Australian Rural Nurses Inc.

The Association for Australian Rural Nurses (AARN) is the peak body for rural nurses, representing approximately 30% of the nursing workforce, approximately 70,990 registered and enrolled nurses (AIHW: Nursing and midwifery labour force 2003). We are responding to the discussion paper within the context of the rural health workforce – predominantly nurses.

The Committee of Management congratulates the Productivity Commission for the very comprehensive report and welcomes this opportunity to have input. We regret that AARN did not submit a view prior to release of the report – we were initially unaware of the review.

In reviewing the document, we support the overall direction of the report and offer *in principle* support to the summary proposals. We agree that there is a need for a collaborative approach to health workforce solutions and that innovation is the key to facilitating better health outcomes in rural Australia. We agree that the broad areas identified in the report for action are all relevant within the rural context, eg the need for:

- workplace innovation
- more responsive education and training arrangements
- consideration for national training recognition and accreditation
- including cross border registration arrangements
- funding related incentives
- improved workforce planning
- ensuring the needs of people with special needs are met, *particularly in the delivery of rural and remote health services!*

The Association also supports many of the sentiments expressed through several of the submissions to the Commission; particularly in relation to the expansion of Medicare MBS items so as to support services provided by nurse practitioners, midwives and senior nurse clinicians.

We are also strongly supportive of block funding and appreciate the attention paid to quality and safety. It is essential that strategies be developed to promote highly professional recruitment and retention strategies.

However, there are a number of key issues of particular relevance to rural Australia which We would like to be considered by the commission.

Nurses are significantly the largest group of health professionals delivering health care to rural and remote communities in Australia (Table 10, pg 164), yet this is not well identified in the paper. For example, when referring to the 'health care workforce' and the 'health care professional' it is predominantly the general practitioner and medical specialist that is discussed. The section on rural and remote health workforce is in reality only about a very small number of health care professionals, GP's and specialists (Table 10) providing care to rural and remote communities.

We urge that, if the commission is interested in the heath care of rural and remote communities then an acknowledgement of who is in reality providing that care is needed. The underlying assumption in this section of the report is that the health care of rural and remote communities

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will only improve with more doctors in rural and remote areas. There is no evidence to support this assumption. What is evident is that the nurse is the major health care provider and strategies are required to facilitate their support, education and professional development.

Strategies to facilitate this support would ideally include discussion in relation to the newly emerging role of Nurse Practitioners, Advanced Nursing Practice and other specialist nursing/midwifery services that have traditionally provided an expanded service in rural and remote areas. AARN would like to stress that even in rural areas where the supply of medical practitioners is adequate; nurses have always provided the majority of primary health care services. This situation needs to be further acknowledged in this report.

Any incentive program aimed at supporting the rural and remote workforce needs to be *equitable.* Nurses and allied health professionals are equally deserving of incentive schemes. Currently these programs favour medical practitioners. We urge that incentive programs be applied across the spectrum of service providers, inclusive of nurses and allied health workers. Incentive programs need to include remuneration packages that are considerate of family, accommodation, access to schools, relocation costs as well as innovative strategies to support ongoing professional development and training and opportunities, via position backfill and locum relief support for recreational leave.

Issues impacting on medical practitioners also affect nurses. For example, nurses working in isolated rural areas are often on call 24 hours a day, reducing 24/7 on-call for nurses is a necessary action if nurses are to be recruited and retained.

Undergraduate and postgraduate Australian Government scholarships need to be equally available for medical, nursing and allied health studies. We also urge that there be an increase in the number of scholarships across the professions along with an increase in the number of HECS capped places at regional universities.

AARN does not support the introduction of yet another tier of health professional. Rather we would prefer to build on the excellent processes already in place to further develop the Nurse Practitioner role. We remain unconvinced that a 'physician's assistant' would in any way alleviate the current situation in rural and remote areas, rather we are concerned that there may be a negative impact on the 'pool' of available health professionals, eg: no increase in overall numbers and a widening gap in the provision of care.

Finally, we note the absence of discussion around the provision of rural maternity services and the role of the midwife, shared care and specialist services. We note the increase in the number of small rural hospitals to close maternity beds for predominantly economic reasons, and would welcome the opportunity to discuss responses to this situation. AARN urges the Commission to undertake broader consultation in relation to sustainable models of maternity care for women in rural and remote communities.

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