Chapter 3
Diversity, culture and place

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Learning objectives

- Recognise and describe the diversity of cultures, social characteristics and physical environments of rural/remote Australia.
- Develop awareness of sociocultural factors in a rural health discourse, particularly in terms of social and cultural capital.
- Identify the implications of various sociocultural characteristics for rural practice.
- Describe relevant relationships between individual and collective/community health and wellbeing.

Introduction

Health and wellness are deeply connected to society, culture and community. Mental and physical health promotion and illness prevention, early disease detection and evidence-based care are important to individual and collective health. To live up to the challenging World Health Organization definition of health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 2006), we need to be aware of, and responsive to, social and cultural concerns. Social relationships and the support of others affect our health and wellbeing, through what can be termed our social capital resources (NRHA 2006). Where we live certainly matters, but so do a lot of other elements, including who we are as people (Pickett and Pearl 2001, Macintyre et al 2002).

The following case studies illustrate aspects of the social and cultural diversity of rural Australia, and the influence of social and cultural factors on rural health and wellbeing.

Case study 3.1 Diversity: challenges and benefits — a Vietnamese doctor's perspective of rural life

Dzung Thi Nguyen is a Vietnamese-born doctor, married with three children, working in a rural town in northwest Tasmania. Her journey of cultural adaptation has evoked a range of emotions since she arrived in Australia. Her name was the first problem. She had to change her name to 'Dzung' from 'Dung' to avoid embarrassment.

Dzung came to Tasmania with her parents as a refugee from Saigon, sponsored by her uncle, a well-established medical practitioner in Hobart. He was a key source of support and guidance, especially in the early days. Hobart has a small and close Vietnamese community, which plays an important role in maintaining Vietnamese language and culture. A church group helped the family integrate into the community. Dzung won a scholarship to a private school and then a place in medicine at university.

Her rural placement during her final year in a small town very different from Hobart was a cultural shock for Dzung. She missed city shopping and Asian foods. The shock was gradually dispelled by the fresh air, tranquillity and friendliness of the town. The local pharmacist introduced her to golf, a sport she enjoyed. The people were friendlier than in Saigon or Hobart. She started to feel at home.

After graduation, Dzung decides to work for a rural health clinic in northwest Tasmania and brings her parents along. She joins the golf club and several community service clubs where she meets other members of the small professional community. The Internet keeps her in touch with relatives, friends and other parts of the world.

Living in a rural town is not all smooth sailing. Her parents are very lonely and feel excluded from senior citizen activities. When her first child starts high school, it is hard to decide whether to enrol her in the local high school or send her to boarding school in the city. The small town offers her law graduate husband limited opportunities.

While Dzung is lucky to have her parents living with her, their cultural traditions sometimes interfere with Dzung's profession. The notion of privacy is treated differently in the two cultures. Her parents are keen to know their neighbours' health problems but Dzung refuses to share on professional grounds.

The family often travels to Hobart and occasionally overseas. To Dzung's amusement, it is quicker to fly from this small town to Melbourne than to travel between suburbs in a big city (DVC 2005).

It does not take Dzung long to get to know the local people. In the eyes of many in the community she is an enlightening multicultural discovery. She feels similarly about them. But living and working as a migrant doctor in this rural town also has its challenges. Dzung avoids eating at the local hotel because she would meet young drinkers who she knows are underage. She would feel obliged to report them, but doesn't want to compromise their trust. She knows that some people travel long distances to the next town to see a GP, which avoids any conflict between personal and professional for Dzung, but at the same time she feels a little hurt that they don't trust her professional confidentiality. However, this once strange rural land is now home.

Discussion

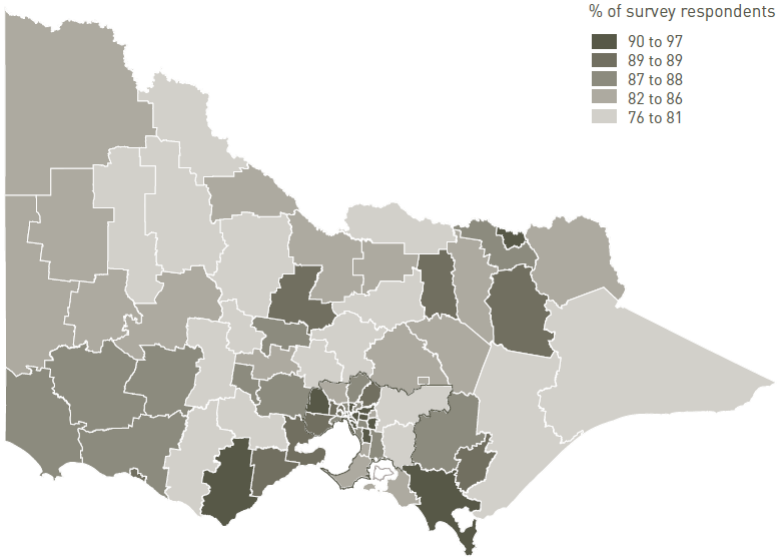
People use various cultural resources, such as language, forms of communication and shared values, in social interactions. Cultural capital (knowledge, culture and education credentials) can be used to exclude particular groups, while privileging others; cultural capital is related to power (Bourdieu 1983).

Social capital resources are networks or relationships, and norms and values that can be used in collective action for mutual benefit (Berkman and Glass 2000, Falk and Kilpatrick 2000). Social capital resources operate at multiple levels: families, groups within communities (such as ethnic minorities or professions) and whole communities. Communities can be either geographic, or what are known as 'communities of common interest'. The Australian rural health professional community is an example of a community of common interest. Effective community-level social capital is associated with high rates of volunteering and trust of individuals and institutions (Putnam 1993a). At the family and group level, social capital is associated with social connectedness and social support. At the individual level, social capital resources, generated at the family and group level, are associated with improved health and life satisfaction (NRHA 2006).

While it is common to interact with people of different ethnic backgrounds in Australian cities, it is rarer in rural areas, as Dzung found. The fact that big cities attract more people of ethnic backgrounds than regional areas does not mean that cultural diversity is not favoured by people living in regional areas. A recent report conducted by the Department for Victorian Communities (DVC 2005) indicates that the vast majority of regional residents in Victoria feel that multicultural factors improve the quality of life. Some communities are more favourably disposed to multiculturalism than others (see Figure 3.1).

Challenges for the learner and teacher

1. Identify the elements of social and cultural capital which supported Dzung as a migrant and as a new rural professional.
2. What were some advantages and disadvantages for Dzung as a migrant doctor working in this rural town? What were the advantages and disadvantages for the community?



Source: DSE (2005)

Figure 3.1 Percentage of residents who feel that multicultural activities make life in the region better

Case study 3.2 Healthy farm families

This case study is adapted from GRDC (2006).

Sustainable Farm Families is a program that works with farm families to improve their health. Dave and Dora are third-generation farmers in South Australia. They live with their three children on a property in the Murray Darling Basin and rely on irrigation for about half their income. Dave and Dora are concerned about rising salinity levels in their area and, like other members of their Farm Management 500 group, adopt environmentally sustainable farming practices wherever they are affordable. When an invitation came to members of their Farm Management 500 group to join the Sustainable Farm Families program, Dave was about to throw it out. But when Dora saw it, she was determined to go. 'They were keen on couples so I thought I should go too', Dave said.

The initial workshop started with benchmarking, that is, taking details of each of the 20 participants' general health, including fasting cholesterol and blood sugar levels, blood pressure, weight, height and body fat. Dora found she risked developing diabetes if she didn't make some changes. The program included a trip to the local supermarket and a close look at labels on various products. Dora said many participants were amazed how much sugar, fat and salt there was in so many of the things they fed their kids.

Other topics included safe work practices and mental health — how to recognise anxiety and other pointers to more significant health problems. Dave noted, 'With the drought biting hard and affecting our income, it's made me realise I need to be careful. Many of the blokes around here are at risk of depression'.

The two-day session ended with each couple preparing an action plan to improve their health, wellbeing and safety. 'We set out to reduce our fat intake and also purchased push bikes for rides with the kids', Dora said. 'Some couples started going on walks together or brought exercise equipment.'

A second session was held 12 months later and began by measuring members' weight, waist, fasting cholesterol, blood sugar and blood pressure and comparing the results to the previous year. 'My blood sugar levels had come down and Dave had lost quite a bit of weight, and some people had stopped smoking', Dora said.

Discussion

Farm families have a strong work ethic, a high level of injury and risk-taking behaviours, higher per capita levels of disease rates and morbidity, and varying levels of socioeconomic disadvantage (Todd 2004, Troeth 2004). Like many rural people, they have a special bond with the land. Wellbeing is also about the environment, the world or worlds that we are part of and live in. Understanding the impact of environmental change on wellbeing is a challenge for all of us as citizens and health professionals. Human wellbeing is increasingly being seen as, at least partially, dependent on the state of the physical environment. As the physical environment becomes degraded, there will be a negative impact on human wellbeing. Many environmentalists are committed to leading carbon-neutral lives by offsetting their use of cars, planes and heating by supporting tree planting. However, plantations can contribute to rural environmental pollution. For example, aerial spraying of plantation forests followed by heavy rain in the Break O'Day area on Tasmania's east coast was associated with degradation of the marine environment and consequent impact on oyster farms in the area; cancer rates in humans in the same area may have increased (Scammel and Bleaney 2004).

Challenges for the learner and teacher

1. Why has the Sustainable Farm Families program targeted couples and members of a farming group?
2. 'It's a stressful occupation because every decision you make is yours entirely, hence you and your dearest, it is totally your responsibility and nobody else's' (female farmer) (Judd et al 2006). How could the Sustainable Farm Families program help people avoid the mental health issues that may arise from this stress?

Case study 3.3 Transforming rural urgent care systems in Mallacoota

This case study is adapted from O'Meara et al (2004).

Rural health professionals and communities have often been concerned about the capacity of their emergency medical services to cope with unexpected health events (Turner et al 2000). When combined with the problems of geography, a paucity of basic health and emergency services presents a major challenge when responding to medical emergencies.

Mallacoota is a small, isolated coastal community with a longstanding concern about the adequacy of its emergency medical systems. It is 520 km east of Melbourne close to the New South Wales border. The population of just over 1000 people swells to between 3000 and 5000 during the holiday season. Many residents are retired professionals from the cities. There is a vibrant arts community.

Mallacoota's urgent care situation was transformed through a community engagement approach that culminated in government funding for a community paramedic model and improved ambulance service communications systems. The community shared their experience to assist other communities facing similar issues.

Mallacoota has no hospital. Its medical centre was staffed by two medical practitioners working on a rotational basis with 24 hour on-call responsibilities. Only four Ambulance Community Officers (volunteers, with limited training) operated locally, supplemented by full-time paramedics during the six-week peak tourist season. The nearest hospitals with fully staffed emergency departments are Bairnsdale, Victoria, 242 km away, and Bega, New South Wales, 144 km away (DHS 2001). The nearest critical care facilities are further away at Central Gippsland Health Service in Sale, Victoria, or Canberra Hospital. The Mallacoota aerodrome is an important part of emergency service management. Crucially, a night landing requires the groundsman to ensure that kangaroos are removed from the enclosed fenced area before the plane can land.

Early consultations with the community and providers revealed a gap between community expectations and the ability and willingness of health service providers to meet these expectations. The situation came to a crisis point when the medical practitioners indicated that they could leave the area if the situation remained unchanged.

The situation was changed when, at the request of the local division of general practice, the Victorian Department of Human Services provided funding for a Transforming Rural Urgent Care Systems (TrUCs) project (O'Meara et al 2004). TrUCs established a community steering committee to lead the project, employed project officers and a university facilitator, and developed links to the community, government, health institutions and health professionals.

Highlights of the policy development work at Mallacoota included:

- community consultation via local press, mail and a successful public meeting attended by 240 local residents to endorse the urgent care vision of the Steering Committee
- development of an emergency and critical care model for Mallacoota by the steering committee and project officers, with input from other stakeholders, and its presentation to the State Minister for Health.

The outcome was adoption and funding of a new ambulance paramedic model for Mallacoota that appears to meet the needs and expectations of the community. In order for full-time ambulance paramedics to provide training for volunteers, the role of ambulance paramedics was broadened to include responsibilities for community and volunteer development.

Discussion

The TrUCs project was a community development process that built community social capital. Social capital resources are used in collective efforts, such as negotiating better health services. These resources are social networks and shared norms and values relevant to the task at hand, in this case improving urgent care services. Trust and a willingness of community members to work for the collective good of the community are indicators of effective social capital.

Social cohesiveness is often associated with social capital; however, it must be accompanied by capable local leadership, appreciation of diversity and links to external networks and resources to produce successful collective efforts (Falk and Kilpatrick 2000). These external networks are sometimes called bridging ties, while ties within groups are known as bonding ties. Not all rural communities are like Mallacoota with strong 'bridging ties' to outside networks, and acceptance of diversity (NRHA 2006).

Crucial to the success of the Mallacoota project were the community consultation and decision-making processes that positively engaged community and developed, and confirmed a shared vision, or expectation, for emergency services. The availability of project officers as facilitators and researchers for the steering committee was also important: joint working requires dedicated time. One of the other major benefits of the process was an evident improvement in community cohesiveness. At least within the area of emergency medical services, the community demonstrated shared values, aspirations and goals. The program has seen a partnership formed among agencies, community groups and commercial enterprises. Community engagement in the political and policy processes forced government departments and service providers to accept a community-driven process, rather than acting out the rhetoric or apparently listening to the community while implementing centrally-driven policy initiatives (O'Meara et al 2004).

Challenges for the learner and teacher

1. Why were the local facilitators and the steering committee important to the process?
2. The nearest hospital with a fully-staffed emergency department is across the state border in New South Wales, and the nearest critical care hospital is, in yet another jurisdiction, in Canberra. What issues might this raise for the Mallacoota community in negotiating emergency care services?
3. Volunteers received training from paramedics in the new service model. The level of volunteering in a community is an accepted measure of social capital. Why?

4. Sometimes, active community leaders like the members of the steering committee experience burn out and withdraw. What succession plan for community engagement in emergency services can you suggest?

Key points

- Higher levels of social capital are associated with improved health, education and life satisfaction outcomes and reduced disadvantage.
- Strong bonding ties can support rural community members and increase social engagement and connectedness, contributing to wellbeing, but must be accompanied by an appreciation of diversity and attention to exclusionary impacts of cultural capital to ensure individuals and groups are not marginalised.
- Rural practitioners must take account of the rural context of the target group, including risk factors and social norms. For example, health promotion programs should consider work behaviours and stresses caused by environmental changes, and values of independence.
- Wellbeing is partially dependent on the state of the physical environment.
- Community cohesiveness and collaboration, accompanied by capable local leadership and links to external networks and resources may strengthen isolated rural communities' positions in the political and policy processes and so improve access to health services.

Recommended readings and resources

- Keleher H and Murphy B (2004). *Understanding Health: A Determinants Approach*, Oxford University Press, Melbourne.

A discussion of the concepts relating health to social and cultural factors.

- Berkman L and Glass T (2000). Social interaction, social networks, social support, and health. In: *Social Epidemiology*, Berkman L and Kawachi I (eds), Oxford University Press, Oxford.

This bulletin highlights different ways of defining social capital approaches that gained consensus among federal departments, and presents an analytical model for measuring the relationship between social capital and health in Canada.

- National Rural Health Alliance (NRHA) (2006). *Healthy Regions, Healthy People*, Position paper. http://nrha.ruralhealth.org.au/cms/uploads/publications/healthy%20regions%20healthy%20people.pdf

This paper addresses the changing health needs of regional populations for health services and opportunities for developing regional infrastructure and health related businesses.

- Berkman L and Glass T (2000). Social interaction, social networks, social support, and health. In: *Social Epidemiology*, Berkman L and Kawachi I (eds), Oxford University Press, Oxford.

This paper discuses the impact that different qualities or dimension of social relationships have on health by placing them in the larger context of social networks.

- Sabatini F. Social Capital Gateway website editorial, Social Capital Gateway, University of Rome, La Sapienza. http://www.socialcapitalgateway.org/index.htm

Excellent online resources for the study of social capital.

- MedlinePlus (2006). *Farm Health and Safety,* the US National Library of Medicine and the National Institutes of Health. http://www.nlm.nih.gov/medlineplus/farmhealthandsafety.html (Accessed 20 November 2006)

Useful online resources on farm health, which can include information about specific diseases and safety issues such as chemical use.

Learning activities

1. Identify some elements of cultural capital that may privilege or exclude newcomers to rural communities.
2. Why might appreciation of diversity vary from community to community? Apart from migrant ethnic groups, which other groups may experience adverse effects on wellbeing in communities that are less tolerant of sociocultural diversity?
3. Identify some health risks that farmers and their families are exposed to working and living on a farm. How might you go about influencing their behaviour to reduce these risks?
4. Australia regularly experiences drought. Many commentators say that water will become scarcer as a result of global warming. What health and wellbeing implications might this have for farmers and other rural residents?
5. Should external agencies like the state health departments and ambulance services be concerned about social capital and community capacity? Why or why not?