Chapter 2
Understanding rural health — key concepts

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Learning objectives

- Describe some of the key concepts to understanding rural health.
- Identify some of the main differences between health practice in rural and urban settings.

Introduction

Rural health is a challenging and complex discipline. Care providers in rural settings need to understand some of the key concepts that underpin rural practice. These concepts relate to the context of care rather than the care itself, and impact on the quality of care, the use of care and the decision-making processes of clinicians.

This chapter provides some background to each of the sections of Part B (Chapters 3–15), introducing the key concepts of rural health used throughout this book: population health and capacity (Section 1); access, equity and support for rural health professionals (Section 2); competencies for rural health practice (Section 3); and eHealth (Section 4). Some details are also provided about the overlapping roles and relationships that a rural clinician inevitably has to deal with.

We begin this chapter with a case study — a story of two young men — that illustrates some of the key concepts. Although anecdotes of this type are a useful introduction, rural health needs to move beyond anecdotes, to be based on empirical evidence and theoretical understanding. Therefore the goal of this chapter is to outline some of the evidence and theory crucial to understanding rural health.

The term ‘rural’ is used throughout this chapter to refer to areas with small population centres that are distanced from metropolitan centres. Most definitions are based on population size, such as the five levels of the Australian Standard Geographical Classification (ASGC), while others, such as the Accessibility/Remoteness Index of

Australia (ARIA) (Hugo 2002), incorporate access and distance to metropolitan areas. Generally, researchers distinguish between urban areas (eg capital cities), regional centres (eg Port Hedland or Bendigo), rural areas (eg small communities in much of Victoria, Tasmania and eastern parts of Queensland and New South Wales), and remote areas (typical in much of Western Australia, South Australia and the Northern Territory). Such geographical definitions of 'rural' are common, but definitions have also been based on cultural distinctions and the level of dependence on primary industry. Rural communities differ in many ways.

Case study 2.1 Johno's story

Shaun had showered and changed after footy practice. The shower had felt good after a long training session where he played on Smitty, known to be one of the best in town and four inches taller than him. His body was tired so he thought he would cut through the hole in the back fence, a short-cut home. As he walked around the back of the old club rooms and past the big old gum trees, he saw his friend Johno, sitting at the base of a tree. He then noticed that Johno had a gun in his mouth.

Shaun ran over to Johno, threw his bag down and said repeatedly, 'This is not the answer, mate'. He crouched on his knees in front of Johno, concern across his face as he shook his head and repeated, 'This is not the answer, mate'. Both of Johno's hands were on the gun and he looked ready to pull the trigger. 'Don't do this, no, no, don't do this', Shaun said. Although Johno had obviously been crying, his face was now blank, staring through Shaun with a numb, cold look.

Johno and Shaun had known each other for a long time. Both 17, they had been friends since primary school, and had continued this friendship through Aussie rules football. The two young men were good players and consistently made the local team, sometimes even playing in the senior teams when players were short. Although they acknowledged each other at school, their respective groups of friends did not mix, so Johno tended to hang out with his non-Indigenous mates, and Shaun with his Indigenous mates. Shaun didn't feel comfortable at school and preferred to work for his community when work was available. However, the boys liked one another, and Johno had visited Shaun in his community a few times and enjoyed fishing with his family. He had not invited Shaun to the family farm, remarking that his parents 'wouldn't approve of me hanging around with you, nothing personal'.

Now, faced with this crisis, Shaun felt panicked but he tried to relax. He sat down in front of Johno and said, 'You know, mate, I know life's a bitch, but this isn't the answer. Think of how we'll all miss you — your friends, your parents. And we need you on the footy field'. Johno's eyes moved and he looked at Shaun, then at the ground, his head between his knees. 'Tell me what's goin' on, Johno', Shaun said. Johno said nothing, but after a few minutes he let the gun fall to the ground as tears ran down his face. Shaun felt better but didn't move. They sat there for over an hour, talking a little, mostly in silence.

Eventually Shaun said, 'I'm not much good at talking, but my Aunty Mary's a really good listener. She works at the Aboriginal health centre here'. He suggested that they go and chat to her. Johno took some convincing, but it was clear to Shaun that Johno did not want to go home and he didn't know what else to suggest, so he persevered and at last Johno agreed.

They walked to the edge of town and found Aunty Mary's house. Shaun asked her if she could talk to Johno. Aunty Mary took them inside, made them a cup of tea and sat Johno at the kitchen table. After a while, Shaun went off to watch TV, leaving Aunty Mary with Johno. The young man told her of his feelings of hopelessness and how trapped he felt: 'There's no other way out'.

Mary listened and counselled Johno, pushing her own family out of the kitchen and sending her husband for fish and chips 'to keep everyone quiet'. After a couple of hours, Mary suggested that she ring Johno's parents. He did not want this to happen but eventually agreed when she suggested meeting them at the local hospital with the doctor present. Reluctantly, Johno got in Mary's car and was driven to the hospital, knowing his parents would be there and be upset. Mary had also arranged for one of the local general practitioners (GPs) to be there to conduct a mental health assessment.

At the hospital, Johno's mother pushed past Mary to fuss over him, while his father shook his head in disbelief: 'What's wrong with the boy?' he kept saying. Johno did not want to talk with his parents present, so the doctor spoke to Mary and Johno together, and then to Johno alone, at which point Mary slipped away, feeling uncomfortable with Johno's parents. The GP decided to admit Johno overnight as he did not feel he was safe at home or unmonitored. He prescribed antidepressants, admitted him and then spoke to his parents.

The following day, the GP, Mary and the hospital social worker (who worked half-time at the hospital and half-time at the school) met with Johno to discuss his situation. Johno said he felt better, but 'a bit embarrassed'. When asked about whom he would like ongoing professional support from, he was clear that the person he wanted was Mary. Mary agreed to provide this support as long as Johno agreed to have contact with the GP, take antidepressant medication and use the social worker if Mary was not available. She also asked that the social worker, who would see Johno regularly at school, have permission to ring her or the GP if she had concerns about Johno. For Johno's part, he was concerned that all his school friends would find out and he begged the social worker to 'keep this on the quiet'. When this plan was discussed with Johno's parents, they were surprised, but eventually accepted the arrangement as Johno's decision.

Mary talked to Shaun; she asked him not to say anything about the incident with the gun and explained that Johno needed support from friends. The social worker kept an eye on Johno's attendance and participation in school, sport and social activities. Johno's mother became more willing to drive him into town for sporting and social activities, and used her church friends for her own support. In this way the community supported Johno and his family, developed a team approach to his care, kept the incident confidential and crossed cultural divides. This is one way in which the community can be a site of health care and prevention.

Population health and capacity

Population health identifies:

- patterns of health across and among the population (eg the poor health status of Aboriginal and Torres Strait Islanders)
- differences between rural and urban health status
- health needs and issues for particular age groups

- disease priorities
- wellbeing and quality of life (including health behaviours, prevention and promotion, as well as attention to stress, and emotional and psychosocial health) (AIHW 2002, 2006c; Thomson 2003; JD Smith 2004).

The goal of population health is to develop targeted interventions to improve health outcomes (AIHW 2006c), and includes the social contexts in which people live (JD Smith 2004).

Rural–urban differentials

Understanding the rural and remote population in Australia can assist health professionals to understand their clients. Between 10 and 30% of Australians live in rural and remote areas, depending on how these areas are defined (Bourke and Lockard 2000). This figure includes approximately two-thirds of the Indigenous population (Anderson and Thomson 2001). Compared to their urban counterparts, slightly more rural Australians are men, proportionally more are married and more are likely to have poorer health status (Dixon and Welch 2000, AIHW 2002). The rural population is also ageing (Bourke and Lockard 2000).

In rural and remote Australia, men, particularly young men, have higher rates of suicide than those living in urban areas. Rural and remote residents also have higher rates of injury mortality (especially road accidents), homicide, smoking, alcohol consumption, communicable diseases and disability (AIHW 2002, 2005a). Babies from regional, rural and remote areas tend to have a lower birthweight, and children living in rural and remote areas have poorer teeth quality (AIHW 2005a). These and other risk factors result in a reduced life expectancy overall (Brown et al 1999; Humphreys 1999; Dixon and Welch 2000; AIHW 2002, 2005a).

Indigenous Australians have much poorer health status than non-Indigenous Australians, with lower birthweights; higher levels of infant mortality, chronic illness, infectious disease and mental illness; and higher rates of injury and suicide (Thomson 2003). These factors result in a life expectancy 20 years lower than that of non-Indigenous Australians (AIHW 2005a).

Compared to their urban colleagues, rural health professionals usually have more Indigenous patients and are more likely to treat trauma or injury, communicable illnesses, and health problems related to ageing and alcohol and tobacco use. Other conditions relate specifically to rural occupations and environments, such as farm injuries and snake bites. Understanding these and other characteristics of the rural population helps practitioners to be more prepared for the clients, families and communities that they work with.

The local community context can promote and improve health and health behaviours but can also undermine them. Examples of factors that can affect the health of individuals include a local culture of drinking, availability of fresh fruit and vegetables, the local economy and the role of sport. Local health professionals need to know about the

community, its support networks and any planned healthy activities. They can identify patterns in health and be proactive in addressing health problems (eg recognising that drought may lead to high rates of depression). One of the benefits of rural practice is that health professionals can usually see the results of their efforts.

Access, equity and support for rural health professionals

Access to equitable health care continues to be one of the key issues in rural health; the practicalities involved in achieving this are the subject of debate. Discussions usually focus on distance to health services in rural areas, and the lack of services and health professionals; however, the situation is much more complex than this. Access issues also include the choice of services, the cost, the nature of the presenting health issue, the confidence in, and quality of, the health care provided, and the geographical, social, political and cultural isolation. The ways in which these issues affect consumers and health professionals differ, depending on the degree of isolation, the health service, the health issue and the consumer.

It is useful to consider the discussion of access by Penchansky and Thomas (1981), which included the five 'A's'.

Affordability of health care, which includes not only the cost of the health service but also the associated costs of travel, time off work and child care, which can be prohibitive. Many rural GPs do not provide bulk-billing, and costs of other services can be substantial.

Availability of health services, which includes the services available locally, and their staffing, waiting lists and hours of service. A major problem facing rural health is the shortage of medical, nursing and allied health practitioners across rural Australia (Hays 2002a, Larson 2002, AIHW 2005b).

Accessibility refers to how easily consumers can access the service. Given the lack of public transport in most rural areas, accessing a health service can involve substantial travel, particularly when specialist care in metropolitan areas is needed. When travel is required, social support is often affected.

Accommodation refers to how well the service accommodates the needs of consumers.

Acceptability is the degree to which consumers find the service acceptable. Services that are not culturally appropriate or acceptable to the consumer are usually not used by the consumer, despite need. This relates to cultural security, see page 37 and Chapter 10.

In the case study given above, Johno was limited to the type of services available to him, but the flexibility of the local rural health services and systems allowed them to respond to his individual needs. The informal after-hours access, coupled with good clinical skills, were crucial in preventing Johno's suicide.

Support for health professionals — overlapping roles and relationships

Patterns of interaction among residents of rural communities differ from those in urban communities. Because there are fewer residents in more isolated regions, most residents in a rural community know or know about other individuals (Wilkinson 1991, Bourke 2001b). This means that most patients and practitioners have relationships prior to and external to the health care consultation, resulting in a lack of anonymity and a blurring of boundaries (Bourke et al 2004). For a health practitioner, privacy is more difficult to maintain because receptionists, patients, nurses and doctors know each other outside the health care consultation. For example, sensitive issues (eg sexual health, HIV, mental illness) may be difficult to discuss with a consumer who is also a friend or neighbour, or consumers may not want to make an appointment about such issues if they know the receptionist well (Purtilo and Sorrell 1986, Doherty 2000, Ullrich et al 2002).

The lack of anonymity also means that information flows quickly and word of mouth is a very powerful medium. In the case study, Johno is clearly worried that a session with the school social worker will not be confidential. Confidentiality can be broken just by someone observing another patient in the waiting room, a medical file on a desk or by someone entering the office of a mental health professional. Rural residents may be stigmatised and socially excluded from every part of the community if some health conditions become known (eg mental illness, brain injury, pregnancy).

People often have multiple roles in rural communities (Scopelliti et al 2004). For example, it is difficult to separate the role of a GP from other community roles, such as being a Rotarian, a player in a sports team or a parent. Multiple roles can provide a health practitioner with additional information about a consumer (Hays 2002a, Scopelliti et al 2004), and although this can be useful, assumptions based on this knowledge may be problematic. Some rural health professionals enjoy this aspect of practice as they feel that they know their patients better (Hays 2002a) but others struggle with separating professional and personal boundaries. Some have developed innovative ways of separating their roles: for example, by informing the community that they are a health professional available for consultation when dressed professionally, but at other times they are another resident and health consultations are not appropriate.

In Johno's story, the team response and the liaison between different models of care (Indigenous health, hospital care and community care) provided Johno with medical and counselling support and a choice of practitioners, while providing effective care and efficient use of specific skills. Key to the team was the sharing of care, understanding and respect of each professional's role, and communication between team members and the consumer (McCallin 2001). Johno's case demonstrates the importance of confidentiality to rural consumers; he preferred a health professional not located at his school because he was concerned about people knowing his business and about town gossip. However, Johno's case also stresses the importance of relationships. His relationship with Shaun initiated intervention and Shaun's relationship with Mary was crucial in resolving Johno's suicidal ideation. Social relationships were crucial to the health outcome — saving Johno's life.

Competencies for rural health practice

1. Cultural security

Cultural awareness training (ie training that teaches about another culture) has been found to be relatively ineffective (WA DoH 2006); in part, because it focuses on other cultures rather than on our own and so reinforces difference. In consultations with clients, both the practitioner's and the patient's cultural positions are present — it is the interaction between these positions that is important as each interaction differs. To improve health services to Indigenous and other cultural groups, it is crucial to acknowledge the presence and diversity of culture. It is also important not to assume that all members of cultural groups and all practitioners are the same.

The term 'cultural security' has been developed and embraced by Indigenous Australians (AHMAC 2004, Henry 2005, WA DoH 2006).

Cultural security represents:

> A commitment that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Indigenous people. It is a recognition and appreciation of and response to the impact of cultural diversity on the use and provision of effective clinical care, public health and health systems administration. (WA DoH 2006)

Cultural security requires the marrying of cultural positions with science and technical knowledge.

Cultural security extends the health professional–consumer interaction to the entire health service to ensure that the type of service, the way it is delivered, and the environment it is delivered in are culturally secure. For example, the way people enter the service, the waiting areas and even the presentation of service information must be culturally appropriate.

Cultural security means:

- providing quality health care to all
- respecting and promoting self-esteem
- addressing language barriers
- respecting differences
- respecting the identities of clients, families and communities
- understanding what is valued in and what works in Indigenous health
- developing efficient and effective health care systems.

Cultural security is the responsibility of all health professionals to ensure that all consumers feel secure in their culture, identity and self when using, accessing and visiting the health service. Creating an environment that is inviting and nonjudgmental and where

clients and their family and friends feel comfortable and able to express their cultural traditions and identities can be achieved in a number of ways. For example, it may require translating information, allowing large groups of visitors, and having big print for older consumers. Because the health practitioner is usually in a position of power, it is their responsibility to act on a situation where a consumer is uncomfortable, intimidated or overwhelmed. This may be as simple as asking a patient how they feel about a procedure, if they want more time or information or asking about their cultural beliefs surrounding a procedure (Browne and Fiske 2001).

Cultural security is further discussed in Ways forward in Indigenous health (Chapter 10) and Cycles of settlement: generating responsive health services for refugees in rural Australia (Chapter 13).

The case study given in this chapter suggests that the Indigenous health service and its workers were able to provide a secure service for Johno that included confidentiality and trust in a health professional. Importantly, cultural security applies both to distinct cultural groups and to identity groups based on such differences as age, gender, medical condition and sexual orientation.

2. Rural clinical practice and health systems

Rural clinical practice means working in a health system that differs from those commonly found in urban areas. The system of health care is the way in which the health service is structured, organised and operates as a result of management, planning, funding, policies and staff. In rural areas, there is an increasing trend away from urban-designed models of health care, and a move towards innovative models that meet the needs of local communities and populations. For example, most small town hospitals are staffed by local GPs rather than salaried doctors, with fly-in/fly-out specialist care; this means that local GPs have both a community and hospital role, and that nurses and some allied health staff have a stronger role in clinical care and the operation of the hospital. In most rural health practices, there is greater attention to primary care, community health and prevention. Many rural models place significant decision making and ownership with the local community, where the community (rather than government funding) drives the model of care through boards, consumer groups and other forms of consultation and decision making. Some rural models of health care include:

- Aboriginal Community Controlled Health Organisations (ACCHOs)
- multipurpose services
- community or consumer designed/controlled services based on local needs and consultation
- GP-based hospitals
- fly-in/fly-out services
- rotating care where practitioners fly in for several days/weeks and then out for several days/weeks or who deliver care on a rotation basis to numerous remote communities

- rural-based practitioners who spend time in urban centres to develop specialist clinical skills
- eHealth, the use of computer, digital and interactive technologies for health care and support.

Practitioners' awareness of the local health system they are working in is crucial if they are to work effectively in their specific context. The expectation that a rural GP-based hospital will operate like a major metropolitan hospital will lead to ineffective practice and care for both the practitioner and the consumer. In order to evaluate the quality and effectiveness of a specific model of care, it is also important to understand how the care system meets the needs of the local community. For example, assumptions that care is poor because a particular service is not provided or does not equate to urban care may not be correct. However, this is often how rural services are assessed.

3. Interprofessional team practice

It has been shown that interprofessional team approaches can improve health outcomes through better planning and identification of problems, less duplication, and more innovative strategies (Gair and Hartery 2001, AMC 2002). In particular, primary health care teams can meet the needs of the community more effectively because they not only focus on treatment and prevention, but also provide better continuity of care (van Weel 1994). Effective team practice is often viewed as a positive feature of rural health practice because it can be developed more easily in smaller health care settings (ACRRM 2002). With large patient caseloads coupled to a low number of health services and providers, rural practitioners know other local practitioners and work together frequently. However, rural professionals usually cannot choose their referrals or other team members, but must work with whoever is available, whenever they are available. There is pressure for the local medical practitioners, nursing, allied health and consumer representatives to work together, as local options are limited. Another key factor is the permeability of organisational boundaries which support team practice.

Team practice does not fit a single template; rather it is best seen as incorporating an adaptable approach that can be modified by users to suit their unique rural health care setting (Hays 2002a). The composition of the team will depend on the degree of autonomy and range of practice skills desired, as well as on the location, patient profile and professional supports, all of which vary widely across rural settings. Working as part of a team and showing leadership as well as collaboration is vital for rural health professionals (Sturmberg et al 2001). This does not mean that interprofessional practice is inherently cohesive, collaborative and harmonious; tension between practitioners working in a team is common. Issues of power, knowledge, control, gender and status are important to team functioning (McCallin 2001).

Horizon scanning

Johno went on to finish Year 12 and then went to university with the support of his parents. He visits Shaun whenever he is home and considers Shaun 'a mate for life'. Shaun says he'll 'never leave his country'. He has found steady work as a cultural officer, has respect throughout his community and is planning on marrying his long-term girlfriend. About Johno, he says, 'not a bad bloke for a gubba!'

As demonstrated, rural practice can be challenging and complex but can have positive outcomes. More systematic research and evaluation of current and innovative models of rural health care is being done.

Much attention has recently been focused on the problems of rural health care, particularly access issues and workforce shortages, yet some practitioners have had a passionate commitment to rural communities for decades. Perhaps this is because practitioners can more easily observe the outcomes of their work, or because they have more personal and committed relationships with their patients and clients, or because they have the autonomy to develop flexible and workable solutions to rural challenges. Some practitioners have an easier connection with the community as a place of care.

Whatever the reason for their commitment, more empirical and theoretical research is needed to understand rural practitioners, rural practice and the quality of health care in rural areas. If such research focuses on the positive as well as the negative aspects of rural health, it is more likely to contribute to addressing some of the problems.

Key points

- Rural populations tend to have poorer health, including higher rates of morbidity and mortality, poorer health behaviours and shorter life expectancy (particularly Indigenous populations).
- Rural Australians have less access to health care and resources, and practitioners have fewer opportunities for training.
- Because rural Australians have less choice, it is vital that health services are culturally secure, so that all consumers feel safe in all aspects of their care.
- Because rural health professionals often have overlapping roles and relationships, extra care must be taken with privacy and confidentiality in the professional and personal domains.
- An interprofessional team approach to health care in rural practice is important, given high workloads, fewer service providers and the nature of primary care. It is also important to understand the health system in which a practitioner is working, as models vary across rural Australia.

As emphasised by the Australian College of Rural and Remote Medicine (ACRRM), rural practice is often generalist, holistic and unpredictable, with fewer services to rely on (ACRRM 2002). Good rural practitioners are:

- clinically competent and able to provide appropriate care
- culturally competent and informed about the context and people
- resourceful and able to seek innovative, appropriate, practical and flexible strategies
- able to create opportunities for improved health and wellbeing
- thoughtful, reflective and critical of their own practice
- skilled in needs assessment and problem solving
- informed of the rural health literature
- critically aware of the key concepts underpinning rural health.

In other words, it is an ability to develop health care solutions matched to the unique circumstances of each rural setting that is critical to successful rural health care practice (Bourke et al 2004). Johno's story demonstrates that the interaction of an awareness of suicide risk among young males, access to after-hours care, social relationships, confidentiality, cultural security and a team approach can lead to good clinical care and the prevention of suicide.

Rural practice has the potential to offer exciting, challenging and meaningful work if the local context and population is understood, access issues are addressed, an innovative model of health care is developed and the service is culturally secure for all members of the local population. Rural health care provides practitioners with the opportunity to be autonomous problem-solvers for a wide variety of health issues.

Recommended readings and resources

- Bourke L, Sheridan C, Russell U, Jones G, DeWitt D and Liaw S-T (2004). Developing a conceptual understanding of rural health practice. *Australian Journal of Rural Health* 1:181–186.

This paper outlines five concepts that are key to understanding rural health and engaging in rural practice: health differentials, access, confidentiality, cultural safety and team practice. It lays the foundation for this chapter and the teaching of rural health at The University of Melbourne Department of Rural Health. It highlights the need to understand the rural context in order to be an effective rural practitioner by demonstrating how local community, environment and social patterns impact on clinical practice.

- Hays R (2002a). *Practising Rural Medicine in Australia*, Eruditions Publishing, Melbourne.

Hays, a rural GP, outlines some of the key issues, challenges and rewards of being a rural GP and engaging in rural practice. The author's insights and experience identify a range of practical and useful approaches to rural practice. His experiences provide detailed examples of how the concepts discussed in this chapter manifest themselves in rural clinical care. Importantly, his approach also demonstrates many of the positive aspects of rural practice, rarely acknowledged elsewhere.

- Thomson N (ed) (2003). *The Health of Indigenous Australians*, Oxford University Press, Melbourne.

This book presents the most thorough discussion of the state of Indigenous health and sickness in Australia. It documents the high occurrence rates of specific conditions and the extent of the health needs of Indigenous Australians across the country. The book is a particularly useful reference for facts and figures about Indigenous health and a good introduction to some of its major issues.

- Wilkinson D and Blue I (eds) (2002). *The New Rural Health*, Oxford University Press, Melbourne.

This is the first book to identify rural health as a separate specialist field in Australia. It presents many of the major issues in rural health and is a compilation of many different perspectives within the interdisciplinary field of rural health. It contains discussions of key issues, and gives examples and evidence of some of the major needs in rural health across Australia, including rural population health, Indigenous health, access to care and workforce recruitment and retention.

- Smith JD (2007). *Australia's Rural and Remote Health, A Social Justice Perspective*, 2nd edition, Tertiary Press, Melbourne.

This book discusses rural health from a primary health care perspective, drawing on public health and related approaches. In this way, it connects the rural environment, population and social issues with health in rural Australia, and demonstrates why rural practice is not limited to the clinical. The book gives attention to Indigenous health, issues of access and equity, culture, workforce and rural health service delivery.

Learning activities

1. Identify three positive aspects of rural health practice and three challenges or difficulties of rural health practice. Which of these would you particularly like, and which would you find most difficult?
2. Talk to a rural or an Aboriginal or Torres Strait Islander health practitioner about their experiences of the differences between rural and urban practice.