified that they provide acute care in response to need without time for recall, follow up or initiating any primary health or preventative care in their communities which are surely the most disadvantaged. Reasons impacting on lack of ability to provide adequate/any primary health care included lack of management support, lack of staff, lack of support, lack of time and lack of safety. This study has identified continuance of two levels of exclusion, the remote communities from equity in health care provision and RANs exclusion from the support of their own profession-despite National Health Strategies and Specific Indigenous Health Strategies. Within health services the tension remains between ideology (the dominant view about how things should be done) and the way things are done in reality.

Design: A descriptive study involving a two stage process of data collection with typical case sampling within a constructivist framework was utilized for the study including;

i) a mail-out to all CRANA nurses,
ii) in depth interviews with RANs

Participants: Remote area nurses throughout Australia (nurses working in small isolated (often Indigenous) communities throughout Australia.

Results: respondents indicated that in single nurse clinics they are unable to provide the level of care that is required

Conclusions: Staffing current single nurse clinics with two or more nurses will improve RAN's ability to provide appropriate Primary Health Care.

What this study adds; Provides documentary evidence that social justice is not being served in remote communities of Australia. Adds to the paucity of formal literature about the reality of RANs' ability to meet to expectations of Governments and consumers in relation to primary health care provision

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Social justice and poverty

Issues of social justice are crucial to those who are most vulnerable in society. Health, housing and education are the basic human rights of every Australian. Poverty within many of Australia's remote communities is primarily concerned with distributional issues, such as the lack of resources at the disposal of individuals, whereas social exclusion focuses on relational issues of inadequate social participation (Gutberlet 1999) p.222-3). In December 1994 The National Aboriginal Health Strategy (NAHS) Committee found that the strategy had never been effectively implemented. All governments had grossly under-funded the remote initiatives, there was a lack of accountability and a lack of political support. They advocated a Human Rights approach to be adopted for funding and to meet the backlog in housing and essential services in remote and rural areas. (*cited in* Dade-Smith 2004 p.112).

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Primary health care

There are three issues to be actively managed in remote Primary Health Care:

1. Reconciling expectations of consumers and staff with funding and other constraints of the practice context.
2. Reconciling ideologically acceptable rhetoric about community control with requirements for a skilled, expert workforce including the need for high levels of technical knowledge for decision making.
3. Reconciling the competencies of health status determinants include historical, political, and economic factors with the need for clear progressive and bounded organizational vision (Wilson 2001).

Every Australian, irrespective of culture, environment, ethnic background or place of residence, has a right to *affordable, accessible* and *appropriate* (sic) health care. This is based on the principle of human rights as it conceptualizes health as a fundamental right as a individual and community responsibility (Mc Murray 1999). Not all researchers view the situation as hopeless. The experience of the Nganampa Health Council is that measurable significant health improvements can be achieved and sustained (van Haaren *et al.* 2000) such as the Mums & Bubs program as run by Townsville Aboriginal & Islander Health Service (TAIHS) as reported in Townsville Bulletin Wed. 11 July 'as a benchmark to close the gap on Australia's indigenous health crisis.'

Not only do excluded groups suffer the negative consequences related to poverty, they are also prevented from being citizens, in the sense of having access to social services and basic infrastructure. They are disadvantaged in terms of access to adequate health and childcare, education, sanitation or welfare assistance and are characterized by isolation, cultural diversity, socioeconomic inequality, health inequality, resource inequity, and a range of climatic conditions. In other words social justice is denied them (Beugre 2002. Gill, 1986

#73; Parsons *et al.* 2003; Rawls 1971); Di Bartolo, 2001 p71) suggest a socially unjust society equates to a violent society, particularly violence in the home.
. The target population was RANs in various locations around Australia in order to compare their experiences of single nurse clinics. The sample was accessed initially via a mail-out to all CRANA members via the quarterly "*Outback Flyer*" and at the CRANA Conference in Darwin in September 2005. Following this a random sample was identified from the respondents for in-depth interviews conducted by the researchers.

Results of in-depth interviews

Concerns about support and safety were expressed 194 times. 69.8 % of respondents identified that they work 24 hour call, 73.3 % identified that they never have emergency relief, 30% identified that they are never able to leave the community. High correlation was noted between the number of days worked without relief, ability to meet the needs of the community and the personal health of the RAN. This was related by RANs to the number of days on 24 hour call and the RAN's ability to undertake further study.

Lack of relief or time out was cited as being a major contributor to burnout and inability to provide care.

Ability to meet the community's health needs

		Days on	Meet needs
Days on	Pearson Correlation	1	.230(*)
	Sig. (2-tailed)		.034
	N	85	85
Meet needs	Pearson Correlation	.230(*)	1
	Sig. (2-tailed)	.034	
	N	85	85

* Correlation is significant at the 0.05 level (2-tailed).

Table 1. Correlation between days on and ability to meet community needs

- *I currently service 9 cattle stations, 13 Indigenous communities and one road house, Population/nurse ration =1:500. I have two health centres and an office in a hospital. I do not have time to give adequate PHC education to my population.*
- *I am putting a "band-aid" on health service delivery. I cover an area of Australia the size of Victoria in mass and distance.*
- *As a sole RAN you are everything at all times, you may touch the Primary Health Care needs but could not honestly fulfil it safely and appropriately or legally in any way.*
- *The RAN and the community are deprived of professional excellence plus care.*
- *being on call 24/7 made it impossible to maintain quality care.*
- *No time, day to day issues take over & trying to catch up after being on-call & called out over rides ability to provide basic care first and PHC second.*

Almost all respondents identified a need for 2 RANs to reduce this situation stating that:

- *There would be…Less stress more relaxed, ability to get jobs done, able to share; discuss ideas/knowledge; able to plan and carry out health promotion/teaching; more house calls to support elderly – invalids.*
- *Less tiring, more time off to consolidate personal/professional relationships/ study to build on knowledge, more attractive work situation for reliving, more time available to mentor students, AHW.*
- *Can help support and train up AHW,*
- *Ensure all health programs for the community are completed each year*
- *Ensure continuing community health promotion and as a support person.*
- *At least there would be someone else turn up to work. Help with long term plan/better identify community needs. Help with trauma/ day to day stuff, 2nd options etc, community care depend on 2 people instead of one, continuity of care, safety enhanced.*
- *Added assistance in an emergency, provide relief for days off, to ensure proper checking procedures are carried out for D.D. checking,*
- *Prevent 1 RN being overworked, over tired; over stressed thereby stalling burnout for a little longer. Provision of professional support. Improved personal safety.*

All respondents indicated that a second RAN would improve both practice and personal safety as well their ability to provide adequate primary health care and follow ups.

> *You can't expect to get outcomes if you don't put in the infrastructure. Somebody to administration work, to do the Medicare billing, to make sure that everybody has got Medicare cards, that they bring them, so that every piece of money that can get back from State funding or government funding can come back in to the community or to the health service.*

Primary health care delivery

RANs identified that they provide acute care in response to need without time for recall, follow up or initiating any primary health or preventative care in their communities which are surely the most disadvantaged. Many identified basic sanitation, hygiene, housing, and water as lacking and not having been addressed in many communities. Reasons impacting on lack of ability to provide adequate/any primary health care included lack of management support, lack of staff, lack of support (see fig 5). Respondents stated that:

> *I don't think that there has been anything much that has changed in the four years that has actually improved the way that I can do my job. There's no equipment here, we haven't got a monitor, we haven't got a defibulator, we haven't got a lot of the stuff you need to do your everyday business really.*

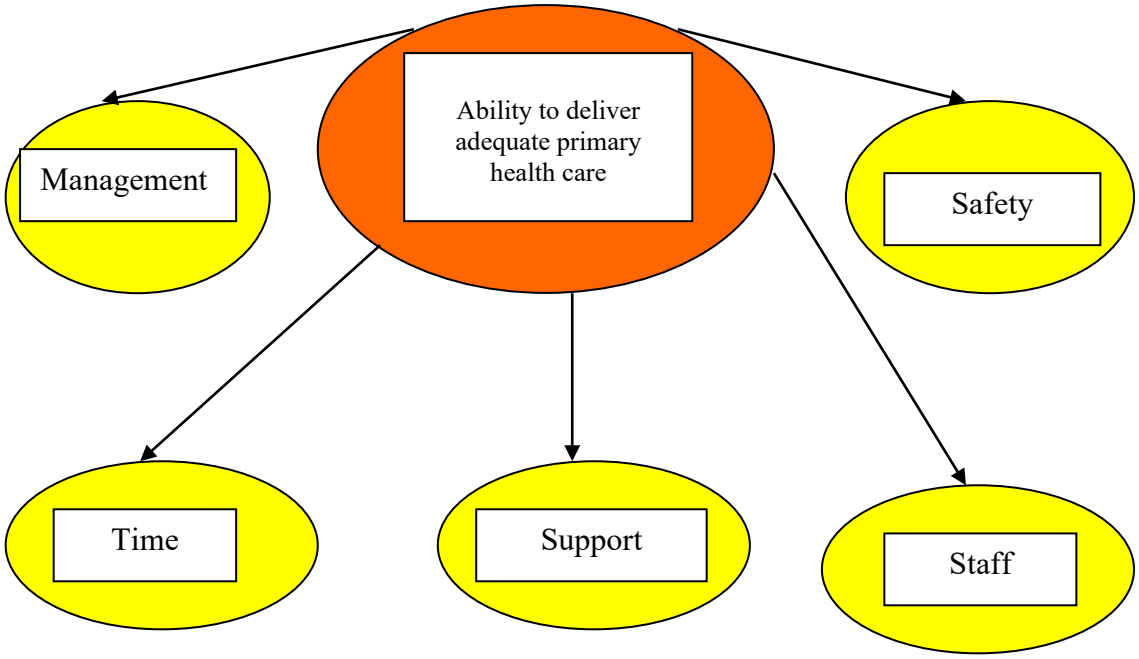

Figure 5. Issues preventing RANs delivering adequate primary health care

This begs the question ; How have the three main issues been addressed to date by policy and practice?

1. **Reconciling expectations of consumers and staff with funding and other constraints of the practice context.** This remains unfulfilled –the Intervention provided a short sharp invasion of health assessment but has it brought about more long term primary health care initiatives?
2. **Reconciling ideologically acceptable rhetoric about community control with requirements for a skilled, expert workforce including the need for high levels of technical knowledge for decision making**. There is no evidence to suggest that for the main part this has happened in most communities.
3. **Reconciling the competencies of health status determinants (such as those identified by the ICF) include historical, political, and economic factors with the need for clear progressive and bounded organizational vision** (Wilson 2001). It is clear from this study that history remains the ultimate decider of all of these factors. There is will but the vision a lacks from and definitive outcomes.

The link between community support and RAN ability to adequately fulfill their role in relation to Primary Health Care indicates the fragility of their positions within communities. This was repeatedly stressed as being a major limitation to their practice and satisfaction as a remote area nurse. All respondents acknowledged the importance of the role of the Indigenous health worker but there was disparity in levels of prior training, access to ongoing education and competence assessment by the RANs. One or two respondents indicated that these workers were sometimes being paid but actually went on walkabout. Many commented that the Indigenous Health Workers could assume a more active role in supporting the RAN if they were provided with a higher level of education and support but again they do not have the time to provide it.

RECOMMENDATIONS

The study has raised more questions than answers….

1. Single nurse clinics **must** be discontinued.
2. The researchers recommend that research is critically needed looking more closely to determine the processes of downward closure being exerted against RANs that continues to exclude them from access to many of the workforce support services that other registered nurses throughout Australia take for granted and thereby the ability to provide adequate primary healthcare.
3. A more appropriate and socially just model for health care needs to be developed to better service the needs of small remote communities in Australia.

7.0 CONCLUSION

Social Justice demands all people have a health service they can trust, provided in the best possible manner by the health team. This study has identified major concerns of RANs endeavouring to provide such care with limited ability due to their location in single nurse clinics in remote Australia. A critical need exists for a changed approach to models of health services in remote Australia. To do so would enhance the ability of RANs to deliver care as per National priorities in remote Australia providing measurable, evidence of improved health outcomes in isolated communities. It would also aid in recruitment and retention of this valuable resource in remote health provision.

Should RANs ignore the moral imperative to keep on keeping on or should they in fact do as RANs that which the Doctors have done and express your dissatisfaction with your feet?

We are not for one moment suggesting that people be left without health care but it begs the question; Why does the situation not change and who will actually take notice to provide a realistic approach to adequate health care for the socially excluded remote populations of Australia? What will happen to change it? Yes a truly unusual occupation with much unfinished business.

REFERENCE LIST

Beugre, C 2002, 'Understanding organizational Justice and its impact on managing employees: an African perspective', *International Journal of Human Resources management*, vol. 13, no. 7, pp. 1091-104.

Gutberlet, J 1999, 'Rural Development and Social Exclusion: a case study of sustainability and distributive issues in Brazil', *Australian Geographer*, vol. 30, no. 2, pp. 221-37.

Mc Murray, A 1999, *Community health and wellness: A Sociological Approach*, Mosby Publishers Australia Ltd, Sydney.

Parsons, J, Merlin, I, Taylor, J, Wilkinson, D & Hiller, J 2003, 'Evidence Based Practice in Rural and Remote Clinical Practice. Where is the evidence?' *Australian Journal of Rural Health*, vol. 11, no. 5, pp. 242-8.

Rawls, J 1971, *Justice as Fairness*, Harvard University Press., Cambridge Ma.

van Haaren, M & Williams, G 2000, 'Central Australian Nurse Management Model (CAN Model) : A Strategic Approach to the Retention andRecruitment of Remote Area Nurses', *Australian Journal of Rural Health*, vol. 8, pp. 1-5.

Wilson, J 2001, 'Remote Aboriginal Health Service Managers: Key Practice Challenges', *Australian Journal of Rural Health*, vol. 9, pp. 138-40.