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Council of Remote Area Nurses of Australia (CRANA)

Submission to the Productivity Commission

The Council of Remote Area Nurses of Australia (CRANA) strives to improve the health of Australians living, working and travelling in remote areas of Australia. It does this by promoting a comprehensive primary health care approach, advocating for a multidisciplinary team approach to health care delivery, and by promoting a cultural safety.

CRANA was disappointed that it has not been consulted on the development of the paper and responds below.

There are many workforce issues of concern to CRANA now and over the next ten years.

Remote area nurses (RANs) have long been the backbone of health service provision in very remote and remote Australia. Many health practitioners have historically been very reluctant to work in remote areas, but RANs have consistently & reliably been there in numbers close to metropolitan rates. This has occurred without any particular encouragement or incentives to do so. Our members enjoy the autonomy, challenge & job satisfaction associated with remote practice. While CRANA has done much to improve the preparation & retention of RANs, there is still much to be done.

Remote Context

The vast majority of our membership live and work in Aboriginal communities scattered across Australia. We also have members in mining communities, farming communities, fishing hamlets, off shore drilling rigs and islands, tourism & railway towns.

Settings include primary care clinics, small hospitals, community health centres, child health centres, occupational health & safety settings & flying doctor services. Others provide visiting outreach services.

Employers include State, Territory & Commonwealth governments, Aboriginal Community Controlled Health Organisations & charitable organisations.

Remote & Very Remote Australia

All communities in very remote Australia have populations of less than 5,000. Remote communities are larger and tend to serve as regional bases from which very remote health services are delivered & managed.

The population in each very remote community is too small to support the private sector (eg private hospitals), the provision of on-site specialist services or private allied health practices. Other than HIC funded GP services in the more affluent communities (eg mining towns), health services therefore need to be provided by salaried health practitioners.

CRANA recently conducted a stocktake of all permanently staffed 24hr health services in very remote & remote Australia. This was seen as the first step in being able to describe, research and manage the RAN workforce. This simple enumeration produced some startling results. Firstly, it clearly demonstrated that RANs form the overwhelming majority of the remote health workforce. Other workforces are small in comparison. While there are more than 5,000 nurses, there are less than 500 Aboriginal & Torres Strait Islander Health Workers, and less than 400 doctors living and working in very remote & remote Australia. Only a handful of allied health practitioners work in remote areas.

Nurses form 77% of the very remote workforce and 88% of the remote health workforce which services 503,000 people.

Secondly, it demonstrated a clear & unambiguous maldistribution of health resources in very remote areas. Communities with a majority of Indigenous people were clearly under resourced in comparison to communities with a majority of non-Indigenous people.

Maldistribution of health resources and workforce within very remote Australia

Indigenous people form 45% of the very remote population. Very remote Australia is the only region where the Indigenous population is of almost equal proportions to non-Indigenous populations. However, the Indigenous and non-Indigenous population is not evenly distributed throughout very remote areas. Settlement has tended to occur along racial lines. Non-Indigenous communities tend to be overwhelmingly so (>80%) and vice versa. 79% (169) of all very remote health services deliver services to communities containing 80% or more Aboriginal, Torres Strait Islander (20) or non-Indigenous people. Only 21% of health services provide services to communities containing a sizeable minority of either Indigenous or non-Indigenous people (21% to 49% of the population).

This data is supported by the CHINS study (2001) which reported 72% (51,768) Indigenous people in very remote areas were concentrated in 110 discrete communities of > 200 people.

Resource allocation for health services in very remote areas therefore tends to be an investment in specific population groups.

Small biases in resource allocation are evident at State / Territory levels, however it is only when jurisdictional borders are removed and resource allocation is examined at a national level that a clear & unambiguous maldistribution emerges within very remote Australia. For example, 25 (80%) of the 31 very remote hospitals are located within non-Indigenous communities. Only 6 (19%) hospitals are located in communities with a majority Indigenous population.

There are contributing factors such as non-Indigenous communities being larger, fewer (71) and less remote (only 10 have a maximum ARIA+ score of 15) than Aboriginal & Torres Strait Islander communities (56 have a maximum ARIA+ score of 15). Non-Indigenous populations also tend to be co-located with industries such as mining, agriculture etc. and to be on paved rather than gravel roads. Non-Indigenous communities also tend to have lower unemployment rates & higher incomes than metropolitan rates, high levels of home & vehicle ownership & functional & reliable health infrastructure such as clean water, adequate sewerage & garbage management. Mortality for the non-Indigenous population is marginally better than metropolitan rates & morbidity does not vary that much from metropolitan rates. Health indicators suggest remoteness does not significantly disadvantage the health of non-Indigenous people living in very remote areas.

Indigenous communities with health services tend to be smaller (the largest is 2,693), more numerous (142) and more remote than non-Indigenous communities. These communities tend to resemble ghettos in comparison to the more affluent very remote non-Indigenous communities. There is no industry to speak of, levels of home or vehicle ownership are low, unemployment is extremely high but masked by CDEP programs, incomes are the lowest in Australia and housing is crowded & inadequate. Health infrastructure such as water supply & sewerage is so poor & unreliable it does not allow residents to maintain their health and communicable diseases flourish. Health indicators are the worst for any group in Australia.

Health Service Provision in Very Remote Austalia

There are only 215 permanently staffed heath services in very remote Australia.

There are 4 models of health service provision in the bush:

Very Remote Hospitals

31 very remote communities have a small hospital run by salaried medical officers or GP's & staffed 24hrs with RN's and EN's. These hospitals are small, mostly non accredited and have <2,000 admissions per year. Community members have access to onsite inpatient care within the scope of GP proceduralists and visiting specialists. Acute or life threatening conditions are transferred to regional hospitals. Most hospitals also have a small community health service attached. A few communities with hospitals also have fee-for-service GP's and 10 have access to ACCHO AMS's which provide the Aboriginal sector of the community with access to a GP & other services. Hospitals also service the surrounding district.

10 hospitals are run by private GPs, 3 by med supers with right to private practice, & 15 by salaried medical officers. GPs provide services to 10 ACCHO AMS's.

Nurses are employed in shifts in all 31 hospitals & in accompanying community health services & the 10 AMS's.

Aboriginal or Torres Strait Islander Health Workers are employed in 6 hospitals and accompanying community health services located in Indigenous communities, and 10 AMS's located in communities with hospitals.

Communities with hospitals are thus provided with a version of metropolitan or rural health care – there are a suite of services: doctor, hospital, community health, ambulance service, chemist, inpatient and ambulatory care provided by several small teams. This is supplemented by visiting specialist & allied health services.

Multi-purpose Services

9 very remote communities have multi-purpose services (MPS's). MPS's offer a range of services including inpatient care, primary medical care, community health & allied health services.

4 MPS's are run by medical superintendents with a right to private practice, 2 by salaried medical officers and 2 by fee-for-service GP's. All MPS's employ nurses.

All but one MPS's are located in communities with less than 10% Indigenous populations.

which are 173 communities with populations ranging from 30 to 1600 people, only have 'clinics' staffed by one or more remote area nurses (RANs). 122 clinics also employ Aboriginal Health

Workers & 20 employ Torres Strait Islander Health Workers. Doctors are available in all communities with hospitals and MPS's, but are only available on-site in 22 (10%) clinics.

Primary Care Clinics

This type of health service is only provided in very remote & remote Australia.

Although sometimes likened to community health services, the scope & type of services delivered through primary care clinics are unlike any service offered in a rural or metropolitan setting. Primary care clinics are charged with providing 'comprehensive primary health care' to communities which range in size from 30 to 1600. This includes 24hr emergency care, primary care services, immunisation & population health programs, and a range of other services delivered by small teams which usually do not include an on-site GP. Inpatient services are not available. If admission to hospital is required the patient is transferred to a regional hospital, sometimes by road, but usually by plane, i.e. the flying doctor service.

Primary Care Clinics are the most common model of health service provision in very remote Indigenous communities. There are 142 Indigenous communities with health services in very remote Australia. 135 (95%) are primary care clinics. 119 are staffed by remote area nurses and Aboriginal or Torres Strait Islander Health Workers. Only 16 include access to an on-site GP in the primary care team. Only 4 of the 16 provide fee-for-service GP services – all in communities of 600 or more.

Nurses and Indigenous Health Workers substitute a range of GP & allied health services in the absence of ambulances, chemists or pharmacies, radiology services, dentists, social workers, drug & alcohol services etc. This is termed adopting the 'extended generalist role' which underpins remote practice.

38 (53%) of the 71 non-Indigenous communities in very remote Australia are serviced by primary care clinics staffed with remote area nurses. These service communities of 90 to 1,000 and tend to be called remote nurse posts. Almost half of non-Indigenous primary care clinics are in communities with less than 10% Indigenous population. 6 of the larger communities (600 or more) also have a fee-for-service GP located in the same town.

There are no benchmarks or funding models for primary care clinics or for providing 'comprehensive primary health care' in very remote and / or Indigenous populations with extraordinarily high levels of morbidity and mortality, poverty *******.

In the 142 Indigenous communities, RANs work with Aboriginal or Torres Strait Islander Health Workers. Only 2 health services are run by AHW's without the support of a RAN.

Adequate preparation for the extended generalist role associated with providing comprehensive primary health care. The RAN's role has evolved from practice without the support of ambulance officers or ambulances, doctors, pharmacists, radiographers, pathologists or other allied health practitioners.

The AIHW National Mortality Database reported 825 Indigenous deaths per 100,000 population in VR areas. This rate is 4 times higher than non-Indigenous people living in VR areas & 80% higher than Indigenous people living in major cities (based on metropolitan death rates using1997-99 figures)
(Glover et al, 2004)

The urban and rural model of health care relies on fee-for-service GP's to fund and deliver primary care services. In the absence of doctors RANs provide primary and 24hr emergence care for community members. CRANA supports RANs in many ways.

CRANA has 6 key strategic objectives designed to foster a sustainable multidisciplinary workforce

Strategic Objective 1:

- To reduce professional isolation experienced by remote area nurses by enabling them to belong to an organization that supports their specialty

Strategic Objective 2:

- Improve continuity of care to people in remote and isolated Australia

Strategic Objective 3:

- Support remote area nursing by continuing to develop and disseminate the specialist body of knowledge relating to best practice in remote area nursing

Strategic Objective 4:

- Support the CRANA programmes, ensuring CRANA is responsive to the needs of the remote area workforce through the provision of relevant, quality education and support programs:
    - The First Line Emergency Care program courses
    - Remote Emergency Care
    - Maternal Emergency Care
    - The Bush Crisis Line and Support Services
    - Clinical Procedures Manual
    - The Remote Health Practice Program
    - Short course in pharmacology for RANs
    - RAN mentor program

Strategic Objective 5:

- Support and value our assets by recognising and rewarding significant contribution to the provision of remote health

Strategic Objective 6:

- Provide a mechanism for the voice of remote area nurses to be heard in the remote, rural health, national nursing arenas and by all levels of government

CRANA manages a number of premier national programs including the First Line Emergency Care Program, which includes the Remote Emergency Care (REC) and Maternal Emergency Care (MEC) courses, the Bush Crisis Line (BCL) and also assists in the ongoing development and delivery of a suite of degrees in Remote Health Practice delivered by the Centre for Remote Health in Alice Springs. This course resulted from curriculum development work initiated and undertaken by CRANA in 1998. CRANA has also produced the National Clinical Procedure Manual, an invaluable clinical text assisting remote health practice.

These programs serve to address issues that militate against recruitment and retention and are offered nationwide and to all health disciplines. BCL is a national 24 hour crisis and debriefing service offered by qualified psychologists and aims to keep people working, to help prevent stress in the workplace and produces literature about these problems as well as running courses in self care and preventing burn out.

The REC course is an intensive 3-day course on managing trauma in an environment where they may be no doctor, and the MEC course delivers training in a similar format to address problems that may be encountered during an unexpected birth. These courses are very hands on and require 4 or 5 expert facilitators. We deliver these courses in remote and regional areas of Australia in order to assist the remote health workforce. We have only recently celebrated our 50th course (Darwin June 2004) and our 1000th participant. Last year we delivered a record 13 courses to 278 participants, and this year we are on track to deliver 16 courses nationally.

CRANA also maintain websites: www.crana.org.au and www.bushcrisisline.org.au to ensure information is disseminated to the remote workforce

CRANA has demonstrated a solid and sustained commitment to a multidisciplinary approach to comprehensive primary health care with our significant achievements in training, education and support. We pride ourselves as being an independent can-do organisation and collaborate strongly across the health disciplines. For example, below is a list of agencies CRANA currently active:

- Northern Territory Remote Health Workforce Agency (NTRHWA)
- Centre for Remote Health (CRH)
- Central Australian Division of Primary Health Care (CADPHC)
- National Nursing Organisations (NNO)
- National Nursing and Nursing Education Taskforce
- National Aboriginal Controlled Community Health Organisations (NACCHO)
- Australian Nursing Federation (ANF)
- Australia College of Midwives Incorporated (ACMI)
- College of Emergency Nurses Australia (CENA)
- Royal College of Nurses Australia (RCNA)
- Australian Association of Rural Nurses (AARN)
- Council of Aboriginal and Torres Strait Islander Nurses (CATSIN)

- National Rural Health Alliance (NRHA)
- AHF reducing time to care/acute coronary syndrome workgroup
- Triage education resource book working group
- National health summit
- Department of Veteran's Affairs Community Nursing Advisory Group
- Services for Australian Rural and Remote Allied Health (SARRAH)

Due to time constraints, this submission is not as comprehensive as we would have liked, however CRANA believes the core issues have been addressed in this document.

CRANA is the only agency supporting the remote & isolated multidisciplinary workforce. CRANA will add great value and insight to policy makers and urges government to consult with it on matters outlined above.

Lastly, CRANA would urge government to disgregate data so meaningful comparisons can be made about the effective and efficient use of health resources. CRANA believes the ARIA classification should be a universal measure across all health sectors.

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The principal goal of CRANA is to improve the health and well being of people in remote and isolated territories of Australia through the principles and models of primary health care and cultural safety