Rural and Remote Health

ISSN 1445-6354

The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy

ORIGINAL RESEARCH

Rural nursing and health care reforms: building a social model of health

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Submitted: *7 Septmeber 2001;* ***Revised:*** *10 December 2001;* ***Published****: 14 December 2001*

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Rural and Remote Health **1 (online), 2001: no.104**

Available from: http://rrh.deakin.edu.au

A B S T R A C T

This paper explores recent shifts in healthcare policy and the implications for rural nursing in Australia. Health care reforms have resulted in the implementation of a 'market forces' ideology, creating tensions between economic imperatives and the need for equity and greater access in rural service delivery. New models of health service delivery have been developed that have significant implications for the way rural health care is defined, practised and received. The issues surrounding the context of rural nursing practice and service delivery are discussed.

Introduction

The formulation of health care policies is known to be a complex process driven by prevailing political and professional pressures[1,2]. The need to balance equity and efficiency influences policy in all health care systems. In Australia, extensive economic reforms have led to the restructuring of health services, which in turn has resulted in an increase in care delivered in the home and in the community. Rationalisation of health services over the last decade has produced dramatic change in service delivery in rural areas of Australia[3]

Equity also continues to be a major concern for policy makers, especially in terms of access to care for disadvantaged populations such as rural sub-groups. Equity is notoriously difficult to define, let alone achieve, given that the health system plays such a small part in generating health[4,5]. Health status has been found to be influenced more by factors such as employment, education, housing, sanitation and socio-economic status, rather than by the health care system. Improved equity in health, therefore, requires greater investment in those factors outside the

formal health system, not just increased access to illness-oriented services.

For rural Australia, access to and provision of health-related services have been continuing factors in poorer health outcomes, particularly for Aboriginal people[6]. Health outcome differentials has been heightened by economic downtown and changing rural demographics. An ageing population and a reduced socio-economic base have altered health care needs in rural areas. Rural communities now require health services involving a more diverse range of promotive, preventive, chronic and social care. Health policy shifts during the 1990s reflect this changing need[7].

Reforms have impacted strongly on the practice and working environments of many rural nurses. Many small rural hospitals have reduced or closed their traditional bed-based services and broadened their focus to preventive, promotive and community-based programs. Many nursing roles have diversified to encompass first-line primary care, community health and emergency care, often in services without medical practitioners, while also providing a range of restorative, rehabilitative, aged and respite care.

Expanded and advanced roles are not new for nurses working in areas of rural Australia, or elsewhere. Rural nurses have provided comprehensive health care at advanced levels over the past century, in services with or without medical practitioners. The significance of their role in rural health care, however, has been largely unacknowledged in policy until now. For many rural communities, nurses have been, and continue to be, the only regular health care professionals, maintaining a health service presence and working in de facto nurse practitioner roles to meet health needs. Previous health policies have not reflected the high level contribution of nursing care to rural health outcomes,[8] nor has legislation supported the advanced role rural nurses play.

In most states of Australia, the value of advanced practice roles is only now being acknowledged through policy frameworks that promote the development and implementation of the nurse practitioner role. The particular value of nurse practitioners for rural and remote areas has already being legitimised by the first Australian appointments in New South Wales[9]. The national rural health policy also now acknowledges the role of rural nursing as crucial to the successful implementation of reforms and the improvement of health outcomes for rural people[7]. In addition, the conversion of many hospitals to community-based services has provided opportunities to greatly expand innovative nursing care options; however, workforce and educational limitations still pose a constraint to this potential.

Although the development of the nurse practitioner role is part of a global change in health care, the majority of rural nurses will not assume such influential roles and nurses overall continue to have relatively little input into influencing and shaping reforms[10,11]. The shortage of, and difficulties in, recruiting and retaining nurses in Australia indicates the conflicting values inherent in the health care policy environment and the lack of support for this provider group. Whilst nursing may be achieving policy recognition at the advanced practice level, economic reforms are also seeing nurses being increasingly replaced with lesser-qualified providers in many sectors[12]. Economic gains may be made however solutions to health care problems may be diminished by this type of rationalisation. Rural nurses are in the unique position of being able to develop and deliver comprehensive care for a wide range of chronic and acute health problems to differing population groups in settings across the home, workplace, school, clinic and hospital[13]. The winding back of professional nursing care, however, is only likely to compound poorer health differentials for rural people. Health policies aimed at furthering a social model of health may in fact only translate into restructuring that achieves little in terms of improved health differentials. The purpose of this paper, then, is to examine some of the major influences behind reforms, the way in which they are being managed and their impact on the delivery of rural nursing care.

The market model in health care

Policy analysts agree that health financing is now the major driving force behind reforms. Whereas equity was the dominant issue of earlier decades, the 1990s saw it displaced by the issue of financing and expenditure[4]. The introduction of economic principles and the rise of managerialism in health care is indicative of what analysts term a 'market forces' ideology in health care[14,15]. This ideology goes further than just cost containment: it changes the underlying principles of the health system, positioning health care as a 'commodity' and care recipients as 'consumers'. Within the 'market forces' ideology in health care, greater emphasis is placed on goals such as increased outputs for decreased inputs, performance and efficacy, quality assurance and financial accountability[14].

The 'market forces' approach has implications for accountability and quality of care. When the traditional logic of centralised state mechanisms for addressing social needs becomes replaced with one of competition and individualism, accountability is narrowed to the sphere of program budgeting; the broader issue of equitable services of a standard to meet citizens' needs is sidelined[14,16]. The 'commodification' of health means that goals move further away from the principles of equity and universal access and closer to economic principles. In attempts to maintain balance in the unpredictable environment of the market place, programs of quality control and evidence-based evaluation proliferate[5]. In such a climate, the regulatory role of the state in health care could be argued to be even more necessary to ensure that the system as a whole does not become fragmented by competing market forces and that it remains socially responsible and effective[4]. However, the capacity of the state for regulation and balance is lessened when it is also a purchaser creating internal markets and fostering competition. Market economy approaches to health create inequalities when those who can pay are able to access greater care than those who cannot.

The impact of rationalisation

For health care providers such as nurses, the emphasis on efficiency and cost containment has meant significant downsizing. The emphasis on community-based care, whilst ostensibly cheaper than institutional care, has meant that care of the ill is increasingly being undertaken in the home, with significantly more work being undertaken by women[17]. The reduction in professional care and regulation has raised concerns around quality, standards and continuity of care, as nursing has had to become more 'profitable'. The public have become more critical of those providing care, more concerned with the broader determinants of health and more concerned about the distribution of health care resources[16,18].

Rural health in Australia has hence become a highly politicised sector that has given rise to numerous disparate responses both from the national and state governments. The volatile environment means that reforms are often reactive across levels and program areas, rather than being integrated and based on sound theories of health. Cohesive policy becomes difficult in a social and human services area that, it is argued, is fundamentally incongruent with market forces theories[2].

The social model of health

The World Health Organization in its World Health Report 2000 indicated that the measure of a responsive and effective health system is its ability to contribute to good health[19]. If a system is to be responsive to the health needs of a population and be effective in generating healthier lives, there needs to be greater attention given to ensuring that the system is built on a theory of health creation. Rather than focussing on illness, resources must be appropriately and equitably utilised in generating good health. A social health model, that is, one aimed at incorporating the social and economic, as well as biophysical context of health status, is now acknowledged as having greater impact on the determinants and generation of health. However, the political will and theoretical framework must also be present for the change to a social health model to occur.

In Australia, there has been an increasing recognition of the need to shift the focus of care away from the treatment of disease toward illness prevention and the promotion of health. Health policies now contain more of the principles of a primary health care model, such as partnerships, public participation and community development. Nationally, there has been increased attention and funding invested in public health programs, primary care and community care programs. However, reforms involving these programs have also been driven by economic imperatives to control expenditure[14] and overall a disproportionate amount of funding continues to go into the detection, identification and treatment of acute and chronic illness[20,21]. Whilst community-based programs may outwardly reduce expenditure, unaddressed social costs and burdens elsewhere will continue to obscure the true impact of health services while an illness-focussed system prevails.

Changing service delivery models

In rural areas, expanded rural funding and service delivery models also represent a potential shift towards a social model of health. New multi-functional and integrated services could provide the infrastructure and capacity to better address the social as well as biophysical determinants of health. These services have moved away from the focus on acute care and are now including more 'primary care' programs, home-care and community-based programs. However, restructuring of service delivery alone may not bring about the philosophical change in health care culture needed to achieve a social model of health. Programs termed 'community care' may be only shifting acute care services out of the hospital and into the community without the health promoting orientation of a community health philosophy. Similarly, reforms to strengthen primary care may retain the focus on the treatment of illness and not necessarily incorporate the community building principles of a primary health care model. The philosophical and theoretical underpinning for the practice of health care must also be reoriented[22].

Without a theory of health as a basis for the delivery of care, the market-driven approach can lead to the health system being defined as the sum of its practical applications and structures. The system itself is seen as the goal, rather than the attainment of health. The connection between the 'medical care' system and actual health is already tenuous, with much of the present care and services having little impact on health determinants[5]. Health policies need to be aimed both within and outside the formal health care system simultaneously in order to reduce inefficiencies and to improve health status from a social health perspective[4]. Monitoring and evaluation should therefore include the measuring of equity of health outcomes. Highlighting equity of outcomes is likely to reveal inefficiencies within the existing system that will allow resources to be redirected to areas and sectors that impact more strongly on health status outcomes[4].

Rural nursing

Over the last decade, the roles of rural nurses have broadened from bedside clinical roles to more expansive roles within rural centres[23]. The rural nurses' role in integrated services is now more likely to encompass greater community health and development activities, front line emergency care, as well as some acute and aged care services[24]. The shift in rural nursing roles can be seen as a merging of the illness and wellness paradigms toward a primary health care role. However, unlike remote area nurses, rural nurses are still predominantly viewed in policy as illness care providers, rather than as primary health care providers. Having worked predominantly within the acute hospital model until recent times, they have been defined from within that model, which is essentially an illness oriented, biomedical model. The discourse on reform rarely recognises rural nurses as significant primary health care providers. The expansion of nursing roles into newer integrated service delivery models means that many rural nurses have not had the opportunity to obtain primary health care education in a wellness paradigm[25].

The demands of the changing health care environment now make ongoing professional education a necessity for practice

as well as professional accountability[26]. Given that rural nurses are the largest group of direct service providers, with in-depth health knowledge across a wide range of care levels and settings, adequate training in primary health care practice is vital to optimising their expertise. A lack of primary health care preparedness puts rural nurses in a position of disadvantage when strategic planning and decision making is taking place, further disaffecting them from the policy processes of new health care delivery. Without nursing input at strategic level, a significant component of local population health knowledge is missing from health care planning[27].

Where the values and preparedness for primary health care do exist, economic imperatives have been found to severely restrict nurses' roles. Smith found that for generalist community health nurses, the need to practise in a way that is consistent with primary health care principles does not sit well with the new type of managerialist reporting and accounting[21]. Narrow budgetary constraints do not allow for the range of activities that are required to successfully implement a primary health care model and to put the principles of community and inter-sectorial development into practice. When time and resources are rationed, less time is devoted to the activities that build social cohesion and strengthen participation and collaboration. These are the very elements needed to improve the health of the rural population, according to current rural health policies[7]. Not only is adequate training needed, but also the organisational culture to support new ways of providing health care in rural areas.

Preparation for new models of practice

Obtaining relevant education for the Australian rural health nurse role is not easy. The shift to new models of service delivery requires knowledge in community and public health, which has not historically been integrated into the basic undergraduate programs for nurses[28]. Graduate diploma level and masters courses have tended to focus on specialist medical fields that do not combine the elements needed for the diversity in rural nursing roles. Public health courses may not include an adequate nursing focus[29]. Specific preparation is required for expert clinicians who can deliver a mixture of acute in-patient, chronic and emergency care, community-based services, as well as social health care programs. The complexity of such roles requires skills in management and leadership in order to compete for funds, develop new programs, foster inter-disciplinary and community partnerships, and participate in policy formation. The continued marginalisation of nursing from the policy decision-making process has been attributed to a lack of policy capacity overall that must be redressed in educational programs. Appropriate rural nursing courses are now increasing and becoming available at the masters level; however, they must still overcome all of the identified barriers to continuing nursing education. These include the isolating nature of distance education; lack of support and culture of learning in employing institutions; cost to individual and family; lack of professional recognition and career structure; professional isolation; and competition for time with family, business or farm commitments. Greater investment in rural nursing by organisational management is required to redress the risks of not preparing the workforce adequately for the delivery of primary health care.

For nurses to fulfil the potential of new advanced primary health care roles in rural services, they require the support and strategic level involvement that reflects the value of these roles. This fact is only slowly being recognised. Governments want more equitable, efficient health care services delivered, yet are not investing equitably in the community or in nursing. The community health sector remains marginalised and under resourced in Australia and hence the system remains unbalanced. The main reason cited in the literature for this situation is that politicians and bureaucrats still have an inadequate understanding of primary health care and the social model of health[21,28]. This is evidenced in the reform discourse, which continually shifts meaning between the terms 'primary care' and 'primary health care', without recognising the distinction between the illness and wellness paradigms[22,28]. Rural nurses will need to build their capacity for primary health care practice throughout the functional, organisational and strategic policy

levels of the system in order to play a stronger part in shaping reforms and new health care delivery. If they fail to do so, the powerful ideologies of the 'market-place' and the prevailing illness model of care will ensure that the social model of health will face many more obstacles.

Conclusion

The shift in rural nursing roles provides an opportunity to strengthen the move in health care practice and delivery towards a broader model of health care. Rural health policies have provided evidence of the varying pressures to bring about this change. Over the decades, reforms aimed at reigning in health budgets have focussed on finance and system inefficiencies, overshadowing the need to base decisions on a theory of health and to monitor aspects of equity in health. Rural nursing is a valuable health resource for rural people; however, a lack of understanding and vision by policy makers, a focus on the commodification of health and a lack of primary health care training in nursing education impact on its capacity for responding to the changing needs of rural communities.

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