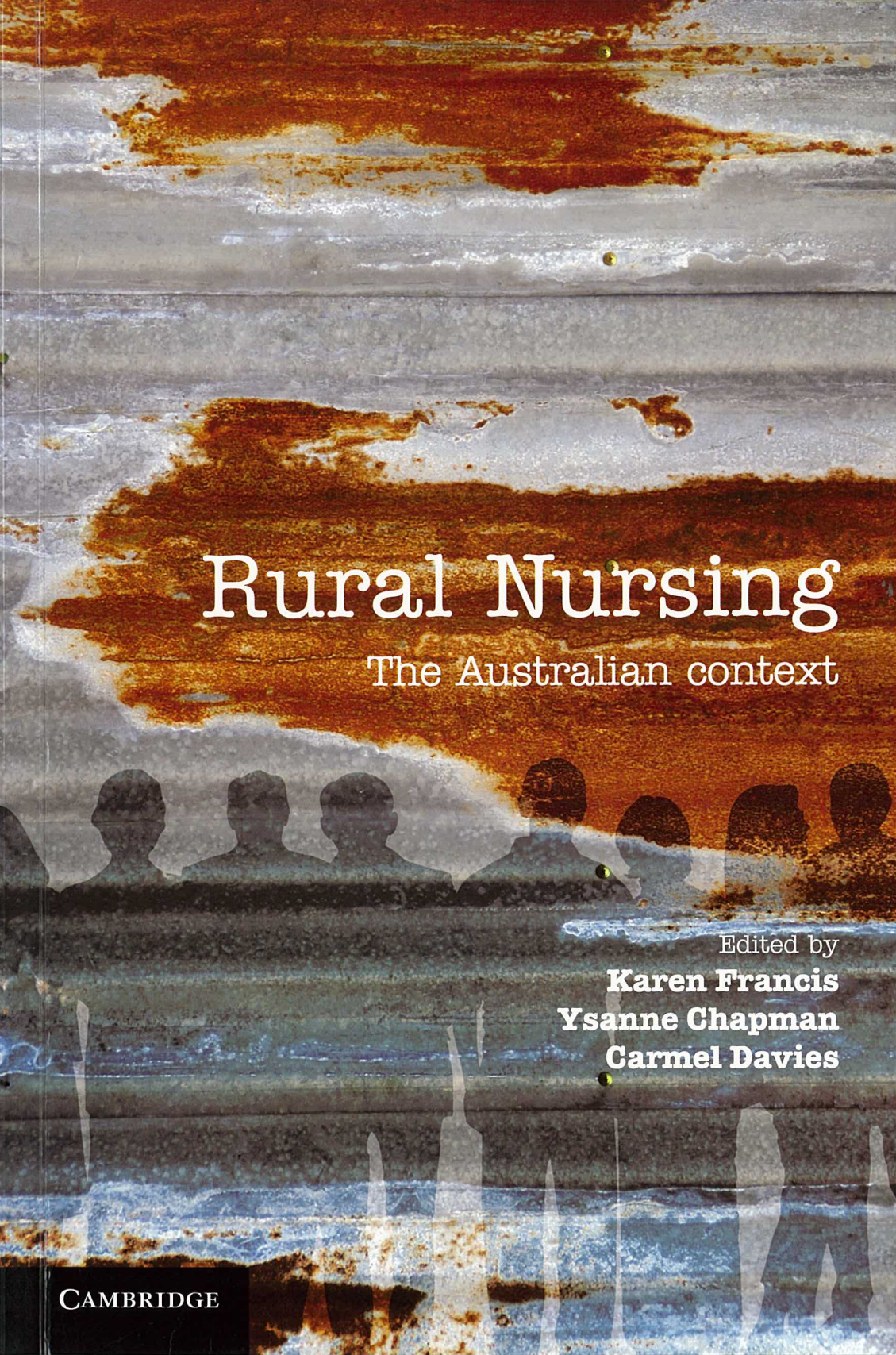

Rural Nursing

The Australian context

Edited by
Karen Francis
Ysanne Chapman
Carmel Davies

CAMBRIDGE

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Karen Francis

I wish to thank all the contributors to this first edition. It is exciting to be part of a new text on rural nursing. In particular I would like to say thank you to my two colleagues, Karen and Carmel. I have had the pleasure of writing with Karen on numerous occasions; one more text is another success in a long line of publications. Over the years I have learned much from Carmel's expertise with words and this publication has been just as inspiring.

Ysanne Chapman

Numerous people have contributed to this book; too many to acknowledge each one individually. But I would like to particularly thank each contributor for their hard work and excellent contributions. I should also mention the rewarding experience gained through working with my fellow editors on this project.

Carmel Davies

1 The context

Karen Francis and Ysanne Chapman

Learning objectives

On completion of this chapter, the reader will be able to:

- describe an overview of the history and culture of the Australian population
- discuss the statistics of the Australian population
- describe the current health priorities for Australia
- provide an overview of how health care is provided in Australia and how the various governments impact on health policy development
- source how education of healthcare workers is provided in Australia.

Key words

- Australia, health policy, population, healthcare worker, education provider

Chapter overview

This chapter provides background to the text. The Australian population, legislative frameworks and policies, health challenges and health priorities are described. A profile of the health workforce in Australia is included.

Background

Australia is an ancient island continent covering 7 682 300 square kilometres (Australian Government, 2013b) and is the world's sixth largest country (Tourism Australia, 2013a). The traditional peoples of this land arrived approximately 50 000 years ago from South-East Asia during the last Ice Age (Tourism Australia, 2013b). These peoples dispersed across the land, adapting their ways of life to accommodate the bounty offered and developing unique

languages and cultures (Australian Bureau of Statistics [ABS], 2013a). The Indigenous peoples established tribal lands and trade partners with neighbouring groups. Kinship ties were formalised as members of the neighbouring groups established relationships that bound tribes and clans together (Indigenous Australia, 2013).

Archaeological evidence suggests that the northern borders of Australia were regularly visited by traders from South-East Asia who contributed to the diversity of the Indigenous populations (ABS, 2013a). European sailors also visited Australia prior to Captain James Cook claiming Australia for England in 1778. Willem Janszoon travelled from Indonesia to Cape York Peninsula in 1606, and Dirk Hartog, another Dutch explorer, came ashore on the west coast of Australia in 1615 and probably interacted with local peoples. Hartog's discovery of the 'Great Southern Land' led to its inclusion in world maps of the time and facilitated increased expeditions by other European sailors (Australian history, 2013). Abel Tasman, another Dutch sailor, is acknowledged for his 'discovery' of Tasmania, which he named Van Diemens Land. La Perouse, a French explorer, was engaged by the French Admiralty to seek out and claim new lands and trade partners for France (Morrisey, 1924). He arrived in Botany Bay two days after Captain James Cook, who was commissioned by the British Admiralty and the Royal Society to take an expedition to Tahiti to record the transit of Venus. In addition, Cook was instructed to travel to New Zealand and then to the 'Great Southern Land' to chart these land masses for future exploration. He was also charged with identifying the potential for trade or extracting resources of interest such as timber and flax for ships' sails and with laying claim for the Crown of new worlds (Museum of New Zealand Te Papa Tongarewa, 2013).

Following his success, the white colonisation of Australia occurred in 1788 with the arrival of the First Fleet (Australian Government, 2013c). History records that initial relationships between the traditional owners of Australia and the colonisers were affable, with trade occurring; however, hostility grew as land was usurped by the colonisers (Australian Government, 2013c). Conflict between the Indigenous peoples of Australia and the white colonisers featured in the subsequent history of Australia.

Australia is, by history and intentional colonial claim, a multicultural nation, bringing together people from Europe, Melanesia and within itself. How this diversity manifested itself and how our culture was realised is the substance of the following section.

Culture

Australian culture is as broad and varied as the country's landscape. Australia is multicultural and multiracial, and this is reflected in its food, lifestyle and cultural practices and experience. Indigenous people, as the traditional custodians of the lands, have an important heritage that plays a defining role in the Australian cultural landscape (Australian Government, 2013d).

This diversity of influences has resulted in a cultural environment that is described by Tourism Australia as lively, energised, innovative and outward looking (2013a). The folklore of the nation has evolved from the Indigenous influence of telling stories. Traditionally, Indigenous Australians shared their heritage and explained understandings of their world through dreamtime and creation stories, oral histories spoken of between families and groups, and through art and dance. Even the life stories of the earliest colonists – many of whom were of Irish descent, the military and convicts transported by the British Government in the 18th and 19th centuries for crimes against the Crown – have been shared and passed on through the generations. These experiences and those of infamous characters who have called Australia home (including Ned Kelly, Captain Lightfoot and explorers who journeyed into the uncharted reaches of the land to discover it), as well as the men and women who have given their lives in times of war and the immigrants who have come to Australia seeking a better life, have all contributed to the rich tapestry of culture that is uniquely Australian (Tourism Australia, 2013a).

Culture in health and illness influences the perception and meanings of health, illness and healing practices and how healthcare information and treatments are received. Understanding and recognising the centrality of culture for Aboriginal and Torres Strait Islander people, which also extends to many other cultures within the Australian landscape, are critical to health practitioners being culturally responsive to the environments in which service delivery occurs. Indigenous Allied Health Australia (IAHA) views cultural responsiveness as an extension of patient-centred care that pays particular attention to social and cultural factors in managing therapeutic encounters with patients from different cultural and social backgrounds (IAHA, 2013). IAHA (2013) also asserts that cultural responsiveness is a cyclical and ongoing process requiring health professionals to continuously self-reflect and proactively respond to the person, family or community with whom they interact. What is healthy in one culture may not be so in another, and vice versa (Harvey & Park, 2011).

There are several initiatives focused on Australian culture that guide health care, and some government departments and professional organisations that provide this direction are:

- Immigration Health Advisory Group (IHAG)
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013
- National Health and Hospitals Reform Commission (NHHRC)
- The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID)
- Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)
- Australian Indigenous Doctors' Association (AIDA)
- National Congress of Australia's First Peoples
- Indigenous Allied Health Australia (IAHA)
- Close the Gap campaign
- Council of Australian Governments (COAG) Closing the Gap in Indigenous Disadvantage (Harvey & Park, 2011).

Culture is one of the determinants of health. As we will see later in the chapter, the population of Australia largely hugs the coastline, and those living in rural areas do not share the same access and equity to health services. Thus, being from a different culture to the mainstream and living in rural or remote locations can impact negatively on access to health services. As we progress through the text, we will spend some time discussing the impact of these and other issues on the health of rural dwellers.

Population

The population of Australia was 23 044 766 as at 5 June 2013 (ABS, 2013f). The ABS reported that the Australian population grew by 1.7% during the year 2012. This growth was a result of a natural increase of 40%. A growth of 60% could be attributed to overseas migration (ABS, 2013b). Data from 2011 indicate that there are slightly more female (11.2 million) than male (11.1 million) Australians. The ratio of males to females, however, is greater outside the capital cities, with the greatest difference occurring in the outback of Western Australia, Queensland and the Northern Territory (see Figure 1.1) (ABS, 2013c).

The majority of the population resides on the coastal fringes in the major capitals of each state or territory. Sydney, New South Wales, and Melbourne, Victoria, are the largest cities in the most populous states in Australia (Tourism

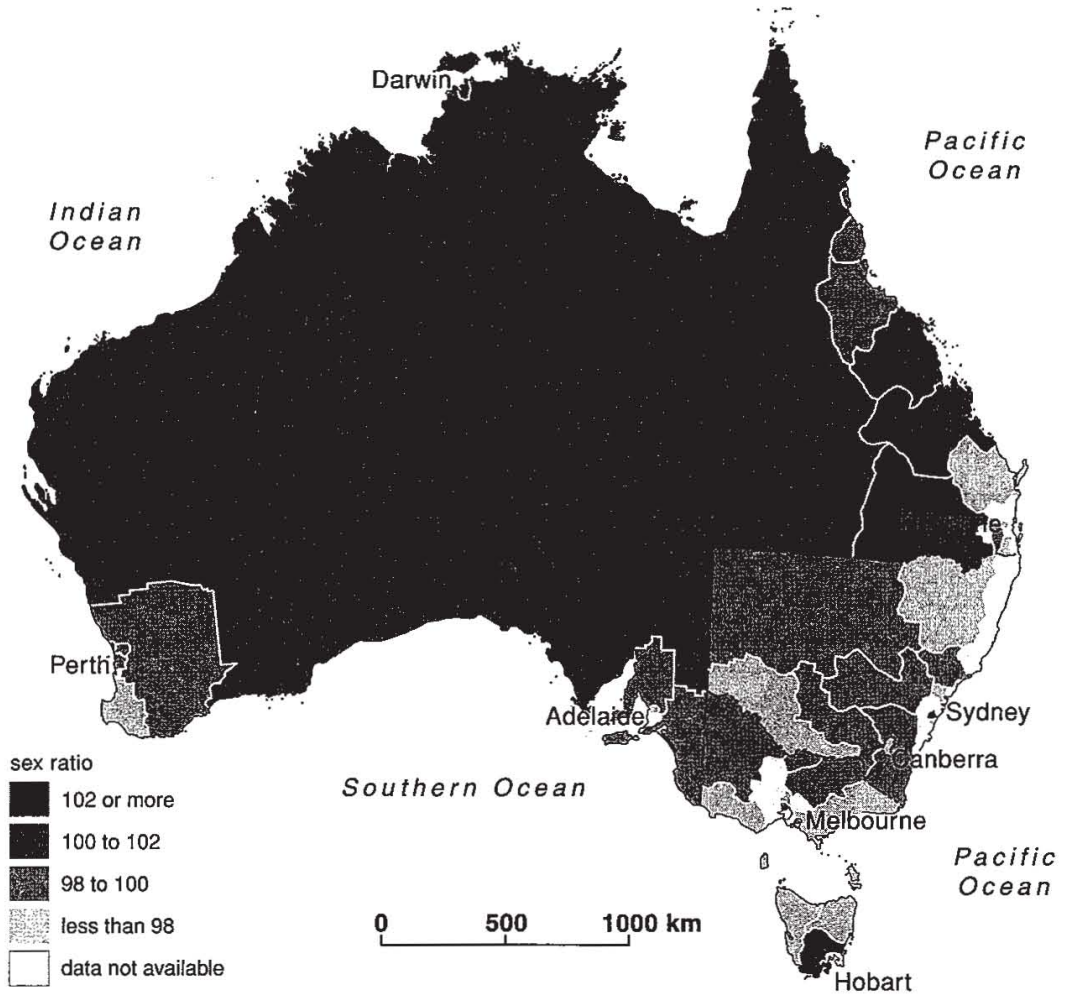

FIGURE 1.1 *Males per 100 females, Statistical Areas Level 4, Australia – 30 June 2011 (ABS, 2013c).*

Australia, 2013a). Recent data indicate that the population has grown in Western Australia, which is probably in part related to the expansion of the mining industry (ABS, 2013g).

Morbidity and mortality data indicate that the major causes of death for Australians are circulatory diseases and cancers (AIHW, 2013a). The ABS reported that, by the 1970s, the incidence of death from circulatory system diseases was declining, offering improved lifestyles as a rationale for this trend. The ABS asserted that the incidence of cancer-related deaths is rising, and that this trend is related to increased longevity of the population. Male deaths from cancers are higher than for females, with males dying from trachea, bronchus and lung cancers that have been linked to tobacco smoking (ABS, 2013d).

Infant mortality rates are 4.55 deaths/1000 live births, with male infant rates (4.87/1000 live births) slightly higher than for female infants (4.21/1000 live births) (Australian infant mortality rate, 2013). In 2010, Indigenous infant mortality rates (7/1000 live births) were greater than for non-Indigenous infants, although the gap is closing (ABS, 2013e; Department of Families, Housing, Community Services & Indigenous Affairs, 2013).

Climate and geography

Australia is situated between the Indian and Pacific Oceans. The land mass is approximately 4000 kilometres from east to west and 3200 kilometres from north to south, with a coastline 36 735 kilometres long. Climatic zones range from tropical rainforests, deserts (20% of the land continent),

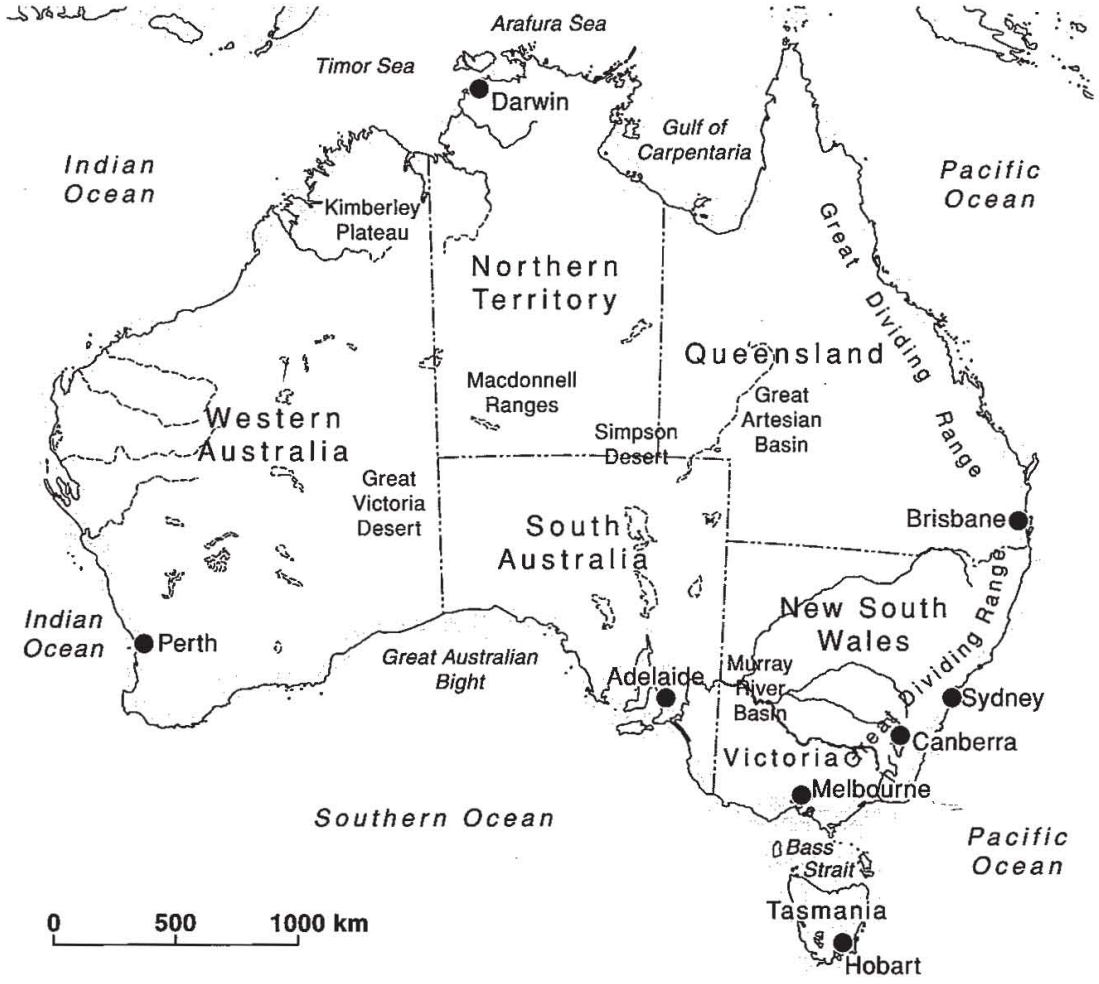

FIGURE 1.2 *Physical map of Australia.*

cool temperature forests and snow-covered mountains (Australian Government, 2013b). Figure 1.2 provides details of the physical features of the Australian landscape.

Australia's climate is varied depending on geographic location (latitude). The northern regions have a tropical climate, while the southern states have a more temperate climate. As the majority of the continent is arid (apart from the coastal fringes and Tasmania), Australia is the world's second driest continent. Summer temperatures are high and winters mild and warm in the north (ABS, 2013d). Rainfall varies, with the highest average rainfall on the east coast of Queensland between Cairns and Cardwell. Figure 1.3 details average rainfall for Australia 1961–1990. The least rainfall during this period was in the arid centre.

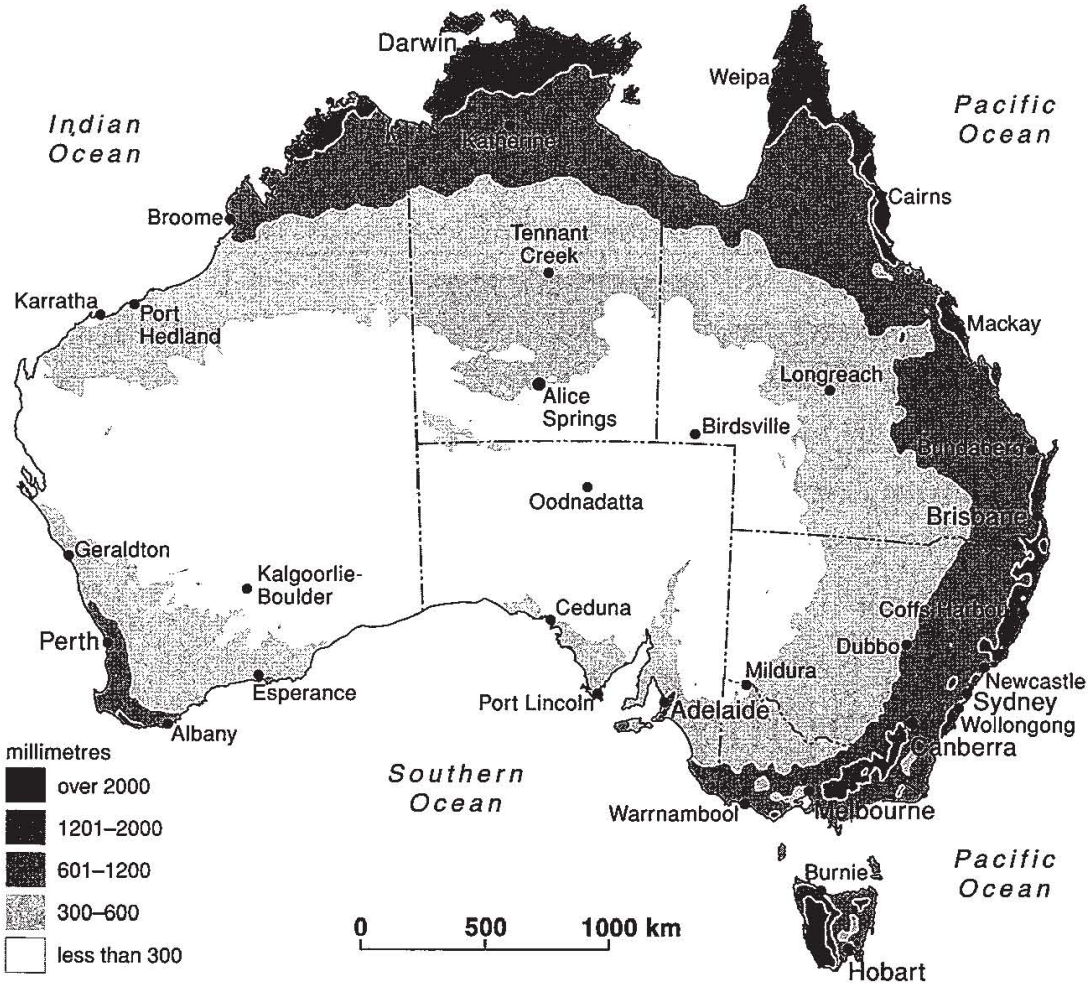

FIGURE 1.3 *Average rainfall for Australia 1961–1990 (ABS, 2013d).*

The government of Australia

Australia, as a former British colony, has remained a member of the Commonwealth of Nations (formally known as the British Commonwealth of Nations). As such, Australia's Government is a constitutional monarchy. Australia recognises Queen Elizabeth II as the Head of State. The Head of State has the power to appoint a Governor-General who acts on her behalf. The powers of government are defined by a constitution that came into force on 1 January 1901; a date referred to as the 'Birth of the Nation'. On this date, six colonies – namely Western Australia, South Australia, Tasmania, Victoria, New South Wales and Queensland – agreed to form a federated nation. A central government was formed that has the power to pass laws that pertain to the whole of the country, as decreed in Section 51 of the Constitution. The state/territory governments have legislative power over all matters occurring within their jurisdictions and are able to establish local governments to manage local matters such as housing, water, roads, sewage and waste disposal (see Figure 1.4) (Australian Government, 2013a).

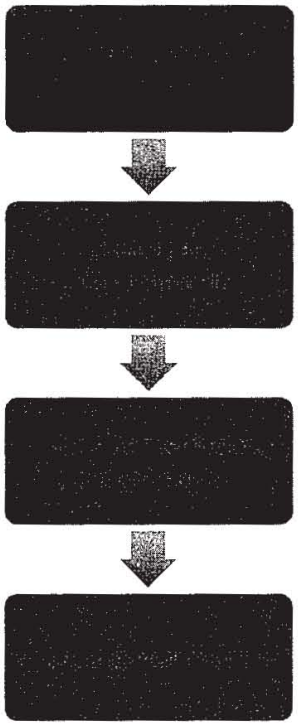

FIGURE 1.4 *Government structure in Australia (Australian Government, 2013a).*

Federal/Australian Government

The Australian Government is elected on a three-year cycle and is responsible for:

- taxation
- defence
- foreign affairs
- postal and telecommunications services
- state and territory governments (Australian Government, 2013a).

State and territory governments

The state and territory governments have responsibility for matters that are restricted to their boundaries, such as:

- police
- hospitals
- education
- public transport (Australian Government, 2013a).

Local government

The final level in the Australian system of government is local government. Local governments are established by state and territory governments and have responsibility for a range of community services (Australian Government, 2013a).

Global and national health policy

Australia, like most nations, views access to health care as a basic human right (Podger & Hagan, 1999). Providing for the health and safety of the nation has been a feature of Australian governments since white colonisation. All levels of government have a role in supporting health care in Australia. The Australian Government directly funds medicine (general practice and specialists) and aged care and has recently taken on responsibility for the regulation of health professionals (Commonwealth Fund, 2013; Podger & Hagan, 1999). State governments are responsible for the delivery of public health services (hospital

and community) and the regulation of private hospitals. Local governments manage public health services such as some child and maternal health services, and parenting services. All Australians have access to health care through Medicare, a national health insurance scheme funded through taxation revenue by the Australian Government. The Medical Benefits Scheme, also funded by the Australian Government, subsidises medications that are listed on a formulary (Francis, Chapman, Hoare & Birks, 2013).

In response to spiralling healthcare costs and recognition that the traditional model of health care was intervention focused, the Australian Government revised the national health priorities, identifying primary care and preventative health care as the way forward (AIHW, 2013a). The World Health Organization has influenced health policy and service delivery in Australia, and this has led to the rethinking and shaping of the national health priorities. The national health priorities for Australia in 2013 were:

- Cancer control
  - The most common causes of cancer deaths in 2010 were lung cancer (8099 deaths), bowel cancer (3982 deaths), prostate cancer (3235 deaths), breast cancer (2864 deaths) and pancreatic cancer (2434 deaths). Survival rates for cancer have significantly improved over time, and 66% of people with cancer survived in 2010 compared with 47% in 1987 (AIHW, 2013a).
- Cardiovascular health
  - The main types of cardiovascular disease (CVD) in Australia are coronary heart disease, stroke, heart failure and cardiomyopathy, acute rheumatic fever and rheumatic heart disease, peripheral vascular disease and congenital heart disease. Approximately 17% of the Australian population have CVD and, although the disease is common for men, it is rapidly becoming a disease found in women of all ages. Rheumatic heart disease is more common in the Indigenous population (AIHW, 2013a).
- Injury prevention and control
  - Injury contributes significantly to the burden of disease, and in 2010 it was assessed to be 6.5% of the total burden of disease in Australia. Approximately 400 000 people undergo an injury yearly, severe enough to be hospitalised. Older females have higher rates of injury as a result of falls. The rates of all injury, however, have been constant since 2000 (AIHW, 2013a).
- Mental health
  - Mental ill-health accounts for 24% of total years lost because of disability in Australia. Mental ill-health is the fastest growing illness factor in

Australia. The *2007 National Survey of Mental Health and Wellbeing* (ABS as cited in AIHW, 2013a) found that 3.2 million Australians had a mental illness in the 12 months prior to the survey. This statistic equates to 20% of the population aged between 16 and 85 years (AIHW, 2013a).

- Diabetes mellitus
  - Approximately 4% of all Australians suffer from diabetes mellitus. This figure represents 898 000 people – a rise from 1.5% in 1989. Data estimate that 87 100 suffer from type 1 diabetes and 787 500 suffer from type 2. Diabetes is more common in the Indigenous population than in the non-Indigenous population, and its prevalence increases with age (AIHW, 2013a).
- Asthma
  - In 2003, 61% of the burden of disease attributed to asthma was said to be in children aged 0–14 years. The prevalence of asthma in younger children has led to the rise of Asthma Friendly Schools in Australia (AIHW, 2013a).
- Arthritis and musculoskeletal conditions
  - Musculoskeletal conditions are the most common chronic conditions affecting almost one-third of the population. Musculoskeletal conditions are defined as conditions of the bones, muscles and their attachments, such as joints. A total of 1.6 million Australians suffer from osteoarthritis, whereas 428 000 are affected by rheumatoid arthritis. In addition, 1.9 million report some form of back problem (AIHW, 2013a).
- Obesity
  - In Australia, three in five adults are overweight. Being overweight is a major risk factor for CVD, type 2 diabetes, some musculoskeletal conditions and some cancers. More people living in rural and remote areas are overweight than people in major cities. The main cause of obesity is the imbalance between energy in and energy out. Energy requirements fluctuate with age and physical expenditure. Attention to food and drink consumption is a priority for anyone who wants to maintain a healthy weight regime. Large body mass was responsible for 7.2% of total deaths in Australia in 2003; this figure equates to 9500 people (AIHW, 2013a).
- Dementia
  - Dementia is a general term that describes a number of different illnesses that lead to a decline in mental or cognitive function. The most well known of the dementias is Alzheimer's disease. Dementia is an illness that is rapidly increasing in prevalence, mostly because of the ageing

> of the population. In fact, the main risk factor for dementia is age. In Australia, the 2006 estimated prevalence of dementia was 1% of those aged 60–65 years, 6% of those aged 75–79 years and 45% of those aged 95 years or more (Alzheimer's Australia, 2005).

These priorities demand that effective preventative health care is seen as the panacea of policy. This focus is true for world health issues. There has been little change in global health issues since 2001 – the main areas needing to be addressed are the elimination of infectious diseases (malaria and tuberculosis being the main protagonists), the control of HIV, the improvement of world nutrition and immunisation and vaccination programs, and the lowering of maternal and perinatal mortality rates (Olila, 2005).

No matter what health priorities are identified, their management and the care of people whose health is compromised lie in the remit of healthcare workers.

Health workforce

The Australian health workforce is diverse, consisting of regulated and unregulated (e.g. nurse assistants, residential care workers, health workers) healthcare workers. Regulated health professionals include nurses, midwives, doctors, and a range of allied and complementary health providers. This group of health professionals has grown exponentially since 2001 (AIHW, 2013b), and that development in itself has increased the cost of the provision of health care. The distribution of this group of health professionals is not evenly dispersed across the nation, with the largest concentration of providers being located in the capital cities and highly populated regions. The exception is nursing, which is relatively evenly distributed across all geographic classifications (Health Workforce Australia [HWA], 2012a), although there are current workforce shortages in this group. Predictions suggest that shortages will worsen if methods to promote recruitment and retention of nurses are not implemented. HWA is advocating for the advancement of nursing practice as an initiative to improve access to health care and as a recruitment and retention strategy (2012b). HWA is a statutory authority established by the Australian Government to coordinate a national approach to workforce reform. This agency:

> ... has been working in collaboration with governments and non-government organisations across health and higher education sectors to address critical priorities in the planning, training and reform of Australia's health workforce (HWA, 2013, para 2).

Health workforce education

The focus by the Australian Government on the health workforce is in response to recognised shortages and misdistribution of some health professional groups (doctors and allied health). Increasing the numbers of students in targeted health programs such as nursing has been one strategy adopted to address the predicted shortages. The Australian Health Practitioner Regulation Agency (AHPRA) works with 14 health professional regulatory boards to regulate and accredit members. The 14 boards are:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Chinese Medicine Board of Australia
- Chiropractic Board of Australia
- Dental Board of Australia
- Medical Board of Australia
- Medical Radiation Practice Board of Australia
- Nursing and Midwifery Board of Australia
- Occupational Therapy Board of Australia
- Optometry Board of Australia
- Osteopathy Board of Australia
- Pharmacy Board of Australia
- Physiotherapy Board of Australia
- Podiatry Board of Australia
- Psychology Board of Australia (AHPRA, 2013).

Nursing education

Educational programs leading to the licensure in any of the professions covered by these boards are accredited and monitored by AHPRA. In Australia, there are two levels of regulated nurses: registered and enrolled nurses. The Australian Nursing and Midwifery Accreditation Council (ANMAC) oversees the management of accreditation through a process of stringent peer review against the professionally agreed framework and competencies of the two levels of licensure. Tertiary education providers (usually universities) deliver accredited programs of study leading to registered nurse licensure (ANMAC, 2010). Preservice programs leading to registration as a registered nurse include three- to four-year bachelor level degrees and postgraduate 'entry to practice' master's degrees. Enrolled nurses undertake diploma level studies offered by vocational education sector providers (TAFE).

Education providers are concentrated in the capital cities, although there are regional universities located in some regional and rural environments. Many of these providers have tailored their programs to include information on regional and rural issues and clinical practice exposure in regional and rural settings to ensure that graduates are equipped for practice in these locales (ANMAC, 2010). In recent years the establishment of clinical schools, particularly in rural locations by primarily medical faculties, has supported clinical rotations of students to sites that were not utilised in the past. Access to accommodation and appropriate supervision for some students in rural and regional areas are issues that have been resolved with the establishment of clinical schools. However, these solutions are not translated to other health professionals, and nurses and allied healthcare workers often incur significant extra costs for undertaking rural and remote clinical placements in their respective degree programs.

Sally is a Year 12 student who lives on the edge of a rural town in New South Wales, 550 kilometres south west of Sydney. She dreams of becoming a nurse and securing a job as a registered nurse in a general practice setting. She lives with her parents, her three older brothers and two younger sisters on a sheep station. Her father and brothers work the sheep station while her sisters are in Year 10 and Year 9 at the high school Sally attends. Sally is the only person in her immediate family who has the ability or desire to go to university. Her younger sister has secured a hairdressing apprenticeship after Year 10, and her youngest sister wants to work in a shop. The closest university offering nursing as a three-year degree or a four-year double degree with midwifery is located 480 kilometres from home. Sally has never left home before and, as the eldest daughter, her mother has relied on her to help in the home and with the meals at shearing time. Sally also suffers from chronic asthma, which is controlled by preventer medication. Her asthma worsens on exertion and at season change.

Questions

1. What motivators does Sally have to fulfil her life's dream?
2. What challenges would she face leaving home?
3. What challenges will the family face if Sally leaves home?
4. How might Sally ensure her job desires are realised?
5. What sorts of decisions do Sally and her parents have to make to send Sally to university?
6. As a registered nurse, what ideas might you give Sally to manage her asthma while she is at university?

Summary

In this first chapter, we have set the scene of living in rural Australia. We have described how rural Australia was settled, the culture of living and working in a rural town, the healthcare system of Australia and the national health priorities. Lastly, we provide a scenario of Sally, a rural Australian girl who wants to become a nurse, and we ask you to focus on the various family issues and challenges Sally might face if she is successful in pursuing her choice of study.

In this chapter, we have covered:

- the Australian population
- health policy
- health challenges and national health priorities
- health workforce.

Reflective questions

1. Discuss the uniqueness of the Australian landscape and the impact on settlement.
2. Consider the Australian population. Discuss the impact of cultural heritage on contemporary Australia.
3. Review the Australian Government structure and identify the responsibilities of each level of government.
4. List the national health priorities and discuss the implications for health services.
5. Consider the Australian health workforce: what contribution do nurses and midwives make?

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