# Nursing Practice in Rural and Remote Canada

RURAL AND REMOTE NURSING PRACTICE:

AN ANALYSIS OF POLICY DOCUMENTS

*A Research Project Supported by the Canadian Health Services Research Foundation*

Documentary Analysis Final Report:
Policy Analysis for The Nature of Rural and Remote Nursing Practice in Canada

# RURAL AND REMOTE NURSING PRACTICE:

# AN ANALYSIS OF POLICY DOCUMENTS


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EXECUTIVE SUMMARY

This documentary analysis final report is the result of the collection and analysis of policy statements, technical reports, nursing practice regulations and standards and reports related to nursing education for rural and remote areas. It is one aspect of The Nature of Nursing Practice in Rural and Remote Canada research project (Appendix A). A more in-depth understanding of nursing practice in rural and remote Canada will be achieved from a combination of four methods: secondary analysis of the Registered Nurses Database (RNDB), documentary analysis, narratives and survey. An integrated final report of all methods will be available in 2004.

The documentary analysis was conducted to achieve a contextual understanding of the policy and practice environment within which rural and remote nurses practice. Relevant English-language documents were analyzed over a 20-month period. A framework was developed from three components of the policy cycle, which are policy formulation, policy implementation, and policy accountability (Rist, 1994). Two guides, with accompanying questions, were developed from the framework to assist in the analysis of the documents (Appendix C & D). Documents were retrieved through web-based searches, contacting organizations, and locating materials through members of the larger research team.

One of the challenges in locating and analyzing documents is the overall limited discussion of the terms rural and remote and the implications for nursing practice in Canada. Generally speaking, this is due to the lack of analysis regarding the theoretical and practical meaning of rural. Overall, the documents that were reviewed give the

impression that the meaning and significance of rural has been taken for granted. Finally, a number of documents emphasize the challenges of recruiting and retaining physicians to rural and remote areas while they fail to address the same issues for other health providers who also practice in these areas.

As mentioned, there has been little discussion or analysis of the terms rural and remote in the policy documents. These terms are often associated with a specific geographic meaning, which is equated with financial reimbursement for a particular type of nursing practice (www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/ten_years_health_transfer/index.htm). The lack of attention to the meaning of rural and remote, and the diversity of such settings, simplifies the complexity of nursing practice in such locales.

The analysis of the documents revealed five thematic areas:

- Advanced Practice,
- Nursing Practice Issues in Aboriginal Communities,
- Educational Preparation of Registered Nurses in Rural and Remote Areas,
- Physician Supply in Rural and Remote Areas, and
- Health Care Delivery in Rural and Remote Areas.

Each of these themes has been discussed in detail in the appendices of this report and are summarized in the main body of the report.

Advanced practice has generated a considerable amount of discussion in a variety of documents in the last few years. Changes to legislation and registration are ongoing across the country. Overall, there is support for this role as exemplified by the

availability of graduate programs to prepare nurses to work in advanced practice and the increased number of individuals working in such positions. Although the documents do not always discuss advanced practice in rural and remote settings, nursing practice in these locales will be enhanced by the availability of advanced practice nurses.

Nursing practice issues in Aboriginal communities includes understanding the band transfer process of health services because increasingly nurses employed in Aboriginal communities will be band-employed. Despite this significant change, the documents that were reviewed are limited in their discussion about the challenging employment conditions of a band-employed nurse. However, the Aboriginal Nurses Association of Canada has taken the lead in addressing such issues. In addition, the educational preparation of Aboriginal persons for the nursing profession is becoming recognized as an issue that needs attention. A recent report identified the barriers and challenges experienced by Aboriginal students in nursing programs and recommended, for example, that additional financial support be provided for relocation costs associated with attending school (Health Canada, 2002).

Educational preparation of nurses for rural and remote areas of Canada has not been discussed at length in the documents that were reviewed. There are only a few nursing programs in Canada that formally prepare nurses for such geographic settings and no evaluation reports of these programs could be located. In addition, there is no indication that the appropriate number of nurses is being prepared for rural or remote areas, or how many of those who are prepared for such settings actually work in them

upon graduation. Some of the programs do prepare nurses for rural and remote areas under challenging circumstances. Furthermore, many of the programs that prepare nurses for rural and remote areas do so at great financial cost because of the resources needed to place students in clinical settings in these areas. In addition, despite the emphasis in the documents on the need for telehealth to be used in rural and remote areas, there has been no investment in equipment or finances to prepare nurses for such technology. The documents revealed the general lack of government assistance to support the additional costs associated with educational preparation of nurses in rural and remote areas.

Documents related to physician supply in rural and remote areas were reviewed for several reasons including that rural health care is a multi-professional challenge and that legislation related to the role of nurses is influenced by physician availability, roles and expectations. In addition, physicians have developed rurality indexes, data on physicians and physician practice problems is most available, and physicians are the most politically organized to address issues related to rural and remote areas. Several key reports have examined the challenges of recruiting and retaining physicians for rural areas and note the importance of nurse practitioners (NPs) (Appendix H) in providing care in rural areas (Barer & Stoddart, 1999; OMHLTC, 2001b). Although considerable effort has been made in developing indexes related to rurality, these scales remain untested and their applicability and usefulness to practice is unknown.

The final theme focuses on health care delivery in rural and remote areas. Alternative modes of delivery were noted in the documents, including the RN First Call

Program in British Columbia and the use of telehealth throughout rural and remote communities in various locations of Canada. The Canadian Nurses Association (CNA) and the provincial nursing associations have developed position statements regarding telehealth within nursing practice, an issue that will continue to lead to discussion about its implications for nursing practice.

The following seven recommendations are based upon the information generated from this documentary analysis.

*Recommendation One*:
**Develop a national rural health human resource strategy by individuals with expertise in rural health issues**

*Recommendation Two*:
**Create alternative payment options for nurses and physicians in rural areas**

*Recommendation Three:*
**Develop scholarships and bursary programs for rural nursing students and rural-based nurses**

*Recommendation Four:*
**Implement initiatives to enable full scope of nursing practice, including advanced practice in rural areas with process and outcome evaluation in rural and remote areas**

*Recommendation Five:*
**Implement educational initiatives and complementary supports for nurses working with Aboriginal peoples**

*Recommendation Six*:
**Implement financial and technological support for universities with a rural-focused mission**

*Recommendation Seven*:
**Offer continuing education for nurses who work in rural and remote areas**

# RURAL AND REMOTE NURSING PRACTICE:
# AN ANALYSIS OF POLICY DOCUMENTS

This final report is the result of the collection and analysis of policy statements, technical reports, nursing practice regulations and standards and reports related to nursing education for rural and remote areas. It is one aspect of The Nature of Nursing Practice in Rural and Remote Canada research project (Appendix A). For this project, the Statistics Canada definition of rural and small town has been adopted, which refers to those who live outside the commuting zones of larger urban centres (du Plessis, Beshiri & Bollman, 2001). Rural nursing practice is largely an under-studied area and only recently it was identified that in 2000 there were 41,502 registered nurses (RNs) in rural and small town areas in Canada (Canadian Institute for Health Information [CIHI], 2002). Through the documentary analysis, combined with narratives, a survey and secondary analysis of the Registered Nurses Database (RNDB), this research project will lead to a more in-depth understanding of nursing practice in rural and remote Canada. An integrated final report of all four methods will be available in 2004.

This final report builds on the interim documentary analysis (Kulig et al 2002) in which some of the material was presented in a similar format. It begins with a general discussion of the documentary analysis, leading to an overview of the data method with highlights of the major findings focusing on major health policy documents (i.e., Romanow Report), rural health issues at the federal and provincial levels, and then issues related specifically to nursing. When conducting the documentary analysis, the following five major themes emerged:

1. Advanced Practice;
2. Nursing Practice Issues in Aboriginal Communities;
3. Educational Preparation of Registered Nurses for Rural and Remote Areas;
4. Physician Supply in Rural and Remote Areas; and
5. Health Care Delivery in Rural and Remote Areas.

These are discussed and expanded within the attached appendices (Appendix E-I inclusively). Finally, the report ends with concluding comments and recommendations.

## Method

The documentary analysis has been conducted to achieve a contextual understanding of the policy and practice environment within which rural and remote nurses practice. Relevant English language Canadian documents were systematically obtained and analyzed over a 20-month period (May, 2001 to January, 2003). Documents included policy statements, technical reports, nursing practice regulations and standards, and reports related to the nursing education for rural and remote areas. Sources were regional, provincial and national government offices, medical associations and professional nursing organizations. French language documents were not included due to a lack of resources for translation.

A framework was developed from the three components of the policy cycle, which are policy formulation, policy implementation, and policy accountability (Rist, 1994). In this analysis, policy formulation includes examining whether or not past and current policy has been developed in relation to rural and remote nursing practice. Policy implementation refers to determining if policy related to rural and remote

nursing practice was implemented. Policy accountability investigates whether there has been accountability by government and professional associations regarding policies and programs directed at rural and remote nursing practice.

The policy cycle framework was used to develop a guide (Appendix B) to analyze individual documents. Questions were developed for each component of the policy cycle to ensure that all facets of rural and remote nursing practice were addressed. Questions regarding policy formulation included:

- What are the definitions of rural and remote?
- Has rural and remote nursing practice changed since these definitions were forwarded?
- What education programs and/or courses were developed and implemented to prepare nurses to work in rural and remote settings?

To address policy implementation, questions included:

- Is the appropriate number of nurses available in rural and remote parts of Canada to meet the needs of the residents?
- Were there changes in nursing regulations that enhanced or inhibited nursing practice in rural and remote areas?

Finally, for policy accountability, the following questions were used:

- What were the anticipated and unanticipated outcomes resulting from the development of policies and programs in relation to rural and remote nursing practice?
- Has the program or policy also changed with more current circumstances?

These questions focused the analysis of the documents while permitting an in-depth understanding of the policies and their implications.

In order to allow easy access by all members of the research team the checklist was converted into a web-based form (Appendix C). When it was converted, additional information was included such as the name of the individual submitting the form, the document title and author, document date, discipline addressed in the document, field of practice (i.e., nursing, medicine), geographic area, intended audience and type of document. The web-based form was developed so that it could be automatically submitted to the principal investigator's (Kulig) email address when completed. Once it was received, it was converted into a word-based document and printed. A list of all the documents that were read was also compiled at this time. Finally, a webCT site was designed exclusively for the documentary analysis team. This site contained the list of documents that were read, a bibliography of materials and a discussion area. A user-friendly feature of this computer program is that messages can be categorized by subject making it easier to retrieve and access older messages.

To test out the web-based form, each team member read the same document and submitted a completed form (Appendix C). During this process, it was discovered that the form did not fit well with documents that discussed other health professions such as medicine. A number of questions were inappropriate or not applicable, resulting in large blank areas on the submitted form. Hence, a second, shorter form was developed for the reports that discuss topics such as rural physicians (Appendix D). The questions from this form were chosen from the initial checklist and captured the broad picture of

rural and remote health issues and the potential impact on rural and remote nursing practice.

A number of activities were used to identify and locate reports and documents that were used in the analysis.

1. Three research assistants (Meyer, Hart & Nahachewsky) conducted web-based searches on policy as it related to general subject headings such as nursing, rural nursing, advanced practice in nursing, medicine and other health professionals, recruitment and retention of health professionals, and nursing standards and regulations.
2. More specific searches were completed on topics such as preparation of First Nations individuals in nursing.
3. Searches were also conducted on provincial and federal government web sites to identify documents related to the nursing profession and health policy in general, and rural health policy more specifically, and government direction in relation to recruitment and retention of health professionals in rural and remote areas.

The initial listing of documents was posted on the rural and remote nursing practice research group listserv, which the entire research team received. Individual members reviewed the list of documents, suggested other reports, and supplied copies of reports that were in their possession. It was deemed important to locate reports and documents that covered broad health care delivery content and then review them to determine their applicability to the subject at hand.

During this time, meetings were held with the documentary analysis research team. When the research study was developed, individual co-investigators and advisory team members were asked to self-select the research methods within which they wanted to participate. A teleconference meeting was held with the co-investigator (Thomlinson) in April 2001 to discuss the actual process of conducting the documentary analysis. A face-to-face meeting was held with the co-investigator and two research assistants in June 2001. It was at this time that retrieved documents were perused and lists of other documents to locate and activities to complete were compiled. Another teleconference call was conducted in September 2001 with the co-investigator and two advisory team members (Curran & Brunskill) to further update the team on the progress of the retrieval of documents, and to discuss the analysis process.

A face-to-face meeting with the co-investigator, one advisory team member (Curran) and the research assistants was held in February 2002, which allowed for further discussion of the documentary analysis and a demonstration of webCT. By the time this meeting occurred, the web-based forms had been tested and revised and all members had read a sample of documents. This meeting was helpful in identifying potential themes and an outline for the interim report. Specific questions were also developed to assist in focusing the reading of the remaining documents in preparation of the preliminary documentary analysis report (Kulig et al, 2002), which was distributed in July 2002. Another meeting was held with the co-investigator (Thomlinson) in October 2002 to re-prioritize the documents and finalize plans for the final report. Due to distance issues, telephone and email discussions occurred with the

advisory team member (Curran) to address any concerns or issues with the preparation of the final report.

The four Co-Principal Investigators had meetings on a regular basis--by teleconference approximately every two months and face-to-face meetings bi-annually. At these meetings, the documentary analysis process and preliminary and final reports were discussed, and ideas were shared regarding method, retrieved documents and the development of recommendations.

## Findings

One of the challenges in locating and analyzing documents is the overall limited discussion about rural and remote and the implications for the nature of nursing practice in Canada. In part this is due to *the lack of analysis regarding the theoretical and practical meaning of rural*. The Rural and Small Town Analysis Bulletin, which is a recent electronic bulletin sponsored by Statistics Canada (du Plessis, Beshiri & Bollman, 2001), is assisting with rectifying this situation. In addition, the reviewed documents give the impression *that the meaning and significance of rural has been taken for granted and is therefore not specifically considered or discussed*. For example, the scope of practice documents for the Northwest Territories (NWT) not only lack definitions of rural and remote, but also do not reflect the uniqueness of nursing practice in the north in the nine principles that are enunciated (Northwest Territories Registered Nurses Association [NWTRNA], 1994). Consequently, the principles could describe the scope of practice in any province or territory in Canada. One other illustration of rural being taken for granted is that a number of the documents are “urbancentric.” For example, in

the original Registered Nurses Association of British Columbia (RNABC) policy report on professional conduct, a comment is made that the nurse should excuse himself or herself from caring for a client when there is a pre-existing social relationship[1] (RNABC, 2000). In rural environments, this would be difficult to achieve given the longstanding social relationships and connections between residents of small communities. Finally, a number of documents *emphasize the challenges of recruiting and retaining physicians to rural and remote areas while they fail to address the same issues for other health providers who also practice in these areas* (CIHI, 2002). The following reports illustrate these concerns, with a number demonstrating that despite the interest in preserving the health of rural Canadians, few of the identified concerns will be addressed without accountability plans and political support.

## *Key Health Reports*

Preserving the health of Canadians and creating a sustainable health care delivery system has increasingly been a focus of reports at the provincial and national levels. This discussion will focus on the most significant of these reports in regards to their applicability to rural nursing practice. The reports provide a cross-country view of what is being discussed regarding health issues.

### *Key Provincial Health Reports*

A case in point is the province of Ontario, which addressed the need for health services restructuring by focusing on primary health care (Primary Health Care,

[1] The most recent version of this policy statement has been revised and emphasizes that caring for individuals with whom you have a personal relationship changes the relationship to a professional one, which needs clarification. Furthermore, it states that if clarification cannot occur, then the nurse should withdraw from providing care (RNABC, 2002b).

recommendations to Witmer, 1999). Definitions of rural and remote focus on access to health services (i.e., rural refers to being able to reach a primary care centre within one hour whereas remote refers to anything beyond the hour). This approach is commonly used in reports that discuss physicians, however, this allows for a limited understanding of these concepts. The overall recommendation of this report is to develop primary health care groups that will include multi-disciplinary teams of physicians and primary health care-nurse practitioners (PHC-NPs). There is discussion of the need to increase the number of available nurse practitioners (NPs) and to combine this role with midwifery to further expand nurses' functions while ensuring such independent practices are viable. An accountability plan and time line is included to ensure that the suggestions are put in place.

Saskatchewan Commission on Medicare (Fyke, Commissioner 2001) addressed concerns about sustaining a quality medicare system in Saskatchewan in a recently released report. In his report, Saskatchewan is considered to be a rural province (although the term rural was not defined) that has had continuous difficulties recruiting and retaining health care professionals. Despite this ongoing challenge, it was noted that quality should not be jeopardized. There was acknowledgement that nurses' skills are not being fully utilized and if these skills were to be used, then health care delivery concerns within the province would be at least partially addressed. Despite the acknowledgement that the province is mostly rural, there were few recommendations that specifically focused on the unique needs of rural residents. Instead, there were recommendations scattered throughout the report that addressed the needs of

aboriginal residents, specifically those who live in the northern area of the province. The recommendations focused on support for holistic health and the need to support the preparation of aboriginal people in health-care related careers. Like many other reports, there is no accountability plan, including a timeline, to ensure that the recommendations are implemented.

A number of recommendations included in the report, however, could potentially have an impact on rural nursing practice. For example, a recommendation for developing a province-wide plan for specialty care can potentially reduce waiting times for rural residents. Developing a 24-hour telephone advice system could also improve access to health care services for all residents, including those who are rural-based. The report neglected to offer suggestions on how to address the shortages of health care providers and the low morale that exists among this group. Although it notes that nurses can have expanded roles, it does not offer any suggestions regarding how this could occur (Saskatchewan Commission on Medicare [Fyke, Commissioner], 2001).

In Alberta, A Framework for Reform (Mazankowski, 2001), which is commonly referred to as the Mazankowski report, was released in December, 2001. This report on health written for the Alberta government suggested strategies for reorganizing the provincial health care system. One underlying theme of the report is that the average Albertan should have a choice in health care services between private and public health care delivery, an approach that is currently not philosophically supported at the national level even though health is a provincial responsibility. Another theme is that

individuals need to take the responsibility to make healthy choices in their lives, which would then help to decrease the use of the system's resources (Mazankowski, 2001).

There are only a few instances in the report where rural is specifically discussed: these emphasize the shortage of physicians in rural Alberta and the shortage of facilities for those with mental health concerns. Recruitment and retention of health care providers is also noted as a chronic concern. Although a number of recommendations are provided, none specifically addresses the unique needs of the rural and remote areas of the province, but some of the recommendations, such as the more effective use of NPs, will impact the rural areas. As well, expanding the role of the licensed practical nurse (LPN) could also potentially change how care is delivered in rural areas (Mazankowski, 2001). The report failed to outline an accountability plan or opportunities for follow-up to ensure that the recommendations were put into place.

At the territorial level, the newly formed Nunavut is just beginning to develop long term plans regarding health services and hence no reports were available to review. The NWT has released a number of reports in which the notion of rural is taken for granted rather than specifically addressed. As well, the issues and concerns of the territories are often described as related to their northern geographic location, rather than being rural or remote. Finally, concerns in the north are linked to aboriginal self-government issues and considered to be political in nature. Nonetheless, a recent report from the NWT (Cuff, 2001) notes the use of Telehealth and the development of the NP program to allay some of the identified concerns in the NWT. In total 56 recommendations were included and a number are of significance to the current

discussion. One specific recommendation suggested that the number of service delivery regions be reduced from nine to three and that clusters of service be developed so that professionals are available in the geographic areas that need them. They also suggested that a Professional Resources Recruitment Team be developed to address recruitment of health care and social service providers. The authors also recommended that any health centres staffed by only one nurse be closed and alternative, but unexplained, plans be implemented to ensure that the community receives care. Finally, it was suggested that graduates be adequately financially compensated to support entering the NP program.

*Key Federal Health Reports*

"The Health of Canadians—The Federal Role" (Kirby Report), the final report prepared by the Standing Senate Committee on Social Affairs, Science and Technology (2001), also addressed rural health issues. Proposed solutions to issues such as the nursing shortage and difficulties in providing quality care in aboriginal communities included:

- sustaining federal support of telehealth in rural and remote areas;
- providing the resources needed to train aboriginal people to become health care providers; and
- developing a national health human resource strategy.

The Romanow Report has echoed or mirrored these recommendations.

The Commission on the Future of Health Care in Canada, more commonly referred to as the Romanow report, was released in November 2002 to much anticipation regarding health care reform and sustainability in Canada. The Romanow

Report focuses on several areas of particular relevance to our discussion, including health care providers, rural and remote communities and aboriginal health. The challenges and issues associated with these three areas are presented by Romanow based upon a collaborative consultation process. Recommendations include establishing a Rural and Remote Access Fund to improve access to care for residents in rural and remote settings as well as recruit and retain an appropriate mix of health care providers in those rural and remote communities. Another recommendation that supports rural nursing practice is to reexamine and change the current roles of RNs so that they may perform expanded duties. The Commission also recommends expanding telehealth as one way to improve access to care. Romanow recommends that aboriginal health funding be consolidated and managed through a newly created group, Aboriginal Health Partnerships (AHP), to better organize and deliver health services to this population.

In summary, several key health reports have been released in the last few years, but only the Romanow report makes a conscious effort to specifically address rural health issues. The recommendations of this report have the potential to impact rural nursing practice providing the financial and political support is in place.

### *Rural Health Issues at the Federal Level*

A national rural health strategy was announced June 12, 2000 by former Health Minister Allan Rock to:

1. address the shortage of health care providers,
2. foster research and support health information technology,

3. improve primary health care,
4. improve the rural health infrastructure, and
5. establish a National Rural Health Council.

Through summits and riding workshops (Health Canada, 2001), rural residents identified issues and made recommendations which have the potential to enhance rural nursing practice. Several of the recommendations were implemented, including the development of the Ministerial Advisory Council on Rural Health in 2001 (Rural Health in Rural Hands, 2002). A recent report from this group examined the rural health challenges in Canada and made over 40 recommendations ranging from how to build healthier rural communities to addressing health information technology in rural areas. Of specific concern to our discussion are the following recommendations:

- to support research on rural health services delivery;
- to enhance telehealth for rural settings across Canada, including supporting research that evaluates such projects;
- to develop a national health human resources strategy to address recruitment and retention in rural, remote and Aboriginal communities;
- to support opportunities for rural residents to gain easier access to health professional education and to provide more financial support for rural residents to receive such an education; and
- to increase opportunities for access to education that incorporates material related to rural areas in academic institutions across the country (Ministerial Advisory Council on Rural Health in 2002).

There has been limited distribution of the report and no indication that the recommendations will be implemented. However, the Romanow report recommended the establishment of a Rural and Remote Access Fund to expand telehealth, address health care provider shortages, and fund new approaches to health care in rural and remote communities (Romanow, 2002). In addition, from the 2003 federal budget, $1.3 billion will be directed to First Nations and Inuit health programs specifically to be directed to nursing and capital development on reserves. The most recent federal budget has also earmarked funding of telehealth applications, which are seen as essential in rural areas (Department of Finance Canada, 2003).

### *Rural Health Issues at the Provincial Level: British Columbia as an Example*

There are few provincial reports that exclusively address health issues and health care delivery for rural residents. Some of the exceptions are the documents from the British Columbia Ministry of Health (BCMOH). Of all provincial and territorial governments, British Columbia (BC) has expended considerable effort in attempting to understand and address rural and remote health issues. In 1995, the BC government released the Report of the Northern and Rural Health Task Force, which identified human resource and program needs for northern and rural areas and included a number of recommendations to resolve outstanding issues (Northern and Rural Task Force, 1995). This report defined rural and remote communities as small population centres over a large geographic area often with single resource bases and large distances between communities (Northern and Rural Task Force, 1995).

A follow-up report on enhancing health services for rural and remote communities (BCMOH, 1999) does not define rural, but referred to rural as being equated with geographic location and distance from more elaborate health services. The numerous challenges associated with delivering health services in rural areas are discussed, and future directions are noted, such as focusing on health care service delivery, service coordination, and human resources. More specifically, the recommendations focused on increased involvement of aboriginal peoples to ensure more appropriate health service delivery, the use of telehealth to enhance rural and remote health services, and the examination of transportation problems for residents in rural areas.

A second follow-up report to the BCMOH focused on reforming the health system, also addressed rural health issues (BCMOH, 2001b). Although rural is not specifically defined, there is discussion about the special needs of rural residents in terms of accessing health care. Of the 25 recommendations, a number specifically focused on the nursing profession, such as improving working conditions and making better use of nurses' skills. One of the recommendations supports the use of NPs while another discusses the need for educational options to increase access for individuals across the province. Assistance with tuition and linking tuition assistance to areas where there are nursing shortages were proposed. If put into place, the recommendations have the potential to have a positive impact on rural nursing practice by recruiting local residents into the profession.

The Assess and Intervene Report (Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia, 2000) included a section on rural and northern nursing. Unlike other reports, there is discussion of three types of rural nurses: those who have remained or returned to their rural home, those who have unexpectedly moved to a rural setting (most often due to spousal employment), and those who consciously chose to relocate to a rural area.

The specific challenges for rural nurses, such as the duality of roles in being both a community member and professional, and the social and professional isolation are noted. As in other reports, the difficulties in recruiting and retaining RNs in rural and northern environments are also acknowledged. Recommendations focused on creating an aboriginal nurses' entry program to increase the number of aboriginal nurses, expansion of the RN First Call program, implementation of nursing support programs through the internet to decrease professional isolation, and examination of other health care delivery system models (i.e., Red Cross Hospitals) that have been successful at retaining nurses to incorporate lessons learned to other health care delivery models in BC.

In the appendices of this report, there is a focus on aboriginal nurse recruitment and retention strategies (Appendix F), and the information directly applicable to rural nursing and nursing practice in aboriginal communities (Appendix F). Recommendations include the establishment of summer employment programs for nursing students, especially those who are First Nations members, and efforts to ensure

that First Nations that have transferred health services to band control have sufficient funds to support nursing staff. The report also points out that the recommendations have costs associated with them, but the savings in recruitment costs will help balance the initial start-up funds.

*The Nursing Shortage*

There is a growing realization by government departments and agencies that recruiting and retaining nurses for rural and remote areas will be even more challenging in light of the predicted nursing shortage. A number of annual reports from provincial governments make specific note of the forecasts for fewer nurses in rural areas and the concomitant affects on health care (Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia, 2000; Saskatchewan Health, 2000; Nova Scotia Department of Health, 2001, 1999; East Prince Health Board, 2000).

An essential underlying factor is the nursing shortage which has been predicted for some time. Ryten (1997) conducted a cohort analysis to determine supply and demand for nurses and found that the need for nurses would increase due to the aging of the population. Given this scenario, Ryten found that there were not enough individuals entering and graduating from nursing programs. The most recent report on nursing human resource projections (Canadian Nurses Association [CNA], [Ryten], 2002d) identifies that by 2011, there will be a shortage of 78,000 nurses that will reach 113,000 by 2016. One discussion paper (CNA, 1997) and follow-up submission to the federal government discussed the predicted nursing shortage and requested that the

federal government undertake initiatives to rectify the projected shortage despite provincial responsibility for health (CNA, 1998a). That same year another document was released that identified the recruitment and retention issues for nurses, noting the specific challenges for northern, rural and isolated areas (CNA, 1998b). In a similar vein, the CNA (2000b) conducted a labor market integration evaluation and found that nurses were underemployed due to higher rates of part-time employment and the fact that two out of 10 nurses decide to leave the profession within three years of graduation. Although not directly linked to rural and remote nursing practice, the findings generated from these reports have a direct impact on this field of nursing because of the decreased number of nurses in general that will be available for recruitment to rural areas.

At the federal level, discussion about the pending nursing shortage and the need to strengthen the nursing workforce began in 1999 with the nursing strategy released in 2000 (Advisory Committee on Health Human Resources [ACHHR], 2000). Further support regarding the reality of the nursing shortage is discussed in Commitment and Care (Baumann, et al, 2001), which emphasizes that unhealthy workplaces have contributed to the nursing shortage. Although these document do not specifically address rural and remote nursing practice issues, the suggestions regarding addressing the nursing shortage will affect the number of nurses available to work in rural and remote areas.

A number of organizations echoed the need for a national nursing strategy in Canada. The Nurses Association of New Brunswick (NANB), (2002) submitted a brief to

Commission on the Future of Health Care in Canada noted that the need for such a national strategy as one of three pressing issues. The report identifies immediate policy interventions such as supporting the recruitment of candidates to the nursing profession and ensuring that nurses have access to continuing education. The federal government was asked to work with the national, provincial and territorial nursing associations to implement such policies (NANB, 2002).

*Developing a Nursing Workforce for Rural Settings*

Rural nurses have been referred to as generalists, with a range of practice, extending from outpost to institutional nursing that includes specific activities such as home care, health promotion and telephone advice (Report to the Minister of Health on the Recruitment and Retention of Registered Nurses and Registered Psychiatric Nurses in British Columbia, 2000).

Several reports have addressed the link between a sustainable health care system and a workforce that experiences a balance between job satisfaction and recruitment and retention. A case in point is the report to the Deputy Minister of Health for Saskatchewan, which discussed health human resource challenges among all front-line health care providers in that province (Backman, 2000). The goal of the report was to provide recommendations to Saskatchewan Health to address such challenges. This lengthy, comprehensive report included stakeholder meetings, discussion groups and solicitation of briefs to ensure a full understanding of the issues was achieved. Similar to other reports, the term rural is not specifically addressed, but the report does address rural practice issues among health care providers. It is recognized that rural areas have

greater difficulties with recruitment and retention and that the province can no longer rely on rural women returning as nurses to their home communities. Of the 30 recommendations, those relevant to rural nursing focus on advanced practice nurses and their development through the offering of an appropriate educational program, as well as bonuses as incentives for rural nurses. Financial assistance with tuition costs for nursing refresher courses for those who have left the nursing profession (RNs, LPNs or psychiatric registered nurses [PRN]) was implemented since the report was released (Backman, 2000).

The shortages of providers in rural areas prompted two potential solutions: either eliminate the service due to the lack of providers or offer the service through a different mix of providers. Other recommendations that support rural health care providers, and decrease the professional isolation, include a formalized peer support system and continuing education opportunities. Finally, although aboriginal health issues are noted in the report, there are no specific nursing education recommendations that address this concern. Instead, it is recommended that aboriginal educational institutions and Saskatchewan Institute of Applied Science and Technology (SIAST) jointly offer courses for home care aides and special care aids. In 2003, the Nursing Education Program for Saskatchewan (NEPS) was extended to a Prince Albert site, where 40 new baccalaureate education seats are available for aboriginal students in a collaborative arrangement between the Saskatchewan Indian Federated College (SIFC) and the College of Nursing, University of Saskatchewan (U of S). In the other two sites for the NEPS program (Saskatoon and Regina), there are currently 88 students.

Working conditions and satisfaction in general among nurses has been the focus of a number of reports in the last several years. Remus, Smith & Schissel (2000) conducted a study to identify nursing environment issues that affect the recruitment, retention and practice of nurses. The 631 respondents in this study noted a number of frustrations with their workplace and their role, including the lack of nurses available to work leading to increased overtime and call-backs, decreases in support staff leading to more clerical duties being conducted by nurses, and feeling that they cannot provide safe, competent care given the heavy patient loads and lack of resources. The report clearly indicates the high level of stress of nurses including physical and psychological abuse they face from co-workers, patients, families, and employers. Of the entire sample, 24% experienced physical abuse (27% of institutional nurses compared to 13% of community nurses); and 39% reported psychological abuse (42% of institutional nurses and 26% of community nurses) (Remus, Smith & Schissel, 2000). Nurse safety was also noted as a problem because of the lack of support staff (i.e., security personnel) during night shifts at hospitals, having to leave community buildings alone late at night after presentations, and worries during home visits when domestic violence has been identified as an issue. These are compounded in rural areas where the settings are much more isolated.

The findings acknowledge the challenges that lie ahead for recruitment and retention of nurses in rural areas. Within the next 5 years, 40% of the rural nurses surveyed expect to retire and this figure jumps to 66% in the next 10 years. In comparison, of the urban nurses surveyed, 34% plan to retire in the next 5 years and

50% plan to retire in the next 10 years. The percentage declaring interest in retirement, combined with the predicted nursing shortage and the lack of support for nursing students to complete clinical placements in rural parts of Saskatchewan, will adversely affect the recruitment and retention of nurses for rural Saskatchewan (Remus, Smith & Schissel, 2000). Interestingly, a labor market analysis of Saskatchewan nursing (including LPNs) paints a much brighter picture (Elliot, 1999). In describing the nursing shortage in the northern parts of Saskatchewan, Elliot rightfully comments that the difficulties in recruiting in 1998 were no different than in the past but fails to specifically address what will happen in these regions in the future given the predicted national nursing shortage.

The Remus et al report includes a total of 21 recommendations that range from paid leave and relief staff to allow for continuing education among nurses, to work safety issues. There are several recommendations that focus specifically on rural issues including that clinical experiences be increased in rural areas for nursing students, that nursing education programs be delivered in multiple formats so that students can remain in their communities as long as possible, that Saskatchewan Health and health districts provide financial support for nursing students while they are completing rural nursing clinical placements, and that rural health districts provide bursaries to nursing students to encourage them to return to rural areas (Remus, Smith & Schissel, 2000).

Workplace quality of life has been raised as an ongoing concern in a number of the reports that were reviewed. Dussault et al (1999) held an invitational roundtable of stakeholders in nursing including RNs, LPNs and PRNs, to examine labor issues for

nursing. This report included a comprehensive review of the literature and identified the concerns regarding the nursing labor workforce (i.e., aging workforce, poor quality work environments), the impact on nursing practice (i.e., heavy workload and inability to provide quality care to clients), the response of the nursing profession to the changes in the health care delivery system (i.e., models for practice and changes to practice) and recommendations by the stakeholders (i.e., improve working conditions, incentives for nurses to return to the profession).

Although rural nursing practice is not specifically addressed in the Dussault et al report, nursing services in aboriginal communities were discussed. In addition, the issues that were addressed throughout the report all apply to rural areas, and in some cases, are an even greater challenge in that setting. For example, recruitment and retention of nurses for rural communities is even more difficult than for urban locales. Although many of the suggestions have been discussed in other reports, it is noteworthy that the same themes continue to emerge. Specific policies and initiatives have the potential to make the necessary changes thereby improving the overall work environment for nurses. One other strength of this report was the identification of several gaps in the literature that if filled, would assist in policy creation and implementation. Information is needed about mobility of nurses between provinces, nursing services to aboriginal communities where access is an ongoing issue, and the capacity of nursing programs to prepare master's prepared nurses. There is, however, no discussion regarding how these gaps could be filled and no specific follow-up or

accountability plan to ensure the recommendations discussed in the report are implemented.

The CNA has responded to worklife issues by hosting a workshop on the Quality of Worklife Indicators (QWI) for Nurses in Canada, which was held in Ottawa, April, 2002 ( CNA, 2002e). In total, eight indicators were generated (span of control, leadership, overtime hours, full-time, part-time/casual ratios, autonomy/scope of practice, professional development opportunities, absenteeism, & grievances). The indicators were not specifically developed for rural nurses, and are to be used cautiously when discussing the quality of worklife for rural nurses. The indicators do, however, provide direction for policy development in regards to nurses' worklife.

The CNA has pointed out the significance of nurses who provide care in rural and remote areas of Canada. In the 2001 brief to the Romanow Commission, the CNA notes the link between rural community sustainability and the location of health care facilities and employees (CNA, 2001a). The CNA pre-budget submission to the House of Commons Standing Committee on Finance (CNA, 2002f) recommends incentives to attract health professionals to rural and remote areas. However, no specific activities are suggested to meet this recommendation.

Other nursing associations have been vocal about the need to prepare, recruit and retain nurses in rural areas. For example, the 2001 RNABC brief to the Ministers of Health Planning and Health Services specifically addressed the need for changes and suggested that nurses can contribute to a reorientation of the health system (RNABC, 2001). The brief addressed an overall plan to change and thereby improve the BC health

care system. This provincial association highlighted the need to (1) improve the effectiveness of the health care system, (2) reorient the health care system through, for example, the acceptance of NPs in providing primary care, and (3) implement strategies to meet the health human resource needs. The latter refers not only to actual numbers of available nurses but also to the need for a healthy workplace, which is equated with success in retaining nurses and commitment to care (RNABC, 2001). Rural nursing is not specifically addressed, but a number of the comments are directly relevant to this area of nursing.

There are 11 recommendations in total under the three main areas as noted above. One of the recommendations is to continue to support the RN First Call program (Appendix I). In this program nurses use clinical practice guidelines to provide care for selected clinical problems in emergencies in rural and remote areas, thereby decreasing the amount of on-call time by the physician while improving health care access for the public (MacKinnon Williams, 2000). Another recommendation formally supports the need to educate, regulate and employ NPs in BC. The final recommendation of interest here is that resources be provided for nursing programs to allow for specialty courses in rural and remote practice. Comments are included about the current distance learning opportunities available for nurses throughout the province, and the need to continue such programming to be cost-effective while increasing accessibility (RNABC, 2001). Interestingly, a cursory examination indicates that the recommendations have little connection to rural nursing. It is only after an extensive perusal of the entire brief that the linkages between rural nursing and the recommendations become evident. This

points to the need to examine documents carefully to ensure that the relevance to rural areas is identified.

A recent report on health human resource planning in Canada concludes that we need a national health human resource coordinating agency to attend to our need for an adequate and well-prepared supply of health care providers (Fooks, Duvalko, Baranek, Lamothe, & Randeau, 2002). The authors note that we need to determine the actual number and mix of health personnel required, because addressing the shortfall in numbers is not effective in long range planning for health care service delivery. Four forecasting models are presented with acknowledgement that their application to nursing is unclear due to the manner in which nursing positions are funded. If we add to this the complexity of the rural settings, identifying an adequate forecasting model becomes even more difficulty (Fooks, et al, 2002).

A number of comments in the report are supportive of nursing and identify the need to expand the nursing role through more formal acceptance of NPs. Overall, very little mention of rural is made and when it is discussed, there is an emphasis on rural physicians. The authors acknowledge that the complexity of the issue requires a national effort through a health human resources coordinating agency, which would focus on activities such as conducting an environmental scan of the current health personnel in Canada, trend identification (i.e., trends in numbers), and developing indicators of the health of Canada's health work force (Fooks, et al, 2002).

The Nursing Strategy for Canada was developed by the ACHHR to present ideas that would strengthen the nursing profession (ACHHR, 2000). The report focuses on the

current educational preparation of nurses, the importance of creating quality workplaces, and the predicted nursing shortage. Eleven strategies were forwarded that would attend to collecting information on the current nursing workforce, preparing more nurses by increasing the numbers of nursing education seats, and developing retention strategies. One other strategy suggested was the development of a nursing advisory committee to focus on nurse human resource planning and management (ACHHR, 2000).

This committee, known as The Canadian Nursing Advisory Committee (CNAC), was established in 2001. It released its report, “Our Health, Our Future: Creating Quality Workplaces for Canadian Nurses” (CNAC, 2002) in the fall of 2002. The committee evolved from the recommendations of the National Nursing Strategy (CNAC, 2002). The report addressed not only RNs, but also registered psychiatric nurses and LPNs, and specifically focused on quality of worklife because this was seen as most crucial to the future of the nursing profession. A thorough discussion of the many factors that impact on the quality of life of nurses is discussed. For example, the lack of access to continuing education and violence in the workplace were both noted. The committee acknowledges that there are insufficient numbers of aboriginal nurses prepared in Canada and that education for rural and remote areas is also deficient (CNAC, 2002).

A total of 51 recommendations are provided ranging from student loan forgiveness to creating practice environments that attract and retain nurses. There are only a few recommendations that focus specifically on rural and remote issues. One

recommendation is for the federal and provincial/territorial governments to collaborate with schools of nursing to maximize technological and face-to-face educational opportunities for nurses who work in rural and remote areas, including those who work and reside in Aboriginal communities. A further suggestion was that this recommendation be in place by 2003. Another recommendation is for the government to invest in nurses working in rural and remote settings to ensure recruitment, retention and improved working conditions. Although the other recommendations do not specifically identify rural, they may still affect rural settings and rural nursing practice because the recommendations are supportive of nursing in general (CNAC, 2002). However, like other policy documents, there is no apparent accountability plan to ensure that the recommendations are put into action.

A number of the above reports note solutions to address the overwhelming concerns within the nursing profession. However, when reports are prepared in an attempt to address such issues, rural nursing practice is more often omitted. For example, a report on nursing skill mix and health care outcomes only discusses rural nursing by referring to published literature from Australia (Hailey & Harstall, 2001). Attention needs to be paid to developing reports that address the full range of settings within which nurses practice.

### *Analyzing the Context of Rural and Remote Nursing Practice*

The broad, contextual issues that have been discussed shape the nature of rural and remote nursing practice. However, there are five specific areas that warrant detailed discussion and consideration when examining and analyzing the current state

of rural and remote nursing practice. Those areas are: (1) advanced practice, (2) nursing practice issues in aboriginal communities, (3) educational preparation of RNs for rural and remote areas, (4) physician supply in rural and remote areas, and (5) health care organization and delivery in rural and remote areas.

*Advanced Practice*

Terms such as NP, clinical nurse specialist and advanced practice nurses have been used interchangeably in a country that has displayed a tenuous relationship at best with the expanded role of nurses (CNA, 1993). Over the years, a number of documents have been produced that have attempted to clarify the meaning of advanced practice, the educational requirements and the legislation of the individuals who are working in these roles.

The CNA has viewed advanced nursing practice (ANP) as “an umbrella term” (CNA, 2000a, p 1) to describe “an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients” (CNA, 2000a, p 1). In the initial report on advanced practice, the CNA prepared a framework to address the issues related to this expanded role of nursing. This framework indicated that the ANP would be a role of the nurse but not a legislated title like “registered nurse.” According to the framework there are five competencies of an advanced nursing practitioner: clinical, research, leadership, collaboration, and change agent. To accomplish these competencies, it is preferred that an ANP undertake graduate preparation. Furthermore, some of the roles of an ANP would include clinical

nurse specialist[2] and NP. The domain of practice for such individuals would predominantly be clinical practice with their regulation maintained within the existing regulatory bodies (CNA, 2000a). The more recent revised CNA document on advanced practice (CNA, 2002a) takes a stronger stand noting that the minimal educational preparation for advanced practice is a graduate degree in nursing.

Furthermore, a recent review of NP competencies in Canada indicated a high level of congruency of provincial competency statements (L. Little, Personal Communication, May 8, 2003).

Discussion on ANP focuses on expanding the role of nurses for the benefit of the profession, whereas others merely perceive such expansion as an alternative to recruitment and retention of physicians in rural areas. Topics such as this are of particular concern when examining nursing practice in rural and remote areas. A case in point is the Saskatchewan Government release of a Memorandum to Cabinet "Improving Access to Rural Health Care" (Bruni, DeWolfe, Nakamura & Stokes, 2001). This particular memorandum defines rural as a population of less than 10,000 but does not exclude communities that are in proximity to larger centres. The recommendations include improving the delivery of primary health care to rural Saskatchewan by permitting nurses to take on more responsibility, thereby alleviating the pressure on physicians. Despite this intention, the report states that resistance will be met by members of the Saskatchewan Medical Association, a not uncommon finding among

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[2] However, in another CNA document on the clinical nurse specialist (CNS) (1993), it is implied that a CNS is an individual who focuses on care rather than diagnostic activities adding further confusion when using these terms.

other medical associations across Canada. The strategies highlight the benefits of partnerships between NPs and physicians and the creation of roles that are complementary. The report notes that the government would only be prepared to fund NPs that are committed to providing care in rural areas.

Not all physician groups have raised concerns about the integration of NPs in the delivery of health care services. At the 1998 Annual Policy Conference of the Society of Rural Physicians of Canada, the focus was on NPs and rural medicine (Society of Rural Physicians of Canada, 1998). The report is actually a dialogue that includes presentations from physicians, nurses and health ministers discussing the concept of the NP in relation to providing care to rural residents. The conference participants forwarded five resolutions, but there was no formal action or apparent mechanism of accountability for their implementation.

The Institute for the Advancement of Public Policy (IAPP) (2001) report on the nature of the extended/expanded nursing role in Canada and notes that NPs are expected to work autonomously and collaboratively with physicians in a variety of settings because of the shifting supply of other health care providers. In remote areas, there has been more acceptance of the expanded role of the nurse due to the limited supply of physicians. Although the IAPP report includes a number of recommendations, there is no plan for accountability to ensure that they are implemented.

Provincially, Newfoundland and Labrador recognized NPs at an earlier date than other provinces (Association of Registered Nurses of Newfoundland [ARNN],

1997b). However, as noted in Table 1, other provinces have passed legislation since then to formally acknowledge the NP role. The specific name applied to this role varies from province to province but there is general consistency in the role across the country. The primary health care or family NP provides health care management for individuals, families and communities including prescribing medications. Most provincial nursing associations in Canada have developed nursing practice standards for nurses and a list of competencies. Other roles for the primary health care or family NP include participating in research, working with communities in community development initiatives and professional leadership. Acute care NPs focus on working in institutional settings providing care to unwell individuals in settings such as cardiac rehabilitation units.

Educational preparation for the NP role has varied from a certificate program after completion of a nursing diploma (Chaytor Educational Services, 1993) to a masters level NP program. The nursing documents and reports foresee the NP role as one of natural expansion for the profession, exemplifying collegiality and collaboration (CNA, 1993, 2000a, 2002a; IAPP, 2001). However, the differences in names and roles from one provincial nursing association to another, and the lack of consistency in nursing education for the role, undermines the expansion in scope.

*Nursing Practice Issues in Aboriginal Communities*

A major component of nursing practice in remote Canada is nursing and health care delivery in Aboriginal communities. Since the early 1900s nurses have been on the front-line providing care in an expanded practice model in these communities (The

Musk-Ox Circle Paper Three Health Services in Northern Canada, 1974). Many nurses work collaboratively with community members and other health and social service personnel to address the health and social needs identified at the local level. To understand the issues faced by nurses who are often the only health care providers within these communities it was necessary to examine government documents and policies relating to the delivery of service. Several crucial factors have, and will continue to have, an important role in the development and delivery of health care. These include:

- transfer of health care delivery to tribal council or local band control;
- the introduction and integration of traditional healing methods;
- the current and predicted nursing shortage;
- the education of Aboriginal persons into nursing.

Knowledge of the impact of government and local policy on practice is critical in light of the rapid changes that are occurring across the country.

Health care delivery to First Nations and Inuit communities originally came under The Northern Health Service of Health and Welfare Canada and was instituted to address the high morbidity and mortality rates of persons in these communities (The Musk-Ox Circle Paper Three Health Services in Northern Canada, 1974). This department has undergone several name changes, first to Medical Services Branch (MSB) and now the First Nations and Inuit Health Branch (FNIHB) of Health Canada. Dependent on the date of the documents that are discussed, the acronym used will be that of the department at that time, recognizing that the responsibility has remained

within the same area of the federal government. Metis living south of the 60th parallel and Aboriginal people who reside off reserve negotiate health services control with the Metis and non-status Indians federal interlocutor (Health Canada, 1999c). When discussing Health Canada documents, the term First Nations will be employed. However, when the term aboriginal is used, it refers to First Nations, Inuit and Metis communities. When the term "Indian" is employed, it reflects the particular historical time period within which the document was published.

*Transfer of health services control.*

A key factor in health care delivery in First Nations communities officially began in 1986 (Indian and Inuit Nurses of Canada [IINC], 1990) with the transfer of responsibility for service delivery to individual tribal councils and bands. By 1999, 41% (or 244) of the 599 eligible First Nations and Inuit communities had signed Health Service Transfer Agreements (Health Canada, n.d. c). In the 1999/2000 Annual Report of First Nations and Inuit Control, it is noted that 81% of eligible First Nations and Inuit communities are involved in the First Nation/Inuit Control Process (Health Canada, 1999c) (Figure 1). The health transfer agreements apply only to those First Nations and Inuit communities south of the 60th parallel, and hence communities in the NWT, Yukon, Nunavut and the northern most areas of Quebec and Labrador negotiate the control of health services with Indian and Northern Affairs Canada (INAC). (For a more complete discussion of this process see Appendix F). FNIHB nurses work and often reside in rural and remote areas; the meaning of these terms is assumed, rather than explicitly defined. One report implies that remoteness is related to accessibility, access

to services, and support (Health Canada, 1993). In terms of accessibility, factors include how close the community is to other towns or cities, and whether a road or scheduled transportation is available. Access to services relates to the availability of stores, banks or recreation services. In this document, support was defined as the distance to the nearest physician, the frequency of the visits by such health personnel, as well as the availability of social service agencies and schools. A report on nursing and health care in First Nations communities by the Ontario Region and band transfer materials on the FNIHB website (www.hc-sc.gc.ca/fnihb-dgspni/fnihb/pptsp/hfa/ten_years_health_transfer/index.htm) note the following definitions:

- Non-isolated community refers to having road access less than 90 kilometres to physician services with an available health centre in the community;
- Semi-isolated community means that there is road access greater than 90 kilometers to physician services but it has either a nursing station or health centre with treatment component available;
- Isolated community refers to a community that has scheduled air transportation flights, good telephone service, but no roads; a nursing station is available for health services; and
- Remote, isolated community is a community in which there are no scheduled flights, minimal telephone or radio access and no roads; health services are provided through a nursing station.

Interestingly, as can be noted by these definitions, the degree of remoteness and isolation is defined by access to services, the type of health service locally accessible, and transportation and communication availability which are directly related to geographic restrictions.

The documents from MSB and FNIHB that were reviewed described the processes that various tribal councils and bands have undertaken and the steps that are to be followed in the transfer process (Health Canada, 1999c, d, & e). The impact on nursing practice and the challenges faced by nurses in this major devolution of service delivery were not available in the Health Canada documents but were discussed in reports produced by the Aboriginal Nurses Association of Canada (ANAC) formerly known as the IINC. The documents that were examined did not describe the financial arrangements made with the tribal council and bands nor was there any discussion of how these arrangements would evolve over time to address future needs (Health Canada, 1999c, d, & e).

A dominant theme throughout the documents was the emphasis on the shift in health care delivery that was to have taken place from the focus on acute care delivery to health promotion and disease prevention (Minister of National Health and Welfare, 1989). From the documentation there was no means of determining whether this shift in focus has occurred, nor to what degree nurses and transferred communities had embraced this change in health care delivery practice. The suggested focus on preventive care is consistent with proposals in the Romanow report (2002) that

emphasize the need to promote population health and therefore decrease the emphasis on acute care needs.

Issues in the transfer process that nurses have faced were identified by the ANAC, 1995, and IINC, 1990 in several band nurse workshops and by a survey of nurses working in First Nations' communities (IINC, 1990). Because of the impact the issues may ultimately have on recruitment and retention of nurses and on health care delivery, the ANAC are to be commended in their efforts to articulate the challenges and to make recommendations to rectify them. Medical Services has since released documents to assist band councils in hiring RNs (Health Canada, 1999c). One of the greatest problems nurses face is to gain acceptance within the community and be recognized for the fact they are professionals meeting standards of competency, ethical practice guidelines, and clear regulations for their practice. This factor is emphasized when non-nurses, who do not have a clear understanding of nursing competencies and professional expectations, administer nursing services.

Nurses register within the province within which they practice. Provincial registering bodies set the competencies and standards of practice for nurses within their jurisdiction. Some provincial associations have not developed advanced practice guidelines which means that nurses often continue to work under the auspices of federal legislation. It was not clear from the reports whether or how provincial nursing associations have participated in addressing registration and liability issues faced by nurses who practice in aboriginal communities, especially with the large numbers of

communities involved in the transfer process. As the process continues, the involvement of the registering bodies would seem to be an imperative.

A number of documents noted that nurses have not been involved in the transfer process although they will be required to implement the changes in delivery (Minister of National Health & Welfare, 1989; IINC, 1990; & ANAC, 1995). There remains a lack of clarity of exactly under which jurisdiction some projects and programs fall. Accountability may lie within FNIHB, the local band, or both. Professional practice liability coverage is another consideration when hiring nurses and must be recognized as an essential element for the nurse to be able to practice in that jurisdiction.

*Nurses and predicted shortage.*

The projected nursing shortage in Canada will have a significant impact on nursing within aboriginal communities as well. There have been recruitment and retention challenges with frequent turnover and vacancies in nursing positions within communities; a problem that has existed over many years. Multiple strategies have been suggested by MSB, First Nations authorities and the Professional Institute of the Public Service to address these challenges. These strategies include:

1) Developing an internship program with specialized education an integral part of the program (Health Canada, 1999b);
2) Identifying the profile of nurses who work in these communities (ANAC, 2000);
3) Provision of clinical support with adequate orientation and ongoing supervision and guidance from senior nurses (Health Canada, 1999b);

4) Addressing housing and lifestyle needs of nurses and their families (Health Canada, 1999b);
5) Developing congruency between the need to prevent excessive workload and "burnout" for the nurses and the expectations of the community for the service that is to be provided (CHCL Comprehensive Healthcare Consultants Ltd., 1995); and
6) Educating Aboriginal persons, particularly First Nations members, as RNs who are more likely to remain in the community (Nowgesic, 1990).

Although the ANAC is clearly the most proactive organization in advocating for aboriginal nurses, particularly within First Nation communities, the membership does not include all of the Aboriginal nurses in Canada. Aboriginal status is made known through self declaration and therefore, it is difficult to obtain accurate data regarding the numbers of Aboriginal RNs in Canada, as well as the numbers of Aboriginal students in nursing programs across the country.

*Education of Aboriginal persons into nursing.*

The most current report on the recruitment and retention of Aboriginal students into nursing has been produced by a joint task force under the auspices of the Canadian Association of University Schools of Nursing (CAUSN) now renamed the Canadian Association of Schools of Nursing (CASN) in conjunction with Health Canada, FNIHB, and the ANAC. The research team for Against All Odds: Aboriginal Nursing (Health Canada, 2002) sought information from CAUSN member schools, Aboriginal students, provincial education/government officials, Aboriginal organizations, FNIHB, and regional nursing officers and associations. An extensive literature and report review

was conducted by the report's authors to thoroughly examine previous discussions and studies on the issue. The issues and challenges faced by Aboriginal students, as well as multiple recommendations are outlined in this report. Recommendations focused on funding for aboriginal students for expenses such as child care, housing and relocation costs, and availability of counselors who are trained to specifically deal with aboriginal issues (Health Canada, 2002).

Programs that discuss the educational preparation of aboriginal nurses will be discussed in the following section, Educational Preparation of Registered Nurses for Rural and Remote Areas. In addition to preparing aboriginal RNs, specialized programs to prepare nurses to practice in remote areas were developed between MSB and Dalhousie University and later McMaster University. The development of advanced clinical skills programs that provide credits toward degrees are now in place in several educational institutions, with support for nurses to attend provided by FNIHB. Examples of such programs include the primary or advanced skills courses at the University of Manitoba, the University College of the Cariboo (Kelowna), and Aurora College (Yellowknife).

In summary, the reports reviewed for this section identified the 1) personal and work related challenges faced by nurses in aboriginal health care delivery (IINC, 1990); 2) difficulties discerning whether the multiple recommendations that were made by the writers of governmental and other documents were followed (e.g., Health Canada, 1999a & b); and, 3) challenges in identifying who is responsible for implementing the recommendations.

*Educational Preparation of Registered Nurses for Rural and Remote Areas*

The current and projected nursing shortage will have a potentially dramatic effect in rural regions as the present cohort of nurses retires. An integrated and collaborative effort between governments, regional health authorities where they exist, nursing associations/colleges, and educational institutions that will prepare nurses for practice in rural and remote settings is essential.

Despite an extensive study of government, educational institutions, and nursing association documents and web sites, little literature was found regarding the education of RNs to work in rural and remote regions of the country (Appendix G). For example, the Standards for Nursing Education in New Brunswick (NANB, 1997) does not mention rural but implies it as an issue, as noted in its 4th principle adopted from the College of Nurses of Ontario: "Accessibility—Accessibility suggests that nursing education programs reduce barriers to access, such as geographic location (emphasis added), language and culture" (p. 1). Other standards of nursing education documents from New Brunswick that were reviewed do not mention rural in their discussion (NANB, 1997). Entry-level competencies developed for the provincial and territorial nursing associations are further examples of documents that have been generically developed without inclusion of specific comments or information about rural or remote nursing practice settings (Manitoba Association of Registered Nurses [MARN], 2000).[3]

The majority of the literature that did address education for remote practice focused on ANP and First Nations and Inuit health care needs and preparation. For

[3] The title and acronym of this nursing association reflects that used in the specific report. Thus, two names and acronyms are used due to the recent change in name of this nursing association.

example, the University of Manitoba, Brandon site, offers a rural nursing/rural health care focus within their four-year curriculum (The University of Manitoba, 1999). Aurora College in the NWT offers a Bachelor of Science in Nursing program from which the students can graduate with a diploma after three years. Due to the geographic location of the program, students engage in rural nursing throughout the entirety of the program (Aurora College – Your Career Starts Here, n.d. a). Aboriginal students are given priority for entrance into the program. The maximum number of students that can be accommodated is 40 and in September, 2002, there were 30 enrolled students (N. Moulton, Personal Communication, February 21, 2003). Aurora College also offers a 16-month certificate Primary Health Care—Nurse Practitioner (PHC-NP) program, which is available through a brokering arrangement with the Centre for Nursing Studies in St John's Newfoundland. Students complete their practicum components throughout the territories, and upon completion the PHC-NP graduates are eligible for registration with NWTRNA (Aurora College – Your Career Starts Here n.d. b). Finally, Aurora offers the Grant MacEwan College Nurse Refresher Program for RNs who need to become reinstated.

In September, 2002 the SIFC offered a four-year nursing program based on the U of S curriculum at the Prince Albert SIFC site (D. Campbell, Personal Communication, February 21, 2003). The program is limited to 30 students with preference given to aboriginal individuals. The physical location of the program dictates that the clinical settings will be predominantly rural. The U of S offers a rural nursing clinical option in the post Bachelor of Science in Nursing program. The program allows students the

opportunity to experience nursing in a rural site to help them increase their knowledge and skills that are needed essential to working in rural areas. The University of Northern British Columbia (UNBC) offers numerous rural-related courses and certificates. For example, rural courses are offered in the undergraduate nursing program. Both theory and practicum components focus on rural and northern-related health issues in many nursing areas including mental health, obstetrics, emergency, and so on. The UNBC also offers a rural option as part of the student's final focus area in the Post-Diploma Program, which is similar to the one offered in the undergraduate program. The Northern Collaborative Baccalaureate Nursing Program (NCBNP), which is offered through UNBC, also has rural-focused options as well as First Nations options for those students who wish to pursue these areas of practice. Finally, the UNBC offers a "Certificate in Rural and Northern Nursing".

In the province of Alberta, baccalaureate nursing programs at Lethbridge, Red Deer, Grand Prairie, Edmonton, Calgary and Medicine Hat place students in rural settings for clinical practica. In the senior year the University of Calgary students can select placements in rural settings that then entails theoretical content on issues in health care and nursing. As a mandatory component of the University of Calgary at Medicine Hat Program, all students must take rural nursing with clinical practice in rural settings. Content of this program focuses on rural populations, environmental health issues, history of nursing in rural communities, and issues for practice. The University of Lethbridge Nursing Program also explicitly focuses on rural nursing

practice and has a mandatory rural nursing course, although rural clinical placements occur throughout the program.

Many educational programs have students who may complete some of their studies in practicums at rural sites. Usually these students are preceptored by nurses who work in rural facilities and home care programs. Placement in a rural setting is often by choice and is not a specific requirement of the nursing program that students have a rural experience. A few programs offer a course in rural nursing and health care practice and theory within the curriculum. No government documents were found addressing the need to provide educational opportunities and assistance for students in rural sites.

The advent and potential expansion of telehealth to rural and remote sites will have a significant impact on the delivery of health care. It was not clear whether any programs were including education on the use of this technology within their nursing programs, even at a preliminary stage. Current nursing students are knowledgeable in the use of computers and computer assisted learning which has become integral to many programs. As telehealth and telemedicine expands, educators will have to think of innovative ways to include the use of this technology within the curricula. As well, technological infrastructure and financial assistance to do so, will be required within the educational institutions.

The availability of the infrastructure within rural facilities and organizations for computers and internet access varies greatly across the country. A FNIHB (2001) information sharing session recommended increased access to clinical information via

computers and teaching their nursing employees about health informatics. Many centres have access to computers for internal use in the facility but dependent on where or how access is provided differs substantially be it in southern Alberta, in an outpost in Newfoundland, in a small town in northern Ontario, or a health centre in the Yukon. There are financial implications to providing such a service and in times of restraint and cutbacks there was no documentation found regarding how or by whom such service should be provided.

One model for the recruitment and retention of RNs for rural practice could be based on the Alberta Rural Physician Action Plan (RPAP) that is supported by Alberta Health (available at www.RPAP.ab.ca). In agreement with medical faculties at the Universities of Alberta and Calgary, support is provided for mandatory and elective rural rotations for medical students and family medicine and specialty residents. Students receive accommodation and travel reimbursement. In addition, they are provided with technological supports such as computer access. Residents in the second year of their program are given tuition re-imbursement for Advanced Trauma Life Support (ATLS) and Advanced Cardiac Life Support (ACLS) courses they take. A key component of the RPAP program is development support for rural physicians who preceptor these medical students. If such a program were to be implemented for nursing students it would require a commitment from government to provide financial support for students who choose to complete rural practicums with the goal of attracting these students to a rural practice. However, such support could be an effective recruitment and retention strategy for nurses in rural sites.

Other programs might include an extended mentoring or orientation program during which time newly employed RNs could develop the breadth of skills required in rural settings. The BCMOH supports mentors and preceptors in the health field, with the goal being to reduce the number of nurses who leave the profession soon after their graduation. In this program, a mentor is an experienced nurse who provides ongoing support to a newly hired graduate nurse, and a preceptor provides support to a student nurse during their final year in the nursing education program. In both instances, the program allows for training and professional development for both the mentors and preceptors, and allows these individuals to have a reduced patient load in order to function effectively within this special role. Health authorities and affiliates of First Nation and aboriginal health organizations within BC were all eligible to apply for special funding from the BCMOH to participate in this program (BCMOH, 2001a). Although this program is not specifically targeted at rural and remote areas, it offers benefits and assistance for nursing practice and nurses within these areas. An unpublished document from the CNA conducted an environment scan on incentives offered to professionals who work in rural and remote areas (CNA, 2002c) Hopefully, a complete examination of the cross-Canada incentives will lead to national recommendations on this matter. At the provincial level, recommendations were made to the Ontario Ministry of Health and Long-Term Care (OMHLTC) to offer nursing students free tuition if they were willing to practice in a rural community after graduation (Registered Nurses Association of Ontario in collaboration with the Registered Practical Nurses Association of Ontario, 2000).

*Physician Supply in Rural and Remote Areas*

A section in relation to physicians has been included for several reasons: (1) rural health care is a multi-professional challenge and therefore it is necessary to review documents relevant to other health professionals, and discuss the impact that they have on the nurses who practice in rural and remote areas, (2) legislation related to the role of nurses, particularly those in ANP, are influenced by physician availability, roles and expectations, (3) physicians have developed rurality indexes and alternative definitions for the terms rural and remote, which would benefit from more detailed critique, (4) data on physicians and physician practice problems is more often available because it is tied to remuneration; (5) physicians are the health professionals who are most organized and politically prepared to address issues related to health services in rural and remote areas.

Hence, an examination of the recruitment and retention of physicians in rural and remote Canada can be useful for the nursing profession.

Of all health services groups, the documents related to physicians are the most focused when discussing the impact of rural and remote geographic settings and issues such as recruitment and retention of physicians. The Canadian Medical Association (CMA) has a task force that addresses rural and remote health issues and some medical specialties have specific committees that address rural and remote issues. For example, the Canadian Association of Emergency Physicians (CAEP) has its own Rural Committee. In addition, The Canadian Society of Rural Physicians (CSRP) has

provincial and territorial chapters across Canada; they communicate with their members through their web site, a peer-reviewed journal and a newsletter.

Some of the reports use the term “underserved” (The CMA, 1992) without critiquing the meaning of this term. Terms such as underserved are largely drawn from the American experience, which may not be suitable in the Canadian context. A number of the articles include definitions of rural and remote and several of them focus on combining geographic distance with variables such as time required to transport individuals who require medical attention at a major health centre.

Another definition of rural focuses on rural practice, which is defined as “practice in non-urban areas where most medical care is provided by a small number of general practitioners” and there is limited access to specialists and advanced facilities (Rourke 1997 as cited in Iglesias, Grzybowski, Klein, Gagne & Lalonde, 1997, p 2). Other physicians have published rurality indexes (Leduc, 1997; Magee, 2000), but there has been limited comparison and critique of the indexes, and there has been no formal testing to determine their applicability to rural health in general.

Other individuals within the medical profession have focused on developing a national framework of rurality (Buske, Yager, Adams, Marcus & Lefebvre, 1999). A rurality index is not intended to define a community as rural, but to “determine its relative degree of ruralness relative to an established norm or relative to another community” (Buske et al, 1999, p 11). A joint project of the CMA, CNA, Society of Rural Physicians of Canada, and the Canadian Pharmacists Association (2003) developed an

index for rurality to assist in the recruitment of health care providers, but it has been too soon to test its applicability.

Overall, the reports that focus on physicians in rural and remote areas address recruitment and retention issues and stress the importance of financial incentive programs, the need to expose students to rural practice during their training, promoting community involvement as a way to attract physicians (CMA, 1992), and regionalizing care such that rural areas are connected to regional centres in order to ensure adequate support for providing quality care (CAEP, 1997). More specific recommendations are often drawn from the broad strategies but there is rarely an accountability process in place to determine whether or not the recommendations were adopted (CAEP, 1997). Related CMA documents address the need for quality care, including quality maternity or emergency care, and provide recommendations to reach this goal. The recommendations, however, focus on training and preparation of physicians and do not recognize the advanced practice nurse as being a colleague. These reports also do not include an accountability process to determine the success of adopting the recommendations (The College of Family Physicians of Canada, the Society for Rural Physicians, and the Society of Obstetrics and Gynecologists of Canada, 1999; Iglesias, Grzybowski, Klein, Gagne, & Lalonde, 1997).

In 2000, the CMA released its policy on rural and remote practice issues (The CMA, 2000). The 28 recommendations address issues such as training, compensation and work/lifestyle support. The policy was prepared to help groups such as communities, policy-makers and governments address the recruitment and retention

challenges of physicians in rural areas. In this brief, they suggest using the Statistics Canada Rural and Small Town Canada definition of rural (those who live outside the commuting zones of larger urban centres, (du Plessis, Beshiri & Bollman, 2001), but also include in their definition the four characteristics of rural communities as identified by the 1999 survey of rural physicians outlined above (CAEP, 1997).

Various reports are available from the Centre for Health Services and Policy Research at the University of British Columbia. Often the reports do not include a definition of remote but have defined rural as less than 10,000 inhabitants with urban considered to be greater than 10,000 inhabitants. The studies that have been completed by the Centre for Health Services and Policy Research have concluded that practice location choices by physicians are determined by the influence of physician spouses, community factors such as presence of schools, and opportunities for spousal employment (Kazanjian, Pagliccia, Apland, Cavalier & Wood, 1991; Pagliccia, Apland & Kazanjian, 1993).

Provincial policy approaches to address problems with the recruitment and retention of physicians in rural communities have led to a variety of programs including subsidized incomes or guaranteed minimum income for physicians in rural areas, funded rural locum programs, tying student loans to return for service commitments in rural areas, and funding for rural physicians to partake in continuing education (Barer, Wood, & Schneider, 1999). The authors conclude that the majority of Canadian incentives for physicians are financial (and hence not appropriate for nursing given the differences in payment systems); the lack of a national mechanism to address

shortages of health professionals partly because health is viewed as a provincial responsibility; and the inconsistency regarding the employment of non-physicians to provide care in “underserved” areas. For example, there is limited education and legislation to prepare and support NPs in an expanded role.

A discussion paper prepared for the Federal/Provincial/Territorial Advisory Committee on Health Human Resources (Barer & Stoddart, 1999) revisited the issue of recruitment and retention of physicians in rural and remote communities. While the focus is on physicians, a discussion about the use of NPs is included in the recommendations for providing health care in rural areas. The need for educational opportunities, regulatory modifications to allow activities such as prescribing medications, and administrative funding arrangements to employ such individuals, is noted. The authors emphasize that NPs are capable of providing primary care in regions that are lacking adequate health services, although the challenges remain in terms of recruiting and retaining them. It is postulated that NP programs will have greater success in attracting rural individuals who wish to return to reside in those locales with their expanded knowledge.

An Alberta study identified practical strategies that communities can employ to recruit and retain physicians (Alberta Health, 1994). They found that community success in recruiting as based on the physical location and catchment size, number of individuals in the established medical practice, incorporation of a partnership approach, and community efforts toward making the new physician and family feel welcome in a community, which demonstrated that they had “fun”. The report

furthermore identified a seven-step recruitment process that was utilized (Alberta Health, 1994).

The McKendry report (OMHLTC, 2000c) was prepared in response to the absence of an Ontario physician human resource policy or plan. This report focuses on examining the current state of policy in relation to the availability of physicians, and on providing recommendations to create a resource plan. The intended effects of the recommendations are presented from the physician viewpoint (i.e., reducing physician workload) rather than viewing NPs as colleagues of physicians and members of the team.

A number of recommendations from the McKendry report were accomplished by OMHLTC as noted in Shaping Ontario's Physician Workforce: Report of the Expert Panel on Health Professional Human Resources (OMHLTC, 2001b). Canadian physicians who took their postgraduate training in the United States are supported to refresh their skills through updated training for the Canadian environment. The number of personnel to assist rural communities in recruiting health professionals was also increased. The Ontario government also expanded the telehealth program (another of McKendry's recommendations) to southern Ontario leading to the hiring of over 100 nurses for this program, which was expected to reduce unnecessary emergency room visits (OMHLTC, 2001b).

The remaining McKendry report recommendations were referred to the Expert Panel on Health Professional Human Resources for further attention. This Panel had two other McKendry recommendations addressed by the OMHLTC, namely the

development of a more reliable physician database and provision of funding for interim increases in undergraduate and postgraduate positions (OMHLTC, 2001b).

Unlike other documents, the report developed by the Expert Panel openly acknowledges not only the shortage of physicians, but other health professionals in rural areas. It also notes how NPs can be used effectively to address the shortage in these areas. The OMHLTC has targeted new funding to increase the number of NPs in underserviced areas and aboriginal communities. More specific issues that need to be addressed in regards to the shortage of physicians in Ontario are discussed in 30 other recommendations in the report, which range from providing incentives to specialists to encouraging physicians to provide more services (OMHLTC, 2001b). Timelines and mechanisms of accountability regarding the recommendations were included in the report with the first to be implemented in 2002. Ongoing evaluation of the Expert Panel's success is required.

*Health Care Delivery in Rural and Remote Areas*

The present economic climate, the growing number of informed consumers and increased demand for broader health services all combine to affect on nursing practices in rural and remote areas.

*Current state of health care delivery.*

Several reports discuss the unique issues impacting the current state of health care organization and delivery in rural and remote areas. One such report, from the Saskatchewan Home Care Workshop 2000 (Fontaine Associated Consulting Services Inc., 2000), discusses challenges for rural nurses such as the lack of volunteers,

recruitment/retention of RNs, cultural uniqueness of Aboriginal populations, and service delivery over large geographic distances. A report by Manitoba Health (Manitoba Health, n.d. a) outlines types of core health services available to Manitoba residents, however, which of these services are available in rural and northern areas is not clearly defined.

The Ontario Nursing Task Force (OMHLTC, 2000b) recommended that money be designated to the training and hiring of NPs. Recent business plans for Ontario's Ministry of Health and Long-Term Care support improving health care access within Ontario's rural and northern regions (OMHLTC, 1999a; 2000a; 2001a). The goal of the 1998/99 business plan was to increase the number of physicians in areas where the numbers are lower than the provincial average. While the 1999/00 plan acknowledges the role of NPs in providing care, particularly among Aboriginal populations, this plan most often refers to recruiting physicians for these areas rather than focusing on the NP's role (OMHLTC, 2000a).

The emphasis of the Ontario business plans, short term, is on the NP providing care to individuals who reside within geographic areas where there are no physicians. The implication is that when educational preparation for physicians includes more rural and northern training, and recruitment techniques are successful, the current limited availability of health care providers will be resolved (OMHLTC, 1999a). There is no mention of enhancing nursing education to include rural experience.

Two significant reports on health in the NWT (2000b Final Report of the Minister's Forum on Health and Social Services for the NWT; Minister's Response to the

1999 Forum on Health and Social Services, 2000a) emphasize the need to put previous recommendations in place to improve service delivery. The reports focus minimally on recommendations specifically to nursing. The emphasis was on long-term plans such as providing northerners with opportunities for education such as NP programs, at local colleges (Northwest Territories Health and Social Services, 2000a Minister's response to 1999 forum).

*Alternative mode of health care delivery.*

Alternative modes of health care delivery may assist nurses in meeting the challenges of providing health care in rural areas. The RN First Call Program in British Columbia (MacKinnon Williams, 2000) was a pilot program started in 1996/97 using RNs in rural and remote emergency departments, to manage minor, uncomplicated injuries and health problems. Following additional educational preparation, RNs assess, diagnose and treat clients with the use of established clinical protocols. Both the British Columbia Nursing Union and the RNABC supported the project. Even though MacKinnon Williams (2000) suggests cautions in the interpretation of the program evaluation due to a limited response, the authors recommended the program be expanded.

The Rural Nurse Responder Program available in the Palliser Health Authority in Alberta is another example of alternative delivery. A nurse first responder is available within their rural community to provide both health information and assistance in emergency situations. Additional education in emergency skills was provided for the nurse (L. Ferguson, Personal Communication, December 2002). This

program is currently under review since health telephone advice lines are now available in the area (L. Ferguson, Personal Communication, January 2003).

The use of telehealth is increasing across the country as another alternative delivery method. Defined as “the use of communications and information technology to deliver health care services and information over large and small distances” (CNA, 2001c), telehealth is most often seen in remote settings, using telecommunication for consultation and diagnosis. Visual images are sent to a health professional or consultant often saving the client a trip out of the community.

Conflict arises between the pressure to use telehealth in remote and isolated areas, and the lack of sufficient policies and resources to support nursings’ role within it. A discussion paper commissioned by the Aboriginal Nurses’ Association of Canada (ANAC, 2001) notes that telehealth may challenge nurses’ scope of practice beyond their educational preparation or their practice guidelines. In addition, nurses’ workload may actually increase with telehealth. The ANAC report recommends nursing programs provide education in technology of telehealth as well as providing distance continuing education programs in telehealth. Educational institutions will require adequate resources to allow all students the opportunity to develop the skills required in the use of telehealth.

Some authors point out potential liability issues of telehealth (Lee, 1997). Health Canada supports these concerns, finding that RNs are not sufficiently prepared (Dal Grande, 2001). This concern is also identified in a Nova Scotia report on telenursing.

Telenursing, one aspect of telehealth, is defined by RNANS[4] as "using electronic links to establish communication with client and or other health professionals, in order to deliver professional nursing services" (Registered Nurses Association of Nova Scotia, 2000). In Newfoundland, an Association of Registered Nurses of Newfoundland and Labrador (ARNNL) statement (2002a) emphasizes the importance of the nurse providing advice in an accountable and competent manner, ensuring they do not work outside of their scope of practice. The ARNNL recommend that agencies develop policies and guidelines for nurses who provide telenursing.

Based on a 1999 recommendation to the OMHLTC, 1999(b) a telephone health advisory/triage program was implemented in 2001 for all Ontario residents (OMHLTC, 2001b). The 1999 report recognized that such a service would be efficient, effective and often decrease visits to health providers. RNs answer calls using a combination of Decision Support software, clinical guidelines and clinical judgment. The service is available 7-days/week, 24 hours/day for all Ontario residents. Access and confidentiality may be compromised in rural areas where party lines are still present and telephones are not available in all homes.

A recent NWT health action plan (Northwest Territories Health and Social Services, 2000b) recommended that telehealth be more available to all NWT residents, ultimately assisting health providers in providing service as well as accessing continuing education.

[4] The RNANS has since changed its name to the College of Registered Nurses of Nova Scotia (CRNNS).

# CONCLUSIONS: ANSWERING THE POLICY QUESTIONS

This documentary analysis has been part of a national study that is examining the nature of nursing in rural and remote Canada. Examining documents such as educational standards, materials on band transfers of health services and governmental reports on rural health issues has provided a contextual understanding of the policy environment within which rural and remote nurses practice. When combined with the secondary analysis of the RNDB, the survey results and analysis of the narratives, a more complete understanding of the complexity of rural and remote nursing practice will be achieved.

The framework for examining the documents focused on policy formulation, policy implementation and policy accountability (Rist, 1994). Within these three aspects, a series of questions were used to guide the reading and analysis of the documents (see page 3 and Appendices A-C). Furthermore, five thematic areas (advanced practice; nursing practice issues in Aboriginal communities; educational preparation of RNs for rural and remote areas; and health care delivery in rural and remote areas) were identified after the initial perusal of the documents. The major issues related to these themes have been discussed at length in the individual attached appendices and summarized in this part of the report.

Returning to the questions raised at the onset of the documentary analysis, this section focuses on the answers that were generated within the documents. Of significance is the lack of clear definitions for the terms “rural” and “remote.” Documents from organizations such as Health Canada (from MSB, currently FNIHB)

link the definitions of these terms with financial reimbursement for nursing practice. Many of the documents that were reviewed fail to include any discussion whatsoever of these terms. It is taken for granted that the theoretical meaning of this term is understood by all individuals within the organization that is preparing the document or by the audience for whom it is developed. Furthermore, such a lack of definitions does not take into account the range of diverse rural and remote communities that exist across Canada. The lack of attention to the meaning of rural and remote and the diversity of such settings simplifies the complexity of nursing practice in such locales.

Advanced practice is a topic within nursing that has generated considerable interest in the last few years. Several provincial government reports have noted the importance of using advanced practice nurses in rural and remote areas as one measure to address the concerns of recruiting and retaining other health professionals, such as physicians (OMHLTC, 2001b; Saskatchewan Commission on Medicare [Fyke, Commissioner], 2001). Of late, the documents that discuss advanced practice have identified more specifically the meaning of this term and the types of competencies and educational preparation required to work within this role (CNA, 2002a). Thus far, the documents have not specifically noted the impact on rural or remote nursing practice but have generally discussed the importance of the expansion of nursing's role to the profession and to the health status of individuals (IAPP, 2001). It is therefore anticipated that the recent changes in policies regarding advanced practice will enhance nursing practice in rural and remote areas.

Nursing practice issues within Aboriginal communities have been longstanding in that working in remote areas has required not only a high level of nursing skill but also the personality and skills to successfully live within such settings. More recent issues revolve around band transfers of health services in Aboriginal communities south of the 60$^{th}$ parallel, which are becoming common place. The impact of such band transfers are widespread due to:

- The increased number of nurses who will work as band-employed health personnel; 60% of the transfers are expected to be completed by 2005 (Health Canada, n.d. c),
- The need for an understanding by the band and community about the meaning of transferring health services to their jurisdiction,
- The need for a clear understanding by both the band and nurse about the contract within which the nurse will be hired,
- The need for a clear set of competencies and educational preparation to ensure the appropriate level of care is provided at the community level, and
- The need for provincial nursing licensure to ensure competencies and liability insurance coverage are met.

Although these impacts are easily identified, the documents are limited in their discussion about them especially in light of their significance for nursing practice. There is also limited discussion about the difficult employment conditions under which the band-employed nurse is working. The ANAC has acknowledged the need to address

such circumstances through a series of workshops and through continuous political advocacy. In addition, FNIHB has also been increasingly proactive of late to ease the challenges associated with band transfers.

Educational preparation of Aboriginal persons within the nursing field has once again drawn greater attention but few of the documents discuss policies to increase the number of such persons in the nursing field. A recent exception is the report Against All Odds: Aboriginal Nursing (Health Canada, 2002), which focused on the barriers and challenges experienced by Aboriginal students' entry to nursing programs. The comprehensive list of recommendations that is included has the potential to rectify the current shortage of Aboriginal nurses in Canada. This is significant because many will work in rural and remote areas of this country.

Educational preparation of nurses for rural and remote areas of Canada is another area that has not been the focus of documents which address rural health. There are several universities that prepare students for rural and remote settings, but no documents could be found that address: (1) an evaluation of such programs, (2) the actual numbers of graduates who work in rural and remote areas, or (3) the impact of the number of nurses prepared for rural and remote areas compared to the number required.

Inter-related with the preparation of nurses for rural and remote areas is the emphasis on the use of technology to deliver health care. One example is the use of telehealth. However, there is no evidence that this technology is being used in the educational preparation of rural and remote nurses. Such a lack of congruence between

policies and associated activities demonstrates the need for policy accountability. Overall, policy accountability is not evident in most of the documents that were reviewed for this report. Consequently, it is difficult to identify the outcomes of the policies in regards to nursing practice in rural and remote areas.

In summary, the documents that were reviewed indicate that there are few policies that specifically address rural and remote nursing. Instead, the discussion focuses on nursing practice in general with the assumption that the policies will be directly applicable to rural nursing. This is not always the case, however, and hence the recommendations in the following section are meant to address some of these limitations.

## RECOMMENDATIONS

A national nursing consortium consisting of the Office of Nursing Policy (ONP), CNA, FNIHB, and CASN can work together to advocate for the implementation of the following recommendations. The use of experts from provincial and territorial nursing associations, nursing unions and nursing programs by this consortium is also important to help ensure that the recommendations will be implemented. It is imperative that the consortium be formulated by Fall 2003 due to the urgency of the issues noted in this report. Financial assistance is required from governments in order to address the following ideas; this is a necessary step in order to strengthen rural nursing practice and hence achieve quality care for Canadians living in rural and remote settings. Examples of activities are included with each recommendation but are not an exhaustive list.

Rather, the national nursing consortium would be responsible for generating a complete list of activities.

*Recommendation One*:

Develop a national rural health human resource strategy by individuals with expertise in rural health issues

Stage(s) of Policy Cycle addressed: Policy Formulation and Policy Implementation

Issues addressed:

- Complexity of rural nursing
- Quality of worklife
- Recruitment and retention issues
- Unique challenges of rural areas
- University-health region collaboration to address rural health

Activities:

- Development of a committee to oversee the national rural health human resource strategy
- Development and distribution of a discussion paper on rural nursing through the CNA office
- Development of multi-disciplinary health programs and initiatives that address the unique challenges of rural health issues

Accountable Agencies: CNA, FNIHB, Office of Nursing Policy (ONP), and the provincial and territorial nursing and government representatives as well as nurse educators

Timeline: Spring 2004

*Recommendation Two*:

Create alternative payment options for nurses and physicians in rural areas

Stages of Policy Cycle addressed: Policy Formulation

Issues addressed:

- Full scope of practice for nurses
- Support for advanced practice

Activities:

- Examination of health regions that currently have alternative payment options
- Implementation and evaluation of alternative payment options in select rural and remote areas across Canada
- Implementation of alternative payment options in rural and remote settings across Canada based upon results of above activity

Accountable Agencies: Governments and health regions

Timeline: Spring 2005

*Recommendation Three:*

Develop scholarships and bursary programs for rural nursing students and rural-based nurses

Stages of Policy Cycle addressed: Policy Implementation

Issues addressed:

- Rural residents need to be encouraged to return to their home areas
- Recruitment and retention of aboriginal peoples in nursing
- Encourage nurses with lapsed licenses to return to practice
- Support rural nurses in their continuing education efforts

Activities:

- Examination of current scholarship and bursary programs for rural residents in nursing
- Development of corporate sponsored scholarship and bursary programs, i.e., with sponsors that are rural-focused such as farming businesses and natural resource companies
- Joint university-health region scholarships and bursaries

Accountable Agencies: Governments, health regions and universities

Timeline: Fall 2004

*Recommendation Four:*

Implement initiatives to enable full scope of nursing practice, including advanced practice in rural areas with process and outcome evaluation in rural and remote areas

Stages of Policy Cycle addressed: Policy Implementation

Issues addressed:

- Full scope of practice
- Integration with physicians and other health professionals
- Consistent roles, titles of NPs within Canada
- Mobility of NPs in Canada

Activities:

- Evaluative research on full scope of nursing practice projects and advanced practice
- Implementation of collaborative university-health region programs and initiatives that support full scope of practice but are appropriate for the specific community
- National regulatory framework for NPs
- National set of standard competencies for education in preparation of the nurse practitioner role

Accountable Agencies: CNA, provincial and territorial nursing associations/colleges, ONP, CASN, universities, CMA, governments, health regions and Canadian Student Nurses Association

Timeline: Spring 2005

*Recommendation Five:*

Implement educational initiatives and complementary supports for nurses working with Aboriginal peoples

Stage(s) of Policy Cycle addressed: Policy Implementation and Policy Accountability

Issues addressed:

- Broader supports for band-employed nurses
- Continued support of the FNIHB Internship Program
- Need for monitoring of current nursing education for Aboriginal peoples
- Need for examination of nursing education for non-Aboriginal peoples who will work with Aboriginal peoples

Activities:

- Creation of distance learning opportunities for nurses working in rural and remote areas with Aboriginal peoples including telehealth
- Annual workshops and bi-annual conferences for nurses working with Aboriginal people to address issues such as being a band-employed nurse

- Evaluation of existing nursing and continuing education programs for those working with Aboriginal peoples and implementation of findings in further program development

Accountable Agencies: FNIHB, ANAC, CNA, CASN, nurse educators, Aboriginal bands

Timeline: Fall 2004

*Recommendation Six*:

Implement financial and technological support for universities with a rural-focused mission

Stage(s) of Policy Cycle addressed: Policy Implementation and Policy Accountability

Issues addressed:

- Preparation of graduate faculty to enhance rural research agenda and create future rural nurses
- Incentives and rewards for rural-based clinical faculty
- Examination of current nursing programs that are rural-focused
- Monitoring of suitability of current rural clinical placements
- Availability and use of technology such as telehealth

Activities:

- Select university sites where telehealth will be available
- Development of graduate programs in rural health and rural nursing
- Examination of incentive models for rural-based clinical faculty and recommendations regarding best practices for incentives and rewards
- Examination of nursing curriculum that is rural focused

Accountable Agencies: Government, universities, CASN, nurse educators, health regions

Timeline: Spring 2004

*Recommendation Seven*:

Offer continuing education for nurses who work in rural and remote areas

Stage(s) of Policy Cycle addressed: Policy Formulation and Policy Accountability

Issues addressed:

- Financial support based on a national index
- Workplace professional support
- Quality of worklife

Activities:

- Use of distance delivery methods to deliver continuing education
- Collaborative university-health region projects to provide continuing education opportunities for front-line nurses

Accountable Agencies: health regions, universities

Timeline: Spring 2004

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## Acronym List

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|---|---|
| Aboriginal Health Partnerships | AHP |
| Aboriginal Nurses Association of Canada | ANAC |
| Advanced Cardiac Life Support | ACLS |
| Advanced Nursing Practice | ANP |
| Advanced Practice Nurse | APN |
| Advanced Trauma Life Support | ATLS |
| Advisory Committee on Health Human Resources | ACHHR |
| Alberta Association of Registered Nurses | AARN |
| Association of Registered Nurses of Newfoundland | ARNN |
| Association of Registered Nurses of Newfoundland and Labrador | ARNNL |
| Bachelor of Nurses | BN |
| Band Council Resolution | BCR |
| British Columbia | BC |
| British Columbia Ministry of Health | BCMOH |
| Canadian Association of Emergency Physicians | CAEP |
| Canadian Association of Schools of Nursing | CASN |
| Canadian Association of University Schools of Nursing | CAUSN |
| Canadian Institute for Health Information | CIHI |
| Canadian Medical Association | CMA |
| Canadian Nurses Association | CNA |
| Canadian Nursing Advisory Committee | CNAC |

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|---|---|
| Canadian Society of Rural Physicians | CSRP |
| Clinical Nurse Specialist | CNS |
| College of Nurses of Ontario | CNO |
| College of Registered Nurses of Nova Scotia | CRNNS |
| Community Health Plan | CHP |
| Comprehensive Health Care Consultants | CHCL |
| Council of Ontario Universities Programs in Nursing | COUPN |
| Critical Incident Stress Management Services | CISMS |
| First Nations and Inuit Health Branch | FNIHB |
| Indian and Inuit Nurses of Canada | IINC |
| Indian and Northern Affairs Canada | INAC |
| Institute for the Advancement of Public Policy | IAPP |
| Licensed Practical Nurse | LPN |
| Manitoba Association of Registered Nurses | MARN |
| Medical Services Branch | MSB |
| Native Nurses Entry Program | NNEP |
| Newfoundland Outport Nursing and Industrial Association | NONIA |
| Northern Collaborative Baccalaureate Nursing Program | NCBNP |
| Northwest Territories | NWT |
| Northwest Territories Registered Nurses Association | NWTRNA |
| Nurse Practitioner | NP |
| Nurse Practitioner – Specialist | NP-S |

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|---|---|
| Nurses Association of New Brunswick | NANB |
| Nursing Education Program for Saskatchewan | NEPS |
| Ontario Ministry of Health and Long-Term Care | OMHLTC |
| Primary Health Care – Nurse Practitioner | PHC-NP |
| Psychiatric Registered Nurse | PRN |
| Quality of Worklife Indicators | QWI |
| Registered Nurse | RN |
| Registered Nurses Association of British Columbia | RNABC |
| Registered Nurses' Association of Nova Scotia | RNANS |
| Registered Nurses Database | RNDB |
| Rural Physicians Action Plan | RPAP |
| Saskatchewan Indian Federated College | SIFC |
| Saskatchewan Institute of Applied Science and Technology | SIAST |
| Saskatchewan Registered Nurses Association | SRNA |
| University of Northern British Columbia | UNBC |
| University of Saskatchewan | U of S |