

# The development of family health nurses and family nurse practitioners in remote and rural Australia

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**BACKGROUND** The World Health Organisation HEALTH21 strategy has firmly placed families and family oriented services at the core of health care delivery.

**OBJECTIVE** In this article we argue that a fundamental reorganisation of primary health care practices in remote and rural Australia needs to be undertaken.

**DISCUSSION** Nurses have been shown to be equally effective and less costly than general practitioners. Family nurse practitioners should be a first point of contact, and family health nurses should be responsible for responding to problems of multiple deprivation and social exclusion in remote and rural areas. These practitioners would, in their respective areas of responsibility, identify, diagnose, refer or treat individuals, families and communities. In effect they would act as gatekeepers to health and social care services. Family health nurses would also aim to support the community in developing and sustaining the capacity to take responsibility for its own health and social care. The main obstacles to these initiatives are concerns of general practitioners and nurses, the inertia of large organisations when faced with the need to undertake radical change and the highly unionised and rule bound nature of Australian nursing.

Historically, two types of nurses work in rural areas in Australia – rural nurses and remote area nurses. Both rural and remote nurses have relatively autonomous practices that are determined by the needs of the communities in which the nurse practices.<sup>1</sup> Nursing roles in rural communities differ from urban practice and are affected by several factors including geographical location, population density of the area, the type of employing agency, and the health needs of the communities.<sup>1,2</sup> Bushy argues that current rural and remote nursing roles are akin to the advanced nurse practitioner, and that rural nurses have skills and

knowledge beyond that acquired in basic nursing education.

Wilson et al<sup>3</sup> report how some National Health Service (NHS) initiatives in the United Kingdom place nurses at the core of primary care services with general practitioners playing a supporting role to nurses. In 2002, there were over 40 walk-in centres operating in England, providing immediate access to nurse led services in primary care.<sup>4</sup> Other UK nurse led initiatives, including NHS Direct, NHS walk-in centres and nursing led personal medical schemes, are all examples of initiatives which place nurses as the first point of contact for primary care services.

Randomised controlled trials in the UK and USA clearly demonstrate that, in general, nurse practitioners have similar patient outcomes to GPs, and in addition, report better patient satisfaction.<sup>5,6</sup> Horrocks et al conducted a Cochrane review to address the question as to whether nurse practitioners provide first point of contact interventions equivalent to GPs in primary care.<sup>7</sup> This review included 11 trials and 23 observational studies. The review concludes that ‘nurse practitioners can provide care that leads to increased patient satisfaction and similar health outcomes when compared with the care from a doctor’. It was

further concluded that current evidence indicates that nurse practitioners can provide interventions which in terms of quality of care are at least as good, if not better, than that provided by GPs. Wilson et al<sup>3</sup> claim that appropriately trained nurses can take on functions currently undertaken by GPs in a more cost effective manner while still maintaining quality of services. In the USA, nurse led mobile health clinics for rural populations have been shown to increase provision of preventive health interventions and decrease use of emergency facilities.<sup>8</sup> The WHO Strategic Directions for Strengthening Nursing and Midwifery Services document clearly supports the view that when nurses are able to fully utilise their skills they will provide high quality interventions at relatively low costs.<sup>9</sup>

Existing primary care roles have not fully addressed the problems of social exclusion and multiple deprivation. Families who are experiencing a range of problems including unemployment, relationship difficulties, poor educational attainment and poor health outcomes, find themselves at the mercy of a whole host of agencies; if they are lucky to access a service in the first place. This fragmented approach to services leaves many families without a comprehensive intervention program. The World Health Organisation Advisory Group of Nursing and Midwifery reported that throughout the world, nurses are the largest and best positioned workforce element in rural health care.<sup>10</sup> The advisory group also reported that nurses, through expanded roles, are increasingly leading new service delivery initiatives which are tackling priority areas and serving vulnerable populations.

## Solution

We suggest that rural and regional Australia further explore alternative models that will involve root-and-branch restructuring of primary care services. This fundamental restructuring would see family nurse practitioners (FNPs) as well as GPs as the first point of contact for

rural and remote communities, and family health nurses (FHNs) as the main care provider for rural communities.

Family health nursing is gaining momentum within the European community as the core structure for nursing practice and is a recommended strategy of the World Health Organisation.<sup>11</sup> The FHN is a WHO (Europe) strategy for improving access to community based interventions and does not have an equivalent in Australia. The FHN provides for practice within a whole range of social networks and it is through this social community function that FHNs emerge as the group of professionals best placed to tackle health inequalities. Current rural health models may be achieving exactly the opposite effect as there is some evidence that the health of socially excluded populations such as indigenous Australians may not be improving relative to other Australians.<sup>12</sup> The FHN would coordinate health care, social care, housing, community building and education services for vulnerable families and communities.

Family nurse practitioners are expert clinicians who demonstrate leadership as consultants, educators, administrators and researchers. These practitioners would assess and manage both medical and nursing problems and are well established in the USA and Canada. Their practice emphasises health promotion and maintenance, disease prevention, and the diagnosis and management of acute and chronic diseases, which includes taking histories, conducting physical examinations, ordering, performing and interpreting appropriate diagnostic and laboratory tests, and prescription of pharmacological agents and other necessary treatments to manage the conditions which they diagnose.<sup>13</sup>

Given the probability that primary care nurses can undertake many, if not all of the functions which are currently the province of the GP, and can do it in a more cost effective manner, it therefore seems logical to adopt a policy of role

interchangeability in which what matters, is that the person occupying a given role can practise competently, rather than focussing on which professional tribe should have a given right to fulfill this role.

## Barriers

Organisational systems do not necessarily operate in a logical manner and consequently many barriers, both real and imagined, will be deployed in response to this article and a number of others making similar suggestions. Wilson et al in a study exploring barriers to the nurse practitioner role in primary care found that GPs were concerned about threats to GP status, job and financial security and spheres of responsibility.<sup>3</sup> These concerns must, on the one hand, be taken seriously and dealt with in a sympathetic manner, but on the other, should not prevent radical changes in the structure of primary care in Australia. It is sometimes argued there are statutory impediments to nurses fulfilling what are seen as medical roles. This is a somewhat bogus argument as history is littered with nurses taking on functions that were once medical functions. It should be noted though, that most resistance to new nursing roles often comes from nurses themselves. The highly unionised nature of the Australian health care workforce also militates against responsive and rapid change.

There is existing evidence that Australian remote area nurses have 'de facto' undertaken the roles of both nurse and GP, even when this has been in contravention to both statutory nursing regulations, because the context of practice demanded inclusion of advanced practice roles.<sup>14</sup> Given the movement by each state to adopt some measure of nurse practitioner roles, it is simply timely to determine an educational structure of what is needed to ensure preparation for rural practice. What appears to be lacking in Australia's rural and remote nursing practice structure is a nationally agreed educational and practice strategy to enhance the role of nurses who wish to

practise family nursing.

### Overcoming barriers

Root-and-branch initiatives such as those proposed in this article cannot be implemented in the fragmented and overly cautious manner in which nurse practitioner roles have, and are currently being, implemented in Australia. There needs to be a nationally coordinated strategy to reorganise family practice in remote and rural areas. A major objective of this strategy would be aimed at tackling social exclusion and the success of the strategy would, in part, be measured by the extent to which it improved those health indicators indicative of social inclusion. The strategy would also put in place a national education plan that would include clear minimum educational and performance standards and arrangements for shared learning between nurses and GPs at the postgraduate level. More contentious is the need for nurse practitioners to be given the same standing and contractual arrangements as GPs.

### Conclusion

The primary health care services provided to families in remote and rural areas across the developed world are changing. Nursing will provide the cornerstone of such changes and many countries have already embarked on such a project. It has been suggested that two new nursing roles, the FHN and the FNP will have a major role to play in future service restructuring. These nurses will require to have specific postgraduate preparation, and in the case of FNP, much of which would be shared teaching and learning with GPs. Family health nurses and FNPs will be the cornerstone of primary care services, it is just a matter of when.

Conflict of interest: none declared.

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