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Title: "You have to face your mistakes in the street: the contextual keys that shape health service access and health workers' experiences in rural areas.

Abstract: Introduction: Rural healthcare provision is limited in many areas because of workforce recruitment and retention issues. Pharmacists and social workers are examples of allied health professionals who play vital roles in the provision of rural health care. Personal factors including an individuals fit with a local community and their professional role were explored to determine the way they affect access to rural health care. Design: Accidental sampling then 11 qualitative interviews with pharmacists and social workers. Setting: Six rural communities with populations less than 5000, New South Wales, Australia. Methodology: Deductive and inductive analysis of data. Results: Exploration of health work in small rural towns identified that participants work and personal experiences are affected by their professional role and associated tasks, and by the way the community perceives that role. Social workers are likely to provide outreach or visiting services and use different professional networks than pharmacists. Social workers tend to perceive their clients problems as related to poverty and rural decline with limited options for successful intervention through the health system. Pharmacists are confident in their role as treatment providers and have a thorough knowledge of their own community, although they use a limited range of other local healthcare providers, tending to rely on doctors. Access to healthcare services is affected by organisational strategies to manage demand on services, privacy and confidentiality and the communitys perception of the effectiveness of the service and the individual worker. Local knowledge and local context shaped the services pharmacists and social workers provided, and the way they managed their personal and professional activities in a small community.

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'You have to face your mistakes in the street': The contextual keys that shape health service access and workforce retention in rural areas

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Abstract

Objective: Rural health care provision is limited in many areas because of workforce recruitment and retention issues. Pharmacists and social workers are examples of allied health professionals who play vital roles in the provision of rural health care. Personal factors including an individual's fit with a local community need to be identified to maintain rural health services.

Design: Accidental sampling then eleven qualitative interviews with pharmacists and social workers

Setting: Six rural communities with populations less than 5,000, New South Wales.

Methodology: Deductive and inductive analysis of data

Results: Social workers are likely to provide outreach or visiting services and use different professional networks than pharmacists do. Social workers tend to perceive their clients problems as related to poverty and rural decline with limited options for successful intervention through the health system. Pharmacists are confident in their role as treatment providers and have a thorough knowledge of their own community although they use a limited range of other local health care providers tending to rely on doctors. Access to health care services is affected by organisational strategies to manage demand on services, privacy and confidentiality and the community's perception of the effectiveness of the service and the individual worker. Local knowledge and local context shaped the services pharmacists and social workers provided and the way they managed their personal and professional activities in a small community.

Conclusion: Access to rural health services is affected by an individual's concerns about privacy and confidentiality, by the reputation of the health care worker, by the value system of the health worker, and their professional training, that ranks the importance of health problems and by the way the community perceives the usefulness or effectiveness of the particular type of health care. Different professions use different networks of health care subsequently approaching rural social conditions and their related problems from diverse perspectives. This influences the health worker's experience of effectiveness in their professional role and the way they manage their high degree of visibility in small communities.

Implications: The need for a systematic evaluation of health service access emphasising the particular aspects of local rural context is highlighted. This work should include investigation of multidisciplinary models of service provision that can address professional boundaries to optimise the range of health care available to small rural communities.

Facing your mistakes in the street: The contextual key shaping health service access and workforce retention in rural areas

Introduction

Worldwide, rural dwellers have poorer health and are likely to die earlier than urban dwellers. There are various reasons put forward for this including farm and road accidents, higher alcohol and tobacco consumption, lack of exercise, limited access to health services, poor quality and declining infrastructure including health services, education, transport and employment opportunities (1.2). All of these are features of, and contribute to, low socio economic status. However, many rural dwellers are more likely to extol the benefits of rural life than note the hardships reflected in official statistics (3). The idyllic notion of the bush remains. This promotes the 'tree-change' concept where jaded city dwellers long to escape to a more peaceful and fulfilling life in the bush.

Remaining one of the few 'worthy causes' in a neo-liberal funding agenda, that aims for minimal government commitment and individual responsibility, the health system commands considerable attention from community and government alike (2). However, recruitment and retention of health care workers are problematic for rural and remote health services. Health care providers and rural communities need to encourage people to make the tree-change to maintain or improve health care services. Most recruitment and retention campaigns are targeted at doctors and their effectiveness has not been evaluated. While health care professional development and workplace issues have been researched, the personal factors that drive people to or from rural/remote areas are less well known.

During 2006 a qualitative study investigating the rewards and barriers of rural health work for pharmacists and social workers found that allied health workers experience similar rewards and barriers in their work as GPs do (4). The study also found personal rewards and barriers to be an important factor in continuing to engage in rural health work. A key finding was that personal factors, including community connections and sense of belonging, are the mediating factors in managing a challenging work environment. The research identified several personal issues described by participants that affect health care delivery in rural areas. Following a brief overview of the project's methodology, this paper discusses the issues of local context and health care access and the way they

influence professional perceptions of privacy and safety. Avenues for future research are identified.

Methodology

Following approval from the Charles Sturt University Human Ethics Committee. (approval number 2006/123) interview participants were sought from the target group of pharmacists and social workers in central NSW.

A convenience sampling method, that is, a sample drawn from an available or convenient group that reflects the problem being investigated (5) was used to identify participants. They had to be working in a town withless than 5,000 residents. Potential social work participants were identified from a list supplied by the area health service social work advisor. Potential pharmacist participants in the towns with social workers were identified from the telephone directory.

Initial contact was made by telephone, the project explained and information and consent forms faxed or emailed to those willing to be interviewed. In July and August 2006 eleven in-depth semi structured interviews with five social workers and six pharmacists located in rural NSW were recorded and transcribed. During the interviews participants were asked to discuss their perception of rewards and barriers currently experienced in their professional, personal and social lives, the networks they used to deliver services and the way these needed to change to meet their community's future needs and what plans they had for the future.

The interview schedule contained three dimensions of rewards and barriers; personal, professional and social. Professional rewards and barriers were those which participants perceived as arising from their employment including; their professional role, duties and also the workplace. Personal rewards or barriers included any aspects of an individual's personal life; intimate relationships, family, health and hobbies for example. Social rewards and barriers were conceptualised as those relating to recreation activities, friends, and community involvement.

The planned sample size was 20 as a pilot project to inform the development of larger projects. However after 11 interviews the pilot sample was considered saturated. That is, further interviews were unlikely to add additional information to what had already been collected (6,7) This decision was made followinga a

workshopheld at a national allied health conference, the findings of which are reported at http://www.ruralhealth.org.au/conferences/sarrah2006/docs/program/workshop4.pdf (8). Thirty allied health workers, educators and policy makers participated in the workshop focus groups answering the same questions as the interview participants. Similar findings from the workshop participants confirmed those of the individual interviews.This enabled the researchers to conclude further data collection within this pilot project was not needed and established clear directions for future research (9).

Data analysis

A deductive analysis was used to examine whether the issues facing pharmacists and social workers were the same as those reported by medical practitioners. This analysis was shaped by the GP literature which had influenced the development of the interview schedule (appendix A). An inductive analysis was also employed to develop the conceptual framework emerging from the data reduction process (5).

The data analysis considered the fact that all of the participating social workers worked for the area health service and all the pharmacists in the community. Other rural practice contexts, such as pharmacists employed in hospitals, may support different work experiences.

Findings

Work roles and networks

Pharmacists and social workers are described as health care workers or allied health professionals although community pharmacists have been frequently omitted from lists of allied health professionals. A substantial part of the work of both professions is communicating with clients about their health problems and needs. However, the differences in work roles are highlighted in the language each profession uses to describe their work and the types of problems they deal with.

Pharmacists treat health problems that may be psychological such as depression but are more likely to be physical illnesses whereas social workers assess needs and provide support for problems that may have an impact on an individual's health but are more likely to be social or psychological than physical in origin. Subsequently pharmacists maintain networks with related treatment providers

such as doctors and social workers are more likely to work with mental health workers or social support providers.

Both professions had concerns about the networks of health care providers in their towns. For example:

> *I see the people whose problems are not serious enough for mental health. They have some anxiety or depression. Trouble is when things get bad and they get suicidal, Mental Health say sorry they're your client not ours.*(social worker)

The future of medical services in the small towns was a common concern for pharmacists. For example:

> *One of the doctors is retiring. The other one is younger but if no one else comes along and he decides to go to I won't have a business anymore.*

Pharmacists were more likely to have contact with GPs and nurses including community nurses in the course of their work and this reflects the treatment orientation of their role. For example;

> *We need doctors and doctors need us.*

A pharmacist, when asked if she had referred to other types of health workers when she was concerned about customers, was unsure what services were available locally:

> *I think a few different ones come out from* [town], *mental health, psychologists. I think we have a social worker here – that's how much I know about social workers.*

Social workers, while finding difficulties in some professional relationships, did not rely on any other single profession as pharmacists did. Pharmacists in this sample only worked in one small town and had generally been in the same location for years. This meant that pharmacists knew their local communities well. For example

> *I've known several generations of some families. It is not uncommon for me to go to funerals and know all the family and all their illnesses.*

The work context of pharmacists was described very differently to that of social workers. Rural social workers were likely to work in a number of small towns providing visiting or outreach services across a large area. For example:

> *I work here three days most weeks and two days at [town]. I also visit [town] once every couple of weeks depending on referrals.*

> *I work between seven small towns.*

Access to health services

Pharmacies in small towns are easily accessible to most community members and provide a free frontline assessment and referral site for health problems. A pharmacist reflecting on issues faced by the local community indicated that the existence of health services does not mean people access them:

> *But I must say, I don't see people who go untreated. When I see them they might be depressed but they're getting treatment for it. The ones who are missing out aren't coming to me or anyone else.*

Access to health services is affected by referral categories and organisational strategies to manage demand on services. For example:

> *Mental Health, the service, is the biggest problem but they're thin on the ground and they have, they appear to have, a knack of 'That's not our area.' You can limit the categories, you can assess a person out of Mental Health* [services]. (Social worker)

Several pharmacists noted however that some community members would prefer to travel to obtain their medication to maintain their privacy. For example:

> *People like to keep their trouble to themselves. I know they'll go to* [town] *to fill their antidepressant prescriptions so they're not known.*

Privacy is a significant issue for rural dwellers, including health workers, who may meet each other socially as well as professionally. For example:

I go to the doctor myself out of town. I'm not going down to the doctor, the two male doctors in town for a pap smear. I talk to them on the phone, you know, every day, and I trust, I trust both the doctors but that sort of stuff. I'll stick to my girl doctor in [nearby town]. (Pharmacist)

The issue of health service access is more complicated than health service provision. For health problems that may be stigmatised in the general community, privacy and confidentiality are central to issues of access.

Health workers may be ostracised in small communities or perceive themselves to be. Several participants commented about their visibility as frontline health workers noting personal experiences and local gossip as factors in people accessing their services. For example;

'You have to face your mistakes in the street. That's the hardest thing and the main difference between rural and city work.' (Pharmacist)

'They have long memories 'round here. If you've got someone offside, a colleague or a client, the story about you will stick around, doesn't matter if it's true or not.' (Social worker)

Appropriateness or effectiveness is also an issue of access. Social workers frequently described their clients as having significant problems that were unable to be resolved through access to the health system. For example:

Sometimes, actually a lot of the time, the things that would really help; a job or education, we can't do that and there's no prospect of doing that in this town. (social worker)

Social workers in this sample frequently described their clients as having problems that could not be addressed by counselling or support via the health service whereas pharmacist participants expressed confidence in their role and health care they provided.

Local Context

Social workers in this sample had a broad experience of rural work because they had had several jobs in several locations over the course of their careers that

ranged from three to twenty five years long. Social workers discussed the characteristics of different areas noting local issues and atmospheres, describing some places as better to work than others. They described rural towns as having distinct personalities related to the town's particular characteristics with some towns easier to fit in to than others. For example:

> 'When I was at [town] *you had to live in a certain area, even along a certain road to be known to have fertile land to fit in. I was married to a shearer and that meant fitting in to a certain clique. Here it's different, there's more professional people, more tourism, it hasn't got the heaviness and remoteness and oppression of unemployment that some other towns have'* (social worker).

> P: [town] *was difficult, it's fairly idiosyncratic. You've got to be pretty comfortable to live in a mining town.*
> I: *What do you mean pretty comfortable?*
> P: *There's a lot of red necked people there. I mean, they can be nice but the outlook is, can be, limited. You can have a great social life so long as you like drinking. Other towns can have more groups, more enterprises, they're just different.* (Social worker)

Discussion of local communities and the context of health work led to descriptions of the personal impacts of rural work. Participants described the way their values and beliefs directed their interactions with people, including the services provided, and the way they managed the lack of separation between personal and professional roles in small rural communities.

Impact of personal and professional values on service provision
The types of services a pharmacist provides can depend on the way the pharmacist views their role and the needs of their community. During an interview a pharmacist stated '*I don't do methadone'.* This was her first community pharmacy position (as owner) after a long career in other pharmacy settings. She was advised not supply methadone by the previous business owner because it wasn't 'worth the trouble':

> *He said they* [people using methadone] *know where you live. You're too visible and you might put your family at risk when people come looking for*

> *drugs. I've had some one come to my house when the shop was closed so I thought that was good advice.*

As a result of this response, subsequent pharmacy interviewees were asked if supplying methadone was an issue for them. Whilst two pharmacists did supply methadone and had no problem with it, others believed it exposed them and their staff to an unidentified risk and was a responsibility of other service providers. For example:

> *We don't need to do that here. I want to feel safe and I want my staff to feel safe.*

Social workers also expressed concerns about their own and their family's safety because of contact with violent or criminal clients. However they were more likely to change their personal activities than their professional ones to manage any concerns. For example:

> *I avoid certain shops because I've made DOCs* [child protection agency] *reports about people who work there.*

Social workers described it as consistent with their role to provide services for a wide range of social and emotional problems including drug use and described it as part of rural social work practice to *'take whoever comes through the door'*. Pharmacists also described their role as dealing with what ever the presenting needs of their community were. What happens after a client presents differs according to the professional assessment of what services are required. For disadvantaged community members with social and emotional problems the intervention pathways could be quite different.

Discussion

The investigation into participants' experiences as rural health workers highlighted; social disadvantage, access to care, local context and individual personal and professional issues as factors that impact on health care service provision. A disease focussed model of health care is the province of doctors and statisticians. It tends to focus on particular health problems rather than incorporating the varied social factors that contribute to a population's health status and the needs of particular groups or local areas (3).

Limited access to health services is consistently raised as a factor that impedes the health status of rural people. Access to health care however is not only determined by the care existing. It needs to be understood within the personal dimension. Some clients feel stigmatised, hopeless or helpless. Health workers also need to be recognised as health service users and potentially personally stigmatised, hopeless or helpless when confronted by needing care. Health education needs to consider the way concepts of professional boundaries, professional identity and duties and personal needs are portrayed. For some pharmacists providing methadone was a personal decision based on their own values and view of drug users as risks to their personal safety. For potential methadone users in some communities this decision makes an enormous difference to their health care options.

Access to rural health services is affected by an individual's concerns about privacy and confidentiality, by the reputation of the health care worker, by the value system of the health worker, and their professional training, that ranks the importance of health problems and by the way the community perceives the usefulness or effectiveness of the particular type of health care.

Social workers in this sample primarily engaged in counselling, but were unable to address the contextual and structural problems they identified their clients as experiencing. Social workers within the health system can perceive their clients problems like depression, as stemming from social issues of poverty and unemployment rather than individual pathology. The dominant discourse of neo-liberalism however, supports assessments of individual pathology and individual case approaches leaving structural problems such as crumbling infrastructure unaddressed (10). Social workers bear the burden.

The poor health status that funds health care workers and brings community members to health centres is as likely to be caused by poverty and disadvantage including drought and its effects, as individual pathology. The neo-liberal agenda however promotes the use of counselling services with many people expecting their diverse problems including poor socio-economic status will be improved by individual counselling.

Pharmacists may recognise problems of disadvantage but professionally perceive less responsibility for dealing with it. They also have the confidence of knowing

that an antidepressant may at least improve the patient's mood, even if the underlying problems are unaffected. The social work profession's problems with bureaucratisation of human services is strongly contrasted with pharmacy's confidence in its professional role and duties.

Regardless of where the responsibility for disadvantage falls, local context plays an important part in health workers' experiences personally and professionally. Local conditions vary from town to town. For example some towns will be more devastated by drought than others. A number of comments were made about personalities of individual towns. Some descriptions included 'idiosyncratic', 'oppressive', 'professional' and 'good'. This indicates that some places are more desirable to work than others and local context plays a part in developing community capacity and in the experiences health workers have in the workplace.

Conclusion

Health workers taking up the tree-change option should be aware that many aspects of social life are going to be magnified in small communities. Their professional and private lives will be visible. The approach of their professional discipline to interventions with disadvantaged groups, their connection with a particular town or area and their own personal values about individual responsibility and the neo liberal policy agenda will shape their ability to become a part of the community.

Implications

The need for a systematic evaluation of health service access emphasising the particular aspects of local rural context is highlighted. This work should include investigation of multidisciplinary models of service provision that can address professional boundaries to optimise the range of health care available to small rural communities.

Reference List

1. Alston, M. From local to global: making social policy more effective for rural community capacity building. *Australian Social Work*, 55: 214-226.
2. Alston, M and Kent, J. Generation X-pendable: young, rural and looking for work. 2001. Wagga Wagga, Centre for Rural Social Research.
3. Alston M, Allan, J., Dietsch, E *et al.* Brutal neglect:Australian Rural women's access to health services. *Rural and Remote Health*, 6.
4. Allan, J, Ball, P, Crockett, J, Alston, M, and Whittenbury, K. It's all part of the package in rural allied health work: A pilot study of rewards and barriers in rural pharmacy and social work. Report of research project: Centre for rural social research Charles Sturt university, 2007.

5. Alston, M and Bowles, W. Research for Social Workers *(2nd Ed).* Sydney, Allen & Unwin. 2003.
6. Strauss A. *Qualitative analysis for social scientists.* Melbourne., Cambridge University Press. 1990.
7. Robson C. *Real world research*. Malden, Blackwell Publishing. 2002.
8. Allan J, Whittenbury K, and Crockett J. Why do you stay: A workshop investigating rural health work. *Building Bridges, Crossing Borders: National SARRAH Conference.* Available from http://www.ruralhealth.org.au/conferences/sarrah2006/docs/program/workshop4.pdf .
9. Sarantakos S. *Social Research.* 2nd edn. , Melbourne., Macmillan. 1998.
10. Allan, J. Whose job is poverty? The problems of therapeutic intervention with children who are sexually violent. *Child Abuse Review* , 15: 55-70.